Meeting of the Board
6 December 2017

Venue: Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

CMDHB Board Members
Dr Lester Levy - Chair
Dr Lyn Murphy – CMDHB Board Member
Apulu Reece Autagavaia – CMDHB Board Member
Dr Ashraf Choudhary – CMDHB Board Member
Catherine Abel-Pattinson – CMDHB Board Member
Colleen Brown – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
George Ngatai – CMDHB Board Member
Katrina Bungard – CMDHB Board Member
Mark Darrow – CMDHB Board Member
Rabin Rabindran – Deputy Chair

CMDHB Management
Gloria Johnson – acting Chief Executive
Margaret White – Chief Financial Officer
Vanessa Thornton – acting CMO
Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Dinah Nicholas – acting Secretariat

Apologies

Register of Interests
• Does any member have an interest they have not previously disclosed?
• Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

Agenda

Part 1 – Items to be considered in public meeting

9.45am 1. Agenda Order and Timing

Board Minutes
9.45am 1.1 Confirmation of Minutes of the Meeting of the Board – 25 October 2017
9.50am 1.2 Actions arising from previous minutes/Immunisation Report
10.00am 1.3 Minutes Community and Public Health Advisory Committee – 18 October 2017
10.05am 1.4 Minutes Hospital Advisory Committee – 4 October 2017
10.10am 1.5 Minutes Disability Support Advisory Committee – 16 August 2017
10.15am 1.6 Executive Committee Establishment (Lester Levy)

Executive Reports
10.20am 1.7 Chief Executive Officer’s Report (including Patient Story) (Gloria Johnson)
10.30am 1.8 Health and Safety Performance Report/Executive H&S Minutes 24.10.17
10.40am 1.9 Communications Report (Janet Haley)

Morning Tea Break (10.45 – 10.55am)

Decision Items
10.55am 4.1 IRD Executive Officer Holder Nomination (Margaret White)
11.05am 4.2 Environmental Regeneration at CM Health (Pauline Hanna)
11.15am 4.3 Quality Accounts (Jo Rankine/Jenny Parr)

Performance Report
11.25am 1.10 Finance and Corporate Business Report (Margaret White)
11.35am 1.11 System Level Measures Performance Scorecard (Benedict Hefford)

11.45am Resolution to Exclude the Public

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## Board Member Attendance Schedule 2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>15 Feb</th>
<th>29 Mar</th>
<th>10 May</th>
<th>21 June</th>
<th>2 Aug</th>
<th>13 Sept</th>
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<td>George Ngatai</td>
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<td>Dr Ashraf Choudhary</td>
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* Attended part meeting only
**BOARD MEMBERS’ DISCLOSURE OF INTERESTS**  
6 December 2017

*New items in red italics*

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
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</table>
| Dr Lester Levy, Chairman | • Chairman, Waitemata District Health Board (includes Trustee Well Foundation, ex-officio member).  
• Chairman, Auckland District Health Board  
• Chairman, Auckland Transport  
• Chairman, Health Research Council  
• Chairman, Regional Governance Group, Northern DHBs  
• Independent Chairman, Tonkin & Taylor  
• Adjunct Professor of Leadership, University of Auckland Business School  
• Lead Reviewer, State Services Commission, Performance Improvement Framework  
• Director & Sole Shareholder, Brilliant Solutions Ltd  
• Director & Shareholder – Mentum Ltd  
• Director & Shareholder – LLC Ltd  
• Trustee, Levy Family Trust  
• Trustee, Brilliant Street Trust |
| Rabin Rabindran, Deputy Chair | • Chairman, Bank of India (NZ) Ltd  
• Director, Auckland Transport  
• Director, Solid Energy NZ Ltd  
• Director, Swift Energy NZ Ltd  
• Director, Swift Energy NZ Holdings Ltd  
• Director, Kowhai Operating Ltd  
• Director, NZ Liaoning International Investment & Development Co Ltd  
• **Director, New Zealand Health Partnerships**  
• Singapore Chapter Chairman – ASEAN New Zealand Business Council |
| 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  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group |
<table>
<thead>
<tr>
<th>Name</th>
<th>Positions and Roles</th>
</tr>
</thead>
</table>
| Dr Lyn Murphy                 | • District Representative, Neighbourhood Support NZ Board  
|                               | • 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)  
|                               | • Senior Lecturer, AUT University School of Interprofessional Health Studies  
|                               | • Member, Public Health Association of New Zealand  |
| Dianne Glenn                  | • Member, NZ Institute of Directors  
|                               | • 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.  
|                               | • Member, 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                 | • Director, Transitioning Out Aotearoa  
|                               | • Director, The Whanau Ora Community Clinic  
|                               | • Chair, Safer Aotearoa Family Violence Prevention Network  
|                               | • Huakina Development Trust (Partnership Clinic)  
|                               | • Community Organisation Grants Scheme (Auckland)  
|                               | • Lotteries Community (Auckland)  
|                               | • Board Member, Counties Manukau Rugby League Zone  |
| Reece Autagavaia              | • Member, Pacific Lawyers’ Association  
|                               | • Member, Labour Party  
|                               | • Member, Tangata o le Moana Steering Group  
|                               | • Trustee, Epiphany Pacific Trust  
|                               | • Trustee, The Good The Bad Trust  
|                               | • Member, Otara-Papatoetoe Local Board  
|                               | • Member, District Licensing Committee of Auckland Council  |
| Catherine Abel-Pattinson       | • Board Member, Health Promotion Agency  
|                               | • National Party Policy Committee Northern Region  
|                               | • Member, NZNO  
|                               | • Member, Directors Institute  
|                               | • Husband (John Abel-Pattinson), Director, Blackstone Group Ltd  |
| Mark Darrow | • Chairman, Primary Industry Training Organisation Incorporated (ITO)  
• Chair, Remuneration Committee, Primary ITO  
• Ex officio, Finance and Audit Committee, Primary ITO  
• Independent Director, Motor Trade Association  
• Chair, Investment Committee, Motor Trade Association  
• Director, New Zealand Transport Agency (NZTA)  
• Chair, Finance and Audit Committee, NZTA  
• Independent Director, Balle Bros Group  
• Chair, Finance and Audit Committee, Balle Bros Group  
• Member, Investment Committee, Balle Bros Group  
• Chairman, Advisory Board, Courier Solutions Ltd  
• Chairman, The Lines Company Ltd  
• Chair, Remuneration Committee, The Lines Company Ltd  
• Chairman, Armstrong Motor Group (Advisory Board)  
• Director, MCD Capital Ltd  
• Chairman, Signum Holdings Ltd  
• Chairman, Toloda Properties Ltd  
• Trustee, Tudor Park Trust  
• Director, Tudor Park Farm Ltd  
• Justice of the Peace |
| Dr Ashraf Choudhary | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Katrina Bungard | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed disability sports  
• Member of NZ National Party |
<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>
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</thead>
<tbody>
<tr>
<td>Rabin Rabindran</td>
<td>BNZ Bank Transitioning</td>
<td>Rabin Rabindran declared a specific interest as Director of New Zealand Health Partnerships.</td>
<td>25 October 2017</td>
<td>That Rabin Rabindran’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>Apulu Reece Autagavaia</td>
<td>Transform Manukau Puhunui Stage 1</td>
<td>Apulu Reece Autagavaia declared a specific interest, being a Member of the Otara-Papatoetoe Local Board.</td>
<td>25 October 2017</td>
<td>That Apulu Reece Autagavaia’s specific interest be noted.</td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td>Transform Manukau Puhunui Stage 1</td>
<td>Mrs Glenn declared a specific interest, being the President of Friends of Auckland Botanic Gardens and Chair of the Friends Trust.</td>
<td>25 October 2017</td>
<td>That Mrs Glenn’s specific interest be noted but not seen as a conflict of interest.</td>
</tr>
<tr>
<td>Lester Levy</td>
<td>WAI Auckland Business Case</td>
<td>Dr Levy declared a specific interest in requesting ARPHS to coordinate a process to determine a significant project(s) to be funded and implemented through the leadership of his shared chairmanship across the three Auckland DHBs and Auckland Transport.</td>
<td>2 August 2017</td>
<td>That Dr Levy’s specific interest be noted.</td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td>CE Report – Alcohol Screening/Community Liquor Outlets</td>
<td>Mrs Glenn declared a specific interest, being a Member of the District Licensing Committee of Auckland Council.</td>
<td>21 June 2017</td>
<td>That Mrs Glenn’s specific interest be noted.</td>
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<tr>
<td>Name</td>
<td>Item</td>
<td>Statement</td>
<td>Date</td>
<td>Decision</td>
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<tr>
<td>Reece Autagavaia</td>
<td>RMO Industrial Action</td>
<td>Mr Autagavaia declared a specific interest in relation to this item, in that his brother is a Junior Doctor at Middlemore Hospital.</td>
<td>15 February 2017</td>
<td>That Mr Autagavaia’s specific interest be noted.</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 likely 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>
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</table>
Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 25 October 2017

Held at Counties Manukau DHB, Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:
Lester Levy (Board Chair)
Rabin Rabindran
Colleen Brown
Catherine Abel-Pattinson
Dianne Glenn
Lyn Murphy
Mark Darrow
George Ngatai
Katrina Bungard
Reece Autagavaia

ALSO PRESENT:
Gloria Johnson (acting Chief Executive)
Margaret White (Chief Financial Officer)
Jenny Parr (Director Patient Care, Chief Nurse & Allied Health Professions Officer)
Vanessa Thornton (acting Chief Medical Officer)
Dinah Nicholas (acting Board Secretary)

PUBLIC AND MEDIA REPRESENTATIVES:
Elizabeth Jeffs, Director Human Resources
Sue Claridge, Auckland Women’s Health Council
Dr Colin Thompson, CM Health

APOLOGIES:
Ashraf Choudhary
Lyn Murphy (for early departure)

WELCOME
The Chair welcomed those present.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
Dianne Glenn - amend to Member of the National Council of Women of NZ.

Colleen Brown – delete Chair of the IIMuch Trust; add Regional Representative on the Neighbourhood Support NZ Board.
AGENDA ORDER AND TIMING
Items were taken in the same order as listed on the Agenda.

BOARD MINUTES
2.1 Minutes of the Meeting of the Board – 13 September 2017

Rabin Rabindran requested a change to Item 4.1 as follows:

Approval of Granting Agency in favour of healthAlliance (FPSC) Limited (Margaret White)
The Acting Chair advised that as he is a Board Member of New Zealand Health Partnerships Limited and Deputy Chair of the NOS Assurance Committee, it may not be prudent for him to Chair this item and he requested Mark Darrow to do so.

Resolution (Moved: Dianne Glenn/Seconded: George Ngatai)

That the Minutes of the Board Meeting held on the 13 September 2017 be approved.

Carried

2.2 Actions Arising from Previous Meetings
Noted.

2.3 Draft Minutes of Community Public Health & Advisory Committee (6 September 2017)

Mumps – Gloria Johnson confirmed that the suggested link between MMR and autism has now been thoroughly disproved by the scientific community. Immunisation coverage is high in Counties Manukau (94% at 2 years and 92% at 5 years) with declines at 2 years sitting at only 2.4% suggesting, reassuringly, that concern about the spurious link between MMR and autism is not a major issue for our population.

Owning my Gout – this was a very interesting presentation and led to a discussion around nurse-led interventions and where the DHB sees itself in relation to nursing interventions with primary care in the next 5-10 years.

Mana Kidz – the CPHAC Committee was deeply concerned to hear about the rise in Rheumatic Fever rates, particularly in schools the DHB is not in. Mr Hefford is advocating with the MoH to increase funding.

3 EXECUTIVE REPORTS
3.1 Chief Executive’s Report
Jenny Parr played a video entitled Andrew’s Story to the Board. These patient stories will start to be played at other committee meetings/groups to get these stories out and heard.

The report was taken as read and the acting Chief Executive summarised the following key areas:
**Staff Engagement** – very impressed with the level of staff engagement at the recent Staff Forum (26 September). A number of very interesting and constructive questions from staff were received from the floor and in follow-up emails. A special staff forum on the organisation’s financial position is to be held in early November.

**Voluntary Cessation Programme** – the Executive Leadership Team agreed (24 October) not to proceed with the VCP programme given the level of concern received from the unions and some staff. This decision will of course affect the organisation’s savings programme for the current year however, ELT will be looking at alternative ways of approaching that. A communication is to be sent out to all staff and the unions today confirming this decision. Management will continue to engage with the unions about how they can assist in relation to the financial pressures the organisation is facing.

**Deep Dive on Maaori Infant Mortality** – Counties Manukau rates remain higher than it is on average for the rest of the country, which is partly due to the interaction between ethnicity and socioeconomic deprivation. Infant mortality includes deaths up to 12 months of age but most deaths are where there are clearly disparities in the neonatal period. Critical areas of focus remain obesity, smoking in pregnant women and continuing to improve engagement of Maaori and Pacific women in antenatal care - all big issues in the Counties Manukau community.

Comments from the Board included:
- Is there any information that links the level of antenatal care with infant mortality.
- Is there any data that shows Maaori providers are doing a better job than mainstream providers.
- How do we assure ourselves that as a system, as a sub-system and at a clinical level, different parts of our population are getting the same service.
- The mortality trend is also going up for Pacifica, how do you choose who to focus on.
- There are also issues for the Asian population, particularly Indian.

The Board requested a deep dive on ante-natal care to cover the DHB’s approach for different population groups, progress made/not made and what evidence there is or isn’t to links to better outcomes.

**Fetal Alcohol Syndrome** – it was noted that the MoH funded Disability Support Service funding does not recognise FASD outside the context of another development, intellectual or Autistic Spectrum Disorder diagnosis. This is particularly important as the speech language therapy and psychology resource needed to diagnose FASD is currently funded through this mechanism at CM Health.

Colleen Brown agreed to discuss this at the next regional DiSAC meeting. There is an opportunity here to engage with the MoH and the Commissioner of Children as they have areas of advocacy they are working on with Government – need a mind shift and a funding shift. This is something that the DHBs should be able to make a big difference in within the next three years.

Colleen Brown asked for some information to be forwarded to her on how information is given to parents so they can make an informed decision about terminating a pregnancy due to identification of a congenital abnormality.
3.2 **Health and Safety Report (Elizabeth Jeffs)**
The report was taken as read.

Board comments included:
- Attendance at Health & Safety Orientation target should be 100% as opposed to 90% - it is extremely important that everyone receives this either formally or informally prior to entering the workplace.
- What is the organisation’s policy in relation to community workers going out into people’s homes.

The Board asked for a report and timeline on the work being undertaken in relation to safety and training of the Community Health Workers.

The Board requested an update on the Community Support Worker who died in a car accident on 31/10/2016.

**Resolution** (Moved: Lester Levy/Seconded: Mark Darrow)

That the Board:
Receive the Health and Safety Report for the period ending 31 August 2017.

*Carried*

3.3 **Corporate Affairs and Communications Report (Janet Haley)**
The report was taken as read.

Janet Haley summarised the report noting:
- This year the DHB has celebrated over 10 languages which reflects the amazing diversity at CM Health, with Tongan Language Week being the most recently celebrated. The video, featuring our staff, reached over 28,000 people on Facebook, over 10,000 views, 104 shares and 34 comments.
- Seen increased media engagement in relation to Ronald McDonald House, both NZ Herald, radio and via social media. The team are taking a ‘watching’ but not actively ‘reacting’ approach.

**Resolution** (Moved: Colleen Brown/Seconded: Dianne Glenn)

That the Board:
Receive the Corporate Affairs and Communication Report for the period ending 31 August 2017.

*Carried*
4 DECISION ITEMS
4.1 CM Health Hospices – Contract Approval and Palliative Care Update (Louise McCarthy)

CM Health contracts with Totara Hospice South Auckland and Franklin Hospice, the two hospices operating in our district, for palliative care services. CM Health has been in discussion with both hospices regarding moving from annual to multiyear contracts to provide the hospices with continuity and stability and to align with the multiyear contracts that Waitemata DHB have with the hospices in their districts. CM Health has made a commitment to Totara and Franklin hospices to introduce a five year contract (3 years plus 2 years right of renewal) from 1 July 2018. Auckland DHB is going through a service design change and aims to have a 5 year contract in place next year with Mercy Hospice.

The paper presented today sought approval in principle to this approach while work is undertaken with the hospices during this financial year to review and redesign the service specifications to align with the model of care arising from the local review of palliative care services and with the regional Palliative Outcomes Initiatives (POI) services.

Board comments:
- Concern was raised that a contribution to cost pressure will be built into the contract from 1 July 2018. It was confirmed that this was not the intention. However, it will be important that the contract is very clear that there is not a commitment to an annual uplift and that we would provide in the contract some kind of clarity about when we would let them know if there was and the size of it and that we could only do that once we had confirmation of our funding envelope.
- Table 1 shows a number of people received Totara Hospice services who were domiciled outside the Counties Manukau area. The Board requested reassurance that these people were entitled to New Zealand funding and an understanding of how many people from Counties Manukau are being managed by hospices elsewhere in the country.

The Chair requested a reconciliation of all of the increases and all of the uptake of demographic uplift so that every time the Board considers something, it can understand what is really being given away. This would inform the ongoing Recovery Plan and our approach to deciding what will be reinvested/disinvested in.

Resolution (Moved: Colleen Brown/Seconded: Catherine Abel-Pattinson)

That the Board:

Endorsed the contract price of $5,422,618.83 for palliative care services with Totara Hospice for the 2017-18 year.

Noted that Waitemata DHB has five year contracts in place for palliative care services with the hospices in the Waitemata district. Auckland DHB aims to transition to a five year contract with the hospice operating in the Auckland district from July 2018.

Approved in principle, development of a five year contract (3 years plus right of renewal for 2 years) for local palliative care services with Totara Hospice and Franklin Hospice, with the aim of
implementing the contracts from 1 July 2018. The proposed contract will be brought back to the Executive Leadership Team, Audit Risk and Finance and Board for approval early in the 2018 calendar year.

Carried

(Sue Claridge departed at 11.35am)

4.2 **BNZ Bank Transitioning (Margaret White)**

Rabin Rabindran declared a specific interest in relation to this item as Director of New Zealand Health Partnerships (NZHP). This was recorded on the Specific Interest Register accordingly.

CM Health will transition to BNZ with the other northern region DHBs and healthAlliance in November 2017. Transition scoping work is underway for the northern region, working with BNZ, with an expectation for the BNZ sweep account to be in place from 13 November 2017. To mitigate transition risk, NZHP have recommended that we keep our Westpac Sweep account running to around 20 November 2017.

Transitioning to BNZ will enable the sector to generate savings of up to $7.3m over the term of the BNZ contract.

**Resolution** (Moved: George Ngatai/Seconded: Catherine Abel-Pattinson)

It is recommended that the Board:

**Noted** that all DHBs have approved BNZ as the new supplier of Shared Commercial Banking Services for the DHB sector effective from June 2017.

**Noted** that NZHP signed the BNZ Transaction Banking Services contract on 8 August 2017 making BNZ the sector’s new transactional banking services provider.

**Approved** the opening of necessary bank accounts with BNZ to transition from Westpac.

**Approved** the authorisation of the CFO and Acting CEO to execute the necessary documents to enable the opening of the BNZ bank accounts, executing the Banking Services Order in relation to the BNZ Transaction Banking Services agreement and executing the Treasury Services agreement with New Zealand Health Partnerships (NZHP).

**Approved** the positions listed in Schedules 1 and 2 as the full list of all Counties Manukau DHB Authorised Banking Signatories to replace all previously approved lists.

**Approved** the Board Chair and Board Deputy Chair:

a) sign the updated Banking signatories Schedules 1 and 2;

b) sign any forms specific to Banks required to effect Board authorised signatories;

c) sign future Schedules 1 and 2 only where there is no change in the Board approved positions but there are staff changes.

Carried
5 DEMONSTRATION

5.1 E-Vitals Demonstration (Stuart Barnard, Sally Dennis, Helen Bretherton and Brian Yow)

The Board was given a demonstration of e-Vitals.

The Chair thanked the presenters noting that the Board would schedule a ward visit in the New Year to enable them to see how e-Vitals really works at the bedside.

(Dr Colin Thompson departed at 12pm)

6 PERFORMANCE REPORTS

6.1 2016/17 Financial Result (Margaret White)

The report was taken as read.

These results reflect a busy winter period that has seen unprecedented demand for ED and inpatient care which has impacted on the elective revenue programme. Mitigating this impact was a strong contribution from the ACC areas programme, favourable movement in creditors and vacancies across the service, partially offset with outsourced personnel.

7 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Catherine Abel-Pattinson)

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:

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<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>
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</thead>
</table>
| 1. Confidential Minutes of 13 September 2017/Actions | 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. [NZPH&D Act 2000 Schedule 3, S32(a)] | Confirmation of Minutes  
As per the resolution from the public section of the minutes, as per the NZPH&D Act. |
| 2. Draft Minutes of the Community and Public Health Advisory Committee and Audit Risk & Finance Committee | 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  
As per the resolution from the public section of the minutes, as per the NZPH&D Act. |
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<td>3.</td>
<td><strong>Transform Manukau</strong></td>
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|   | 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**
|   | [NZPH&D Act 2000 Schedule 3, S32(a)] | 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)]
| 4. | **Draft Quality Accounts** | 
|   | 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. | **Communication with the Sovereign**
|   | [NZPH&D Act 2000 Schedule 3, S32(a)] | The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. | [Official Information Act 1982 S9(2)(f)]
| 5. | **Risk Management 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. | **Communication with the Sovereign**
|   | [NZPH&D Act 2000 Schedule 3, S32(a)] | The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. | [Official Information Act 1982 S9(2)(f)]
| 6. | **Facilities Master Planning Strategic Assessment** | 
|   | 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. | **Communication with the Sovereign**
|   | [NZPH&D Act 2000 Schedule 3, S32(a)] | The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. | [Official Information Act 1982 S9(2)(f)]
| 7. | **Final 2016-17 Annual Report** | 
|   | 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. | **Communication with the Sovereign**
|   | [NZPH&D Act 2000 Schedule 3, S32(a)] | The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. | [Official Information Act 1982 S9(2)(f)]
| 8. Establishment of Otara Clinic Hub | [NZPH&D Act 2000 Schedule 3, S32(a)] 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. | [NZPH&D Act 2000 Schedule 3, S32(a)] [Official Information Act 1982 S9(2)(f)] 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. |
| 9. National Oracle Solution | [NZPH&D Act 2000 Schedule 3, S32(a)] | [Official Information Act 1982 S9(2)(i)] Negotiations Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. | [Official Information Act 1982 S9(2)(j)] 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. |


BOARD CHAIR
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<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tr>
<td>25 October</td>
<td>Demonstration – E-Vitals</td>
<td>The Chair noted that the Board would schedule a ward visit in the New Year to enable them to see how e-Vitals really works at the bedside.</td>
<td>21/2/18</td>
<td>Board Secretary</td>
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<tr>
<td>25 October</td>
<td>Decision Item – CM Health Hospices</td>
<td>The Board requested reassurance that the 73 people who received Totara Hospice services and who were domiciled outside the CM area, were entitled to NZ funding and an understanding of how many people from CM are being managed by hospices elsewhere in the country.</td>
<td>6/12/17</td>
<td>Louise McCarthy/ Benedict Hefford</td>
<td>6.12.17 update • all service users were entitled to NZ funding. • a number of patients had their address incorrectly recorded and they did in fact reside in Counties Manukau • the remaining patients lived in Otahuhu on the ADHB/CMDHB border. CM Health will do further analysis regarding these cases and will discuss with ADHB. It is likely that a similar situation exists for Mercy Hospice (ADHB) in relation to CMDHB domiciled residents who live in Otahuhu.</td>
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<td>6.12.17</td>
<td></td>
<td>The Chair requested a reconciliation of all of the increases and all of the uptake of demographic uplift so that every time the Board considers something, it can understand fully what is really being given away.</td>
<td>21/2/18</td>
<td>Margaret White</td>
<td></td>
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<tr>
<td>DATE</td>
<td>ITEM</td>
<td>ACTION</td>
<td>DUE DATE</td>
<td>RESPONSIBILITY</td>
<td>COMMENTS/UPDATES</td>
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<td>25 October</td>
<td>Health and Safety Report</td>
<td>The Board asked for a report and timeline on the work being undertaken in relation to safety and training of the Community Health Workers. The Board requested an update on the Community Support Worker who died in a car accident on 31/10/16.</td>
<td>6/12/17</td>
<td>Penny Magud</td>
<td>Refer Item 3.2 on today’s agenda.</td>
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<td>6/12/17</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 3.2 on today’s agenda.</td>
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<td>25 October</td>
<td>CE Report</td>
<td>The Board requested a deep dive on ante-natal care to cover the DHBs approach for different population groups, progress made/not made and what evidence there is, or isn’t, to links to better outcomes.</td>
<td>21/2/18</td>
<td>Carmel Ellis</td>
<td></td>
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<tr>
<td>2 August</td>
<td>Health and Safety Report</td>
<td>The Chair commented on a strategic risk workshop that was held recently at ADHB, an initiative of Dame Paula Redstock, the Independent Chair of the ADHB Finance and Risk Committee. The workshop identified that there was a difference in alignment for how Board members and the Executive look at risk from the point of likelihood and consequence. The Board members drew different conclusions and the reality is that the conclusions in Board papers are the conclusions of Management. <em>The Chair suggested that it would be beneficial for CMDHB to also hold a workshop, which would also test the conclusion reached at ADHB.</em> The establishment of the Executive Health and Safety Committee a positive formation. The Board would like to see evidence from the Committee of health and safety at work. It was</td>
<td>21/2/18</td>
<td>Kerry Bakkerus</td>
<td>Refer Item 3.2 on today’s agenda.</td>
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<tr>
<td>DATE</td>
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<td>2 August</td>
<td>Financial Performance</td>
<td>The Chair advised that the metro-Auckland DHBs need to consider an alternative mechanism for IDF’s to better manage risk for all parties with a process that is less transactional. He requested that a paper on this matter be submitted to the metro-Auckland Boards in February 2018 for their consideration.</td>
<td>21/2/18</td>
<td>Margaret White</td>
<td></td>
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<tr>
<td>2 August</td>
<td>2017/18 Māori, Pacific and Asian Health Plans</td>
<td>The population is growing and changing very quickly and to best utilise resources the DHB will need to move towards more of a system approach (all parties, not just the DHB). It was noted that Professor Paul Spoonley (Massey University) has said that Auckland is the most rapidly ethnically changing major city in the world. This creates many challenges for the region in terms of language, approach, disease patterns, epidemiology and the like. It was agreed to invite Professor Spoonley to present his insights on Auckland’s growing ethnical diversity to the Board.</td>
<td>Pending</td>
<td>Margie Apa</td>
<td>25.10.17 – An invitation has been issued to Professor Spoonley, we are awaiting a response.</td>
</tr>
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<td>21 June</td>
<td>CE Report</td>
<td>Immunisation rates for Māori and Pacific still require improvement. The Chair requested that a plan be brought back to the Board, including benchmarking against others areas, and identifying differences in approach.</td>
<td>6/12/17</td>
<td>Benedict Hefford</td>
<td>Refer Item 2.2 on today’s agenda.</td>
</tr>
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</table>
Recommendation

It is recommended that the Board:

Receive the Deep Dive – Childhood Immunisation report.

Prepared and submitted by: Carmel Ellis, Integration Manager Child Youth & Maternity on behalf of Benedict Hefford, Director Primary Community & Integrated Care.

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>B4SC</td>
<td>Before School Check</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>GP</td>
<td>General Practice</td>
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<tr>
<td>IMAC</td>
<td>Immunisation Advisory Centre</td>
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<tr>
<td>LMC</td>
<td>Lead Maternity Carer / Midwife</td>
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<tr>
<td>NIR</td>
<td>National Immunisation Register</td>
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<tr>
<td>OIS</td>
<td>Outreach Immunisation Services</td>
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<tr>
<td>PHN</td>
<td>Public Health Nurses</td>
</tr>
<tr>
<td>PMS</td>
<td>Patient Management Systems</td>
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<tr>
<td>SLM</td>
<td>System Level Measures</td>
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<tr>
<td>WCTO</td>
<td>Well Child Tamariki Ora provider</td>
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Executive Summary

Counties Manukau Health is one of the higher achiever DHBs for childhood immunisations with overall coverage fluctuating between 94-95% over the course of the past five years. Despite overall coverage being high, an equity gap still exists for Māori.

Figure 1 - CM Health Immunisation Milestone Achievement at 8 months

![CM Health 8 Month Immunisations Performance by Ethnicity - to September 2017](image-url)
Herd immunity is a form of indirect protection from infectious diseases that occurs when 90-95% of the population are fully immunised. For Counties Manukau high levels of coverage have been maintained, providing good protection for our children under five.

Analysis of the monthly breakdown of CMH progress for Quarter 1, 2017/18 shows that we are missing a potential 38 Māori pepi (7.9%) each quarter. Given the low numbers, a revolutionary approach is not required as this would pose the risk of disrupting the system and a potential decline in overall coverage and the demise of our herd immunity.

**Figure 2 – Eligible cohort Māori quarter 1: 17/18**

<table>
<thead>
<tr>
<th>Quarter 1 (2017/18)</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>Quarter</th>
<th>Coverage%</th>
</tr>
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<tbody>
<tr>
<td>Eligible</td>
<td>157</td>
<td>159</td>
<td>161</td>
<td>477</td>
<td></td>
</tr>
<tr>
<td>Fully Immunised by target age</td>
<td>137</td>
<td>136</td>
<td>147</td>
<td>420</td>
<td>88.0%</td>
</tr>
<tr>
<td>Declined Immunisations</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>19</td>
<td>4.0%</td>
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**Co-hort which we have the ability to influence**

| Fully Immunised after target age            | 7    | 3      | 2         | 12      | 2.5%      |
| *Not Fully Immunised target age-passed      | 6    | 13     | 7         | 26      | 5.5%      |
| (catching up on earlier missed immunisations)|      |        |           |         |           |
| Total                                       | 13   | 16     | 9         | 38      |           |

**Background**

The decision to immunise often starts during pregnancy aided by early supportive engagement with maternity services. Non-engagement or late engagement has a range of negative consequences for both mothers and babies, one being the risk of uniformed decision making based on negative or informal information received within the community.

To address the underachievement of Immunisations for Māori we need to address the contributing factors within our local community. This requires reframing the way we communicate about maternal and childhood immunisations, revising access and service expectations to immunisations at Primary Care and Outreach Immunisation Services and delivering a simple efficacy immunisation story which is consistently promoted through earlier engagement with maternity and child health services.

Currently information on immunisation is promoted to women and whaanau through LMC/Midwives, WCTO, GPs and hospital clinics with advice, pamphlets, posters, health websites or health phone as the predominant sources of information. Informally information is through friends, family, community, websites eg Google, lobbyists media communications which is often alarmist and negative.

As women often make their decision to immunise their baby during pregnancy and in the postnatal period we need to improve the ways in which we deliver encouraging and consistent information and ensure that they meet the information needs of our Māori women and whaanau. Our maternal immunisation pregnancy coverage is between 10 - 14% which means that fewer babies have immunity from their mother’s and risk of infection is high particularly when immunisations are further delayed.

**Barriers to achieving high coverage for Māori include:**

- Low early engagement rates with maternity services in the 1st trimester of pregnancy
- Lack of consistent information in the antenatal period
- Active decisions to delay the commencement of the primary course of childhood immunisations
- Late handover of baby from LMC to WCTO, which is higher in Māori and Pacific pepi
- Other priorities or complexities within the whaanau i.e. financial problems, unwell child or children, transport
Proposal

The CMH Immunisation working group are proposing a multi pronged approach to change the way we communicate about immunisations to get collaboration between child health providers, and improve health literacy on immunisations with parents / caregivers and their whaanau.

We are also proposing a small pilot with WCTO to provide an alternative setting for routine childhood immunisations to ocure.

Initiatives by workstream

1. Change the way we communicate about immunisations
   1.1. Development of a simple efficacy story for immunisations in maternal and childhood immunisations to share with health providers to ensure consist messaging
   1.2. Build knowledge with LMC / Midwives with promotion of Boostrix and flu vaccinations during pregnancy, and foster intentions to immunise
   1.3. Motivational interviewing and health literacy training for DHB / WCTO / OIS/ midwifery staff
   1.4. Immunisation programs in GP services - every parent is welcomed from the receptionist to the practice nurse into a supportive environment with their baby for GP engagement and immunisations.
   1.5. Social media promotion on benefits of immunisation (population are adept at using social media on phones); websites for mums to access user friendly simple information with links to IMAC for more detail.

Implications

- This is longer term due to workforce training in primary care, maternity services and WCTO; and development of the efficacy story to be relevant to our families and consistent across the health providers. Using health literacy and a motivational interviewing approach we will be more patient centric than current informational approach.
- By fostering immunisation knowledge to pregnant women and uptake of pregnancy immunisations we can improve immunity from mother to newborn babies and prevent hospitalisation for very young babies with pertussis (whooping cough) and raise importance of on-time immunisations.
- To communicate effectively with an inclusive whanau approach with kānohi-ki-te-kānohi i.e. face to face support, is necessary with a sound and simple efficacy story on pregnancy and childhood immunisations. We cannot prevent pregnant women from being exposed to information discouraging immunisation, but we can improve the ways in which we deliver encouraging and correct information and ensure that they meet the information needs of everyone.
- Social media approaches are suggested as our cohort is very active on social media and currently get discouraging information. However we need to be careful to present a well-reasoned efficacy story as it can also attract attention from the anti-vax lobbyists.

2. System support for specific groups to engage with health services
   2.1. Meet health targets of early engagement with maternity services in 1st trimester of pregnancy focusing on Maaori and Pacific pregnant women
   2.2. Meet health targets of newborns enrolled with a WCTO by 28 days of age; and newborns enrolled with a GP by 14 days of age are both impacted by referral from LMC/ Midwife and handover to enable on time 6 weeks checks with both GP and WCTO
   2.3. GPs patient management systems (PMS) need to have faster acceptance of newborns, acceptance whether family is known or not to start engagement of the baby with health services, regular update contacts with each visit
• The 1st pregnancy trimester engagement project for women is under development and is being integrated with smokefree pregnancy, AOD programs, identifying SUDI risk, and promoting pregnancy Immunisations. In conjunction with screening at 1st and 3rd trimester, using a ‘triage midwife/navigator’ and using shared care pathways will enable better management of higher risk pregnancies and better outcomes.

• The Well Child Tamariki Ora earlier enrolment project with LMCs/Midwives is working to get earlier handover of referrals to enable the core one check by six weeks.

• The Newborn enrolment project is working to eliminate the delays in GP acceptance of a baby’s referral to enable the GP 6 week check and to start the immunisation program.

3. Reduce barriers to access

3.1. Pilot childhood Immunisations through Well Child providers in Manurewa and Papakura. The pilot would focus on timeliness to ensure all babies within this locality start their immunisations on time.

3.2. Well Child Nurses (vaccinator certified) able to offer child immunisations as part of the Well Child schedule.

3.3. Mid-week and Saturday drop-in immunisation clinics provided by WCTO to provide an alternative setting for whaanau.

Implications

• Requires negotiation with PHO alliance and MOH as Immunisations are a core GP/Primary Care function. Possible GP resistance as this is considered core GP business and potential loss of income.

• Requires full scoping for cost of setup of vaccinator training, additional FTE time required, certification assessment, cold chain management vaccine fridge, data loggers and chilly bins for out-lying well child clinic, fee to vaccinate.

Summary

To get better immunisation results we need to strengthen awareness in the antenatal phase. This includes the efficacy story as many health providers are not always aware of the importance of maternal immunisations. We also need to improve information flow between local health providers to be able to keep track of pregnant women and their babies.

By fostering immunisation knowledge to pregnant women and uptake of pregnancy immunisations we can improve immunity from mother to newborn babies and prevent hospitalisation for very young babies with pertussis (whooping cough) and raise importance of on-time immunisations. This requires a different communication approach to our health workforce and community.

We also need to provide flexibility of access points beyond just the GP practice and a supportive environment as we encourage families in Well Child Tamariki Ora services and into GP practices to access their Child’s health entitlements.
Minutes of Counties Manukau District Health Board  
Community and Public Health Advisory Committee  
Held on Wednesday, 18 October 2017 at 9.00am – 12.30pm  
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)  
Dianne Glenn  
Katrina Bungard  
Rabin Rabindran  
Reece Autagavaia  
John Wong

ALSO PRESENT

Gloria Johnson (Acting Chief Executive)  
Margie Apa (Director, Population Health & Strategy, Acting GM Maaori Health)  
Benedict Hefford (Director Primary, Community and Integrated Care)  
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)  
Vicky Tafau (acting Secretariat)  
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Sue Claridge, Auckland Women’s Health Council.

APOLOGIES

Apologies were received and accepted from Ashraf Choudhary and George Ngatai.

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with the following amendments:

Colleen Brown - District Representative, Neighbourhood Support New Zealand – add.  
Dianne Glenn – now Member, National Council of New Zealand, stepped down as VP.
1. **AGENDA ORDER AND TIMING**

Items were taken in the same order as listed on the agenda.

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 6 September 2017.**

**Resolution** (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

That the minutes of the Community and Public Health Advisory Committee meeting held on 6 September 2017 be approved.

**Carried**

2.2 **Action Items Register/Response to Action Items**

A brief discussion was held around Gout and its potential link to family violence. Margie Apa agreed to follow up with Lily Fraser, GP to see if there is any evidence to support this.

Rheumatic Fever target - CPHAC was in agreement that the current number of 4.5 is aspirational for this community.

3. **BRIEFING PAPERS**

3.1 **Franklin Locality Update (Kathryn du Luc)**

Kathryn du Luc, GM Franklin Locality took the Committee through her presentation highlighting:

- The population of Franklin is set to double by 2023.
- Franklin’s integrated model of care is the “one cluster” locality supported by an enhanced virtual team of:
  - specialists and community health professionals who work collaboratively to support complex patients;
  - palliative care – hospice, GPs, community hospital, community health team;
  - connecting with social services and social welfare
- Next steps for Franklin Locality include:
  - Pukekohe Hospital – the integrated model and development of the Locality Hub
  - Phase Two of the Mental Health Integration
  - Social Service Integration – Children’s Team to Franklin
  - Supporting the System Level Measures
  - Supporting Planned Proactive Care including children
  - Health Coach support self-management
  - Supporting Enhanced Primary Care
  - Developing Clinical Networks

The Chair thanked Kathryn for her presentation and the continued locality efforts in the Franklin area.
3.2 SUDI National Programme Update (Benedict Hefford)

The overall goal of the national SUDI prevention programme (NSPP) is to reduce the incidence of SUDI to 0.1 in 1000 infants by 2025.

The national programme will target two key modifiable risk factors for SUDI which are:
1. being exposed to tobacco smoke during pregnancy; and
2. bed sharing.

A range of other evidence-based key modifiable risk and protective factors including alcohol and drug use will also be addressed along with encouraging immunisation, breastfeeding and infant sleep position.

All DHBs have been apportioned an annual funding amount based on a weighted funding formula of the SUDI key modifiable risk factors within the DHB’s population (smoking during pregnancy, maternal age under 25, pre-term births and artificial feeding at six weeks). DHBs will be contracted to deliver services that at a minimum meets the needs of the high risk population estimated by the funding formula. The funding formula has estimated the high risk population in Counties Manukau DHB to be 1,629 babies and their whaanau/families.

DHBs are expected to undertake a stocktake of current activities to identify local strategies and initiatives aligned with the NSPP priority areas. The purpose of the stocktake will be to identify gaps within service, identification of areas for regional collaboration and the development of programme logic model to guide decision making around the use of the additional investment.

CM Health is currently undertaking the stocktake with the expectation that a local plan will be completed by November 2018.

The Committee requested that this paper be submitted to the next MHAC meeting for their information.

3.3 Mumps Outbreak Update (Margie Apa)

*Mumps Outbreak* – ARPHS have been managing the Auckland region mumps outbreak since January 2017. The initial cases identified in January were acquired overseas. Over 400 cases have now been notified, community spread is established and seeding from cases bring infection in from overseas continues. Of the 415 cases notified to ARPHS from January-September, 155 cases (37%) have been living in Counties Manukau.

Mumps outbreaks are occurring throughout New Zealand.

The majority of cases are in people aged 10 – 29 years. This cohort has a low vaccination rate due to a historically poor vaccination recall and supply systems and the publicity surrounding the disproven link in the media between autism and MMR from 1998 onwards.

The suggested link between MMR and autism has now been thoroughly disproven by the scientific community. It is unknown how many people still maintain this perception in Counties Manukau however, immunisation coverage is high in Counties Manukau (94% at 2 years and 92% at 5 Years) with declines at 2 years sitting at only 2.4%, suggesting, reassuringly, that concern about the spurious link between MMR and autism is not a major issue for our population.
3.4 Healthy Weight Action Plan for Children/Draft Action Plan (Margie Apa/Benedict Hefford)

The Metro-Auckland DHB Healthy Weight Action Plan for Children has been developed to contribute to our vision that “All Tamariki in the Auckland Region of New Zealand are of a healthy weight”.

The plan has been developed collaboratively across the region and intends to clarify the role of the three metro-Auckland District Health Boards (DHBs) and Healthy Auckland Together (HAT) in preventing and reducing the rates of unhealthy weight through to 30 June 2020. The plan takes a life-course approach with identified actions for key target populations, including women prior to and during pregnancy, pre-school and school aged children and adolescents. We also place particular importance on ensuring the actions meet the needs of our Māori and Pacific populations who are disproportionately affected by this issue.

Margie Apa advised that CM Health has opted to go with region in developing this plan and each DHB is trying and testing different things, so there has opportunities to share learning’s. The continuum approach is very important, from pregnancy to infant, through to school age children.

It was noted that the Committee would like to see the region have a child obesity pathway for GPs.

Mr Hefford advised that the Committee will receive a further update on the Action Plan in six-month’s time.

The Committee asked Mr Hefford to come back to them with responses to the following questions:

- Page 43 1st bullet point – what does the constitution refer to.
- Has there been any link with Counties Manukau Sport in relation to this work.
- Page 59 – provide some further information in relation to the smartphone app and website.
- Page 71 - what are the actions associated with the plan and how will they be driven in Counties Manukau, where is the money coming from.

The Committee requested that this paper be submitted to the next MHAC meeting for their information.

The Committee asked Mr Hefford to arrange a presentation from Healthy Families NZ for the New Year.

Resolution (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

The Community & Public Health Advisory Committee:

Noted the Metro Auckland District Health Board Healthy Weight Action Plan for Children was endorsed by the Executive Leadership Team on 5 September to go forward to CPHAC.

Endorsed the Metro Auckland District Health Board Healthy Weight Action Plan for Children with the changes mentioned above in the above actions, that it was agreed will be reported on in six months’ time.

Carried
4. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution** (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

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>
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<th>General Subject of items to be considered</th>
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<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 2.1 Confirmation of the Public Excluded Minutes of the Community and Public Health Advisory Committee Meeting – 6 September 2017 | 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. [Official Information Act 1982 S9(2)(i)] |
| 2.2 Response to Action Item | 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. [Official Information Act 1982 S9(2)(i)] |
| 3.1 Community Hub Network Strategic Assessment | 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. [Official Information Act 1982 S9(2)(i)] |

**Carried**

The open session of the meeting concluded at 11.20am.


______________________________
Colleen Brown, Committee Chair
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee

Held on Wednesday, 4 October 2017 at 1.30pm
Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Lyn Murphy (Committee Chair)
Ashraf Choudary
Catherine Abel-Pattinson
Dianne Glenn
Mark Darrow
Rabin Rabindran

ALSO PRESENT

Phillip Balmer (Director Hospital Services)
Margaret White (Chief Financial Officer)
Gloria Johnson (acting Chief Executive)
Vanessa Thornton (acting Chief Medical Officer)
Janet Haley (Senior Communications Advisor)
Dinah Nicholas (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Sue Claridge, Auckland Women’s Health Council and Holly Neilson, Maternity Service Consumer Council attended the public section of this meeting.

APOLOGIES

No apologies were received for this meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

There were no specific interests to note with regard to the agenda for this meeting.
1. **AGENDA ORDER AND TIMING**

   Items were taken in the same order as listed on the agenda.

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Hospital Advisory Committee meeting held on 23 August 2017**

   *Resolution (Moved: Dianne Glenn/Seconded: Mark Darrow)*

   That the minutes of the Hospital Advisory Committee meeting held on 23 August 2017 be approved.

   *Carried*

2.2 **Action Item Register**

   NZREX Drs – HAC 15 November - presentation from David Hughes.

3. **PROVIDER ARM PERFORMANCE REPORT**

   Phillip Balmer introduced the report.

3.1 **Executive Summary**

   *Shorter Stays in ED* – continued high volumes of both presentations and hospital occupancy has again meant the ED has been unable to achieve the target. Work is underway to rapidly assess current capacity and forecasted demand for the next 3-5 years to inform short-term investment in expanding capacity in time for next winter.

3.2 **Project Initiatives**

   The report was noted and taken as read.

3.3 **Balanced Scorecard**

   *Excess Annual Leave Dollars* – Internal Audit has picked up instances where annual leave has not been entered into One Staff and will be undertaking a further investigation into this.

3.4 **Finance Report** (Margaret White)

   *Electives* – this year the Finance Team will be holding back a sum equivalent to the undelivery on electives in the Funder in a ring-fenced fund specifically for electives so that later in the year when we are hopefully in a position to be able to make that up, it will be additional funding available to the Provider to compensate for the timing of that additional expenditure which we would expect to be above budget. We got caught out last year with our IDFs and electives, this year we are trying to keep that accounted for carefully so we have the funding available.

   *Clinical Supplies* - the Chair requested an update on Supply Chain management and Clinical Supplies. Margaret White advised that Pauline Hanna could provide an update on what the region is doing on enhancing the supply chain generally and an update on the One-Link contract that is currently being renegotiated.
3.5 Emergency Department, Medicine and Integrated Care (Brad Healey)

*Bowel Screening* – negotiations continue with the MoH in relation to the model of service delivery. Largely, we have received agreement for the model put forward but the problem will be the funding as our modelling shows a funding gap after 2-years and thereafter. We want to do this in a financially responsible way, we don’t want to start delivering the service then realise the funding is inadequate as the MoH will not be responsive. Funding will be specific for the programme and outside the PBFF. There will also be an impact on our facilities and workforce.

(Sue Claridge and Holly Neilson departed at 2.50pm)

*Scorecard* - the Committee asked that Gastroscopy be added to the Scorecard adjacent to Colonoscopy so the Committee can ensure one is not suffering because of the other.

*Medical Assessment Project* – the aim of the project is to look at how we can improve care delivery both from a patient and staff perspective. The objective is a length of stay of less than 28hrs.

*Integrated Care* – we need to turn the current model around to make it more patient focussed. We will be taking a five year view and looking at how we can utilise the existing space better and if there are any opportunities to take some services off the MSC site that are not critically important that they remain there. This needs to be done in conjunction with the overall Facility review of the MMH site.

3.6 Surgery, Anaesthesia and Perioperative Services (Mary Burr)

*Volumes* - August was a very busy month, one of the busiest ever for acute and electives.

*Safety* – there were no patient falls or CLAB infections for August.

*Revenue* – higher than budget mainly due to having no Tahitian burns. ACC revenue was also up.

*Ophthalmology* – good progress continues. Overdue follow-ups have improved by 586 in August mainly due to having Advanced Practitioners now working alongside the Optometrists. The new Ophthalmology outpatient facility with five clinic rooms is working well.

3.7 Central Clinical Services (Phillip Balmer)

*Radiology/MRT workforce* – there has been a further increase in the MRT vacancies. Existing staff are covering the vacant shifts to ensure the service is maintained however, we are expecting some new staff to arrive in November/December and a significant cohort of new graduates coming on board as part of the annual new graduate intake.

3.8 Kidz First and Women’s Health (Nettie Knestch)

*MCIS* – MoH have confirmed they are continuing with the MCIS however, are light on the details about when it will be fit for purpose. In the meantime, we continue with the product as it is whilst awaiting the Ministry advice. The CM Health Anaesthetists have since confirmed that they will not use it and will go back to a combination of paper and Concerto as the problem is getting the information out of the system.
Midwifery Workforce – in April the consensus was that maternity services should always be provided by midwives however, a lot of the big DHBs, particularly in the urban centres, rely heavily on registered nurses working in the post-natal areas so it will be important to get the Midwifery Advisory Group and DHB Shared Services overall predictions of how many midwives we are going to need nationwide. Any national strategy will have to include training, recruiting and retention. In Counties Manukau, we also have the added problem of having LMC shortages as well as a midwifery shortage, we are holding but not growing as we cannot attract people to relocate and come and work in Auckland. Jenny Parr advised that she has recently written to the Midwifery Council asking them to reconsider the route into midwifery which is currently a three year direct entry programme only to a post-graduate programme.

3.9 Adult Rehabilitation and Health of Older People

Physiotherapy Department – it was noted that the Physiotherapy Department received ‘fully attained’ ratings across all criteria as part of the ACC Surveillance Audit of Sector Standards. Several strengths of the department were highlighted including ongoing initiatives and professional drive for continued development. The auditors noted the momentum of this drive was not top-down but initiated from the physiotherapists working in each department. Additionally, their ability to manage such a large and varied workload while still maintaining client centred care and developing ongoing innovations was noted. The Committee agreed to send a letter of congratulations to the Department.

3.10 Mental Health and Addictions

Franklin ILoC – this team has been in place since November 2016 with NGO and CADS FTE joining the team in March/April. The team have been slowly expanding their reach across general practice, schools, aged residential care and marae. Recent feedback from the Franklin GP Principals Group credited the work of the team for turning mental health services from ‘one of the most inaccessible services to one of the most accessible’. A recognition that services needed to be more accessible and flexible was a major driver for the development of the ILoC part of the model of care.

3.11 Facilities
The report was noted and as read.

3.12 Middlemore Central (Dot McKeen)

Winter Lessons Learned – winter planning begins in November every year when running through the lessons learned sessions. Discussion includes all data related to patients, length of stay, readmissions during winter etc, resources used, both staff and beds and get a forecast from McKesson based on 6-months actual data and 6-months forecast.

Historically winter peaks in August however, this year volumes increased in May and did not drop. Paediatrics also peaked early at the same time as Adults which prevented the use of ‘C’ pod for adult patients. Additional overnight adult clinical space had to be created in Gastro clinic and TADU.
Next year we need:
- more resourced beds to avoid clinical risk of using non-inpatient areas overnight.
- more staff and need to start recruitment early given the time required for onboarding.
- to ensure that all rosters match demand, both in acuity and numbers with more senior decision-making at the weekend to better facilitate discharging.
- More focus on Transition of Care with localities to pull patients to community proactively using Goal Discharge Date.

4. CORPORATE REPORTS

4.1 Director Patient Care, Chief Nurse and Allied Health Professions Officer (Jenny Parr)

Nursing – currently recruiting for 133FTE.

Certification Update – the next Certification visit has been confirmed for February 2018 and will focus on corrective actions. Planning is underway for the visit which will involve the completion of a self-assessment template and submission of evidence prior to the visit.

Health Care Assistants – the Committee requested clarification if HCAs have a Level 3 or Level 4 NZQA or equivalent qualification.

4.2 HR Report

The report was taken as read.

5. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Ashraf Choudhary/Seconded: Lyn Murphy)

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:

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<tr>
<td>2.1 Public Excluded Minutes of 23 August 2017</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>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
<tr>
<td>3.1 Patient Experience and Safety Report</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</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons.</td>
</tr>
<tr>
<td>3.2 Facilities Master Plan</td>
<td>Communication with the Sovereign</td>
<td></td>
</tr>
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<tr>
<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>The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative.</td>
<td></td>
</tr>
</tbody>
</table>

**Carried**

The open session of the meeting concluded at 3.53pm

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Lyn Murphy, Committee Chair
Minutes of Counties Manukau District Health Board
Disability Support Advisory Committee
Held on Wednesday, 16 August 2017 at 1.00pm
Meeting Room 6, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Catherine Abel-Pattinson
Dianne Glenn
Katrina Bungard
Dr Lyn Murphy
Apulu Reece Autagavaia

ALSO PRESENT

Annelise de Wet (for Jenny Parr)
Dinah Nicholas (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present.

APOLOGIES

Apologies were received and accepted from Gloria Johnson and Apulu Reece Autagavaia for lateness.

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

Colleen Brown and Lyn Murphy both declared a specific interest in relation to Item 3.1 on today’s agenda. This has been noted on the Specific Interests Register.
1. **AGENDA ORDER AND TIMING**

   Items were taken in the same order as listed on the agenda.

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Disability Support Advisory Committee meeting held on 16 November 2016.**

   **Resolution** (Moved: Colleen Brown/Seconded: Dianne Glenn)

   That the minutes of the Disability Support Advisory Committee meeting held on 16 November 2016 be approved.

   Carried

2.2 **Action Items Register**

   The Committee asked that the previous Committee’s outstanding actions be added back onto the Action Item Register.

2.3 **Terms of Reference**

   Issues that the Committee need to consider over the next few months:

   - Look at extending the scope of DiSAC to include mental health as the Committee could bring a difference perspective. Currently mental health falls under CPHAC and HAC.
   - Elder care requirements due to our ageing population. Currently no government mandated voice for older people and there is a lot of abuse that gets swept under the carpet. We have CYF to support the family but nothing to represent the patient voice for elder care and mental health. This again comes under CPHAC but no reason why it shouldn’t also come to DiSAC.
   - The DiSAC ToR specifies responsibility in the Health of Older People area however, expertise is missing from the Committee now that it no longer has a representative from the Older Person community. Feels like the Committee is going backwards.
   - Lack of communication between disability services and the main health providers. Information not being updated between providers. No one person or organisation takes responsibility.
   - Some providers make communicating with them difficult. Some examples provided included: they don’t answer their phones particularly the 0800 numbers, they don’t return calls, they don’t email information when they say they will.
   - Revisit the need for professional Health Navigators that can assist joining the dots up. Health Navigator is more a tool for health professionals, not easy to navigate. For example, there are approximately 40 different MSD funded organisations in Franklin locality that all have some aspect of health and all do great work but how is a patient or caregiver supposed to navigate that system. MSD has fragmented the system so much unintentionally that nothing joins up now. We need to move away from lots of contracts and start looking at how we make it easier for people to navigate, simplify the system – a few points of contact is better.

   The Committee discussed undertaking a stocktake of the local disability sector, by locality, either through Ko Awatea or AUT students via Lyn Murphy, to give a wider understanding of what services are currently available. The findings can then be used as an example to
take to the other 2 Auckland DHBs and perhaps work with MSD to eliminate the fragmentation of services.

- Whirinaki funding has been reduced (a team of specialists have been reduced in number).
- Rehabilitation for brain injuries.
- Support and training for caregivers of long term condition patients at home.
- Gap between Taikura and the DHB handover.
- People with disabilities living alone not getting enough compensation to live on.
- Is South Auckland growing in a way that will promote a healthy community (ie) are we really looking at where we place facilities in order to assist people with disabilities accessing them. Are they in the right places for those that need them.

Next Steps:
- Jenny Parr to look into the reason why the Whirinaki funding has been reduced and the reason for that and report back to the Committee (22 November).
- Jenny Parr to look into what support the DHB gives to caregivers of complex LTC patients in the form of support and training and report back to the Committee (22 November).
- The Chair to talk to Jo Agnew and Samantha Dalwood to see if they have tried to map/scope what disability services are currently available and report back to the Committee (22 November).
- Jenny Parr to discuss the stocktake with Ko Awatea and report back to the Committee (22 November).

Colleen Brown confirmed that she will work to align the CM Health ToR with the A/WDHB ToR in conjunction with Jo Agnew (ADHB) which can then be submitted to our Board for approval so the Committee can move forward as a regional committee.

The Committee noted that it would be highly disappointing if not all the current CM Health Committee members were not reappointed to the regional DiSAC Committee as all members bring a strong disability focus and a lot of experience and insights to the meetings.

(Apulu Reece Autagavaia arrived at 1.10pm)

3. FOR DISCUSSION

3.1 NZ Disability Strategy

Waitemata and Auckland DHBs have been working together on the development of a joint New Zealand Disability Strategy Implementation Plan. They are holding two community meetings on 30 August and 1 September for people to communicate their thoughts and ideas.

CM Health has not participated in this process to date however, there is an opportunity to join the work over the coming months by initiating and progressing similar public engagement. The feedback would need to be gathered in a timely fashion in order to ensure it contributes to the final outcome. At this stage it is due to be considered at the joint Waitemata and Auckland DHB DiSAC meeting scheduled for December 2017.

The Committee agreed that CM Health need to participate in the process to produce a regional Implementation Plan and will need to hold a community meeting in October along the same line as Waitemata & Auckland DHBs.

Next Steps:
- Colleen Brown to discuss with Jenny Parr to get a community meeting set up.
Resolution (Moved: Lyn Murphy/Seconded: Colleen Brown)

The Disability Support Advisory Group endorsed Counties Manukau District Health Board to work with Waitemata and Auckland District Health Boards to produce a Regional implementation plan.

Carried

3.2 Improving NZ Disability Data (Dr Doone Winnard)

Concerns have been expressed in previous DiSAC meetings, both locally and regionally, about the limited population data available about people with disabilities to support service planning and improvement.

In June 2017, Stats NZ released an information paper on the new use of a short set of questions about disability in two of NZ’s household surveys – the NZ General Social Survey and the Household Labour Force Survey. This will allow us to get greater value from those surveys by enabling information already collected to be broken down by disability status.

The NZ Disability Survey has previously been undertaken after each of the last four censuses however, it is not being undertaken after Census 2018. The next NZDS is not planned until 2023 which is not helpful for planning purposes for a DHB like ours which is experiencing rapid growth.

Next Steps:
- Doone Winnard to contact Alison Reed at Auckland Council to see if they are thinking of doing a report for the disability community along the same lines as the Auckland Council Report on Older Aucklanders and report back to the Committee (22 November).
- Colleen Brown to email the Office of Disability Issues in Wellington to find out who is doing the national data collection for disability and report back to the Committee (22 November).

3.3 Deaths of Intellectually Disabled People

A Radio New Zealand article on 6 March 2017 noted that ‘the deaths of intellectually disabled people are being incorrectly recorded in Australia, research has found, and the same problem is likely to exist in New Zealand’. A team from the University of NSW found some people with Downs Syndrome who had died of pneumonia or heart failure would have Downs Syndrome written on their death certificate though the condition did not directly cause their death.

Dr Martyn Matthews from Idea Services, an arm of IHC New Zealand, did a small scale study of 54 people who died in 2015. He found very similar kinds of things, that people were often coded wrong with the intellectual disability being coded as the cause of death.

It is a human right’s issue about how people describe you however, you are only covered by Human Rights legislation when you are alive. The Guide to Certifying Death was written in 2001 and the Guide on Writing Death Certificates was written in 1996.

The Human Rights Commission view this as a social justice issue.

The Committee queried whether this could just be a coding issue. If we are going to implement the NZ Disability Strategy which sets out that the person who is disabled gets the same treatment as non-disabled people across the board, then shouldn’t we undertake a small investigation of a hundred or so death certificates to see what that turns up. We need a good understanding from someone who understands this.
Next Steps:

- Jenny Parr to look into whether there are ICD-10 codes for saying someone died from cerebral palsy or downs syndrome and report back to the Committee (22 November).
- Jenny Parr to request a CM Health Pathologist comment on the Radio NZ article to see if they think this could be an issue here in New Zealand and report back to the Committee with a view to looking at a small review of some death certificates if that was thought appropriate (22 November).

Resolution (Moved: Colleen Brown/Seconded: Dianne Glenn)

The Disability Support Advisory Group received the Deaths of Intellectually Disabled People paper.

Carried

3.4 Video Remote Interpreting Service Trial (Henry Milligan, healthAlliance)

Telehealth is the ability to deliver healthcare at a distance by remote transmission of audio, video and clinical data. This will allow for real-time consultations with an ability to record these for later use. It will also allow for virtual interpreting services.

healthAlliance are currently working through Stage II of trials for the video remote interpreting service which is to complete 80 patient appointments outside of MSC.

This is a regional project and is anticipated to be rolled out between December 2017 - February 2018.

3.5 Disability Friendly Hospital Maps (Chester Buller)

At CM Health, way finding maps are available for consumers and visitors to use to find their way around the large hospital campus. However, what about those in the disability community who need to have a different set of information in order to make their access to hospital services easy.

The Committee discussed the buildings on the Middlemore campus and the lack of ramp access for disabled people.

Next Steps:

- Colleen Brown to email Phillip Balmer to advise that the Committee would like to undertake an accessibility audit of the Middlemore campus facilities to assess whether they have ramp access for disabled people. It was suggested that Vivian Naylor undertake the site audit. Colleen will work with Chester Buller to write the brief for the audit.
- Colleen Brown to contact HQSC to see what they did with Mid Central DHB to make their campus accessible for disabled people and see whether they are interested in doing a joint project with CM Health.

4. GENERAL BUSINESS

There was no general business.
The meeting concluded at 3.55pm.


Colleen Brown, Committee Chair
Counties Manukau District Health Board
Establishment of Executive Committee of the Board

Recommendations

It is recommended that the Board:

**Approve** the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/New Year Board recess.

**Decide** membership of the Executive Committee.

**Agree** that the Executive Committee be given delegated authority to make decisions on the Board’s behalf relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from a Committee or the Chief Executive (same arrangements as last year).

**Note** that all decisions made by the Executive Committee will be reported back to the Board at its meeting on 21 February 2018.

**Agree** that the Executive Committee be dissolved as at 21 February 2018.

Prepared by: Dr Lester Levy (Board Chairman)

**Glossary**

NZPH&D Act - New Zealand Public Health and Disability Act 2000

**Purpose**

To seek the Board’s approval to establish a committee to conduct pressing Board business during the Christmas/New Year recess.

**Background**

The final normal scheduled meeting of the Board for the year is today, 6 December 2017. The next meeting is on 21 February 2018. There might be some items of business requiring approval at Board level that need to be processed during this period.

Under the NZPH&D Act (Schedule 3 Clause 38) there is provision for the Board to establish one or more committees for a particular purpose or purposes.

**Proposal**

As in recent years, it is proposed that the Executive Committee should have a relatively small membership so that it can be convened at short notice, should this be necessary.

It is expected that, by their nature, any items referred to this Committee are likely to need to be taken in public excluded session. The date and agenda items of any meeting(s) would, as soon as confirmed, be advised to all Board members and meeting(s) publicly notified if they involve any open meeting agenda reports.
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: Gloria Johnson, Acting Chief Executive

News and Events Summary

The level of acute demand and associated pressure on services has subsided over recent weeks with the arrival of spring. The annual review of data from the winter period was presented and discussed at a forum of clinical and managerial leaders on 14 November. It illustrated the marked jump in presentations and occupancy experienced this winter by comparison with previous years and the increased utilisation of various services as a result. There had been a marked increase in use of strategies to decongest the Middlemore wards, including discharge earlier in the day, use of the discharge lounge, nurse-facilitated discharge, transfer to Manukau Superclinic beds and use of POAC and reablement to facilitate earlier discharge. However, these steps had not been able to compensate sufficiently for the underlying shortage of resources to manage the growth in demand; it was clear that at least one whole additional ward would have been required to avert the stalling of patient flow from the Emergency Department and accommodation of patients in non-ward areas which occurred. Planning has already commenced for next winter and various interventions found useful this year to improve coordination of resources and speed discharge will be expanded. In addition work is underway on additional staffing requirements and the Immediate Demand and Remediation programme business cases to address facilities constraints.

Despite the pressures on our workforce because of rising demand over the past year, we are still attracting and retaining staff. Over the summer months we welcome new graduates joining our workforce from the universities. This year it has included 54 interns from the medical schools and we have had 80 acceptances for our New Graduate Nursing Positions. The annualised percentage of the workforce who resigned for voluntary reasons (which excludes health-related, redundancies, end of contract and dismissals) reduced again to a result of 8.34% in October. October’s turnover result is 2.8% below the same period last year and 2.7% below 6 months prior. After seeing consistent increases over the previous year, not only at Counties Manukau but also in national and regional DHB turnover, October is the fifth month in a row that our turnover result is below the average turnover result of 10.11%. It is critical though that we are mindful of the pressures on our workforce. Without a well-trained and highly functioning workforce we cannot deliver healthcare; they are our most valuable asset and we must actively look after their welfare and professional development. A number of the items below refer to programmes which contribute to that.

Finance Forum

The Chief Financial Officer Margaret White led a presentation on CMH Finances to a staff forum on 28 November. This was attended by the Board Chair and the Audit Risk and Finance Committee Chair. The presentation aimed to improve understanding by staff of how our financial position has evolved, to outline the magnitude and nature of the challenges we face with respect to our operational budget, cash flow and capital requirements and to explain what the turnaround plan involves.
Community Nurse Prescribing

Thirty three nurses have just completed the inaugural Registered Nurse Prescribing in Community Health: Trial and Evaluation. CMH and Family Planning New Zealand are the New Zealand trial and evaluation sites for this new scope of prescribing. A celebration was held on 6 November 2017 to mark this very significant milestone. The group includes nurses working in Secondary schools, Primary Care, Mana Kidz and Public Health Nursing.

The programme has prepared nurses who have been supplying medication under standing orders to undertake a blended learning programme to meet the required learning outcomes for a Nursing Council-approved recertification programme. The nurses are now authorised to prescribe from a limited list of medicines using Auckland Regional Health Pathways as clinical decision support for common skin, ear, and sore throat conditions as well as over-the-counter medicines. Nurses who have completed the Family Planning Certificate in Sexual Health and Contraception are also able to prescribe a limited range of medicines in this area. The education programme has a significant focus on pharmacology, health literacy and antimicrobial stewardship.

Nurse prescribing in the community allows greater access to medicines at the point of care. The nurses find that they have greatly improved assessment skills and critical thinking and improved team relationships with their prescribing mentors. Overall it will support a more comprehensive and efficient approach to health service delivery.

Leadership Development Graduations

Recent weeks have seen some of our leaders achieve success in their professional development journeys.

Leading Quality Care – In mid-October we had the first cohort of frontline clinicians complete the Leading Quality Care programme. The aim of this programme is to deepen leaders’ understanding of themselves, who they are as leaders, and how their leadership style has influence over others and the patient experience. Jenny Parr was on hand to congratulate and celebrate with them.
Te Taki Paeora, *(Maaori & Pacific Accelerated Development Programme)* – It was great to see the participants in the Te Taki Paeora programme complete their 12 month programme, which fosters growth in self-belief, confidence and leadership capability in staff from our Maaori and Pacific workforce.

The name Te Taki Paeora is derived from concepts of leadership and the Southern Cross constellation, which captures the aspiration ‘to reach for the stars’ as well as our pursuit of Paeora (Healthy and well Maaori & Pacific People).

The participants shared the life changing journey that they had been on through the process. ‘*I look forward to being able to make change for Pacific & Maaori people in any way possible,*’ said Jorjia Stewart as she summed up her presentation. Encouraging her colleagues, Tiana Talata’ina said ‘*You can achieve what your mind sets out to do.*’

Looking forward – Over the next 2 months we anticipate the completion of another Emerging Leaders Programme and the second cohort of our Doctors as Leaders Programme.

Whakamana Takuta Maori Dinner

The Whakamana Takuta Maori working group has been making steady progress this year in taking steps to develop and support the Maori medical workforce and students at CM Health. An inaugural dinner was held on 31 October, attended by a mix of SMOs (including GP Rawiri Jansen), RMOs and medical students. It was a very enjoyable networking opportunity for the eighteen attendees and will hopefully be followed by steady growth in the breadth and strength of the network.
Patient Safety Week

The theme of this year’s national Patient Safety Week, held on 6-10 November 2017, was ‘Let’s Talk Medicines’ encouraging patients to understand and ask questions about their medicine; and to encourage health professionals to follow Al2DET/health literacy principles.

The reasons behind the Health Quality & Safety Commission’s choice of the ‘Let’s Talk Medicines’ theme were:

- It aligns with the World Health Organization’s global patient safety challenge on medication safety.
- In the national in-patient experience survey, the question “Did a member of staff tell you about medication side effects to watch for when you went home?” consistently gets one of the lowest scores.
- There are a large number of medication errors; adverse events related to high-risk medicines in particular can be extremely serious.

The theme also linked well with the ‘Choose Wisely’ campaign which promotes four questions all patients should ask their health professional to help them Choose Wisely:

- Do I really need to have this test, treatment or procedure?
- What are the risks?
- Are there simpler, safer options?
- What happens if I do nothing?

The following three patient questions were the focus of ‘Let’s Talk Medicine’:

- What is my medicine called?
- What is it for?
- When and how should I take it?

Activities during Patient Safety Week included a Clinical Area Competition, which required each area to showcase relevant aspects of medication safety, using posters, display boards, videos and other means to get across key medication safety messages to patients and family/whanau.
The winner was Te Rawhiti Community Mental Health Clinic (above). The team designed and implemented many medication safety related items showcasing their creativity, including an owl made from medication packages placed in reception stating ‘be wise and know about your medicines’, a medication passport which was co-designed with patients, a ‘top 20 medications’ sheet in easy-to-understand terminology using evidence-based information, as well as a clothesline with medication-related questions pegged on in the clinic waiting area. Prize: KeepCups for all staff and a catered morning tea, which the team enjoyed on 22 November.

Future Focus

Regional Long Term Investment Plan

A presentation was given to the national Capital Investment Committee (CIC) on 13 November outlining key aspects of the draft Northern Region Long Term Investment Plan (NRLTIP). This was well received as a piece of work indicative of significant regional collaboration and providing for the first time a picture of the magnitude of the investment challenge we face, particularly in the face of the rapid growth and aging of the population across metropolitan Auckland. The plan will be brought to Boards for consideration and approval in the New Year and consideration has begun of the resources which might be required to oversee implementation of the plan. In the meantime the draft plan has provided Ministry of Health and Treasury officials with useful information to feed into their briefing of incoming Ministers. Our own CM Health Immediate Demand and Remediation Programme Business Cases are aligned with the draft NRLTIP and the strategic cases are due for consideration by CIC this month. Our strategic cases are being put forward together with similar cases from WDHB and ADHB to ensure that we remain visibly aligned and coordinated in our approach to the CIC.

Clinical Pathways

Metro Auckland DHBs and PHOs have agreed a further five year work programme and budget for ‘business as usual’ clinical pathways development, localisation, deployment, and evaluation. The Pathways programme is hosted by Counties Manukau Health and funded 50/50 between the three Auckland DHBs and seven PHOs.

The pathways programme aims to reduce unwarranted clinical variation, improve quality of care, and streamline the patient journey across primary, community and hospital services. Utilisation of pathways has grown steadily since its launch three years ago, with over 1,000 unique devices now being logged into the pathways platform per week. In the last quarter, the site was accessed over 40,000 times by clinicians viewing pathways content.

The work programme for the next five years includes improving consumer access, socialising the pathways with a wider clinical audience, and ensuring effective evaluation and monitoring with an equity focus.
Preparation for Tiaho Mai transition to the new Mental Health facility

The Building Capability Team is supporting staff in Tiaho Mai as they prepare for the move into the new building and the transition to a new model of care. Key activities have included staff engagement workshops, mentoring for clinical leaders, the introduction of leadership capabilities for key clinical roles and planning ongoing supervision for qualified staff within the unit. The work will support long-term professional development for the staff in this service.

Alcohol Position Statement

The Executive Leadership Team considered and endorsed a CM Health alcohol-related harm position statement in November (refer Appendix 1). Externally available position statements on this topic were already in existence at thirteen of the other DHBs and the development of this position statement had previously been endorsed as a component of CM Health’s Alcohol Action Plan 2016-2020, as a way of supporting communities and intersectoral partners to influence the social determinants of hazardous drinking and alcohol-related harm. The position statement has been shared with Auckland and Waitemata DHBs as they may wish to develop similar statements.

Performance and Outcomes Priorities

This is provided to demonstrate progress on the National Health Targets and present actions required to meet and maintain targets by the Ministry due date.

Health Target Summary – 2017/18

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Results</th>
<th>Status by 30 June 2018</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>AT RISK</td>
</tr>
<tr>
<td></td>
<td>October 2017 (individual month result): 92%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: The ED health target has not been met for the month of October.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To note however is that performance has improved since winter 2017 (July 2017 result of 84%). October ED presentation volumes show a 2.5% decrease when compared to October 2016 volumes. However year-to-date (YTD) presentations are 50,108 which represents a 3.6% increase from YTD volumes last year. Consistent surge presentation rates and consistently high hospital occupancy have impeded patient flow throughout the hospital meaning our ED has been unable to process patients within the target timeframe. A range of initiatives are underway to address underlying system challenges and manage demand.</td>
<td></td>
</tr>
<tr>
<td>*<em>Elective Surgery</em></td>
<td>Elective surgery will increase by an average of 4,000 discharges per year</td>
<td>ON COURSE</td>
</tr>
<tr>
<td></td>
<td>September 2017 (Q1 2017/18 result): 99.6% (target 100%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ESPi2: 32 FSA breaches (0.3%) for September (target 0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ESPi5: 29 treatment breaches (0.8%) for September (target 0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: The electives health target was narrowly missed in Q1 with a final shortfall of 19 discharges. The shortfall is a result of the high winter pressure on beds, high volumes of acute patients and a shortage of anesthetists resulting in a significant number of elective theatre sessions needing to be cancelled. Volumes are expected to be back on target by the end of Q2.</td>
<td></td>
</tr>
<tr>
<td><strong>Faster Cancer Treatment</strong></td>
<td>90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.</td>
<td>ON COURSE</td>
</tr>
<tr>
<td></td>
<td>October 2017 (individual month result – indicative only): 87% (4 capacity breaches from 30 patients, two at Auckland DHB and two at CM Health)</td>
<td></td>
</tr>
</tbody>
</table>
**Immunisation**

95% of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Māori and Pacific population groups).

October 2017 (individual month result): 94% for total population (Māori coverage: 89%, Pacific coverage: 94%)

**Raising Healthy Kids**

95% of obese children identified in the Before School Check (B4SC) Programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)

October 2017 (individual month result): 100% total population (Māori: 100%, Pacific: 100%)

**Tobacco Primary**

90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

October 2017 (individual month result): 84% total population (Māori: 82%, Pacific: 85%)

Note: it is normal for performance to drop in the first month of a new quarter due to PHO enrolment changes. It is expected that the target will be met by the end of Q2.

**Maternity**

90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

September 2017 (Q1 2017/18 result): 94% (Māori 93%, Pacific: not reported)

Note: Data only available quarterly.
Reducing harms from alcohol in our communities

Position Statement

Counties Manukau Health (CM Health) cares about the achievement of equitable health and wellbeing for the population we serve. Alcohol-related harms are major contributors to inequities in health and wellbeing outcomes. We support working together with people, whaanau, families, communities, health agencies and other partners to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm.

1. We support a broad and comprehensive package of evidence-based strategies that equitably prevent and reduce hazardous alcohol use and alcohol-related harm including:
   • restricting the availability of alcohol
   • increasing the minimum legal purchase age
   • increasing the price of alcohol
   • reducing alcohol advertising, promotion and sponsorship
   • drink driving countermeasures.

2. We support equitable access to high quality and culturally-appropriate healthcare services including assessment for hazardous alcohol use, brief and earlier intervention, and referral to treatment when indicated.

3. We support improving and refining information on hazardous alcohol use and alcohol-related harm in the Counties Manukau population and the geographical area we serve.

4. We support and encourage research and evaluation to ensure interventions targeting hazardous alcohol use and alcohol-related harm are effective and equitable.

Alcohol in our communities

Alcohol is not an ordinary commodity. It is an intoxicant, toxin, and addictive psychotropic drug. Alcohol has been normalised and largely accepted by society, and causes more harm than any other drug in society. Hazardous alcohol use contributes to large physical and mental ill-health, social, and economic burdens in New Zealand and globally, with impacts extending across sectors. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whaanau, friends, and the wider community.

In New Zealand, inequitable outcomes are apparent with men, Māori, young people, and those living in more socioeconomically deprived areas at higher risk of alcohol-related harm. Although many Pacific people do not drink alcohol at all, Pacific adults that do drink alcohol are more likely to have a hazardous drinking pattern than non-Pacific adults. The harmful health impacts of hazardous alcohol use in New Zealand are divided almost equally between injury and chronic disease outcomes and burden both inpatient and outpatient hospital services, and primary care services in the community. Alcohol-related health conditions are not confined to the minority that experience alcohol dependence with even low consumption increasing the risk of some chronic conditions (e.g. breast cancer).

In Counties Manukau district has an ethnically diverse population with strong cultural values. It is home to New Zealand’s second largest Māori population and largest population of Pacific peoples. In
Counties Manukau, it is estimated\(^1\) that 13% of adults aged 15 years and over (approximately 50,000 people) have hazardous alcohol use. Prevalence of hazardous alcohol use in Maori is disproportionately high at 29%.\(^{10}\) For people living in the Counties Manukau district there are, on average, five alcohol off-licence\(^{ii}\) premises within a five minute drive, and 30 off-licence premises within a 10-minute drive of where people live. Furthermore, one quarter of the schools and preschools are located within a five minute walk of at least one off-licence premise, and over half are located within a 10-minute walk of at least one off-licence premise.\(^{iii}\)

Rationale for our position

Hazardous and harmful alcohol use is identified as a major contributor to inequities and is amenable to healthy public policy.\(^{11}\) Each of the evidence-based strategies below is identified as an area for national action in the World Health Organization 2010 Global strategy to reduce the harmful use of alcohol.\(^{12}\)

1. **Equitable prevention of hazardous alcohol use and alcohol-related harm**

   - **Restricting the availability of alcohol**
     - Increased alcohol outlet density is associated with increased alcohol-related harm.\(^{13}\) Alcohol outlets are inequitably distributed in New Zealand with more alcohol outlets situated in socioeconomically deprived areas,\(^{14}\) further contributing to the unequal distribution of harm. There is strong evidence pertaining to the beneficial effects of reduced trading hours on alcohol-related harm.\(^{15}\)

   - **Increasing the minimum legal purchase age**
     - Young people are more vulnerable to alcohol-related harm than other age groups.\(^4\) Alcohol use during mid-to-late adolescence is associated with impacts on brain development.\(^{16}\) Raising the purchase age reduces adolescent access to alcohol, reduces harmful youth drinking, and raises the age at which young people start drinking.\(^1\)

   - **Increasing the price of alcohol**
     - Raising alcohol prices is internationally recognised as an effective way to reduce alcohol-related harm.\(^{17}\) Policies that increase the price of alcohol delay the start of drinking, reduce the volume consumed per occasion by young people, and have a greater effect on heavy drinkers.\(^{18}\)

   - **Addressing alcohol advertising, promotion and sponsorship**
     - Alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, drink more if they are already consuming alcohol,\(^{19}\) and makes it more difficult for hazardous users of alcohol to abstain.\(^{20}\)

   - **Drink driving countermeasures**
     - The risk of motor vehicle accidents increases exponentially with increasing alcohol consumption.\(^{21}\) In New Zealand, it has been estimated that over a quarter of road traffic injuries across all road user groups involve alcohol.\(^5\) Laws setting a low level

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\(^1\) Crude prevalence  
\(^{ii}\) Bottle stores, licensed supermarkets and grocery stores  
\(^{iii}\) GIS analysis from Auckland Regional Public Health Service
of blood alcohol concentration at which one may drive legally and well-publicised enforcement significantly reduce drink-driving and alcohol-related driving fatalities.¹

2. **Equitable access to high quality and culturally-appropriate healthcare services**
   - Assessment, brief advice, and referral to specialist services when indicated in healthcare settings (e.g. general practice²² and Emergency Departments²³) reduce hazardous drinking and alcohol-related harms. Detoxification is an effective treatment for alcohol dependence and addiction.¹

3. **Improving and refining information on hazardous alcohol use and alcohol-related harm**
   - Robust data are needed to accurately describe the burden from alcohol, inform decisions on what strategies and initiatives to develop and fund,¹² and support our communities and intersectoral partners with their alcohol data needs.

4. **Research and evaluation to ensure effective and equitable interventions**
   - Research is needed to identify evidence-based interventions for the communities we serve. Evaluation is required to measure the effectiveness of implementation and impact on equity.

Policy and legislative environment

CM Health’s position on alcohol in our communities has been developed in the context of the national policy and legislation outlined below. Additionally, the principles of Te Tiriti o Waitangi iv and the United Nations Declaration on the Rights of Indigenous Peoples v necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Māori and non-Māori.

**National Drug Policy 2015 to 2020**

The National Drug Policy²⁴ frames alcohol and other drug (AOD) problems as, first and foremost, health issues. The Policy aims to minimise AOD-related harm and protect health and wellbeing by delaying the uptake of AOD by young people, reducing illness and injury from AOD, reducing hazardous drinking of alcohol, and shifting attitudes towards AOD. Evidence-based strategies included in the Policy are:

- **Problem limitation:** Reduce harm that is already occurring to those who use AOD or those affected by someone else’s AOD use through safer use, ensuring access to quality AOD treatment services, and supporting people in recovery.
- **Demand reduction:** Reduce the desire to use AOD through education, health promotion, advertising and marketing restrictions, and influence conditions that promote AOD use.
- **Supply control:** Prevent or reduce the availability of AOD through border control, supply restrictions, licensing conditions and permitted trading hours.

**The Sale and Supply of Alcohol Act 2012**

This Act²⁵, replacing the previous Sale of Liquor Act 1989, adopts a harm minimisation approach. Its adoption followed a lengthy review by the Law Commission⁸ which recommended greater restrictions to the sale and supply of alcohol. Compared to the previous Act, alcohol-related harm is more broadly defined as both direct and indirect harm to an individual, society or the community caused by the excessive or inappropriate consumption of alcohol. The Act provides for Territorial Authorities (TAs) to develop and implement a Local Alcohol Policy (LAP). The aim of a LAP is to minimise alcohol-related

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¹⁰ Te Tiriti o Waitangi principles: Participation, partnership, and protection

⁹ Ratified by New Zealand in 2010
harm through measures to control the local availability of alcohol. Ideally, they should address local concerns and target inequities in alcohol-related harm. LAPs are drafted in consultation with the police, alcohol licensing inspectors, and Medical Officers of Health (MOoH), and include community input.

The Counties Manukau district spans three TAs, all of which have either adopted LAPs (Hauraki and Waikato District Councils\(^vi\)) or are progressing towards adopting LAPs (Auckland Council\(^vii\)). The two adopted LAPs place proximity limits on new off-licences with reference to facilities (schools, early childhood centres and playgrounds) and other off-licences. The Provisional Auckland Council LAP places a two-year freeze on new off-licences in 23 areas that experience high levels of harm, 13 of which are in the Counties Manukau area. All three TAs have restricted maximum trading hours for both off and on-licences\(^viii\).

The Act has increased the role of the MOoH in the licensing process, whereby they are now required to enquire into all licensing applications and provide input into LAPs. In the Auckland region, this role is provided by the Auckland Regional Public Health Service on behalf of all three metro Auckland District Health Boards including CM Health. District Health Boards are required to respond to TA requests for alcohol-related health information to inform their LAP.


\(^viii\) Premise where the sale, supply and consumption of alcohol is authorised on site (ie- Hotel, restaurant, bar)
References

Counties Manukau District Health Board
Occupational Health and Safety Performance Report

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period ending 31 October 2017.

Prepared and submitted by: Occupational Health and Safety Service on behalf of the Director Human Resources Elizabeth Jeffs.

Purpose

The purpose of the Health and Safety (H&S) report is to provide monthly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Counties Manukau District Health Board.

Executive Summary

There were no notifiable events for October 2017 and the profile of incidents is similar to previous months.

An audit of the DHB’s injury management practices was undertaken by an ACC appointed auditor on 1 and 2 November 2017. The audit has confirmed that the DHB continues to meet tertiary level requirements in the ACC Partner Programme. The report, while noting some areas for improvement, is very positive and acknowledges that the DHB has robust health and safety governance and performance reporting. A full audit will occur in mid-2018.

The organisation has purchased and begun to use the “TROPHI” tool which designed to reduce the risk presented by moving and manual handling. This is a “Tool for Risks Outstanding in Patient Handling Interventions” and is an internationally validated method for evaluating how well a care organisation is monitoring and managing the patient handling risk to staff, patients and the wider organisation.
Performance Scorecard

<table>
<thead>
<tr>
<th>Lagging Indicators</th>
<th>Leading Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Reported Incidents</td>
<td>Attendance at H&amp;S Orientation</td>
</tr>
<tr>
<td>Staff</td>
<td>97</td>
</tr>
<tr>
<td>Contractors</td>
<td>2</td>
</tr>
<tr>
<td>Students</td>
<td>0</td>
</tr>
<tr>
<td>Visitor</td>
<td>5</td>
</tr>
<tr>
<td>Number of Injury claims</td>
<td>H&amp;S Representative training completed</td>
</tr>
<tr>
<td>Staff</td>
<td>14</td>
</tr>
<tr>
<td>Contractors</td>
<td>10</td>
</tr>
<tr>
<td>Students</td>
<td>1</td>
</tr>
<tr>
<td>Visitor</td>
<td>1</td>
</tr>
<tr>
<td>Lost time Incidents</td>
<td>Pre-employment health screening completed</td>
</tr>
<tr>
<td>Staff</td>
<td>3</td>
</tr>
<tr>
<td>Contractors</td>
<td>0</td>
</tr>
<tr>
<td>Students</td>
<td>0</td>
</tr>
<tr>
<td>Visitor</td>
<td>0</td>
</tr>
<tr>
<td>Cost of Injury claims</td>
<td>Staff flu vaccination uptake</td>
</tr>
<tr>
<td>Staff</td>
<td>$9,500</td>
</tr>
<tr>
<td>Contractors</td>
<td>0</td>
</tr>
<tr>
<td>Students</td>
<td>0</td>
</tr>
<tr>
<td>Visitor</td>
<td>0</td>
</tr>
<tr>
<td>Number of Notifiable Events</td>
<td>Staff hand hygiene</td>
</tr>
<tr>
<td>Staff</td>
<td>0</td>
</tr>
<tr>
<td>Contractors</td>
<td>0</td>
</tr>
<tr>
<td>Students</td>
<td>0</td>
</tr>
<tr>
<td>Predominant Incident Profile</td>
<td>Pre-employment health screening completed prior to commencement</td>
</tr>
<tr>
<td>SSFE</td>
<td>21</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>18</td>
</tr>
<tr>
<td>Aggression and Violence</td>
<td>31</td>
</tr>
<tr>
<td>Slips/Trips/Falls</td>
<td>13</td>
</tr>
</tbody>
</table>

*Pre-Employment Health Screening (PEHS) Completed – Actual Oct data of 127% reflects that OHSS has completed additional PEHS for the month, for staff members who are due to commence employment later in 2017 or early 2018.

Scorecard Comments

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at Health and Safety Orientation 96%</td>
</tr>
<tr>
<td>49 Welcome Day attendance bookings were made with 47 attending. Those who did not attend were ill or had conflicting priorities. They have been re-booked into other sessions.</td>
</tr>
<tr>
<td>H&amp;S Representative training completed</td>
</tr>
<tr>
<td>The aim is to have 190 fully trained Health and Safety Reps by March 2018. Currently we are slightly behind the annual target, due to low attendance during September and October. However, registrations for future workshops have increased, due to additional efforts in promoting the workshops, and contacting individual managers and health &amp; safety representatives. In addition, 23 Managers have been trained during October, with a focus on risk management and use of the CM Health risk register.</td>
</tr>
<tr>
<td>Pre-employment health screening completed prior to commencement</td>
</tr>
<tr>
<td>New hires and transfers that commenced to the on-boarding phase in October.</td>
</tr>
<tr>
<td>Lost time Injuries</td>
</tr>
<tr>
<td>3 Lost time injuries occurred in October. The causation of these injuries were 2 Moving and Handling and one Slip/Trip/Fall incident.</td>
</tr>
</tbody>
</table>

Notifiable Events

There were no notifiable events in October 2017.
12 Month Rolling Trend at a Glance

Staff incidents (IRS)
Staff are being encouraged to report all incidents, it is to be noted that actual incidents and near misses are being reported as incidents. It is pleasing to note that staff incident reporting is increasing for the rolling 12 month period, which provides an opportunity for the improvement of risk identification and mitigation processes.

Pre-employment Screening
Pre-employment screening remained steady for the rolling 12 months, with a peak in August and September due to a large number of new intakes from the Northern Regional Alliance for Registered Medical Officers.

Attendance at H&S Orientation
47 employees attended the Welcome Day inductions in October. Investigation into comparing number of new starters with number of new employees receiving induction, will be undertaken within the coming months.

Number of injury claims
Injury Claims reflect a steady decline over the rolling 12 month period, as less injuries occurred in September and October.

Key
- Increased performance
- Steady performance
- Decreased performance
Reported Incidents

Summary

The incident profile consists of the following top four injury types for October 2017 including all employee, visitor and contractor incidents:

- Aggression and Violence: 31
- BBFE: 21
- Moving and Handling: 18
- Slip, Trip and Falls: 13

The number of reported incidents for the current reporting period (October) has decreased from the previous reporting period (August). There was a decreased number of incidents reported in September, which was partly due to some incidents within the Mental Health Service being reported as clinical incidents only with no follow up report made to OHSS. This issue has been addressed via OHSS attendance at the Mental Health risk review meetings. There is now an undertaking from key managers that any incident which involves aggression from a client toward a staff member will also be reported as a health & safety incident.

Body Blood Fluid Exposures and Slip, Trip and Falls have remained fairly constant, while Moving and Handling has decreased significantly.

The balance of incidents is mainly defined as ‘Other’. These relate to minor incidents such as insect bites and contact with static objects.

All incidents are followed up with the relevant manager of the work area to investigate and to close off.
Reported Incidents

Rolling year-on-year monthly average comparison:
Previous 12 months – 105
Current 12 months – 112.4

The year-on-year average number of reported incidents are higher than the previous period.

Environmental factors with no immediate injury impact but which have been notified is included in the ‘Other’ category.

These relate to hazards and risks such as excessive noise, glare, cleanliness, temperature, damaged property, blocked/obscured entrances and trespass. These incidents are followed up by the relevant manager of the work area.

Current Period:
104 incidents were reported in October 2017.

The incident profile remains consistent with other reporting periods with aggressions and violence, BBFE, moving and handling and slips/trips/falls remaining as the predominant incident profile.
Reported Incidents - Aggression and Violence

Rolling year-on-year monthly average comparison:

Previous 12 months – 20.3
Current 12 months – 23.6

The number of aggression and violence incidents fluctuated over the rolling year with a sharp increase in August and a sharp decrease in September. There is an upward trend on aggression and violence incidents year on year.

Current Period:

29 of the 31 Aggression and Violence incidents were directed at staff. The remaining incidents were directed at contractors and visitors.

The following incident types were recorded:

- Assault – Physical: 13
- Behaviour – Aggressive: 12
- Behaviour – Inappropriate: 2
- Assault – Verbal/gesture: 2
- Incidents remain high in Mental Health and EMIC.
Reported Incidents - BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly average comparison:

Previous 12 months – 22
Current 12 months – 23.5

BBFE incidents reported for the rolling 12 months have increased slightly.

All BBFE notifications are followed up with a detailed investigation by the OHSS clinical team to determine if the incident was a true or not-true event. The aim is to provide immunity screening and treatment as deemed appropriate. BBFE events are also referred to the work area managers for further follow up.

Current Period:

21 BBFE incidents were reported in October.

Causation profile:

Inattention/Distraction: 8
Acts of others: 3
Other: 3
Defective Tools/Equipment: 2
Patient Condition: 2
Fatigue/Tiredness: 1
Incorrect Work Techniques: 1
Policy/Safety Rule Violation: 1
Reported Incidents - Moving and Handling

Rolling year-on-year monthly average comparison:

Previous 12 months – 21.1
Current 12 months – 20.9

The trend for Moving and Handling incidents has remained relatively constant over the rolling 12 months. Incidents continue to be closely monitored and investigated.

A steering group has been appointed to advise on the risk in the organisation.

Current period:

Two Lost time injuries resulted from the moving and handling incidents reported in October. All claims are being managed by the injury claims management team.

Causation profile:

Lifting/carrying/load size: 9

Awkward posture/ equipment malfunction/ job factors/ action/behaviour of employee or patient/affiliate, human factors: 8

Assistance unavailable: 1
Reported Incidents – Slips, Trips, Falls

Rolling year-on-year monthly average comparison:
Previous 12 months – 13.8
Current 12 months – 13.4

Slips/Trips/Falls incidents have remained relatively consistent for the rolling year, but remain a significant cause of injuries at CM Health.

Causation profile:
Surface - slippery/wet: 3
Slipped/tripped/stumbled: 3
Awkward position/posture, lifting/handling/carrying: 2
Action/behaviour of employee/affiliate: 2
Human factors: 3
Reported Incidents – Workforce and Division

Reported Incidents Summarised by Category and Workforce for October 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Administration &amp; Management</th>
<th>Allied Health &amp; Technical</th>
<th>Medical</th>
<th>Non-Clinical Support</th>
<th>Nursing/Midwifery/HCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault / Behavioural</td>
<td>22</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>BBFE</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Slip/Trip/Fall</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reported Incidents Summarised by Division & Category for October 2017

<table>
<thead>
<tr>
<th>Division</th>
<th>Aggression and Violence</th>
<th>BBFE</th>
<th>Moving and Handling</th>
<th>Slip/Trip/Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARHOP</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>CCS</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>EMIC</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Facilities Services</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Franklin Locality</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kidz First</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Ko Awatea</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Manukau Locality</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MMC</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SAP</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Women's Health</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
## Key Health and Safety Risks and Actions to Remediate

Listed below are the key risks with a high risk remaining after remedial actions have been taken:

### Risk: Occupational Health and Safety - Aggression and Violence

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Executive H&amp;S Committee steering group met for the initial discussion on the Terms of Reference for the group and will meet next with a focus on the work plan.</td>
<td>An Aggression and Violence Steering Group, chaired by the Chief Medical Officer, is due to meet for next steps in the coming month.</td>
</tr>
<tr>
<td>The Community Mental Health teams have engaged in discussions with healthAlliance and the region to trial appropriate options of Personal Duress Alarm systems.</td>
<td>CM Health has agreed to undertake a Proof of Concept alarm monitoring period with 15 – 20 key workers across the various Community Health Sites. This includes the use of a mobile device with the appropriate application and a duress alarm.</td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk remains the same at present.

**Original Risk**

### Risk: Occupational Health and Safety - Community Health Work

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Community Health, H&amp;S Induction handbook is being reviewed again as an improvement initiative, given the focus on this risk. The aim is to ensure that the information remains current and up-to-date.</td>
<td>Community teams will be engaging in reviewing the home visiting process, specifically with focus on the following:</td>
</tr>
<tr>
<td>In alignment with the legislative requirement to work with our staff, Community teams have been requested to review the handbook and the appendices that apply to their specific location and to provide feedback.</td>
<td>• awareness of clinical risk assessment</td>
</tr>
<tr>
<td></td>
<td>• environmental checks</td>
</tr>
<tr>
<td></td>
<td>• option of home visiting with a colleague</td>
</tr>
<tr>
<td></td>
<td>• use of mobile phones</td>
</tr>
<tr>
<td></td>
<td>• staff whereabouts procedure</td>
</tr>
<tr>
<td>Safe Home Visiting training is continuing for all staff who visits service users in a community setting. Twenty full day courses are being provided with the capacity for 390 staff to attend by the end of this year. To date 227 have attended. Four workshops are scheduled for the remainder of the year.</td>
<td></td>
</tr>
<tr>
<td>A lone worker monitoring and distress application has been approved through proof of concept for trialling in the community. This is being led by Health Alliance and is a joint initiative with ADHB.</td>
<td></td>
</tr>
</tbody>
</table>

**Residual Risk:** The risk remains a constant with the DHB having excellent processes and training in place for a violate area.

**Original Risk**
## Risk: Occupational Health and Safety - Slips, Trips and Falls

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents of slips, trips, falls continue to decrease year-on-year but remain a predominant causation of injury.</td>
<td>12% of the incidents in October relate to slips, trips, falls. These incidents continue to be the one of the most significant causations of injury at CM Health. This remains consistent with other industries, nationwide.</td>
</tr>
<tr>
<td>The umbrella baggers have proved to be very effective during the winter weather.</td>
<td>Activities will continue to focus on reporting of trends and with the proactive communication with Facilities when repairs are required.</td>
</tr>
<tr>
<td>21% Of Slips/Trips/Falls were due to human factors or inattention while walking while 18% were due to wet/slippery/sticky surfaces.</td>
<td>Liaison with the Cleaning Service continues to ensure that wet floors are managed quickly, to reduce the risk to staff.</td>
</tr>
<tr>
<td>1 Lost time injury were reported in October due to a slipped on a wet surface and are being managed by our Injury management team.</td>
<td>Slips, trips, falls continue to be a focus of discussion in health &amp; safety training, with reporting of near misses also encouraged.</td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk has decreased following operational interventions by Facilities and the Cleaning teams. Causation is often due to human factors and errors such as distraction, which always remains a challenge to manage.

### Risk: Occupational Health and Safety - Safe Moving and Manual Handling

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>A budgeted amount as agreed by the Director of Hospital Services has been allocated to safe moving and handling training.</td>
<td>The General Manager ARHOP has led a working group. The working group has purchased the use of the “TROPHI” tool. This is a “Tool for Risks Outstanding in Patient Handling Interventions” and is an internationally validated method for evaluating how well a care organisation is monitoring and managing the patient handling risk to staff, patients and the wider organisation.</td>
</tr>
<tr>
<td>Involvement of the CM Health Workforce Capability Team has been confirmed.</td>
<td>The implementation of the tool will commence with training for 13-14 data collectors to conduct baseline assessments with consideration given to areas where the most injuries occurred.</td>
</tr>
<tr>
<td>Improvement advisor resourcing and the project approach have been discussed with Ko Awatea to support the Moving and Handling initiative.</td>
<td>Data collection will occur during the summer period when hospital capacity is more stable. Data collector groups include Occupational Therapists, Physiotherapists and Nursing staff.</td>
</tr>
</tbody>
</table>

From the assessments the specific needs of the
organisation and services will be determined and appropriate interventions based on the risks and opportunities will be developed.

<table>
<thead>
<tr>
<th>Original Risk</th>
<th>Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>The residual risk remains the same at present.</td>
<td></td>
</tr>
</tbody>
</table>

### Risk: Compliance - Health & Safety Training Framework

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Health &amp; Safety Representative and Champion Training programme is continuing with 93 participants trained to date.</td>
<td>The training plan and program has been communicated via Daily Dose and other appropriate communication channels and provides a selection of dates for managers for the balance of 2017.</td>
</tr>
<tr>
<td>Currently 72 employees are working through the unit standard AS/NZS 29315 to achieve the above. Tutorials for the Health &amp; Safety Representative unit standard assessment continue to be conducted twice a month.</td>
<td>The aim is to target every manager who is responsible for maintaining and updating a work area risk register in the future.</td>
</tr>
<tr>
<td>The aim remains for 190 Representatives and Champions to be trained by 31 March 2018.</td>
<td>Health &amp; safety training dates for 2018 have been identified and are currently being confirmed with Building Capability and Ko Awatea.</td>
</tr>
<tr>
<td>Uptake for the Risk Management training for managers has steadily increased over recent months, with 23 managers trained in October.</td>
<td>Training on the new Online Site Inspection Tool is continuing. Reaction from trial users has been very positive. Final fixes to the application are also being implemented.</td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk is low as CM Health has a framework in place to enable participation, consultation and engagement with staff in the development of systems, processes and procedures for health and safety at work.

### Risk: Compliance - Contractor Management

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Capital Works projects are fully compliant. They have active assurance regimes, are monitored, measured and validated by third party H&amp;S auditors.</td>
<td>An external audit of H&amp;S Management systems and compliance requirements is progressing with an external H&amp;S Risk Specialist conducting a number of interviews with key contracting stakeholders across all of CM Health.</td>
</tr>
<tr>
<td>Facilities are assured of compliance.</td>
<td>The evaluation is due for completion November/December, due to the complexity and diversity of the scope.</td>
</tr>
<tr>
<td>The Hospital and Facilities Contractor management process remains immature and will require resourcing, under the Facilities (and possibly other) functions to provide organisational assurance for H&amp;S as required</td>
<td></td>
</tr>
</tbody>
</table>
## Risk: Wellness - Employee Wellness

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Wellness, which is the focus of a Capstone Project (which is part of the Emerging Leaders Course through Ko Awatea and University of Waikato) continues to progress. The 2017 survey analysis has been completed and is being incorporated into the capstone Project Report.</td>
<td>Results from the survey will be presented as part of the presentation the Capstone Group will deliver to their peers and leaders in November 2017. The 2016 drafted Wellness strategy will be reviewed following feedback from the Capstone group, to ensure relevance and consistency in approach.</td>
</tr>
</tbody>
</table>

**Residual Risk**: The residual risk remains unchanged. The General Manager of Facilities and Engineering has indicated the risk to be low for Capital Works, based on external specialist feedback and review. The risk for the overall management for CM Health Contractors remains the same.

## Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current number of employees who have been trained as H&amp;S Representatives is 347. This includes training on both the old and new curriculum.</td>
<td>Those who had previously received training based on the old module (old legislative requirements) are being identified and communicated with to ensure retraining on the under the requirements of the Health &amp; Safety at Work Act 2015. The level and frequency of communication with H&amp;S Representatives has increased. This is to ensure that worker engagement and participation is maintained, while assisting Health &amp; Safety Representatives to consistently perform at a high level.</td>
</tr>
</tbody>
</table>

**Residual Risk**: The residual risk remains unchanged. The General Manager of Facilities and Engineering has indicated the risk to be low for Capital Works, based on external specialist feedback and review. The risk for the overall management for CM Health Contractors remains the same.
Workplace Inspections Conducted

For the September/October 2017 inspection cycle, OHSS received 95% (115) of the total (121) expected submissions showing a very high response rate across the organisation.

The low uptake in Mental Health is due to the relocation currently underway. OHSS provides oversight and is involved in the relocation meetings. OHSS is working closely with managers and Health and Safety Representative for the different locations to identify the new work areas. This will be completed by the time of the next inspection.

Workplace Inspection locations have been amended to match with the new divisional update that occurred in September 2017. Going forward the locations will be mapped to the updated organisational RC codes. Historical data for the Workplace Inspections are available, but does not match the new data set and therefore no historical data is shown in the graph below. Most changes occurred in Localities, Corporate, Hospital Services, SAP and EMIC.

The purpose of the Workplace Inspections is for the manager and staff safety representative to identify the hazards around the workplace, assess the risk and have a plan to manage and mitigate the risk.

Feedback from the Inspections indicate that the majority of hazards relate to facilities, building and equipment maintenance and improvement, as well as other similar housekeeping items.

The next inspections are due to be completed in December 2017.
General Service Updates

Driver Safety

Following a fatal incident involving a staff member driving to deliver patient medications, the OHSS queried the driving processes at CM Health.

It was established, in consultation with expert Risk Consultants and CM Health internal and external legal counsel, that the process currently in place at CM Health was sufficient to meet requirements for non-commercial drivers. For all employees who use a CM Health vehicle, a check is made that they have the appropriate license so as to confirm that the NZTA has approved them to drive on the New Zealand roads. The details of the license is retained within “AutoCentral” – the vehicle booking system in use within CM Health.

This system requires that each person who books out a vehicle, has a valid driver’s license and will not permit bookings to a person who has not registered or who has an expired license.

CM Health does not undertake any driver training as a standard. The organisation does offer professional driver training courses for those that frequently use CM Health vehicles, on a case-by-case basis. These can be booked through the relevant Service Managers.

Community Health and Lone Workers

OHSS have been actively involved with lone worker safety through incident investigations and working with Community Services and Mental Health. This includes review of the Community Health Orientation Handbook which has a key focus on home visiting and also meeting with Community and Mental Health teams to discuss work activities and risks.

In addition, OHSS has also been involved with review of the proof of concept for a lone worker security and distress application. This is being led by Health Alliance and is a joint initiative with ADHB. Individuals have also been identified for participation in a six week trial of this application starting late November.

Accredited Employer Programme Injury Management Audit Report

The audit has confirmed that Counties Manukau continues to meet tertiary level requirements in the ACC Partnership Programme. The report notes that:

“CM Health has demonstrated a commitment to health and safety improvement. The following strengths and initiatives were specifically noted by the auditor:

- Robust health and safety performance reporting.
- Health and safety governance review.
- Daily stand-up meetings which enables communications between Occupational Health & Safety Service (OHSS) and Service Managers.
- Processes for managing work injury claims are clearly documented.
- CMH and Wellnz work closely together to facilitate positive rehabilitation outcomes where possible.”

Focus group participants of managers and employees confirmed increasing levels of health and safety awareness and general understanding the “everyone has a responsibility”. Areas for ongoing improvement identified by the focus groups included working in the community i.e. lone worker risks and stress/fatigue associated with workloads and shiftwork.
The main area identified by case studies for further improvement related to the need for improved levels of communication with their case manager.

**Glossary for Monthly Performance Scorecard and Report**

<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost time incidents</td>
<td>Any injury claim resulting in lost time.</td>
</tr>
<tr>
<td>Lost time injury Frequency Rate</td>
<td>No of lost time Injuries per million hours worked.</td>
</tr>
<tr>
<td>LTIFR (Lost Time Injury Frequency Rate) = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.</td>
<td></td>
</tr>
<tr>
<td>Injury Severity Rate</td>
<td>Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked.</td>
</tr>
<tr>
<td>LTISR (Lost Time Injury Severity Rate) = (Number of Lost Hours / Hours Worked) x 1,000,000.</td>
<td></td>
</tr>
</tbody>
</table>
| Notifiable Injury/illness         | (a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations.  
(b) any admission to hospital for immediate treatment  
(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance  
(d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals.  
(e) any other injury/illness declared by regulations to be notifiable. |
| Notifiable Incident               | An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person’s health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident. |
| Notifiable Event                  | Death of a person, notifiable injury or illness or a notifiable incident.                                                                  |
| Pre-Employment                    | Health screening for new employees.                                                                                                          |
| Worker                            | An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer. |
| Reasonably Practicable            | Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters. eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk. |
## Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
</tr>
<tr>
<td>ARF</td>
<td>Audit, Risk and Finance</td>
</tr>
<tr>
<td>BBFE</td>
<td>Blood and/or Body Fluid Exposure</td>
</tr>
<tr>
<td>CCS</td>
<td>Central Clinical Services</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Programme (Counselling)</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>EMIC</td>
<td>Emergency Medicine &amp; Integrated Care</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSNO</td>
<td>Hazardous Substance New Organisms Act</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
</tr>
<tr>
<td>IRS</td>
<td>Incident Reporting System</td>
</tr>
<tr>
<td>JCC</td>
<td>Joint Consultative Committee</td>
</tr>
<tr>
<td>LTI</td>
<td>Lost Time Injury</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MMC</td>
<td>Middlemore Central</td>
</tr>
<tr>
<td>OHSS</td>
<td>Occupational Health and Safety Service</td>
</tr>
<tr>
<td>PHCS</td>
<td>Primary Health &amp; Community Services</td>
</tr>
<tr>
<td>PEHS</td>
<td>Pre-Employment Health Screening</td>
</tr>
<tr>
<td>SAP</td>
<td>Surgical, Anaesthesia &amp; Perioperative</td>
</tr>
<tr>
<td>SPEC</td>
<td>Safe Practice and Effective Communication</td>
</tr>
<tr>
<td>WellNZ</td>
<td>Injury Management Third Party Administrator</td>
</tr>
</tbody>
</table>
**Executive Health, Safety and Wellbeing Committee Minutes**
*24 October 2017, 9am – 10.30am*
*Middlemore Central Room 2*

<table>
<thead>
<tr>
<th>#</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review of previous minutes</td>
<td>Communications regarding the committee via Daily Dose still to be completed.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Wellness Strategy</td>
<td><strong>Discussion:</strong> Reviewed the draft Wellness Strategy&lt;br&gt;<strong>Action:</strong> More work required to get to a final document</td>
<td>Elizabeth</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Discussion:</strong> ACC management review shows great results due to the added FTE CMH has. The additional FTE shows a decrease in costs etc.&lt;br&gt;<strong>Action:</strong> To include in Daily Dose?</td>
<td>Elizabeth</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Discussion:</strong> Moving and Handling Committee hasn’t progressed.&lt;br&gt;<strong>Action:</strong> Elizabeth to meet with Dana</td>
<td>Elizabeth</td>
</tr>
<tr>
<td>3</td>
<td>Behaviours of Concerns Committee</td>
<td><strong>Discussion:</strong> Behaviours of Concern ToR reviewed. It was noted that due to the size of the committee they were unable to meet before mid/late Dec.&lt;br&gt;<strong>Action:</strong> Elizabeth to review group size with Vanessa and to discuss resource requirements</td>
<td>Elizabeth</td>
</tr>
<tr>
<td>4</td>
<td>Asbestos Management Plan</td>
<td><strong>Discussion:</strong> Andrew provided a summary from the recent HMT update. A review of Middlemore is currently underway to get oversight of all areas affected with asbestos. Galbraith building started one and a half weeks ago. Once the review is completed a management plan will be completed and a risk register set up for regular monitoring.</td>
<td>Andrew / Philip</td>
</tr>
<tr>
<td>5</td>
<td>Regional H&amp;S collaboration opportunities</td>
<td><strong>Discussion:</strong> Facilities and Engineering Regional collaboration meeting with a focus on Health and Safety</td>
<td>Andrew / Philip</td>
</tr>
<tr>
<td>6</td>
<td>Air Quality &amp; AC concerns opportunities</td>
<td><strong>Discussion:</strong> Coming into summer there are a lot of complaints around the thermal climate around Middlemore. Discussion also around the testing of air quality.&lt;br&gt;<strong>Action:</strong> Andrew to provide communications to staff via Daily Dose regarding heat management</td>
<td>Andrew</td>
</tr>
</tbody>
</table>
and the escalation process for clinical areas.

<table>
<thead>
<tr>
<th></th>
<th>Contractor Management – Brent Sutton review</th>
<th><strong>Action:</strong> Elizabeth to follow up with Brent Sutton on progress</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td></td>
<td>Elizabeth</td>
<td></td>
</tr>
</tbody>
</table>

|   | Other business | **Discussion/Action:** Elizabeth advised she would like to provide additional data for the Board report. Example: 70% people had not taken a 2 week holiday in the last 12 months. Which could be a result of rostering errors. Payroll report on late changes discussed. **Discussion:** Hazardous Substances - the risk register has Elizabeth assigned to this update which is due to ELT by August 2017. **Action:** Andrew to work with Pauline Hanna and to prepare a paper on resource requirements |   |
| 8. |                                            | Andrew                                                      |   |

**Meeting ends**
Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 13 October to 13 November 2017.

Prepared and submitted by Janet Haley Acting General Manager Corporate Affairs and Communications and Margie Apa, Director Population Health, Strategy & Investments Directorate.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 13 October to 13 November 2017.

Major Issues or Events

- **Inquest into the death of Heather Bills**: The coronial inquest has filed its report. The DHB is considering the implications of the Coroner’s report.
- **Ronald McDonald House**: Subsequent on-going media interest has centred on the Southern DHB with some reference to previous publicity on CMDHB.
- **Rosters for junior doctors**: Roster negotiations are still in progress. ADHB has issued a statement on behalf of the region.

Positive stories in the media

1. Diana Phone wins pharmacist of the year. Featured in Pharmacy Today
2. Proactive medication safety column from the perspective of a community pharmacist
3. Positive smokefree story featured in the Eastern Courier
4. CM Health mentioned in NZ Listener article titled ‘keeping business grounded’ and was part of a story called flight risk. The story talked about CM Health’s efforts in reducing carbon emissions.

Media and Email Enquiries

Approximately 40 media enquiries received. Significant media issues addressed during the period are included in the section titled ‘major issues or events’.

The Corporate Affairs and Communications Group manage a generic communications email box responding to all emails and connecting people to departments. For this period 120 emails were received. 64 were not related to communications issues and, where appropriate, were referred to other departments and services at the CM Health.

Routine Sector Communications

There are four regular e-newsletters that update on operational issues (e.g. referral pathways) and highlight issues and/or developments relevant to specific segments of the local healthcare sector. Through this reporting period one e-Update for Primary Care and one e-Update for Maternity Care were issued.
Campaigns in Development

- **Census** – The team have been working with CM Health’s population health team, StatsNZ’s communications team and the Northland DHB’s communications team to develop a plan that supports StatsNZ’s promotional strategy, develops enhanced promotional activity exclusively for CM Health’s population, and works collaboratively, where appropriate, with Northland DHB on activities that raise awareness of the census, and encourages participation [completion] of the census.

- **Mumps** – Due to an increase in Mumps cases in South Auckland, a targeted communications campaign was undertaken in October and November to raise awareness of the signs and symptoms, and the call to action – check with your doctor to find out if you are immunised or not, and if not, get immunised. Dr Maryann Heather from Southseas Healthcare was filmed for social media encouraging our Pacific community to get immunised and an A5 leaflet was printed and distributed through the CM Health Fanau Ola team to high school nurses and Pacific churches.

- **Facilities Master Planning** – A communication plan was developed to support the work taking place around two key pieces of work: Facilities Remediation Programme and Immediate demand Programme. The aim of the communication plan is to increase awareness and visibility of the work taking place and to reassure people that we are getting on with things. An internal web page is being created to increase staff access to information.

- **Transition from four digit extensions to five digit extensions**: To meet telecommunication needs as CM Health grows in services and facilities, phone extensions will change from four digits in length to five. This transition will take place late February 2018. A communication action plan has been created to support this work.

**Internal communication**

**Key focus: Patient safety week**

Communication Planning for Patient Safety Week (PSW) began late September and a range of collateral was produced to support the week. The theme this year was to highlight the importance of patients asking health professionals about the medications they’re prescribed. Communication material included posters, pull-up banners (which can be used again), social media campaign, videos, blogs, media (advice column on medication safety in the Manukau Courier) and posting of articles in Daily Dose and on Paanui. The medication safety video, which featured our own staff was promoted through a variety of channels. It reached 7,307 people on FB with 3.4 views and over 100 positive reactions. The staff safety display competition proved popular with a number of creative entries.
The ward display competition was a great success

Other key internal communication activities

- **Moving Forward Together Professional updates**: Help with fortnightly Nursing, Midwifery and Allied Health team updates on behalf of Jenny Parr.
- **Communication strategy** drafted for Directorate of Patient Care. Awaiting feedback
- **Social Media**: Celebration of Fiji, Nuie and Tokelau language weeks. **Engagement with Nuie language week reached 28,392 people, 104 shares and 260 reactions.** This was an amazing response.
- **Four patient safety leadership walk-arounds** attended. Key content/messages shared via internal channels and FB.
- Coverage and promotion of **Allied Health Awards and OT Week**
- Assistance with **Quality Accounts**
- Assistance and promotion of antibiotic awareness week, diabetes awareness week and stop pressure injury day.
- Communication support for **‘Pay it forward’ initiative**. This is being driven by a group of young doctors who want to encourage people to be kind to one another. A range of activities are planned starting early December.
- **Festive communication plan developed**. Leading up to Christmas a number of activities are planned throughout the organisation. We shall capture, celebrate and share these moments via our channels. It’s also a hard time for some people so we shall provide some tips on staying well and where people can go for support.
- **Team Counties blogs**: There were three TC Blogs published this reporting period: (Hospital Pharmacists: Promoting medication safety from admission to discharge, celebrating our allied health staff and exhibition celebrates the role of art in mental health recovery).

External communication key activities

- The external comms team have been working with CM Health primary care project team and The Warehouse retail group to explore incorporating family health messages into the retailers staff health and wellbeing programme targeted at the three Counties Manukau stores and the airport-based distribution centre. The first topic is pregnancy and newborn care and two focus groups with staff from these locations are planned to test CM Health messaging before fine tuning and delivering in March-April 2018.
- The team ran a workshop with the CM Health Maternity Consumer Group in October on the pregnancy journey and how that is experienced by South Auckland women. Information from this
workshop will help shape the delivery of a universal resource for women about how and when to access services and support during pregnancy.

- We are working with the Fanau Ola team on resources to communicate with our Pacific community on how the emergency department works. Emergency consultant, Dr Josh Tutone and Fanau Ola nurse Leilani Jackson were filmed for social media posts and these will be available online towards the end of November.

- Other notable activities include team working with staff from the Middlemore Foundation to look at strategies to raise the profile of the Middlemore Foundation to CM Health staff to our South Auckland communities; contributing to the Lessons Learnt Winter Report authored by David Hughes; participation in the Alcohol Harm Minimisation Working Group; and supporting the Kia Ora Hau Ora workforce development team’s communications activities.

**Digital Channels**

**Website** ([www.countiesmanukau.health.nz](http://www.countiesmanukau.health.nz))

The site shows a slight drop in traffic this period as is consistent with the passing of winter. Our population continues to be heavy mobile consumers with 48% of our traffic coming from mobile devices.

![Figure 1 Web Site Data Metrics from Google Analytics](image)
Social Media

This was a good period of growth for all our social channels. The CM Health Facebook page is the exemplar, with its consistent growth and development, but it was good to see that with the increase in post volumes across all the channels we were either able to maintain our follower increases from the last period, or improve them.

<table>
<thead>
<tr>
<th>Social Media Channel</th>
<th>Total Followers</th>
<th>Follower Increase</th>
<th>Messages Sent</th>
<th>Impressions</th>
<th>Impressions per Post</th>
<th>Engagements</th>
<th>Engagements per Post</th>
<th>Link Clicks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health Facebook</td>
<td>7,156</td>
<td>9.90%</td>
<td>43</td>
<td>304,784</td>
<td>7,088</td>
<td>4,516</td>
<td>105</td>
<td>91</td>
</tr>
<tr>
<td>Healthy Together Facebook</td>
<td>8,262</td>
<td>0.10%</td>
<td>18</td>
<td>35,964</td>
<td>1,998</td>
<td>348</td>
<td>19.3</td>
<td>64</td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,467</td>
<td>1.60%</td>
<td>126</td>
<td>23,310</td>
<td>185</td>
<td>84</td>
<td>0.7</td>
<td>22</td>
</tr>
<tr>
<td>CM Health LinkedIn</td>
<td>4,650</td>
<td>5.60%</td>
<td>18</td>
<td>58,863</td>
<td>3,270</td>
<td>839</td>
<td>46.6</td>
<td>524</td>
</tr>
</tbody>
</table>

Figure 6 Summary of Reach and Engagement Metrics for each Social Media Channel

Audience Growth Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Total</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fans</td>
<td>22,535</td>
<td>+4.5%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>669</td>
<td>4.5%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>39</td>
<td>1.6%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>157</td>
<td>+3.4%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>865</td>
<td>+3.8%</td>
</tr>
</tbody>
</table>

Figure 7 Audience Growth Overview by social media channel CM Health Facebook

CM Health Facebook

Continually our best performing channel, we now have over 7100 active followers with the total fans increasing by 9.90% since previous reporting period. Despite a 20% decline in messages sent, our per-post reach has risen since the last period. Engagement is still going strong, propped up nicely by our Niuean Language Week post which accounted for 20.4% of this month’s engagement alone.
<table>
<thead>
<tr>
<th>Post</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counties Manukau Health</td>
<td>920</td>
<td>104</td>
<td>8.3%</td>
<td>28,392</td>
</tr>
<tr>
<td>Happy Niuean language week! Nga'i, Alva and family share the importance of their language and what it means to them. Why not use some of these Niuean phrases throughout the week! #NiueanLanguageWeek</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) October 16, 2017 11:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>340</td>
<td>123</td>
<td>14.0%</td>
<td>19,174</td>
</tr>
<tr>
<td>Do you know an awesome Registered Nurse with Emergency Care experience? We are on the lookout for talented Registered Nurses both locally and internationally to join us at Counties Manukau Health. Our Emergency Department is one of the busiest in Australasia with over 110,000 adult and paediatric patients per year providing a wide range of clinical experience. It is a modern purpose built facility providing a wide range of clinical care and is one of two major trauma centres for the Auckland region and supports the National Burns centre for New Zealand. Please click here to apply <a href="http://ow.ly/7O0r30gmULW">http://ow.ly/7O0r30gmULW</a> - For more information please call William Wang on 09-289 6007. #TagYourFriends #DoYouKnowHim? #WeNeedYou #TagAnAwesomeRN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) November 06, 2017 4:00 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>324</td>
<td>36</td>
<td>11.4%</td>
<td>6,214</td>
</tr>
<tr>
<td>Teo! This week we’re celebrating Tokelau language week! Sisters Lelta and Alisa share a little bit about their Tokelauan culture and how to say hello. Why not give it a go? #TokelauLanguageWeek #Excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) October 26, 2017 9:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>280</td>
<td>34</td>
<td>7.0%</td>
<td>8,840</td>
</tr>
<tr>
<td>Today our Orthopaedics team is involved in World Thrombosis Day to increase global awareness of thrombosis, including its causes, risk factors, signs/symptoms and evidence-based prevention and treatment. We are also looking for Nurses with a passion for Orthopaedics, there are a few places in New Zealand that can offer you the experience of working with a nationally recognised Orthopaedic department. Click here to apply <a href="http://ow.ly/BluU30QcbFH">http://ow.ly/BluU30QcbFH</a> #WorldThrombosisDay #OrthopaedicDepartment #CMHealthCareers #HealthCareers #NurseJobs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) October 13, 2017 11:58 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 8 Top 4 CM Health Facebook Posts by Reactions**
Healthy Together Facebook

This month was a little bit slower for Healthy Together. A decrease in messages sent resulted in fewer impressions. However our engagement is on par with the averages we receive for this channel. With 19% of our impressions being viral, we reached around 603 people each day.

Top 4 Posts by Reactions:

<table>
<thead>
<tr>
<th>Post Description</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
</table>
| Healthy Together - Counties Manukau  
This amazing webinar! The work she does in our community, particularly in lifting Maori health, is inspirational. #whakaukutawhenua #kiairoi  
@WTVNZ Watch Sunday THE GOOD DOCTOR! TVNZ OnDemand  
(Post) November 06, 2017 10:22 am | 91 | 6 | 7.0% | 2,231 |
| Healthy Together - Counties Manukau  
Māori and Pasifika Treads Training: Auckland engineering and horticulture students have been working tirelessly today to finish building vege gardens at Rawiri Community House. These gardens will help the team at Rawiri to continue to help feed our communities. Awesome work! #teamwork #mahiwhithapupure #kompassion  
(Post) October 27, 2017 3:00 pm | 46 | 5 | 10.7% | 568 |
| Healthy Together - Counties Manukau  
Auckland University population health student Tangihia and Atisston College Year 13 student D'Voil engaging with the Manukau Community at the Community Expo, Southhair Shopping Centre.  
(Post) October 12, 2017 2:10 pm | 30 | 3 | 3.6% | 1,078 |
| Healthy Together - Counties Manukau  
Last Friday was the Franklin Positive Ageing Expo at the Pukekohe Indian Association Hall. Our Pukekohe Home Health Care team, Mental Health Services for Older People Community Team, and Needs Assessment team talked to the community about their services available for the elderly and their whānau.  
(Post) October 24, 2017 10:29 am | 24 | - | 7.1% | 749 |
CM Health Twitter

This channel’s numbers are down slightly due to fewer sent messages being sent. We reached over 600 people per day with our most popular tweet receiving 446 impressions. Our CEMARS recertification achievement gave us a small boost in engagement this month with a 4% engagement rate.

Top 5 Posts by impressions:

<table>
<thead>
<tr>
<th>Tweets</th>
<th>Top Tweets</th>
<th>Tweets and replies</th>
<th>Promoted</th>
<th>Impressions</th>
<th>Engagements</th>
<th>Engagement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health</td>
<td>@cmhealth</td>
<td>Oct 17</td>
<td>Recruitment and Pacific Workforce teams recently attended Joolfest, great opportunity for us to connect with youth. #Healthcareers #Jobfesx pic.twitter.com/QzDhmREvHh</td>
<td>445</td>
<td>7</td>
<td>1.6%</td>
</tr>
<tr>
<td>CM Health</td>
<td>@cmhealth</td>
<td>Nov 2</td>
<td>CEMARS recertification achieved! @B_MSolutions #CEMARS reaallforproof #excellent @BVRIR_Health pic.twitter.com/00kM7c3</td>
<td>378</td>
<td>15</td>
<td>4.0%</td>
</tr>
<tr>
<td>CM Health</td>
<td>@cmhealth</td>
<td>Oct 27</td>
<td>Showers/Wind today! With a high of 17°C and a low of 13°C. #Aucklandweather</td>
<td>375</td>
<td>3</td>
<td>0.8%</td>
</tr>
<tr>
<td>CM Health</td>
<td>@cmhealth</td>
<td>Nov 6</td>
<td>Do you know an awesome Registered Nurse with Emergency Care experience? For more information please call William Wang on 06 259 6007. pic.twitter.com/SODIBoeHGQ</td>
<td>345</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>CM Health</td>
<td>@cmhealth</td>
<td>Nov 2</td>
<td>We need you! Join our Midwifery Team! To find out how you can join us, please email <a href="mailto:nursesmidwifejobs@mddemore.co.nz">nursesmidwifejobs@mddemore.co.nz</a> or Phone - 09 259 3840 pic.twitter.com/FmpAihra</td>
<td>321</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>CM Health</td>
<td>@cmhealth</td>
<td>Nov 3</td>
<td>What a busy time to a student! Good Luck to everyone that is sitting exams in the coming week! Study Hard! pic.twitter.com/vuLupBq2Qs</td>
<td>314</td>
<td>2</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

Figure 10 Top 6 Tweets by impressions
A strong month for this channel, as our post volume increased we noticed a 20% increase in per-post impressions and 15% in engagement. We reached over 20,000 people, up 4.8% from the previous period. With recruitment being our largest focus on this channel, we consequently see over 5800 unique views of the careers section of the CM Health website.

Top 3 Posts by Engagement:

![Post 1]

Counties Manukau Health

We want the best Psychiatrists out there! Do you know someone who is? We are looking for passionate Psychiatrists to join our team and we are looking to be part of a change that truly makes a difference in people's lives. Read more at https://bit.ly/20zGk6s and reach out to our Head Psychologist @Psychiatrist. We're here for the world!

Impressions: 2412
Engagement: 2.5%
Likes: 37
Comments: 21

![Post 2]

Counties Manukau Health

Do you know an awesome Registered Nurse with Emergency Care experience? We are on the lookout for talented Registered Nurses both locally and internationally to join us at Counties Manukau Health. Our Emergency Department is one of the busiest in Australia with over 120,000 adult and paediatric patients per year providing a wide range of clinical experience. It is a modern purpose-built facility providing a wide range of clinical care and is one of two major trauma centres for the Auckland region and supports the National Burn Centre for New Zealand. Please click here to apply https://bit.ly/20zGk6s and for more information please call William Yang on 02 283 5031. #TagATrustFunder #DoYouKnowHeM #KahaNurse #OzsH招聘EmployNZ

Impressions: 3222
Engagement: 18%
Likes: 39
Comments: 20

![Post 3]

Counties Manukau Health

Meet Renae Taylor, an awesome Speech and Language Therapist working with the community at CM Health. How did you become a Speech and Language Therapist? I completed a Bachelor of Arts majoring in Psychology then took a year off working as a carer for children with special needs. It was during this year off that I saw what SALT does and thought that this would be perfect for me. Then I completed the Masters of Speech Language Therapy/Practica at the University of Auckland and became an SALT. What do you love about your job? The best part about this job is that we get to see people in their own homes, which I think allows us to develop more meaningful relationships. Another great part of this job is that we get to work closely with so many other disciplines and health professions like Physio, Occupational Therapy, Dietitian, Nursing, Dentists, Social Work, GPs, and other medical specialists. If you are looking for a new career in health care in contact with John from the CM Health Recruitment team on 02 276 5030 out 3421. #TagATrustFunder #DoYouKnowHeM #AllieHealthCareers #WakateaKohuoroHeM #KahaNurse #OzsH招聘EmployNZ #Speechie

Impressions: 1027
Engagement: 16%
Likes: 7
Comments: 8

Figure 11 LinkedIn Top 3 Posts by engagement
Counties Manukau District Health Board  
IRD Executive Officer Holder Nomination

Recommendation

It is recommended that the Board:

**Receive** the paper on the IRD Executive Officer Holder Nomination.

**Note** that this paper was endorsed at the Audit Risk and Finance (ARF) Committee meeting of 15 November 2017 to proceed to the 6 December Board meeting.

**Recommend** the appointment of Gordon Herdman, Manager Financial Control, as the Executive Officer Holder for Counties Manukau DHB with respect to IRD Tax related matters.

**Recommend** the Chair of the Audit Risk and Finance Committee signs the attached IRD Executive Officer Holder Nomination Form.

Prepared and submitted by: Timneen Taljard - Deputy CFO on behalf of Margaret White - Chief Financial Officer

Purpose

The paper is to recommend to the Board the appointment of Gordon Herdman as the Executive Officer Holder for IRD Tax related matters and to recommend that they appoint the Chair of the ARF Committee to sign the attached IRD Form.

Overview

Currently Counties Manukau DHB IRD Tax filing is completed manually and we would like to move to electronic filing, which is more efficient. IRD offers a role called the Executive Office Holder (EOH) who acts as the super user for an organisation/specified Tax Payer number. This person can create, modify and/or remove other people able to electronically communicate with IRD with respect to the Tax Payer number. This could be for filing tax returns electronically (e.g. GST, PAYE and especially the payroll files for earnings) or for secure email to IRD if there is something needing communication with them.

We propose that Gordon Herdman, Manager Financial Control (healthAlliance) be appointed as the EOH for Counties Manukau DHB. Gordon is the regional tax expert and is already the EOH for healthAlliance, New Zealand Health Partnerships Limited and Northern Region Alliance. He has also been responsible for manual filing of ADHB, WDHB and CMDHB tax returns. Auckland DHB has recently appointed Gordon as their EOH. Please note that there can only be one EOH and this position can create new users. It is anticipated that Gordon would need to create other users in healthAlliance to ensure there is sufficient cover for this i.e. payroll, GST, FBT, Withholding Tax. However, the EOH would act for “all electronic tax interactions” if required.

IRD will only accept an EOH Nomination Form (refer attached) signed by a member of the Board. We recommend to the Board that this form be signed by the Chair of the ARF Committee.

Appendix

1. Appoint an Executive Office Holder to act on your behalf – IR401 Form
Appoint an Executive Office Holder to act on your behalf

Complete this form to appoint an executive office holder to act on behalf of your organisation with Inland Revenue. This includes making enquiries, receiving statements, financial authority and registering for and managing a myIR secure online services account for your organisation.

Business/Organisation Information

Organisation's name: Counties Manukau District Health Board
Organisation's IRD number: 61244816

Executive Office Holder Please provide details of the person who will be the Executive Office Holder.

The Executive Office Holder is an individual who has an administrative or supervisory authority within the organisation:
• who has been specifically appointed to perform special duties in that regard and
• who has obtained specific written authority from the governing body to become an account owner for that non-individual organisation. (Note: this is different from a tax agent).

For a company, trust or partnership anyone can be appointed into an executive office holder position i.e. wages clerk.
For a club, society or school the Executive Office Holder must hold an official position which has a governance or leadership type role in the organisation i.e. chairman, president, chief executive officer, treasurer, secretary. Documentation supporting their position must be attached.

Name: Gordon Herdman
IRD number
Executive office holder's date of birth
Street address: 

Current position occupied (eg Chief Financial Officer)

Owner Please provide details of a valid owner who has the delegated authority to appoint an executive office holder.

Valid owners are:
• For a company – a director
• For a trust – a trustee
• For a partnership – a partner
• For an estate – the administrator or executor of the trust
• For a school – principal or chairperson of the school board of trustees
• For a Body Corporate – owner of the professional administration company, chairman or secretary of a body corporate
• For any other non individual – business owner, chairperson/president of the governing board or committee.

If you are not able to provide an IRD number and/or we have no record of the owner, documentation supporting their position must be attached.

Owner’s Name: 
Owner’s IRD number
Owner’s street address
Owner’s position (eg director, partner, etc)

Owner’s signature

Appointing an executive office holder does not change your responsibilities. You are still responsible for you or your organisation’s tax matters; for example you need to make sure that any returns are filed and tax paid by the due date.

Please print and sign the form. Once complete, attach any supporting documentation, and either:
• Scan and email the form to executiveoffice@ird.govt.nz
• Fax to 0600 473 329
• Post to: Inland Revenue, PO Box 39010, Wellington Mail Centre.
On receipt of the form, it will be processed within 5 working days (forms received by email within 48 hours). You will receive a letter confirming the appointment of the Executive Office Holder.
Counties Manukau District Health Board
Environmental Regeneration at Counties Manukau Health Strategy 2017-2050

Recommendation

That the Counties Manukau Health Board

Receive the document entitled, Environmental Regeneration at Counties Manukau Health Strategy 2017-2050.

Note the achievement of the five year target of reducing carbon emissions by 20%, with an audited result of 21.2%.

Approve the vision of Counties Manukau Health being carbon neutral by 2050 and the associate high level targets.

Prepared by: Pauline Hanna, Executive Project Director, Counties Manukau Health, endorsed by the Executive Leadership Team.

Glossary
DHB District Health Board
GHG Greenhouse Gases
CEMARS Certified Emissions Measurement and Reduction Scheme
MMH Middlemore Hospital
MSC Manukau Super Clinic campus
EAG Environmental Advisory Group (Counties Manukau Health)

Purpose

The purpose of the attached document is to describe:

i. The environmental sustainability journey Counties Manukau Health has taken since 2012 when the Board set a target to reduce carbon emissions by 20% by 2017 and;

ii. The proposed Strategy, “Environmental Regeneration at Counties Manukau Health 2017 to 2050”, updated following the successful accomplishment of the five year target.

Summary

Counties Manukau Health has a proven track record in environmental sustainability, being a certified member of the Certified Emissions Measurement and Reduction Scheme (CEMARS) programme since 2012. Membership and certification through CEMARS was achieved at the time a target of 20% reduction in carbon emissions was set by the Counties Manukau Health Board in 2012. CEMARS provided guidance as to a programme of work to achieve the target and an independent measurement methodology.

In October 2017, the annual measurement of carbon emissions at CM Health was undertaken and we are very pleased to advise that the target of 20% emissions reduction was exceeded with an actual reduction of 21.2%.
It is now timely to refresh the strategy, firstly by re-framing the Programme as one of *Environmental Regeneration* as the next evolution from environmental sustainability.

The proposed Vision is that *Counties Manukau Health* will be carbon-neutral by 2050 and the document sets high level but bold targets towards achieving this, along with a revised approach to socialising and communicating the overall programme.

**Costs, Resourcing, Funding**

This Strategy is submitted without a request for funding at this time. It is founded on the basis of building on what has already achieved and strengthening that foundation. However as progress is made and ideas developed further add value, business cases will be completed, prioritised through the Executive Leadership Team and submitted to the Counties Manukau Health Board.

**Northern Regional DHBs - Alignment**

With the growing focus on climate change the healthcare sector needs to plan accordingly. Counties Manukau Health currently leads the way with its work and achievements to date, within the Counties Manukau community as well as the health sector. It is the desire of the EAG to continue this leadership role.

There is currently an environmental network across the Northern Region DHBs that collaborates on an intermittent basis exchanging ideas, project details and successes. It is proposed to strengthen this network with emphasis on procurement and supply chain activities through a more formal multi-disciplinary group regularly convened through healthAlliance FPSC.

**Conclusion**

The targets described in the Strategy are bold and will involve taking a collaborative, integrated inter and intra organizational approach. The starting point is to building on existing regional relationships and work already underway and broadening that nationally. By adopting the principles of practice as suggested by the National Health Service, we will create a culture of stewardship.

**Appendix**

1. Environmental Regeneration at Counties Manukau Health 2017 to 2050 Strategy
Counties Manukau Health will be carbon neutral by 2050

Strategy Document

2017-2050
Executive Summary

Global opinion and scientific evidence suggests an urgent need for the world to reach carbon zero by 2050. In doing so, the impact of increasing global temperatures and ensuing climate change will be minimised. The New Zealand emission profile shows a mismatch between activities aimed at reducing carbon and those activities that actually add to New Zealand’s carbon footprint. Many opportunities exist, demonstrated by the adoption of environmental management programmes by large organisations both globally and locally.

The Auckland Council’s Low Carbon Action Plan aligns with many tertiary establishments situated in Auckland. Healthcare organisations across New Zealand are focussing on environmental sustainability since low carbon outcomes are generally regarded as being cost efficient, especially in terms societal costs and in relation to public health gains.

 Counties Manukau Health (CM Health) has a proven track record, being a certified member of the Certified Emissions Measurement and Reduction Scheme (CEMARS) programme since 2012. CM Health achieved the original 20% emissions reduction target by 2017 and new targets are outlined in this document, along with a revamped approach to socialising and communicating the overall programme.

We have refreshed our Environmental Sustainability/Regeneration Programme Mission Statement to reflect our maturity:

**CM Health will be carbon neutral by 2050**

There is a growing need to adapt to climate change and in the forthcoming few years the healthcare sector needs to plan accordingly. Worsening weather events as a result of climate change will adversely impact mortality and morbidity rates. Health services need to be able to cope with the resulting increased pressure on services. In addition, the healthcare sector needs to promote resilience to assure service continuity. The closing statements within this document set the scene for further discussions as this is relatively new territory for the healthcare sector in New Zealand.
Introduction

This document provides the detail and context in the form of a revised version of the environmental sustainability/regeneration strategy at CM Health. The former environmental sustainability strategy has been in place in its current form since 2012. It is a timely revision since the achievement of the 20% carbon reduction target that the organisation strived towards expires in 2017.

In order to set new targets and ensure the environmental strategy is tailored to the health system, regional, national and global alignment is required. An understanding of how CM Health links in with other organisations and institutions will allow for more informed decision making.

The initial discussion provides an overview of global opinion, including the Global Green and Health Hospitals Network, the NHS Sustainable Development Unit (SDU) and the Sustainable Development Goals. The focus then shifts to the New Zealand (NZ) context.

The national Ministry of Health target for carbon indicates a shortfall and highlights the importance of urgently reducing carbon emissions. The Auckland Council and several tertiary institutions within the Auckland region are all attempting to reduce the environmental harm of their day to day operations. As will be seen, there is a tendency to focus on common areas; travel, energy and waste all being key focal areas.

Before detailing what this means for CM Health, the discussion describes the situation in the context of the healthcare setting in New Zealand. Out of twenty District Health Boards (DHBs) five are actively working on environmental sustainability programmes, namely Wellington (CCDHB) Waitemata (WDHB) Northland (NDHB) and Auckland (ADHB).

The next section of this document will provide an overview of the current situation at CM Health in advance of stipulating new targets, set and endorsed by the Environmental Advisory Group. The final component of this discussion document describes a new approach to socialising the programme in the form of a comprehensive communication framework (One Planet Living). By adopting this framework, the new and revised environmental regeneration strategy will come to life, enhancing engagement, feeding the passion and interest, facilitating change; directing CM Health further along the journey towards regenerative healthcare practice.

The final section focuses in on climate change adaptation which presents the platform for further discussions into the resilience of the workforce and service infrastructure in the face of the changing climate.
Global Opinion

Global scientific opinion continues to confirm that we must reduce greenhouse gas emissions to keep global warming below 2°C, to avoid dangerous impacts of climate change. In 2011, the Royal Society of NZ stated that emissions from industrialised countries need to be reduced by 80-95% by 2050 relative to 1990. This would mean that the shorter-term targets negotiated in Paris in December 2015 needed to be at least 40% by 2030 relative to 1990 for industrialised countries.

Both the Royal Society of NZ (2011) and Australian Academy of Sciences (2015) suggested the need to reach zero carbon emissions by 2050 (refer to the references for pdf hyperlink). This is broadly in line with the level of global emissions reductions considered necessary to limit future human-induced global warming to not more than 2°C above preindustrial levels. ¹,²

As the climate crisis continues to accelerate, Global Green and Healthy Hospitals (GGHH) organized the 2020 Healthcare Climate Challenge to mobilize health care around the world to protect public health from climate change. Counties Manukau Health is one of many highly regarded global healthcare systems that have signed up for this Challenge. The Challenge is based on three pillars: mitigation (reducing healthcare’s own carbon footprint), resilience (preparing for the impacts of extreme weather and the shifting burden of disease) and leadership (educating staff and the public while promoting policies to protect public health from climate change).

The 2020 Healthcare Climate Challenge, launched in 2015, was a rolling series of events around the world that culminated in Paris at COP21, the United Nations’ (UN) Climate Conference. Leading health systems were recognized with awards, including CM Health. Since then, thousands more hospitals and health systems have participated in the 2020 Challenge. Kaiser Permanente being one of those Anchor Institutions³, setting ambitious environmental performance targets, details of which can be found in Appendix 1.

The Sustainable Development Unit in the United Kingdom (UK) has been leading the change with this regard. The National Health Service (NHS) Carbon Reduction Strategy sets out a challenging reduction target of 80% to be achieved by 2020. Their focal areas are-

- Leadership, engagement and workforce development
- Carbon hotspots (energy, transport, waste etc.)
- Commissioning and procurement
- Sustainable clinical and care models
- Healthy, sustainable and resilient communities
- Metrics, innovation, technology and R&D
- Creating social value

¹ Australia’s 2030 Emission Reduction Target
² Gazetting NZ 2050 Emissions Target (2011)
³ http://community-wealth.org/strategies
The NHS SDU follow four principles of sustainable clinical practice:
1. Prevention (early detection, health promotion)
2. Patient involvement (Many patients could take on a greater role in the management of their own healthcare)
3. Leaner service delivery (Preferential use of treatment options and medical technologies with less resource use)
4. Low-carbon alternatives (Preferential use of treatment options and medical technologies with lower environmental impact)

In doing so, a culture of stewardship is created where answers to questions are sought in relation to preserving the planet for our descendants.

The UN launched a new set of global Sustainable Development Goals and targets in 2015 to demonstrate the scale and ambition of this new universal Agenda, building on the Millennium Development Goals. The current carbon footprint for NZ and the Ministry of Health target indicates a shortfall and highlights the importance of urgently reducing carbon emissions. The goals (see Figure 1) and implicit targets aim to stimulate action in areas of critical importance for humanity and the planet. Refer to Appendix 2 for more detail.

![Figure 1. The Sustainable Development Goals (SDGs)](image)

This means NZ and all other UN member states will be expected to use the SDGs to frame their domestic development policies for the next 15 years. Of the 17 SDGs four goals are primarily concerned with environmental issues and climate change:

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5 [http://www.cid.org.nz](http://www.cid.org.nz)
• Goal 6. Ensure availability and sustainable management of water and sanitation for all.

• Goal 13. Take urgent action to combat climate change and its impacts.

• Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development.

• Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
NZ Emission Profile

In 2013 NZ’s total greenhouse gas emissions amounted to 81.0 million tonnes of carbon dioxide equivalent (Mt CO2-e) \(^2\). This is an increase of 14.2 Mt CO2-e from the 1990 level of 66.7 Mt CO2-e (a 21.3 % increase). Total emissions decreased by 1.1 Mt CO2-e (1.4 %) between 2012 and 2013, while net emission remained static. The agriculture and energy sectors represent the two largest contributors to the profile, together contributing 87.5% of the total emissions in 2013. Net emissions were 54.2 Mt CO2-e in 2013 as a result of 26.8 Mt CO2-e removals by the land use, land use change and forestry sector (LULUCF).

Agriculture was the largest contributing sector to NZ’s emissions in 2013. It contributed 39.2 Mt CO2-e, and comprised 48% of total emissions (see figure 2). Energy was the second largest sector, contributing 31.7 Mt CO2-e, comprising 39% of total emissions. Industrial processes and product use (IPPU) and waste both contributed 5.1 Mt CO2-e, (each making up 6 per cent of total emissions).

![Figure 2. New Zealand’s greenhouse gas emissions in 2013 (by sector, in million tonnes of CO2e)](image)

In July 2015, the NZ Government announced that the post-2020 climate change target is to reduce greenhouse gas emissions to 30% below 2005 levels, by 2030 (see Figure 3). New Zealand will meet these responsibility targets through a mix of domestic emission reductions, the removal of carbon dioxide by forests and participation in international carbon markets.
This graph was published in MfE’s 2014 ‘Briefing to the Incoming Ministers’ document and shows the challenge faced with regards to NZ’s emission profile. The dark blue line represents gross emissions, the light blue line shows emissions that count under Kyoto (our gross emissions minus carbon sequestered each year in the forests planted post-1990 as they grow). The red line shows where we actually need to be – “CP1” was the old Kyoto agreement and “Transition Period” is the Government’s target of a 5% reduction in net emissions by 2020.\(^6\)

The rising cost of carbon also needs to be considered. Since the NZ Emissions Trading Scheme (ETS) is up for a review, an increase in energy bills has been forecasted. On the 13 April 2016, the carbon price was $13. This is at least likely to increase by double by 2020 and double again by 2050\(^7\). For organisations with high energy demands, this additional cost will undoubtedly be passed down, further adding to the argument to develop low carbon plans.

In response to these challenges the Auckland Council: Low Carbon Plan sets out a 30 year pathway and a 10 year plan of action to transform towards a greener more prosperous liveable low carbon city, powered by efficient affordable clean energy and using resources sustainably. This plan led by the Auckland Council Sustainability Office focusses on five key areas of transformation and plans are underway to foster and develop a more collaborative approach between the Auckland DHBs and the Auckland Council-

- Travel
- Energy use and generation
- Built environment
- Zero waste
- Forestry, agriculture and natural carbon assets

\(^6\) Environmental Stewardship for a prosperous NZ (2014)
\(^7\) [http://www.mfe.govt.nz/publications/climate-change](http://www.mfe.govt.nz/publications/climate-change)
Results in terms of progress towards lowering carbon have yet to be announced since the plan was only implemented fairly recently although Auckland City is now a member of the C40 network. C40 is a network of major cities from around the world who work together to provide support to their respective climate change efforts under six initiative areas within the realms of mitigation, adaptation and sustainability. C40 actively help cities replicate, improve and accelerate climate action. These city-only working groups provide for honest knowledge exchange, enabling cities to tap into the global expertise of their peers as well as connect with technical partners. Through networks, cities find opportunities to undertake joint projects in areas of mutual interest and benefit.

**Auckland Tertiary Sector**

The tertiary sector plays an important role in terms of shaping policy, developing research agendas and providing education around sustainability and climate change. They employ large numbers of people, often have large faculties; in addition to catering for many thousands of students on campus.

**Auckland University of Technology (AUT)** has set a five year target- to have the architecture in place, having created a culture for sustainability and a roadmap for sustainability activities which is well understood and being implemented throughout AUT. With a 10 year target- to demonstrate innovative leadership in sustainability which enables graduates and staff to flourish as sustainability practitioners and create a sustainable future. Over the next 10 years those goals and areas are:

- Learning and teaching
- Research
- Governance, leadership and staff
- Partnership and engagement with communities

The University of Auckland recognises the need to use resources efficiently, intersecting with a commitment to environmental sustainability. Policies and practices support the sustainability of the University both in a financial sense, through effective resource utilisation, and in creating an environment those communities can enjoy and be proud of. Past experience indicates that further significant reductions in resource consumption and carbon dioxide emissions are achievable, despite continued growth of the University. A strong commitment to leadership in sustainability is reflected in teaching, research and service activities.

The University of Auckland aims to reduce the following by 2020:

- Energy consumption by 2%
- Wastewater by 14%
- Paper by 17%
- Waste to landfill by 21%
- CO₂ emissions by 15%

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Unitec recognises their responsibility to reduce waste and continue to make a large impact through a dedicated environmental strategy. They have committed to greening their campus by adopting the 10 One Planet Living Principles (to be discussed in more shortly).

The following targets have been set:
- Reduce Carbon Emissions by 30% by 2025
- Reduce Carbon Emissions by 50% by 2030 (Ultimate aim of zero carbon)
- Generate ≥ 1% of Unitec’s energy renewably onsite by 2025
- Increase proportion of renewable energy usage to 75% by 2020
- Increase proportion of renewable energy usage to 100% by 2030
- Increase space utilisation to 56% by 2020

New Zealand Health Systems

The NZ Public Health and Disability Act 2000 Section 22, Objective (j) requires that DHBs ‘exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations’. It has been suggested that 3-8% of a country’s total GHG emissions come from the health sector this is based on United States (US) and UK analyses. New Zealand is probably closer to the UK estimate (3%), see page 2 of: http://www.who.int/hia/hgebrief_health.pdf

Auckland District Health Board (ADHB) became members of CEMARS in 2015. They have no current dedicated sustainability lead and have assigned the CEMARS project to an existing role. A carbon reduction target had been set and they are aiming for a 10% reduction by 2020.9

Waitemata District Health Board (WDHB) was awarded Enviro-Mark Gold and has been part of the Enviro-Mark framework for many years, being the first DHB to have a dedicated sustainability lead. In all activities WDHB seek to:
- Maximise efficiency, minimise harm by targeting sustainable procurement, energy and carbon management, waste management, water management and designing the built environment.

Canterbury District Health Board CDHB is Energy-Mark10 certified and joined CEMARS in 2014 but no longer has a dedicated sustainability lead. Issues are being faced regarding senior organisational sign off of sustainability targets.

Capital and Coast District Health Board (CCDHB) and Northland District Health Board (NDHB) also have sustainability leads in place. NDHB aim for the following reductions by 2025 compared to 2016:

10 http://www.enviro-mark.com/our-members/members/canterbury-district-health-board
- 15% absolute carbon emission reduction
- 13% absolute energy reduction
- 10% reduction in commute related emissions
- 30% reduction waste to landfill
- 50% reduction paper use
Counties Manukau Health

Progress to date can be summarised by the following figure (Figure 4). Greenhouse gas emissions are expressed in tonnes of carbon dioxide equivalent and have been measured since 2011/2012. The first year represents baseline data, prior to environmental programme implementation. Two sites are included within the measurement Middlemore Hospital and Manukau SuperClinic/Surgery Centre (MMH and MSC). Emissions are tracking in the right downward direction.

The main emission sources include those related to energy, work related air travel, fleet cars and freight, nitrous oxide and waste. Recycling programmes are operational in many CM Health facilities, covering glass, hard plastic and soft plastic, metal, cans and paper, cardboard and e-waste. Desk top cubes have been introduced along side recycling bins in administration areas. Vermi-culture installations (worm farms) have been successfully situated at a handful of smaller sites to divert organic food waste from landfill.

Carpooling programmes are running at MMH, this includes providing dedicated priority car parking. Active travel promotions run periodically throughout the year, covering walking, cycling all forms of public transport. Cycle facilities are available at MMH and MSC to encourage staff to cycle. Plans have been discussed to introduce an offsetting programme, for senior medical officers’ (SMOs) work related air travel since travel is one of our top emission sources.

The Environmental Advisory Group (EAG) formerly Environmental Sustainability Board (ESB) serves as an expert group focusing on progressing initiatives and decision making to fulfil the purpose of the environmental regeneration programme. Counties Manukau Health has had a dedicated sustainability lead since joining the CEMARS programme in 2012, being the first DHB in Australasia to join the programme.
Communication is a crucial component of any programme and the following methods are already in place:

- Monthly newsletter
- Regular CEO blogs
- CEO forum
- Daily Dose
- Social media: Twitter, LinkedIn, Facebook.
- External webpage
- GGHH platform

For more details around the results of the programme, refer to the Annual Reports, listed on the Environmental Sustainability Website on Paanui.

Figure 5. Screenshot of the ES website homepage.
There is a need to set a new target, taking CM Health beyond the 2017 goal of reducing our carbon emissions by 20%. The following Mission statement represents our overall aspirational goal:

**CM Health will be carbon neutral\(^{11}\) by 2050**

This new long-term vision builds on the commitment to the existing environmental sustainability programme, and will further align business practices with the Healthy Together purpose of helping people and communities thrive.

Meetings were held in December 2016 which allowed for the discussion around strategy setting (refer to Appendix 3 for a summary of the main points discussed).

The following focal areas (see figure 6) are determined by the organisational carbon footprint and measured by the CEMARS programme. They are additionally supported by the literature and evidence provided in the preceding sections of this paper. There are other focal areas that will be addressed and included as the programme progresses.

Key consideration is required in terms of adopting a whole of systems approach since alterations in the current models of care and treatment modalities are required. Tackling the target areas summarised below provide the opportunity to direct attention to carbon hotspots but are by no means to be taken as an exhaustive list. The programme in itself continues to evolve and as such, the Driver Diagram (Appendix 4) will be updated to reflect this evolutionary process.

<table>
<thead>
<tr>
<th>Year</th>
<th>2025 % reduction</th>
<th>2030 % reduction</th>
<th>2050 % reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carbon</strong></td>
<td>30%</td>
<td>50%</td>
<td>Zero</td>
</tr>
<tr>
<td>Energy consumption</td>
<td>30%</td>
<td>50%</td>
<td>Zero</td>
</tr>
<tr>
<td>Waste volumes to landfill (nonhazardous)</td>
<td>30%</td>
<td>50%</td>
<td>Zero</td>
</tr>
<tr>
<td>Travel related emissions</td>
<td>30%</td>
<td>50%</td>
<td>Zero</td>
</tr>
<tr>
<td>Supply Chain % contracts meeting environmental standards</td>
<td>20%</td>
<td>% increase</td>
<td>50%</td>
</tr>
</tbody>
</table>

Figure 6. CM Health Environmental Performance Targets (high level)

Specific indicators within each area have been detailed in the driver diagram in the appendix (Appendix 4) but the following section offers a short description of examples of measures within each of the categories presented in Figure 6.

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\(^{11}\) Carbon neutrality is achieved by balancing a measured amount of carbon released with an equivalent amount sequestered or offset.
• **Energy**
Minimising the environmental impact of energy and utilities used to provide health services throughout the CM Health estate will help drive down emissions and costs. A new energy policy has been approved which sets out this direction and supports the aims of the environmental sustainability programme.

• **Waste**
Reducing waste to landfill volumes by optimising recycling focusing primarily on reducing the volume of general, medical and sharps waste. In addition, CM Health will look to add in an organic waste collection service by 2020. Furthermore, working with key suppliers and promoting the uptake of product stewardship schemes will assist with reducing waste generation rates.

• **Travel**
Reducing single occupied vehicle driver rates by 10% by 2020 and by 30% by 2030 will be a useful indicator to adopt. Plans also include offsetting all SMO work related air travel. Working with existing Auckland Transport schemes, ridesharing will be targeted, cycling promoted and a subsidy towards public transport explored. A travel strategy to support this work is also underway.

• **Supply chain**
Purchasing products and materials that meet environmental standards will be a key indicator and a number of other initiatives will be actioned in support of this action. Reducing the amount of meat served to patients, staff and visitors will also fall under this category as does purchasing from local suppliers/communities where possible. Incorporating pharmaceuticals into this field will also allow for the measurement of the environmental impact of anaesthetic volatile agents.

• **Engagement (see below)**

The table in Appendix 5 provides more details of the projects both underway and planned.

**Communication**

Developing a comprehensive communication strategy helps socialise the ES programme, raise awareness and encourage employees to take part in the suite of initiatives aimed at reducing the organisational carbon footprint. The literature reveals there are benefits of introducing a pledge\(^\text{12}\). By inviting employees to sign a pledge to reduce their own carbon footprint, individuals are more inclined to take ownership and actively seek out ways of being more sustainable. In addition, encouraging employees to take part offers health and lifestyle benefits beyond the direct measurable carbon benefits. Literature shows levels of satisfaction increase

\(^\text{12}\) [http://sustainability.berkeley.edu](http://sustainability.berkeley.edu)
when organisational and individual values align (Refer to Appendix 6 for details of the pledge).

**One Planet Living Principles**

Rooted in the science and metrics of ecological and carbon footprinting, 10 One Planet principles are used to structure thinking and inform holistic action. These principles stem from Bioregional’s experience of working on BedZED, a pioneering eco-village in South London, UK. Together, the principles provide a holistic framework to help organisations and project teams examine the sustainability challenges faced, develop appropriate solutions and communicate the actions being taken to key stakeholders such as colleagues, the supply chain, clients, customers and local and national government. These tie in nicely with the GGHH framework and our CEMARS programme. Figure 7 provides a summary of each principle and will be used to communicate and frame our programme of work, linking in with each component of the pledge.

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**Zero carbon**
Making buildings energy efficient and delivering all energy with renewable technologies

**Zero waste**
Reducing waste, reusing where possible, and ultimately sending zero waste to landfill

**Sustainable transport**
Reducing the need to travel, and encouraging low and zero carbon modes of transport to reduce emissions

**Sustainable materials**
Using sustainable and healthy products, such as those with low embodied energy, sourced locally, made from renewable or waste resources

**Health and happiness**
Encouraging active, sociable, meaningful lives to promote good health and well being

**Equity and local economy**
Creating bioregional economies that support equity and diverse local employment and international fair trade

**Culture and community**
Respecting and reviving local identity, wisdom and culture; encouraging the involvement of people in shaping their community and creating a new culture of sustainability

**Land use and wildlife**
Protecting and restoring biodiversity and creating new natural habitats through good land use and integration into the built environment

**Sustainable water**
Using water efficiently in buildings, farming and manufacturing. Designing to avoid local issues such as flooding, drought and water course pollution

**Local and sustainable food**
Supporting sustainable and humane farming, promoting access to healthy, low impact, local, seasonal and organic diets and reducing food waste
A range of methods will be adopted, and if required, existing ones adapted to support the communication strategy. Measures will be adopted to communicate the programme both externally and internally.

External measures will include using social media and posters with the aim of enlisting the assistance of members of the community. In addition, showing individuals how to best adopt a more suitable and meaningful lifestyle whilst taking on a leadership role with regards to regenerative practice.

For internal communication, the webpage and intranet site will remain, material posted and content updated as and when needed. The monthly newsletter will also continue on. Social media, currently used, will undoubtedly continue to be used more and more as the emphasis on social media continues to grow.

It is proposed that the forum will take place as a way of achieving wider support. Content has been developed using the climate change science literature, setting the context for New Zealanders whilst acknowledging the global impact of climate change, global warming and the many opportunities to do good. Education around each area will include four sessions (see Appendix 7 for further details).
Adaptation to climate change

This section first outlines the risks resulting from climate change to the public’s health and to service delivery. It then describes an overview of the response required from the health sector based on information collated from existing data. Lastly this section highlights a number of recommendations for the system to take forward.

The risks to the health sector include those to the health of the population, and risks to the delivery of services through changes in service patterns and to the infrastructure\textsuperscript{13}. Headline risks include the increasing likelihood of flooding events, alongside impacts on service disruptions and communities. The effects are expected to be unequally distributed, affecting deprived people and groups the most.

The health estate infrastructure in New Zealand is unlikely to be resilient to the changing climate with a number of health care buildings possibly situated in flood risk zones. Clearly these impacts also apply to partner services and supply chains which will have a knock on effect on the health of people and the health sector’s ability to deliver care.

The health sector needs to plan to:
- reduce mortality and morbidity associated with severe weather events and climate change
- promote resilience and service continuity to ensure sound service delivery

Climate change action results in health and financial benefits. Barriers to climate change action include short termism, financial constraints and system fragmentation. Recommended ways of overcoming these barriers to change have been reported. Embedding climate change into local thinking and decision making will help address the risks to health services. Infrastructural changes to accommodate the changing climate will also add to the resilience of health service delivery in the longer term.

The health sector also needs to monitor the developing impacts of climate change. In the Auckland region alone, there will be heavier rain and soil erosion, increased coastal hazards, increased drought/ fire risk, higher frequency of mental disorders, increased incidence of diseases such as salmonella, and increased risk of Dengue Fever, Ross River Virus. Further research to fully understand the best ways of developing climate resilience, supporting the development of sustainable cities and the impacts of a changing environment on health are being developed at the local and central government level.

\textsuperscript{13} \url{http://www.sduhealth.org.uk/areas-of-focus/community-resilience/adaptation-report.aspx}
Summary

The evidence presented throughout this document supports the development of a new revised version of the existing Environmental Sustainability programme for CM Health. There is a clear and recognised need to focus on carbon reduction and many challenges face CM Health. Lowering carbon arguably lowers costs and evidence to support this is mounting. For example, the number of jobs in the sustainability sector in the US has increased; showing clean energy is good for the environment, businesses and the whole economy\textsuperscript{14}.

The targets described are bold and will involve taking a collaborative, integrated inter and intra organizational approach. By adopting the principles of practice as suggested by the NHS SDU, we will create a culture of stewardship. This shift in culture requires a focus on prevention and health promotion, increased patient involvement, leaner service delivery and seeking low carbon alternatives.

Socialising the programme, as described, will achieve many benefits. Using communication tools like the One Planet Living Principles will help solidify the approach. Providing education on a recurring basis will help gather continued support, to gain more momentum and to ensure long term success of the regeneration programme as the programme continues to evolve.

The health sector is dealing with a high number of priorities and cost pressures which can make it difficult to prioritise action on climate change. However a number of actions can be taken to improve resilience and to reduce the likelihood of climate change which will also bring health benefits for individuals, communities and services. Many of these actions also bring financial savings so can be considered as multi-win measures. The health sector should seriously consider these actions.

\textsuperscript{14} \text{http://www.climateactionprogramme.org/news/sustainability_sector}
Reference Material


2. Environmental Stewardship for a prosperous NZ (2014)

3. Australia’s 2030 Emission Reduction Target

Appendices

Appendix 1 Comparison of Environmental Performance Targets

NAZCA also captures the commitments to climate action by companies, cities, regions, investors, and civil society organizations in an attempt to have one big global overview.

<table>
<thead>
<tr>
<th>Feature by Feature Comparison</th>
<th>Carbon</th>
<th>Electricity</th>
<th>Water</th>
<th>Renewable energy</th>
<th>Waste</th>
<th>Travel</th>
<th>Single Occupancy Vehicle</th>
<th>Number of car park spaces</th>
<th>Supply chain</th>
<th>Environmental standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health</td>
<td>Neutral 2050</td>
<td>Zero 2050</td>
<td></td>
<td>Zero 2050</td>
<td>Zero 2050</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100% 2050</td>
</tr>
<tr>
<td>International healthcare</td>
<td>Net positive 2025</td>
<td>Reduce intensity 25% per square foot</td>
<td>Increase onsite generation to 0%</td>
<td>Recycle 100% non hazardous</td>
<td>30% by 2030</td>
<td>500 fewer by 2030</td>
<td></td>
<td></td>
<td></td>
<td>50% by 2025</td>
</tr>
<tr>
<td>Tertiary (Auckland)</td>
<td>Reduce by 15% by 2020</td>
<td>Reduce by 2% by 2020</td>
<td>Reduce waste water 14% 2020</td>
<td>Increase renewable energy by 75% 2025</td>
<td>Reduce by 21% 2020</td>
<td></td>
<td></td>
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<tr>
<td>DHBs</td>
<td>Reduce by 15% 2025</td>
<td>13% absolute energy reduction</td>
<td>5% decrease 2018/19</td>
<td>Reduce by 30% by 2025</td>
<td>10% reduction 2025</td>
<td>72% to 66% by 2026</td>
<td>100% bio cups 2019/19</td>
<td>Enviro-Mark Gold</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix 2 Sustainable Development Goals

Goal 1. End poverty in all its forms everywhere.
Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
Goal 3. Ensure healthy lives and promote well-being for all at all ages.
Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
Goal 5. Achieve gender equality and empower all women and girls.
Goal 6. Ensure availability and sustainable management of water and sanitation for all.
Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all.
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.
Goal 10. Reduce inequality within and among countries.
Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable.
Goal 12. Ensure sustainable consumption and production patterns.
Goal 13. Take urgent action to combat climate change and its impacts.
Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development.
Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.
Appendix 3 Summary of Meetings held in December

Notes from ES meetings held on December 6 and 7, 2016.

Present Dec 6: Dave Galler, Andrew Kerr, Andrew MacCormick, Philip Healy, Allan Edmondson, Debbie (minutes).

Present Dec 7: Pauline Hanna, Clinton Pinto, Catherine Hocking, Helen Polley, Janet Hayley, Erin Eydt, Graeme Lindsay, Stella Welsh, Renee Greaves, Barbara Broome, Myra Barrett, Debbie (minutes).

Apologies: Rob Burrell, Ian Kaihe-Wetting, John Black, Samantha Barber.

1. Describe an aspirational direction of travel by setting a long term goal of zero neutral by 2050.

Promote the programme in terms of meeting the requirements associated with CSR. Engaged and active leadership at all levels is essential, from executive sponsorship to every area endorsing the programme.

Short term and long term goals need to underpin the overarching carbon zero target. Purchasing credible carbon credits should not be discounted in the future should this need arise.

2. Put together a 5 point plan identifying key focal areas.

Targeted work in the following areas-
- **Energy and water** - work with new energy manager on energy conservation, not forgetting the importance of water conservation. EAG to feed into an Energy Policy.
- **Travel** - Review underway. Footprint component must include work related air travel. Representatives from the Consumer Council really need to be involved in the Travel Review. Some great suggestions were made around site inaccessibility, this needs to be included in any strategy going forward that affects end users.
- **Waste** - continued work on waste reduction activities (upstream and downstream). Set a waste reduction target of 30% reduction by 2018 and zero nonhazardous waste to landfill target by 2040.
- **Supply chain** - continued work with main suppliers, adding more emphasis on making alterations at the policy level. Supply chain targets could include ensuring 50% of materials are made from recycled products.
- **Communication** - focussing on increasing engagement and shifting culture. Use of multiple methods- social media, video, posters, Driver Diagram. Using
onto an existing campaign might help with engagement such as the Palm Oil
Campaign (as Auckland Zoo has done) and/or becoming a Fair Trade
organisation. We also need to improve the external face of the organisation—
we have yet to have public place recycling for example.

3. **Apportion a weight to each.**

Energy has a relatively higher impact on our carbon profile and will therefore be
awarded a higher weight. The newly appointed energy manager will be working on
all utilities, focussing on measuring/monitoring and reducing electricity and gas
consumption in the first instance.

Travel to include patient and visitor travel. Working regionally with Auckland
Transport and focussing on health outcomes and health impacts. (Travel Strategy
Review has recently commenced). As Sir Muir Gray stated several years ago,
sustainable practice is about improving health. **Comment and feedback to be sought
from Dr Alex Macmillan.**

4. **Continue to work on culture/engagement/communication.**

A suggestion was made to set up a meeting with Lester Levy in the hope to discuss
the benefits of adopting a unified and collaborative regional carbon reduction
approach. Also as a means of discussing true costs, the idea came about to putting
together and publishing an **opinion piece**. An example being—of the financial
expenditure required for a new build, 20% is taken up at the start and the remaining
percentage required covering the operational lifetime costs. The more emphasis is
placed on future proofing in the design phase, the lower the lifetime costs.

Historically, BAU practices and accounting mechanisms are set up to foster short
termism where services are more or less encouraged to purchase the cheapest
product/service. A narrow approach is adopted and the wider impact of decisions
made are not taken into account.

Make sure members of the **Consumer Council formally join the EAG**. Debbie will
send Renee the membership and meeting details. IT was mentioned that the
programme needs to be socialised more widely and members of the community
enlisted to join. Posters could be placed in waiting rooms and assistance requested
to help us meet our carbon reduction goals.

5. **Rename our programme focussing on regeneration,
stewardship/guardianship.**

Repurposing our programme focusing much more on true costs, health impacts,
social and economic value interdependencies signifying a culture shift. Food Waste
to Plate and Travel Strategy are examples of the shift being made towards regeneration by incorporating wider benefits.

Rather than calling our programme a sustainability programme led by a sustainability officer and sustainability advisory group- new labels should be assigned. Renaming the programme and using simpler words came up as a discussion. The following words were used- Healthy environment, Healthy People, Healthy Planet, Green, Well, Clean. Ideas were bandied around including- Environmental Stewardship Programme- led by an Environmental Manager/ Environmental Advisory Group. Recommendation came about- to seek advice from Dr Rhys Jones and find out about a programme title that reflects the Maori culture, emphasising the notion of stewardship/guardianship.

(NB Kaitiakitanga means guardianship and protection. It is a way of managing the environment, based on the Māori world view. A kaitiaki is a guardian)

Choosing to add in a tag line to the Healthy Together brand might be a way forward with regards placing more emphasis on the programme.
Appendix 4 Driver Diagram ES Strategy (draft)

Environmental Sustainability Driver Diagram

Aim

Primary driver

Secondary driver

Change idea

Energy and utilities used to provide health services throughout the CMH estate is actively used and managed and the environmental impact minimised

- Combined improvement of energy performance of building and staff

- Waste minimising of energy consumption

- Implementation of energy efficient practices

- Procurement of energy

- Establish an energy management plan

- Share the site and program with key stakeholders, senior management and public

- Establish an energy management team

- Share experience with other sites

- Establish and improve energy efficiency

- Implement an energy management system

- Incorporate conservation principles in the use of resources (electricity, water, gas)

- Undertake energy audits

- Ensure energy efficiency awareness campaigns

- Our waste to landfill volumes are reduced to a minimum

- Good practices for recycling

- Waste management and education

- Prevention of foods and resources

- Establish a waste management team

- A waste audit is conducted and updates as necessary

- Implement a recycling scheme

- Reduce waste management and cost

- Patient/visitor and staff transport accessibility is improved while reducing traffic congestion and travel related emissions

- Utilisation of public transport

- Improved public transport options

- A reduction in public transport emissions

- Engagement with patients/visitors and staff

- Integration within key stakeholders and establishing an engagement team

- Engagement with Auckland Transport and optimising the range of services available (PT Buses, One Airport Express, Walk and Workshops, Community Taxis and application)

- Reduce use of fleet (land transport) and promote electric vehicles in order vehicles

- Network for the future

- Evaluate the viability of alternative vehicles

- Optimise weight of vehicles

- Precise mass for vehicles sold

- Improved infrastructure to support active travel facilities between hospital sites

- Implement a transport access and mobility strategy

- Staff and community are engaged with the sustainability programme

- Good relationship with existing and new suppliers

- Clear guidelines and evaluation criteria

- A number that suppliers and procurement relationship strategies

- Good reporting and feedback

- Understanding the education programme

- General communication through social media and non-sustainable media

- Internal communication to promote social media and a change in communications tools

- Actively engage with leadership teams, meeting high involvement events

- Effective communication to use a wide range of communication mechanisms

- Underpinned by activities

- Develop and update a communication strategy and plan

- Link to stakeholder support and interest

- Enable a strategic and practical sustainability events and sustainable development program

- Work closely with other CMH and DHB sustainability teams

- Engage in shared goals and sustainable programmes as well as the engagement

- Services are resilient and the community prepared to face the impacts of climate change

- Understanding the health projects for the Auckland region

- Establishing Climate Change Resilient Ecosystems and decision making

- Implement a change in communications processes

- Establish a Climate Change Advisory Committee

- Establish a Climate Change Advisory Committee

- Support community development of climate change resilience

- Support community development of climate change resilience
### Appendix 5 Projects underway and planned

<table>
<thead>
<tr>
<th>Cost</th>
<th>Benefits</th>
<th>Estimated return on investment</th>
<th>Timescale</th>
</tr>
</thead>
</table>
| **Automatic computer sleep programme** *(Energy)* | Nil | • Lower carbon footprint  
• Less energy wasted/lower electricity consumption  
• Minimum savings of $50 per computer | Immediate  
Savings $55k pa | Currently being rolled out, commenced October 2017 |
| **Organisation wide recycling** *(Waste)* | 12 month operational cost $68k (FTE)  
One off implementation cost $4k  
Waste reduction costs 12 months $80k | • Reduce general/medical waste volumes/costs  
• Reduced carbon footprint  
• Reduce labour of orderlies  
• Increased end user satisfaction  
• Modeling opportunity to roll out regionally and nationally  
• Reduce environmental impact of transportation | Less than 1 year payback | March 2017 |
| **CUP Campaign- Using durable kitchenware** | Nil | • Reduced foam cup spend, plastic cutlery spend,  
• Reduced general waste volumes  
• Lower CO2e emissions  
• More environmentally conscious culture | Reduced spend of $10k expected | End of 2017/18 FY |
| **Carbon emissions reduction** | Cost per kg of CO2 | • CO2 emissions have lowered by 3,772 tonnes of CO2e over the course of our Certification programme has saved $290,000.  
• External costs (or the environmental cost indicator) are based on European methodology to value environmental external costs per environmental effect.  
• This costs give an indication of the costs the society would be willing to pay to mitigate that specific environmental impact.  
• For global warming this value equates to NZ$ 0.77 /kg CO2e. | We expect to reduce our footprint by 500 tonnes saving $38,500 in external costs | End of 2017/18 FY |
| **Food Waste to Plate** *(Waste)* | Capital investment  
*(Infrastructure, Hungry Bins and Plant boxes)* | • Reduce general waste stream up to 230 tonnes per year  
• Reduce environmental impact of transportation  
• Revenue from compost, liquid fertilizer, worms and plant box outputs  
• Reduced labour for kitchen personnel  
• Modeling opportunity to roll out regionally and nationally  
• Opportunities to develop composting/growing skills for community members | Nett revenue year 2 $50k  
Nett revenue year 3 $210k | 2017/18 |
| **Hand dryers in public toilets** *(Supply chain/waste)* | Capital cost for hand dryers  
*(hand dryers, installation and contingency)* $180k | • Reduce general waste volumes/costs  
• Reduced paper towel costs  
• Reduce labour of cleaners  
• Increased end user satisfaction  
• Less toilet blockages therefore less expenditure required for these to be fixed | 12 months payback  
Nett saving of $180k pa | For review in 2017/18 |
# Projects 12-24 months

<table>
<thead>
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<th>Cost</th>
<th>Benefits</th>
<th>Estimated return on investment</th>
<th>Timescale</th>
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<tbody>
<tr>
<td>Energy conservation (Energy)</td>
<td>• Lower organisational carbon footprint</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Less energy wasted/lower electricity consumption</td>
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<td></td>
<td>• Develop a new energy strategy to identify a range of interventions related to conserving all utilities (commercial gas, water and electricity)</td>
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<tr>
<td>New role- Energy Manager reporting to GM Facilities. Expenditure allocated to implement projects including software and metering</td>
<td></td>
<td></td>
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<tr>
<td>Travel Strategy (Travel)</td>
<td>• Lower the environmental impact of site related travel activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial consultation phase has been instigated and expenditure allocated</td>
<td>• Target the whole of the community: to include employees, patients and visitors</td>
<td></td>
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<tr>
<td></td>
<td>• Work collaboratively across the region to improve the infrastructure and support the development of greenways (safe cycling and walking routes)</td>
<td></td>
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<tr>
<td></td>
<td>• Enhance the biodiversity of the local area and preserve the condition of existing conservation sites</td>
<td>Review commenced March 2017</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6 Make a Pledge

At 7.22 tonnes per capita New Zealanders are among the biggest greenhouse gas emitters per person in the developed world. And our emissions are getting bigger - growing 21% between 1990 and 2013. Higher CO2 emissions mean more rapid climate change - more drought, heat waves, severe storms, sea level rise, wildfires and biodiversity loss. By pledging to reduce your carbon emissions you play your part in creating a solution. We need more renewable energy, clean transport and better efficiency. Good for your health and wealth! Make your pledge from the list below (examples provided) then share it to inspire other colleagues, fellow Kiwis, and businesses.

- Put your devices away for an evening
- Restore a metre of stream
- Leave the car at home
- Use sustainable products at home
- Eat more local
- Offset
- Compost
- Plant a tree
- Purchase Fair Trade
- Give a day

Calculate your carbon footprint

Calculate your carbon emissions to help identify where you can make the biggest difference. Reducing your carbon footprint by choosing renewable energy, clean transport and being more energy efficient is good for your health and wealth!

https://www.enviro-mark.com/tools-and-resources/calculators
Appendix 7 Details of Education Forum

The education forum will have the following aims.

1. To socialise the ES programme and the concept of sustainable healthcare practice.
2. To provide a forum of support and discussion around ES initiatives, share existing knowledge and develop a directory detailing contact details of clinical champions.
3. To provide education around climate change, mitigation and adaptation around the main principles as a means of structuring thinking and informing actions.
4. Provide a rolling programme of education allowing the audience the opportunity to opt in for sessions.

The audience will be organisation wide and should be offered at a range of venues including MMH (Ko Awatea), MSC, Pukekohe Hospital, Papakura.

Session overview
Session 1: Background and context, setting the scene, climate change science and importance of measuring carbon.
Session 2: Practising sustainable healthcare practice, what this means for CM Health, ES programme overview
Session 3: Become a clinical champion: introduce the pledge, develop the network and share the knowledge and expertise
Session 4: Recycling: how are we doing, what can we recycle, how can we improve?

Timing/venue
Lunchtime session 12-12.45
Introduction 5 minutes
Main presentation 20 minutes
Discussion and feedback 20 minutes

Evaluation methods
Feedback forms
Email

Start date
March 2017
Counties Manukau District Health Board
2016/17 Quality Accounts

Recommendation

It is recommended that the Board:

**Receive** the 2016/17 Quality Accounts.

**Approve** the 2016/17 Quality Accounts for publication electronically on the CM Health and HQSC websites.

**Prepared and submitted by** Jo Rankine Quality Assurance Manager on behalf of Jenny Parr Director of Care, Chief Nurse and Allied Health Professions Officer.

Executive Summary

DHBs are required to publish an annual Quality Account (‘the Accounts’) and make this available to the HQSC. They attract a wide and diverse audience including media, politicians, other DHBs, our own staff and patients / whaanau. The Board provided comment on these Accounts at their October meeting which has been incorporated into these Accounts. They are complete except for the Chair’s Foreward.

Purpose

The purpose of this paper is to seek the Board’s approval to publish the 2016/17 Quality Accounts on our CM Health and Health Safety and Quality Commissions (HSQC) website.

Background

DHBs are required to publish an annual Quality Account (‘the Accounts’) and make this available to the HQSC. The Accounts are a supplementary document to the CM Health Annual Report and are endorsed by the ELT and approved by the Board. They attract a wide and diverse audience including media, politicians, other DHBs, our own staff and patients / whaanau. The Board provided comment on these Accounts at their October meeting which has been incorporated into these Accounts.

Proposal

That these Accounts be approved by the Board and made available electronically on the CM Health and HQSC websites. Please note they are complete except for the Chair’s forward.

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Opening Statements

Foreword from the Chair and Chief Executive

Board Chair to provide
Executive Summary

Quality Accounts Highlights

**Leadership**
Patient Safety Leadership team visits over 60 areas. Over 200 attendees, 300 staff and 250 patients participate in the process.

**Healthy Together Technology**
eVitals roll out to clinical areas (late 2017)

**Patient Experience**
- Inpatient survey completed by 6,500 patients.
- 8/10 people rated overall care as excellent or very good.
- 1,142 staff attend training in health literacy.
- Volunteers contribute 9,357 hours.

**Health System Integration**
- Safety in Practice rolled out to 78 practices.
- CM Health joins healthpathways community – over 20,000 users.
- 465,000 outpatient appointments across all facilities in 2016.

**Patient Safety and Excellence**
- Deteriorating patient programme making progress – national warning score and call for concern.
- Mana Taurite: Equity in Health campaign launched – 21 collaborative project teams.

**Workforce Development**
- Ko Awatea LEARN – 47,000 users across 15 NZ DHBs

**Facilities**
- Openings: Paataka Place, Stroke Ward, new Laboratory
Strategy

Counties Manukau Population

The community we serve in Counties Manukau in 2017

- **Are fast growing**
  - 545,720 people
  - 1-2% more people every year
  - 70,000 more people by 2025

- **Are youthful**
  - 122,570 children
  - 1 in 2 live in the most socioeconomically deprived areas
  - 13% of New Zealand’s children live here

- **And ageing**
  - 61,730 people aged 65 years and over
  - 4% more older people every year
  - 22,000 more older people by 2025

- **Are vibrant and diverse**
  - Counties Manukau is home to:
    - 16% Maori
    - 21% Pacific
    - 25% Asian
    - 40% Born overseas
  - By 2025:
    - 17% Maori
    - 21% Pacific
    - 28% Asian
    - 34% European/Other

- **Their health is not the same**
  - Life expectancy at birth:
    - 84 years non-Maori, non-Pacific
    - 76.6 years Pacific
    - 74.8 years Maori
  - 196,500 people live in the most socioeconomically deprived areas
  - 1,100 people receive care for a mental health condition
  - 62,000 people smoke
  - 2 out of 3 people are overweight or obese

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4. Based on unadjusted prevalence of overweight (BMI 25-25.9) and obese (BMI 30 or more) for CM Health adults aged over 15 years. Unadjusted prevalence for 2011-2014, New Zealand Health Survey. May 2015.
**Embedding our Values**

Over the past 12 months we have continued to embed and promote the organisation’s values through a variety of activities.

**Our people development**

- Values-led training for all staff and leaders continues to be provided as part of a portfolio of development programmes.
- The values are threaded through various leadership programmes.
- Four hour ‘Leading the Values’ continues to be embedded in our Foundations of Management programme for new managers.
- The values have been incorporated into Job Descriptions for clarity of expectation.
- Values integration will be integral to our Performance and Development Appraisals.
- Bespoke activity – work undertaken with individual teams and services is built on a foundation of the organisational value.

**Awareness**

- Welcome Day – Introduction of our values for all new staff continues.
- The values underpin our Mindfulness Based Resilience at Work programme, coaching and mentoring, and continue to be key part of our Patient Experience year.
- Supporting all of this is ‘Our Shared Values Pledge’, which outlines a clear set of behaviours that ‘we want to see’ and behaviours that ‘we don’t want to see’. This is supported by the ABC and BUILD frameworks, which provide staff and managers with tools for providing appreciative feedback (ABC) and constructive feedback (BUILD).

**Attraction/Branding**

Advertising templates and advertisements have been updated to incorporate the organisation’s values.

**Pre-screening recruitment questions**

We have included a values question as a part of our pre-screening questions that all applicants interested in working at CM Health are required to answer. “Which of our organisation’s values do you strongly identify with? Please explain why.”

**Interview templates**

Interview templates have been updated to include values based interview questions.

**Training for existing hiring managers**

Recruitment has rolled out a masterclass on Recruiting to Values to around 230 existing hiring managers. All new hiring managers also go through a Recruiting to Values intensive session through the Foundations of Management programme.
Delivering Healthy Together 2020

The Health Together strategy describes CM Health’s vision for achieving equity in key health indicators for Māori, Pacific and communities with health disparities by 2020.

Achieving the goal of health equity requires significant and sustained investments in organisational change. To ensure that change is approached the most effective and systematic manner, the Executive Leadership Team (ELT) created the Investment and Change Steering Group (ICSG) – a forum that provides delivery oversight across all CM Health’s programmes and projects.

Under the ICSG, project selection and prioritisation processes have been put in place and are supported by a disciplined portfolio-based approach to planning, resourcing and delivering programmes and projects. The ICSG is providing a greater focus on benefits planning, monitoring and realisation – ensuring that value is gained from our investments in change. Scarce organisational resources are being realigned and allocated to where there can deliver the most value.

As a result, CM Health now has a smaller number of more focused projects and programmes organised into portfolios. The types of programmes and projects range from small service improvement to the delivery of large assets. Collectively, all programmes and projects are supporting the organisation to change the health system so that health equity is achieved.
**Priorities 2016/17**

Key achievements are outlined below under our three Healthy Together strategic objectives that are closely aligned to the April 2016 New Zealand Health Strategy (NZHS) themes. Each of these achievements have contributed to the national strategy, as highlighted by the NZHS themes: *People Powered, Closer to Home, Value and High Performance, One Team, Smart System.*

### Healthy People, Whaanau and Families

<table>
<thead>
<tr>
<th>People Powered</th>
<th>Closer to Home</th>
<th>Value and High Performance</th>
<th>One Team</th>
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<td>- A community driven suicide prevention framework for Māori has been developed. This is supported by a Kaitiaki Roopu for suicide prevention in Counties Manukau, established as a result of a community hui which included representation from over 17 provider and social sector organisations.</td>
<td>- Ambulatory sensitive (potentially avoidable) hospitalisations in 0-4 year old Māori tamariki have reduced by five percent.</td>
<td>- 93 percent of eligible adults living in Counties Manukau have had their CVD Risk Assessment in the last five years.</td>
<td>- Through our primary care Alliance, over 29,000 patients have now been through the Planned Proactive Care. This result was supported by at least 15 community multidisciplinary team meetings each month, and an over 50 percent increase in the number of secondary care clinicians using SharedCare, from approximately 775 in June 2016 to 1,275 in June 2017.</td>
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<td></td>
<td>- CM Health and Primary Healthcare Organisations (PHO) have worked collaboratively to design and deliver the Enhanced Primary Care (EPC) pilot, which aims to deliver a more sustainable model of general practice. In 2016/17 the EPC modular design was tested through a pilot of nine general practices. The key focus areas were to understand and redesign patient access to general practice through promotion of patient portals, understanding of telephone data and reconfiguring reception roles and space; as well as develop metrics required to quantify the model of care changes.</td>
<td>- The number of children and young people discharged from community mental health and addiction services with a transition (discharge) plan has increased steadily over 2016/17 from 84 percent in Q4 last year to 95 percent in Q4 this 2016/17.</td>
<td>- Planned Proactive Care for children was launched in March 2017. The Planned Proactive Model of Care for Children programme within CM Health is a primary care led initiative targeted at children with long term conditions. In 2016/17 the roll out programme focused on eczema; asthma; and constipation.</td>
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<td></td>
<td>- In 2016/17 CM Health began work implementing the newly developed integrated model of care for mental health and addictions (MHA) services. A key focus of this work is the development of new locality-based, primary care-facing teams (Integrated Locality Care Teams) with the purpose of supporting MHA care in primary care and providing easier, more timely access to MHA support closer to people’s homes. The Franklin Integrated Locality Care Team was established in November 2016, with the three other locality teams planned for early in 2017/18.</td>
<td></td>
<td>- In 2016/17 CM Health piloted the Owning My Gout Project in which pharmacists work together with GPs and nurses to manage gout patients. This pilot project has been hugely successful and won Professional Service of the Year at the 2017 New Zealand Pharmacy Awards.</td>
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1 Formally known as the At Risk Programme (ARI)
## Healthy Communities

- Counties Manukau is home to approximately 15,000 Māori youth (rangatahi) aged 15 to 24 years, with many experiencing poorer health outcomes compared to their peers. Between August and November 2016 YouMe NZ, a youth-led group, launched their Love Your Life campaign which was focused on improving mental health awareness through a wellness-focused and “love your life” social movement.

- Ko Awatea launched a Health Equity campaign to address the health inequities experienced by Māori and Pacific people. The campaign has funded a range of initiatives focused on workforce development, responsiveness of services to Māori and Pacific communities and initiatives for healthy and vibrant children.

- In June 2017 the CM Health Board agreed that CM Health should, along with Auckland DHB (ADHB) and Waitemata DHB (WDHB), become a Youth Employment Pledge Partner under the Youth Employment Pledge, which aims to address rising youth unemployment within the Auckland region, and focuses specifically on growing the Māori and Pacific workforce. The Pledge was signed in July 2017.

- The Immunisation Health Target was achieved for Pacific children with 96 percent of eight month old Pacific children being immunised on time.

- CM Health achieved the Better Help for Smokers to Quit primary care Health Target equitably for all ethnicity groups in June 2017.

- Pre-school enrolment in oral health services has increased for all ethnicity groups since December 2015. Enrolment rates for Pacific pre-schoolers have increased by 9.5 percent to 85 percent enrolment in December 2016, and from 69 percent to 87 percent for Asian children.

- 60 percent of Pacific students enrolled in our regional Pacific Workforce programme (Programme W&AT) successfully secured a job in their respective areas in the health sector.

- Immunisation coverage for eight month old pepi Māori has increased three percent to 89 percent; with more improvements planned.

- In 2016/17 there was a focus on strengthening our school-based health service model across Counties Manukau. A comprehensive model has been in place at Papakura High School since July 2016 and GP and Nurse Practitioner services in schools and kuras have been operating in 11 high schools during 2016/17.

- CM Health’s performance towards the Raising Healthy Kids National Health Target has improved from 29 percent in Q1 to 98 percent in Q4, with equity across all ethnicity groups. This means that 98 percent of obese children identified in the B4 School Check programme in Counties Manukau were offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

- A Pacific Child Health Network was established with 11 Pacific Childhood Education Centre and home base of which is a forum for raising awareness in regards to health issues affecting Pacific children.

- The South Auckland Social Investment Board (SIB), of which CM Health is a member agency and host for the SIB Implementation Office, has achieved the deliverables set in the Cabinet endorsed Social Investment Plan for 2016/17. The SIB undertook a high level analysis of universal and targeted social service coverage for 0-5yr olds in Maangere. Since March, the SIB has funded small scale service changes to respond to the gaps identified, and get deeper insights on social investment opportunities for 0-5 year olds and their whānau in Maangere.
## Healthy Services

- **Rheumatic fever rates for Pacific** people living in Counties Manukau show an almost 40 percent reduction in rheumatic fever hospitalisations, from 48.4 per 100,000 back in 2013 down to 29.8 per 100,000 hospitalisations in 2017.

- As at May 2017, CM Health has achieved scores equal to or above the national average for all four patient experience domains measured in the **National Patient Survey**: communication, coordination, partnership and physical and emotional needs.\(^2\)

- As at June 2017, CM Health achieved **three of the National Health Targets**, with significant improvement also having been made towards the Faster Cancer Treatment Health Target (performance has improved from 75 percent in Q1 to 78 percent in Q4).

- In August 2016 construction started on CM Health’s **new Mental Health Inpatient Unit, Tiaho Mai**. Construction is progressing well and the project is due for completion in 2018.

- CM Health was the only DHB in the first tranche of the **Investor Confidence Rating (ICR)** in late 2016 to receive an ‘A’ rating from Treasury. This reflects excellent performance across all aspects of asset and management planning examined.

- **Value and High Performance**
  - 2016/17 was year three of the regional **Safety in Practice Programme** and involved 42 practices across the three metro Auckland DHBs\(^3\) and six PHOs. The programme aims to work with GP practices to create a consistent approach to enhancing quality improvement capability. In Counties Manukau in 2016/17, practices participated in areas such as results handling, Warfarin and opioid prescribing, cervical smears, and CVD Risk Assessment.

- **Contract work in the Pacific region** was successfully completed, including training of clinical health professionals from Fiji and Kiribati. Also successfully launched tele-health with the National Health Service of Samoa.

- The Auckland-Metro DHBs and Alliance Leadership Teams submitted the jointly developed **System Level Measures Improvement Plan**. Development of this plan was led by our PHOs in partnership with DHB clinical and service leaders, and has highlighted the strength of this relationship and reflects shared system wide accountability and integration across community and hospital care providers.

- **Community Central** became operational in 2016/17, processing all requests for Community Health Teams across all four CM Health localities, with efficiencies already recognised. Community Central provides centralised intake and triage for our community teams, supporting this through improved scheduling and rostering.

- **One Team**
  - During 2016/17 the Division of Surgery, Anaesthesia and Perioperative Services undertook a large **Theatre Optimisation Project** which resulted in an increase of five percent in theatre utilisation, increased electives sessions and list utilisation, reduction in day of surgery cancellations and enhanced booking processes.

- **Smart System**
  - **In 2016/17** electronic radiology orders were implemented and the roll out across CM Health is underway. This new electronic system is working well and helps to improve visibility of the request, saves time, improves referral quality and reduces test duplication.

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\(^3\) Auckland DHB, Waitemata DHB and Counties Manukau DHB together comprise the ‘Auckland Metro DHBs’
Future Focus 2017/18

In 2017/18 CM Health will continue to work towards our Healthy Together strategic goal, as well as focus on activities that will advance the New Zealand Health Strategy that “all New Zealanders live well, stay well and get well”.

The six national Health Targets remain a key priority in 2017/18, including a focus on keeping kids healthy through the Increased Immunisation and Raising Healthy Kids Health Targets. Providing Faster Cancer Treatment for people living in CM Health remains a government priority for 2017/18.

2017/18 is the first year of the government’s two new Better Public Service targets which are aimed at government agencies working efficiently and effectively together. CM Health will work with other sectors to increase engagement of future mums with health services, and reduce potentially avoidable hospital admissions for children.

Regional work on the System Level Measures will continue, further strengthening the collaborative relationship between the Metro Auckland DHBs, four PHO and GP partners who have led improvement plan development for each of the six measures.

We look forward to the final year of construction to rebuild our new acute mental health unit, Tiaho Mai, scheduled to open in 2018. The northern region DHBs will continue to collaborate on long term planning for future investments in services and facilities. In addition, we will be getting on with our local hospital site developments already approved by the Executive Leadership Team and Board.

CM Health’s involvement in the South Auckland Social Investment Board will continue in 2017/18 with the goal of improving support and outcomes for children and young people living in South Auckland, through better intersectoral working.

CM Health’s 2017/18 priority is to sustain high quality services at a time of unprecedented health service demand. Service development and planning in 2017/18 will be guided by our identified priorities for change as we continue to target our activities to make the biggest impact for our population while ensuring financial sustainability.
**Performance**

**System Level Measures**

The Ministry of Health (MoH) has been working with the sector to co-develop a suite of System Level Measures (SLMs) that provide a system-wide view of performance. The SLMs are high-level aspirational goals for the health system that align with the five strategic themes of the New Zealand Health Strategy 2016 and other national strategic priorities such as Better Public Service Targets. The SLMs have a focus on children, youth and vulnerable populations.

From 1 July 2016 the SLMs framework replaced the Integrated Performance and Incentive Framework (IPIF), and required Alliance Leadership Teams (ALT) to develop an improvement plan outlining planned activity. For 2017/18 onwards, this plan sits as an appendix to the Annual Plan.

Since the SLM framework was implemented, Counties Manukau and Auckland-Waitemata ALTs agreed to work together on a Metro Auckland SLMs Improvement Plan. A regional SLM Steering Group and working groups for each measure were established to support this process. Building on the SLM work in 2016/17, a 2017/18 metro Auckland SLMs Improvement Plan was recently approved by the MoH.

The approach to the development of the Metro Auckland SLM Improvement Plan is outlined in the diagram (Figure 1) below.

*Figure 1*
Measures

The metro Auckland SLM Improvement Plan includes the following elements:

a) The four SLMs implemented from 1 July 2016:
   1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds.
   2. Acute hospital bed days per capita.

b) For 2017/18, two new (developmental) SLMs:
   5. Youth access to and utilisation of youth appropriate health services.

c) For each SLM, an improvement milestone to be achieved. These are set by local ALTs. The milestone must be a number that either improves or maintains performance from the district baseline or reduces variation to achieve equity.

d) For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally. These are set by local alliances, DHBs, Primary Health Organisations (PHOs) and district alliances will drive implementation of SLMs.

Performance

In 2016/17, Counties Manukau Health met its SLM improvement milestones. Please see below (Figure 2) for a scorecard outlining regional progress.

Figure 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2016/17</th>
<th>Performance Actual</th>
<th>Performance Trend</th>
<th>Actual for Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure: Rate per 100,000 domiciled 0-4 year-olds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 2016/17: Maintain current (baseline) rate for each DHB</td>
<td>Auckland DHB 8,265</td>
<td>6,549</td>
<td></td>
<td>Year ending Mar-17</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau DHB 7,348</td>
<td>7,029</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata DHB 5,427</td>
<td>5,463</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metro Auckland Region 6,916</td>
<td>6,401</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute Hospital Bed Days Per Capita</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure: Age-standardised rate per 1,000 domiciled population.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 2016/17: Two percent reduction in standardised rate</td>
<td>Auckland DHB 466</td>
<td>427</td>
<td></td>
<td>Year ending Dec-16</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau DHB 455</td>
<td>452</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata DHB 425</td>
<td>407</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metro Auckland Region 448</td>
<td>428</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Experience of Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure: DHB Adult Inpatient Experience Survey: Aggregated Domain Score (10).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 2016/17: Maintain an aggregated domain score of 8 (10) across the three DHBs</td>
<td>Auckland DHB 8.0</td>
<td>8.2</td>
<td></td>
<td>Quarter ending Mar-17</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau DHB 8.0</td>
<td>8.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata DHB 8.0</td>
<td>8.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Amenable Mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure: Age-standardised rate per 100,000 domiciled 0-74 year-olds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target 2016/17: Maintain current (baseline) standardised rate for each DHB</td>
<td>Auckland DHB 98.7</td>
<td>80.6</td>
<td></td>
<td>Year ending Dec-16</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau DHB 135.6</td>
<td>109.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata DHB 84.9</td>
<td>70.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metro Auckland Region 80.2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
National Health Targets

CM Health’s performance against the National Health Target expectations in 2016/17 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with primary health care and PHOs, and their commitment and leadership to focus resources towards improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

### Health Targets

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Quarter</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shorter stays in Emergency Departments</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>95 percent of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours.</td>
<td></td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Improved Access to Elective Surgery</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>The volume of elective surgery will be increased by an average of 4,000 discharges per year.</td>
<td></td>
<td>110%</td>
<td>108%</td>
<td>107%</td>
<td>107%</td>
</tr>
<tr>
<td><strong>Faster Cancer Treatment</strong></td>
<td></td>
<td>75%</td>
<td>74%</td>
<td>76%</td>
<td>78%</td>
</tr>
<tr>
<td>85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.</td>
<td></td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Increased Immunisation</strong></td>
<td></td>
<td>29%</td>
<td>62%</td>
<td>91%</td>
<td>98%</td>
</tr>
<tr>
<td>95 percent of eight-months-olds will have their primary course of immunisations (six weeks, three months and five months immunisation events) on time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Raising Healthy Kids</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017(^4).</td>
<td></td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.</td>
<td></td>
<td>86%</td>
<td>89%</td>
<td>N/A</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>90 percent of pregnant women who identify as smokers upon registration with a DHB - employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^4\) Performance against this target is based on the number of referrals sent and acknowledged. 2016/17 was the first year of the Raising Healthy Kids Health Target and the target was achieved by quarter 4 through the establishment of an electronic referral pathway to primary care. The electronic referral pathway has been operational since 30 September 2016, with target results based on six-month retrospective data.

\(^5\) Due to ongoing issues with the Maternity Clinical Information System (MCIS), results for the Maternity Smokefree Health Target were not available in Q3. The issue was resolved and performance could again be measured in Q4.
Health Quality & Safety Commission Markers

The Health Quality & Safety Commission (HQSC) is driving improvement in the safety and quality of New Zealand’s healthcare through its quality improvement programmes.

The quality and safety markers\(^6\) (QSMs) will help us evaluate the success of the programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred.

The QSMs are sets of related indicators concentrating on specific areas of harm:

- **Medication Safety**
- **Falls**

  **Falls quality and safety marker**

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• **Healthcare Associated Infections:**
  - Central Line Associated Bacteraemia (CLAB) (marker retired in December 2014)
  - Surgical Site Infection (cardiac and orthopaedic (hip and knee arthroplasty) surgeries
  - Hand Hygiene

  **Hand hygiene quality and safety marker**

  **Counties Manukau Health**

  ![](chart1.png)

  Hand hygiene national compliance data is reported on three times every year, therefore no data point is shown specifically for quarter 4 in any calendar year.

  **Safe Surgery**

  **Safe Surgery quality and safety marker**

  **Counties Manukau Health**

  ![](chart2.png)

  The process measures show whether the desired changes in practice have occurred at a local level (e.g. giving older patients a falls risk assessment and developing an individualised care plan for them based on the findings of the assessment). Process markers at the DHB level show the actual level of performance, compared with a threshold for expected performance. The outcome measures focus on harm and cost that can be avoided.
The markers chosen are processes that should be undertaken nearly all the time, so the threshold is set at 90 percent in most cases. Outcome measures are shown at a national level, to estimate the size of the problem that the programme is addressing.

The markers set the following thresholds for DHBs' use of interventions and practices known to reduce patient harm:

- 90 percent of older patients are given a falls risk assessment.
- 80 percent compliance with good hand hygiene practice.
- Safe surgery measures are the levels of teamwork and communication around the use of the three paperless surgical checklist parts: sign in, time out and sign out via direct observational audit (with a minimum of 50 observational audits per quarter per part required before the observation is included in uptake and engagement assessments).
- 100 percent of audits where all components of the checklist were reviewed.
- 95 percent of audits with engagement scores of 5 or higher.
- 100 percent of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision.
- 95 percent of hip and knee replacement patients receiving 1.5g or more of cefazolin or 1.5g or more cefuroxime.
- 100 percent of hip and knee replacement patients having appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine (marker retired in July 2016).

### Serious and Sentinel Events

Any injury suffered by a patient during their stay in hospital is truly regrettable. CM Health is committed to learning from incidents of serious harm so that similar incidents do not happen again. Each year, in association with the HQSC, CM Health releases a summary of the in-depth and comprehensive investigations that take place after every serious incident. The report for 2016/17 will be released in late 2017.

Injuries suffered by patients when they fall are the most common ones in the hospital. Falls cause more minor, moderate and severe injuries than any other type of reported incident. In this year’s report, 23 patients were seriously injured after a fall. These injuries included significant head injuries, broken bones and skin lacerations that required stitches. Each of the incidents was reviewed to ensure that the comprehensive programme of falls prevention in place at CM Health had been followed. Understanding where improvements to the programme need to be made and how to better help staff keep patients safe are the main drivers for the review. Over the last year, there has been ongoing work to ensure accurate and timely assessment of falls risk and reliable implementation of falls prevention intervention.

There were 27 other incidents leading to actual or potential serious patient injury. In the last two years there has been a drive to report all moderate to severe hospital acquired pressure injuries. In this year’s report we have investigated the causes of eight pressure injuries. There has also been increased attention to incidents relating to birthing and four cases have been reviewed in depth. Five incidents related to medication error where the wrong dose or medication was administered.

We have also circulated a number of brief summaries of the lessons learnt from events called ‘Our Open Book’ with themes of privacy breaches, mental health events and retained items.
Pukekohe Intermediate Dental Clinic

On Monday 23 January 2017, employees at the Pukekohe Intermediate Dental Clinic were alerted to a potential contamination of the air supply used to supply the dental rooms. Staff observed that water was coming from the air supply button on a triple syringe (dental equipment), the dental chair and the cart. A service technician was called to the clinic and found that a redundant hose, left behind from a loan suction pump, had been attached to the air compressor intake with the other end secured in a grey water tundish, allowing the grey water to be sucked into the air compressor air receiver, then into the clinic air supply.

The compressor and air supply to the surgeries were isolated immediately and clinic employees were advised to cease use of all dental equipment. Appropriate actions were taken to contain the situation, plan and manage the contact tracing and communicate with the patients and whaanau affected; and investigate the cause of the problem.

After initial assessment an emergency response process was initiated, led by CM Health. An Incident Management Team was established and decisions were made about the need for contact tracing, communication with parents and key agencies. A conservative decision was made to offer blood tests to approximately 2,100 children who had received treatment in the clinic over previous months, as it could not be immediately ascertained how long children had been exposed to the grey water discharge. None of the 1,700 children, whose parents agreed to testing, had results indicating infection by blood borne viruses. An independent investigation into the cause of the incident was commissioned by WDHB which runs the clinic.

Inpatient Experience Survey

The patient experience survey was launched in August 2014 to replace the paper-based survey that was sent to patients after their discharge from hospital. With the survey, patients are sent an email or text invitation to complete an online survey. There has been a focus on getting email addresses from as many patients as possible. CM Health now has over 52,300 patient email addresses up from just 200 in early 2014.

The survey has now been completed by nearly 6,500 patients. Patients consistently reported that good communication and being treated with dignity and respect were most important to them. On average, eight out of 10 of those who completed the survey rated their overall care as excellent or very good.

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CM Health strives to do better and finds the comments and suggestions that patients provide make a considerable difference, particularly in regard to cleanliness and the quality of the food provided. The survey results are reviewed by senior managers and the Board. Survey results are published in a monthly report in hard copy and on the CM Health website.

Our aim for 2017/18 is to continue to improve uptake by the elderly and our Māori and Pacific patients who are not well represented in the responses. We are looking at the use of tablets on the day of discharge to capture feedback.

**Privacy and Risk Management**

**Risk Management**

CM Health understands that the decisions we make or where we choose to focus our attention brings with it risk. Delivering on our Health Together strategy is critical to the success of delivering quality health care to our communities. As part of delivering our strategy, we need to understand the risks we face and more importantly how we manage these.

Our objective is to ensure that we clearly understand our risks, ensure the adequacy and effectiveness of the mitigations in place and have a robust process for continuous monitoring and review.

We have previously updated our risk management framework and are continuing to implement this across the business. This includes the creation of a Risk Forum, comprising representatives from across the business. The objective of the forum is to improve risk transparency and reporting at a service level. We have improved risk reporting to the Audit, Risk and Finance Committee with a detailed Risk Heat Map and corresponding risk register.

We will continue to review and adjust the programme of work, as appropriate to improve risk management maturity across the organisation.

**Privacy**

CM Health recognises the importance of protecting personal information about our staff and patients in all business activities. Protecting an individual’s privacy is about respecting a person’s rights and is fundamental to maintaining trust and freedom of expression.

In response to the Government Chief Privacy Officer’s Privacy Self-Assessment, we have initiated a programme of work to improve privacy maturity. Our programme of work encompasses activities to increase maturity of governance, improve business processes and increase awareness of staff responsibility for the management and protection of personal information.

The programme of work includes refreshing policies and procedures, revision of privacy processes, communication and training to deliver privacy improvement outcomes. We recognise that to deliver consistent continuous improvement the programme of work is not a single piece of work but is iterative and constant.

CM Health will be evaluating progress against our goals annually through the Government Chief Privacy Officer’s Privacy Self-Assessment process.
Health and Safety

Occupational health and safety is one of the principles that are core to organisational health goals, and is in line with Equal Employment Opportunities principles.

The Health and Safety Management System (HSMS) aims to provide CM Health with a means of delivering continuous, consistent and effective health and safety practices across all of its business activities and operations. Application of the HSMS is a mechanism for the delivery of objectives detailed in CM Health’s business plans and Health and Safety Policy and Plan.

The HSMS takes a structured approach for managing activities using an integrated methodology built upon a platform of recognised national and international standards.

External assessments are undertaken with the aim of comparing improvement trajectories that consider activities that relate to the Health and Safety.

Framework elements which include:
1. Governance and Assurance
2. People Engagement, Development and Leadership
3. Hazard and Risk Management
4. Injury Prevention and Incident Management
5. Emergency Response Planning and Management
6. Procurement of Contractors and Suppliers
7. Health and Safety Process, Methods and Document Control
8. Infection Control, Hazardous Materials and Waste Management
9. Safety in Plant and Equipment and Maintenance
11. Inspections, Monitoring Checks and Audits
12. Public, Visitor and Client Safety
13. Change Management

Each of the thirteen elements have sub-elements that are assessed during the review,

The system is supported by a robust Health and Safety Plan which presents a strategic and operational approach that is underpinned by an increased focus on risk. Currently Health and Safety risks are aggregated and prioritised to present controls and mitigations in a risk-based framework.

Risks currently being actively managed in a joint partnership approach with our employees include working in the community, Safe Moving & Handling. Aggression and violence is a risk that will follow the same engagement and partnering approach, both within the organisation and in the region in the future.

CM Health successfully maintained tertiary accreditation as a result of the bi-annual external ACC Workplace Safety Management audit. This level of accreditation allows CM Health a 20 percent discount to the annual CM Health ACC levy and represents an industry recognised endorsement that the organization has an effective health and safety framework and effective practices in managing workplace injuries.

These activities alongside senior management and Board commitment to implement and improve health and safety practices will continue to ensure that CM Health provides a quality framework for a safe working environment for our staff.
Patient Safety Groups Overview

There are a number of work streams that report to the Safety, Experience, Certification and Measurement Operational Group (SECMOG), including patient safety work streams, such as:

- Central Line Associated Bacteraemia (CLAB)
- Falls Prevention
- Hand Hygiene
- Medication Safety
- Perioperative Harm (SSI, safe surgery)
- Pressure Injuries
- Restraint Minimisation
- Venous Thromboembolism (VTE)

and clinical effectiveness work streams, such as:

- Care Standards/Care Compass
- Certification Corrective Actions
- Controlled Document Committee
- Copeland Risk Adjusted Barometer (CRAB)
- Opioid Collaborative
- Plan of Care

The purpose of SECMOG is to have operational oversight of these patient safety and experience activities and related improvements across the system and to support the work streams that deliver improved patient safety, experience and clinical effectiveness outcomes.

The following are highlights from some of these groups.
**Falls Prevention**

The aim of the Falls Prevention Group for this reporting period was to maintain the focus on falls risk assessment and individualised care planning and provide analysis of data and direction for a targeted reduction in serious harm from falls.

The Falls Prevention Group conducted an in-depth analysis of the falls that resulted in serious harm as reported to the HQSC in 2015. This resulted in a CM Health *Our Open Book* communication being developed outlining the findings and learning which distributed to staff and well received.

Falls Awareness Week was held on 4-8 April 2016 with a focus on education for staff around the reasons why patients fell and were harmed. The sessions included local data on falls, a case review of serious harm from a fall and an opportunity for staff to have further discussion. Falls prevention resources from the HQSC were distributed to all the inpatient areas.

The Falls Group is involved in a number of activities to reduce falls across the organisation with a focus on enhancing front-line ownership of falls prevention such as the testing of a Post Fall Checklist and Falls Huddle process.

Figure 4 below shows the number of falls with major harm per 1,000 bed days. Since January 2014, on average, there has been an 18 percent reduction in falls with major harm.

**Hand Hygiene**

The aim of the Hand Hygiene team for this reporting period was to increase awareness of the ‘5 moments of Hand Hygiene’, i.e. before touching a patient, before clean/aesthetic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings) and to continue to achieve minimum 80 percent compliance across all gold auditor clinical areas whilst spreading national gold auditor programme organisation wide.

- In the last audit period (April-June) hand hygiene was 84 percent overall. A total of 12 units are now involved in the hand hygiene audit programme, including seven new areas.
- Education sessions were given to each new area and auditing is commenced giving the Charge Nurse a breakdown of compliance after each session.
- A total of five gold audit hand hygiene workshops were provided in order to train the gold auditors.
- Quarterly meetings were held with gold auditors.
Figure 5 below shows the hand hygiene performance at CM Health and the signals of improvement in the rate.

**Figure 4**

![Hand Hygiene Performance](image)

**Medication Safety**

One of the aims of the Medication Safety team for this reporting period was a continued commitment to the use of electronic medication reconciliation (eMR) by engaging team based pharmacists and doctors.

Figure 6 below shows the high risk patients with electronic medication reconciliation (eMR) completed within 48 hours of admission. Improvements in October and November 2016 reflected peaks in performance in eMR across both medicine and surgery. This target is yet to be reported nationally as CM Health is only one of five DHBs where eMR has been implemented.

**Figure 5**
Pressure Injuries

The aim of the Pressure Injuries Group for this reporting period was for a result of zero Stage 3, 4 or unstageable pressure injuries across the organisation. Overall the reduction in hospital acquired pressure injuries since June 2012 has been maintained.

- Annual Stop Pressure Injury Day was held on 17 November 2016. In celebration of the day, staff were invited to take part in a pressure injury prevention themed crossword competition. There was also a webinar with a focus on heel pressure injuries and a power point presentation was provided for the Wound Care Coaches to use in their respective areas to educate further on staging of pressure injuries.

- A number of working group actions were formed from the analysis of data from the annual pressure injury report (August 2016) and will be a focus for the Pressure Injury Group in the upcoming year, including a review of the pressure injury e-learning package on Ko Awatea Learn, to strengthen package content on how to complete the pressure injury risk assessment to give a more accurate risk score and the design of a flow chart on what to do when a pressure injury occurs and process of necessary documentation i.e. incident reporting, ACC forms, pressure injury investigation process, and SSE process.

Figure 7 below shows the severe pressure injuries (Stage 3, 4 or unstageable) per 100 patients on monthly audit. There has been a sustained reduction in the overall number of pressure injuries since June 2012 but common cause variation in Stage 3, 4 and unstageable pressure injuries since that time.
**Safe Surgery**

The national Safe Surgery programme aims to improve perioperative care by encouraging teams to consistently apply evidence-based practices and safety checks to all patients and by improving teamwork and communication. A paperless surgical safety checklist has been introduced and includes full team engagement, briefing and debriefing at the start and end of an operating list, and a set of teamwork and communication tools.

- The aim of the Safe Surgery (reduce perioperative harm) team for this reporting period was a commitment to ensure that the surgical safety checklist is being used in paperless form as a teamwork and communication tool rather than an audit tool.

- The Safe Surgery QSM takes the form of an observational audit of the safer surgical checklist in a similar manner to ‘gold audit’ of hand hygiene and is used to look at how engaged teams are.

- Sign out, in particular, has proved a difficult time to audit but the auditors redoubled their efforts, particularly focusing on the time out and sign out, and improvement has been seen in this area.
IANZ Accreditation Laboratory Results

Highlights

- The Laboratory Service, excluding Histology, successfully relocated to a new, purpose built facility within Harley Gray Building on 30 September 2016. The move required meticulous planning for IT and equipment and was achieved with precision, resulting in very little disruption for the hospital.

- Biochemistry analytical platforms and automation linking specimen reception to analysers in Biochemistry and Haematology were an additional significant change.

- Histology specimen tracking system, Cerebro, was implemented during November 2016 to improve patient and staff safety.

Key Performance Indicators (KPI)

After a settling in period to the new facility and equipment, all KPIs are back on target. The Northern Region DHB Laboratory turnaround time benchmarking shows CM Health Laboratory back in the top half.

Laboratory Accreditation Status

IANZ Accreditation to ISO 15189:2012 provides formal recognition that the laboratory has been independently assessed in five key areas:

1. Competence and experience of staff.
2. Integrity and traceability of equipment and materials.
4. Validity and suitability of results.
5. Compliance with appropriate management systems standards and competency to carry out services in a professional, reliable and efficient manner.

During April 2017, IANZ accompanied by expert pathologists and scientists, conducted a routine reassessment (peer review) of the Laboratory Services covering all areas under the scope of accreditation which includes all analytical areas, Specimen Reception, Phlebotomy and MSC Laboratory Service.

The assessment identified seven corrective actions (CAR) and 80 recommendations. Six of the CARs have since been cleared. The remaining CAR relating to Histology accommodation is ongoing from the 2015 assessment.

The process to identify suitable accommodation and get approval for budget, design and fit out has been protracted. Monthly reports to IANZ demonstrating progress towards a resolution is a requirement to continue accreditation.
IANZ Accreditation Radiology Results

The Radiology service at CM Health had their annual IANZ surveillance assessment in June 2017, marking ten years since they became accredited.

Following a decline in the number of Radiologists and Medical Radiation Technologists’ (MRT) in the department, combined with a continued increase in demand and complexity of cases, they received one Corrective Action Request (CAR) recognising there are significant constraints to staff resourcing.

The service was “commended for the dedication and commitment evident by all staff members... to ensure the quality of service provided is not compromised...” while the shortage remains. Measures are in place and ongoing to recruit new staff and reduce the risks associated with low staff levels.

A few strong recommendations were received and improvements are being made where needed. The IANZ Assessment was an encouragement to staff as IANZ commended them on their “diligence to patient care and continuation of imaging service provision under the apparent constraints.”

The implementation of e-Order referrals has commenced and continues to roll out across the DHB, with positive feedback to date.

A project to rationalise and improve the management of clinical consumables in the Radiology service has led to significant savings over the past year. Production planning across the department continues to be effective in assisting the service to meet MoH targets when possible.
Primary Care Accreditation

Cornerstone and Foundation Standards

One of the Minimum Requirements in the national PHO Services Agreement is that the PHOs’ enrolled population and casual service users receive services that are safe, effective, consumer-centred and of acceptable quality. To achieve this objective, the PHO is required to ensure that all of its practices can demonstrate they have met the Foundation Standards by 30 June 2017.

Cornerstone Aiming for Excellence is an accreditation programme for general practice in New Zealand which is designed to improve overall service quality through a process of self-assessment and peer review. Cornerstone includes the Foundations Standards and provides the means to assess general practice systems against the national standard for New Zealand general practices.

The Royal New Zealand College of General Practitioners’ awards accreditation is based on the recommendation of Health and Disability Auditing New Zealand Limited. As at 30 June 2017 there were 112 general practices (including satellite sites) in the CM Health district. Of this number, 91 (81 percent) were Cornerstone accredited, a further 12 (11 percent) had met the Foundation Standards and only eight practices were working towards meeting either the Foundation Standards or Cornerstone accreditation. Of these eight practices, most are awaiting a booked assessment date.

This information is outlined further in the table below – Figure 8.

Figure 7

<table>
<thead>
<tr>
<th>CM Health PHOs</th>
<th>Alliance Health Plus Trust</th>
<th>East Health Trust</th>
<th>National Hauora Coalition</th>
<th>ProCare Networks Ltd</th>
<th>Total Healthcare Charitable Trust</th>
<th>CM Health Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of general practices (including satellite sites)</td>
<td>20</td>
<td>22</td>
<td>10</td>
<td>45</td>
<td>15</td>
<td>112</td>
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<td>No. of CM Health practices that are Cornerstone accredited at 30 June 2017</td>
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<td>22</td>
<td>3</td>
<td>31</td>
<td>15</td>
<td>91</td>
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<tr>
<td>No. of CM Health practices that have met Foundation Standards at 30 June 2017</td>
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<td>0</td>
<td>1</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>No. of CM Health practices at 30 June 2017 that have not yet met Foundation Standards or are not Cornerstone accredited</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>
Patient Safety and Excellence

Patient Safety Week

The theme of Patient Safety Week (PSW) held on 31 October – 4 November 2016 was ‘Let’s Walk the Talk’, which means doing what we say we will to provide the best and safest care for our patients and whaanau, every time.

During the week of 31 October – 4 November 2016, there were a number of activities arranged intended to engage patients, staff and visitors in a conversation about patient safety including:

- the Patient Safety Team visited clinical areas between 31 October and 2 November to see the visual showcases as part of the PSW competition. The Scott Dialysis Unit epitomised the ‘let’s walk the talk’ competition theme. The Unit has worked hard at improving their hand hygiene rate and in October 2016 achieved 95.7 percent in their first gold audit. Their falls prevention work has included adopting Dr Anne Marie Hill’s education package and co-designing a pamphlet with their patients to understand ways they can keep themselves safe whilst having their dialysis treatment.

- patient safety ‘bright spots’ displays from work streams such as Venous thromboembolism (VTE), Pressure Injuries, Falls, Opioid Collaborative, Sudden Unexpected Death in Infancy (SUDI), electronic medication corridor from 31 October – 2 November for people to read about their activities.

- volunteers asked 87 patients across 14 wards four questions about their experience of safety in the hospital. These questions were:
  - When you are in hospital, what matters most to you in regards to safety?
  - During this hospital visit, what safety messages have been discussed with you?
  - Why do you think staff are talking to you about these safety messages?
  - What are some of the things you are doing to help us keep you safe?

  The feedback gathered from patients was reviewed and distributed to clinical areas.

- a Patient Safety Grand Round was held on Thursday 3 November which included a presentation by Dr Peter Gow ‘Make the right thing the easier thing to do’ and ‘Turning safety on its head’ by Dr Carl Horsley.

In 2017, Patient Safety Week will run from 6 – 10 November. The approach for the week which will be a consumer focus on medication safety which is line with the World Health Organization’s five-year medication safety challenge. The main questions that will be communicated throughout PSW are likely to be:

- What is my medicine called?
- What is it for?
- When and how should I take it?
Infection Prevention and Control

By definition, infection prevention and control (IP&C) activities are designed to improve patient outcome and experience when accessing health services. This is done by attempting to eliminate the most common adverse outcome of the healthcare experience, Healthcare Acquired Infection (HAI).

Surveillance projects

Currently CM Health runs ongoing prospective surveillance programmes:

- **Joint Implant Surgical Site Infection, both local and national data submissions**
  This programme feeds primarily our own client group, the orthopaedic surgeons. It provides data relating to the procedure and the outcome (infection/no infection). It is a fully collaborative programme between IP&C, Orthopaedics and Infectious Diseases. The end point (infection) is identified and confirmed by all participating groups, to improve the reliability of the data.

  The Joint Implant Surgical Site Infection database also provides data to other orthopaedic studies. The resulting data is used internally in consultation to develop possible improvements. The database exports quarterly to the national database for national league tables.

- **Multi Resistant Organism (MRO) Tracking**
  This programme monitors the patient warnings and lab screening results to ensure the minimum risk of patients acquiring MROs during healthcare provision.

  With the rapid increase in the severity of the resistance pattern for some imported organisms, the control of colonised and infected patients is one of patient safety and operational sustainability. Recent imports from high risk areas, such as India, have proven virtually untreatable with currently available antibiotics.

- **Caesarean Section Infection Surveillance**
  This programme prospectively gathers data on caesarean section readmission infections on a continuous and ongoing basis.

- **Blood Stream Infections Surveillance**
  All positive blood cultures are reviewed and assessed for hospital acquisition.

- **Clostridium Difficile (C diff) Surveillance**
  All C diff cases are viewed and tracked for outbreak management.
Multi Resistant Organism Tracking

This programme monitors the patient warnings and lab screening results to ensure the minimum risk of patients acquiring Multi Resistant Organism (MRO) during healthcare provision.

Figure 8

As can be seen in Figure 9 above, the challenge to CM Health from MROs in our catchment area continues to increase. Our internal hospital acquired rate has remained trending down. This has recently started to flatten out as new MROs appear.

With the rapid increase in the severity of the resistance pattern for some imported organisms, the control of colonised and infected patients is one of patient safety and operational sustainability. Recent imports from high risk areas such as India have proven virtually untreatable with currently available antibiotics.

As can be seen in Figure 10 above, the overall CM Health MRO rate has been stabilised as improved environmental decontamination processes are implemented. It should be noted that the increase in carbapenemase resistant organisms (CRO) is still a new major concern.

Figure 9
**Clostridium Difficile tracking**

Tracking of this specific organism is required due to the northern hemisphere experience with toxigenic mutations and the resultant mortality increases in healthcare services. Our programme aims to detect any increases early.

**Non surveillance projects**

*Environmental Decontamination*

Overseas and local data both support the role of the environment in the transmission of potentially harmful organisms such as MROs and Norovirus.

IP&C has been a lead in developing new processes to improve discharge and isolation cleaning and decontamination. CM Health is the first facility in Australasia to implement an automated total area decontamination system, starting in the high risk burns/ICU area and extending across the organisation’s main facility. This has been instrumental in the control of at least three pan-resistant imported MRO cases, including one probable cross infection and also the rapid resolution of two Norovirus outbreaks. This project’s association with the hand hygiene programme constitutes major patient safety initiatives. The role of environmental decontamination was further demonstrated in a recent Klebsiella pneumoniae.

Currently a major project on discharge bed cleaning is being continued in conjunction with the Clinical Governance Group. This will aim to further mitigate the risk of MRO transmission within the hospital by consistent quality decontamination of bed spaces between patients.

**Faster Cancer Treatment**

Performance against the Faster Cancer Treatment (FCT) health target has improved significantly over the year. Our focus for improvement remains on the development of sustainable pathways within each tumour stream to enable access to diagnostics, treatment and care coordination for all patients with a suspicion of cancer, not just those who meet the FCT criteria.

Tumour streams are ensuring there is an action plan within each tumour stream and at a project level to ensure consistent achievement of the target as it has risen from 85 to 90 percent.

*Figure 10*
Medical Oncology, Galbraith Infusion Centre

Since February 2017 CM Health has successfully piloted the administration of maintenance Herceptin infusions for a cohort of patients that have completed chemotherapy and radiotherapy for breast cancer. Additional (breast oncology) outpatient clinics are also provided and throughput volumes have increased for both clinics and infusion since the commencement of the pilot.

There are 8-10 patients attending for infusions and up to 40 patients in the outpatient clinic. The infusion centre operates one day a week currently and forms part of a regional project to provide delivery of oncology closer to the patients' home. The pilot is currently under evaluation and recommendations will inform future decision making.

Figure 11
Healthy Together Technology

eVitals Project

In October 2016, the CM Health Board approved a proposal to implement eVitals – an electronic solution for collecting patient observations and nursing assessments.

eVitals utilises MKM Health’s Patientrack solution which aligns with regional and national strategies already implemented at Waitemata, Canterbury and West Coast DHBs.

eVitals will move us from ‘paper heavy’ to ‘paper light’ processes by introducing improved workflow and technology, enabling staff to obtain and monitor patient information at the bedside using tablet devices.

eVitals standardises care by automatically calculating the Early Warning Score (EWS) and prompting staff when observations and assessments are due or incomplete. eVitals will be rolled out with the National EWS.

Evidence from New Zealand and the UK indicates that the introduction of eVitals can have the following benefits:

- **Patient safety**
  - reduction in the number ICU days.
  - increased levels of clinical attendance following EWS scores requiring escalation.

- **Patient experience and staff satisfaction**
  - improvements in quality of care.

- **Process, productivity and compliance**
  - improvements in compliance with EWS and nursing assessment protocols.
  - improvement in the accuracy of EWS calculations.

eVitals will be progressively rolled out across all inpatient areas from August 2017.

Phase 1 introduces the electronic calculation of the EWS, and replaces paper charts for weight, smokefree assessment, bowel, fluids, cannula insertion and neurological assessment.

Phase 2, later in the year, will see the introduction of electronic assessments and care plans for Pressure Injury (SKINS), MORSE falls and CAM/Delirium.
Medication Safety/Opioid Collaborative

Opioid medications, such as morphine, are beneficial for pain management, but they can cause constipation with resulting distress for patients. In hospital, the risk of becoming constipated can also be further increased from other factors, for example, not eating or drinking before surgery and mobilising less than usual.

As part of the 18-month NZ HQSC’s Safe Use of Opioids National Collaborative, a CM Health interdisciplinary group have been involved in quality improvement related activities to improve the prevention of constipation from opioids at Manukau Surgery Centre (MSC) Wards 1 and 2. The resources and processes developed to form a care bundle for reducing patients’ risk of constipation include:

- patients about the Step-wise guidance for the prescribing and administration of laxatives with opioids to prevent and manage constipation.
- patient information pamphlet developed using a patient co-design (partnership) approach.
- guidance for clinical staff on how to correctly and consistently use the patient information pamphlet to educate prevention of constipation from opioids.

Use of the care bundle at MSC Wards 1 and 2 resulted in significantly improved rates of laxative co-prescribing and administration with opioids and tracking and documentation of patients’ bowel function. By the end of the 18-month time period, the mean rate of opioid-induced constipation at MSC Wards 1 and 2 had reduced from 40 percent to 11 percent, see Figure 13 below.

The care bundle is now in the process of being rolled-out for use in most other care areas across CM Health.

Figure 12
Patients at Risk Team

Introduction to Call for Concern

Reducing ward patient events has historically focused on ward health professionals recognising and responding to patient deterioration in a timely manner. More recently the focus has shifted to enabling healthcare consumers to call for concern based on the premise that patients and families often recognise changes in their own, or a family member’s condition before medical and nursing staff.

A co-design approach

In December 2015 we explored Middlemore Hospital ward patients’ and families’ perspectives of:

- recognising their acute illness/deterioration.
- identifying the need for a Call for Concern service.
- barriers that may influence patients and/or their families using a Call for Concern service.
- what would patients and their families like a Call for Concern to look like?

Following interviews with 41 patient and/or family members, we identified:

- patients and families were aware of why they, or their family member were in hospital and noticed a change or deterioration in their condition.
- when asked “what matters to you right now” the majority of patients expressed the importance of recovering and returning to their normal lives.
- the majority of patients and families felt reassured, relieved and safe once the escalation response teams arrived.
- overall the support for a Call for Concern service was perceived positively with most patients identifying that they would utilise such a service if one was introduced.

In November 2016 a Call for Concern service was piloted on a surgical ward.

The Call for Concern Service has now been rolled out to four wards. Since introducing the Call for Concern service, the Patient at Risk team has received 11 Calls for Concern; two from patients and 11 from patients’ families.

The Call for Concern service has been enthusiastically received by ward staff. There has not been an overwhelming number of Calls for Concern from patients and families; all calls have been for genuine reasons, and all issues raised by patients and their families when calling for concern have been resolved in a timely manner.
**AMBER Bundle of Care**

While most patients recover from an inpatient episode, sometimes staff recognise that with the level of uncertainty in the patient’s condition the outcome could go either way. If the patient dies, it can come as a surprise for the family/whaanau who may not have realised their family/whaanau member was so unwell.

To improve communication and ensure everyone is on the same page, a project team introduced the AMBER Care bundle. AMBER stands for:

- Assessment
- Management
- Best practice
- Engagement
- Recovery uncertain

Essentially it is a prompt to activate a communication process between staff, the patient and their family/whaanau that ensures a consistent approach to goals of care. AMBER care is applied during a period when a patient has an uncertain recovery as this is a time when information sharing needs to be clear and open so that everyone understands the risks and can discuss the treatment options. It is also an opportunity for the patient’s preferences and wishes to be discussed, and increases the chance of patients having their needs met. The process (Figure 15) allows patients to have some control over their recovery when feeling at their most vulnerable.

*Figure 13*

**Progress**

The tool was first trialled on two wards in late 2015 to early 2016. The formal evaluation identified that the uptake was positive but slow, and it was agreed to extend the rollout to more wards with the assistance of a full-time facilitator. In early 2017 the facilitator commenced and by June the AMBER care bundle was embedded into seven wards. Feedback was positive and the formal evaluation identified many benefits such as an increase in family meetings, documented plans, resuscitation status completion, a reduction in futile interventions and most importantly improved patient journeys.

The next step is to roll AMBER across the entire hospital to improve the patient experience through effective communication and a consistent approach to care.
Mana Taurite: Equity in Health

“We all have a role to play in reducing inequalities in health in New Zealand. Regardless of how we measure health... we find that particular groups are consistently disadvantaged in regard to health. And these inequalities affect us all.”

Ministry of Health, 2002

In 2016/17, CM Health initiated the campaign ‘Mana Taurite: Equity in Health’. This campaign aims to contribute to the CM Health’s Healthy Together strategy of achieving health equity for Maaori, Pacific, and high needs communities of Counties Manukau by 2020, by supporting work in the areas of childhood obesity and workforce development. Our campaign vision is to “enable all of our community to live longer, more abundant, and healthier lives”.

The Breakthrough Series: IHI’s collaborative model for achieving breakthrough improvement, is being utilised to achieve this work. By working together across health services, community agencies and with the community, we aim to reduce health disparities.

The purpose of the campaign is to innovate and identify what works to reduce health inequities for the community of Counties Manukau by:

- reducing the disparity for childhood obesity/ healthy weight for children from Maaori and Pacific communities in Otara – Counties Manukau (Healthy Kids work stream).
- reducing the disparity for identified health outcomes for Maaori and Pacific patients and whaanau in participating services in Counties Manukau (Healthy Services work stream).
- increasing the number of Maaori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community (Healthy Systems work stream).

21 collaborative project teams are working as part of the Health Equity Collaborative. The teams include health professionals, managers, community members, improvement advisors and clinical leaders.

In the first phase of the work, teams have identified the current environment using both academic evidence and focus groups. Most teams are in a ‘testing’ phase where teams test many ideas, initially through small tests to gain confidence in the change ideas and interventions, and then moving to larger scale tests to ensure effective confidence prior to implementation. The campaign is scheduled to continue through 2017/18 to enable the implementation, scale and spread of work that is of value to the organisation.

While the campaign has a key focus on health equity, there are many other strategies and work occurring throughout the district that will also continue to increased health equity for Maaori and Pacific communities in 2016/17.

Achievements to date

- A leadership group made up of key members of the Executive Leadership Team and community leadership provides governance and direction. This meeting is chaired by a member of the community.
- Delivered two engagement sessions on 1 August 2016 and 6 September 2016. The sessions attracted large numbers of staff and community that felt passionate about the need to reduce inequities and improve health outcomes in our community.
- 26 collaborative teams were selected to be part of the campaign. These teams are seeking to understand what it would take to reduce inequities in their area of interest.
Three Learning Sessions were delivered on 30 November 2016, 17 March 2017 and 14 June 2017.

Delivered monthly master class programme “Taking your place in the journey” and “Engaging Effectively with Maaori” and supporting improvement methodology.

All project teams have identified their project aims and completed a driver diagram. This forms the basis of their work throughout the campaign. Most teams expect to provide early insights by December 2017.

Monthly progress reports allow for effective governance and have resulted in some groups transitioning of the campaign.

The project teams are divided into three workstreams; Healthy Systems, Healthy Services and Healthy Weight and Healthy Kids.

The Healthy Weight, Healthy Kids work encompasses interventions across the age groups from preconception to the school years, and includes a focus on prevention (health promotion), early intervention (universal and targeted) and intervention. Interventions target obesity at a variety of points in the development of overweight and obesity.

The Healthy System work encompasses interventions from entry into CM Health, recruitment, workforce retention and leadership development.

The Healthy Services work focuses on those health conditions that are preventable but are often present in vulnerable communities.

Teams are encouraged to become ‘equity aware’ and ‘equity responsive’ and to incorporate equity assessments and frameworks in their thinking around their projects.

Figure 14

### Healthy Services Project Team Summary

<table>
<thead>
<tr>
<th>PROJECT NAME</th>
<th>PROJECT DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every $ Counts</td>
<td>To examine the CM Health planning and funding procurement system and processes with an equity lens in order to determine current state and improve the system.</td>
</tr>
<tr>
<td>ED: Alcohol ABC approach</td>
<td>To test and implement a screening and brief intervention for hazardous alcohol use in ED.</td>
</tr>
<tr>
<td>5G Gout</td>
<td>To recruit and train Maaori and Pacific Gout champions to develop a kaupapa approach to gout education and provide peer support.</td>
</tr>
<tr>
<td>Lungs 4 Life</td>
<td>To develop and test a best practice approach to identifying and treating Maaori and Pacific children with bronchiectasis.</td>
</tr>
<tr>
<td>Hang Tough, Don’t Puff!</td>
<td>To increase Maaori and Pacific referrals to and engagement with the Smoke-free service and to increase quit rates.</td>
</tr>
<tr>
<td>Link4Life</td>
<td>A collaborative project with Hopewalk NZ, community-led suicide prevention movement, to enable Pacific and Maaori families affected by suicide to be champions and leaders in their community for suicide prevention.</td>
</tr>
</tbody>
</table>
### Healthy Systems Project Team Summary

**Work-stream benefit:**
*To increase and retain the number of Māori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community by December 2018.*

<table>
<thead>
<tr>
<th>PROJECT NAME</th>
<th>PROJECT DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rauhi Mai</td>
<td>A collaboration between a collective of education, community and health providers to support the development of a Youth Health Advisory Training group. This is to support gaining a better understanding of the cultural and survival mechanisms of Māori Youth. This is also in alignment with a system level measure to improve youth health service.</td>
</tr>
<tr>
<td>Diversifying Allied Health Workforce</td>
<td>To formalise existing Allied Health Workforce Diversity Hui and expo events to engage with high school students and their whaanau to increase community representation in workforce.</td>
</tr>
</tbody>
</table>
| P.L.U.S.                      | To establish a clinical placement (and support programme) for Pacific nursing students from second year placement to NetP recruitment in Ward 34E.  
  
P - Pasefika (Pacific)  
L – Lagolago (Support)  
U – U’u lima faatasi (holding hands together to guide)  
S – Savali faatasi (walk together to achieve the goal) |
| Pacifica 2-7-4                | To scaffold Pacific RNs from the start of their undergraduate programme into year two of employment.                                                                                                                     |
| Whakamana Takuta Māori        | To mentor/professionally develop young Māori medical students and doctors at CM Health to promote recruitment, retention and professional development.                                                                     |
| LEAP                          | To support local Māori and Pacific community members through mentoring, up skilling and clear pathways to employment within CM Health.                                                                                   |
| Effective/Supportive Pathways to Education for Māori | To review and create efficiencies in the transition of Māori secondary students into tertiary studies and employment with a specific focus on health careers with critical shortage of Māori. |
**Healthy Kids, Healthy Weight Project Team Summary**

**Work-stream benefits:**

To increase the number of women with a healthy weight gain in pregnancy; to increase the physical activity of children in ECEs / aged 0-4 years; to increase the physical activity of children in schools / aged 5-13 years; To increase the healthy eating of children in ECEs / aged 0-5 years; to increase the healthy eating of children in schools / aged 5-13 years; and to increase the positive healthy eating and activity messages received by children in our Counties Manukau Communities.

<table>
<thead>
<tr>
<th>PROJECT NAME</th>
<th>PROJECT DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Braking the Cycle</td>
<td>To form a bike club for 5-14 year olds to increase physical activity.</td>
</tr>
<tr>
<td>Childs’ Play</td>
<td>To co-design with mothers and whaanau, the delivery of Fundamental Movement Skills interventions for children from birth to five years.</td>
</tr>
<tr>
<td>Healthy Mums and Babies 4 Life</td>
<td>To test whether a lifestyle intervention for obese pregnant women leads to anticipated changes in diet and physical activity.</td>
</tr>
<tr>
<td>Kidz First ED Screening</td>
<td>To develop a brief screening programme in Kidz First ED/ inpatient to identify obese and overweight children.</td>
</tr>
<tr>
<td>Kura Kai Ora</td>
<td>To co-design key messages with Maaori and Pacific children (and Toi Tangata and Pacific heartbeat) to develop a toolkit of health promotion messages for schools.</td>
</tr>
<tr>
<td>Planned Pregnancy: It’s a Woman’s Choice</td>
<td>To reduce childhood obesity by facilitating improved preconception care and maternal weight through planned pregnancy and maternal messaging.</td>
</tr>
<tr>
<td>Prepare Together</td>
<td>To develop a best practice approach to deliver group education sessions for women with diabetes planning pregnancy, and individualised education and pregnancy planning for women with complex diabetes.</td>
</tr>
<tr>
<td>Weigh While We Wait</td>
<td>To work with one GP practice/LMCs to test promotion of healthy weight gain in pregnancy.</td>
</tr>
</tbody>
</table>
Care Capacity Demand Management

July 31 marked the first visit of the Safe Staffing Healthy Workforce Governance Group to CM Health. Accompanying this group was the MoH’s Chief Nurse, New Zealand Nurses Organisation (NZNO) Chief Executive, and a number of staff from Waikato DHB, including the Executive Director of Nursing, together with the Director of Nursing. Representing CM Health was the Director of Patient Care, Director of Nursing, Director of Hospital Services, the Healthy Together Technology Project Lead, and the Middlemore Central team.

The visitors were welcomed with a Powhiri, and the data was presented, alongside a presentation from the Assignment and Workload Management (AWM) Coordinator, about process and project work to date, followed by report from the Short Stay Unit (SSU) Governance Group.

Whilst we are some way away from having our tool and data accepted as validated, there was an acknowledgement of all the work and effort made to date, and an offer made to share data, and include the AWM Coordinator on the National Forums to learn about Care Capacity Demand Management processes. This support is limited as SSU and NZNO Support trend care and believe we should be using this product.

Our focus moving forward will be to continue to be on safe staffing, with inter-rater reliability studies, and education of staff around variance response management processes.

Leadership Walkarounds

Over the past months the Leadership Walkarounds have focused on the medical wards, post the reconfiguration to align new teams with specialties to these wards. The reconfiguration has seen new teams working together in different wards. It has been impressive to see the work that was done to prepare, and to see the new teams working well together.

The evaluation of the Leadership Walkarounds continues to make slow progress, with the busy demand on the hospital over winter.

In August, CM Health will present the Opportunities for Certification with the Leadership Walkarounds at the Duly Authorised Agency group’s professional development study day in Wellington.
Women’s Health

Prescribing of Neonatal Vitamin K

Historically the dose and route of administration and who gave the neonatal Vitamin K was documented on CM Health’s Immediate Postnatal History and Examination form. This was raised as a certification corrective action in 2014 against the Health and Disability Services Standards (2008); Medication Management Standard 3.12 as the Immediate Postnatal History and Examination form did not include all of the components required for a prescription in accordance with the Medicines Regulations 1984.

As the majority of babies only require a once only dose of intramuscular Vitamin K and no other medications, a survey was undertaken of the other DHBs to ascertain what form they used to prescribe Vitamin K for example: the ‘8 Day National Medication Chart’, the ‘Day Stay National Medication Chart’, or their own DHB form. Further, the Neonatal Unit and CM Health Medication Safety pharmacists were consulted. Following the feedback received it was determined that a prescription template would be developed to meet the legal requirements of a prescription and included on the Immediate Postnatal History and Examination form.

In October 2016, two trainee interns retrospectively audited 85 Immediate Postnatal History and Examination forms of babies who had received intramuscular Vitamin K to determine the level of compliance in the documentation of the: infant’s name and NHI, weight, legibility of prescription without alteration, date of prescription, name of Vitamin K in full block capital letters in blue or black ink, route of administration, dose, and name and signature of the prescriber. Analysis of the data revealed that only four of the 85 forms (4.7 percent) met all of the above criteria.

The revised Immediate Postnatal History and Examination form with the Stat Vitamin K prescription template was presented to the Drugs and Therapeutic Governance Group at their January 2017 meeting. The Drugs and Therapeutic Governance Group signed off on the Vitamin K prescription template and the use of the form on the proviso that it included the words paediatric formulation and the prescriber’s registration number.

The Immediate Postnatal History and Examination form was tabled at the Maternity Quality Forum meetings and circulated to senior midwifery staff to make any other necessary amendments to the form prior to it being sent for desk top-publishing and printing.

Communication was provided to all CM Health midwives, obstetric doctors, Neonatal Care, Emergency Department and lead maternity carers in May 2017 regarding the requirements for the prescribing of intramuscular Vitamin K on the Immediate Postnatal History and Examination form.

The revised Immediate Postnatal History and Examination form with the Stat Vitamin K prescription template was launched on 1 June 2017. A re-audit will be performed three months post-implementation.
Neonatal Early Warning Score

Following a recent serious adverse event review, it was recommended that a graphical recordings chart be introduced for at-risk neonates to show trends in neonatal vitals status and to provide guidance about when neonates should be referred for medical review and when an emergency code should be called. A multi-disciplinary steering group was established to design and implement a Neonatal Early Warning Score (NEWS) Chart and accompanying guideline.

This NEWS Chart has been based on one currently in use at Canterbury DHB, and adapted to reflect local requirements. The NEWS Chart will be a standard form of documentation for all newborns and will be implemented across maternity services, though only those babies with risk factors for sepsis or physiological deterioration will require ongoing monitoring. The following parameters will be recorded: respiratory rate; work of breathing; respiratory support; oxygen saturations; temperature; heart rate; tone and behaviour; and blood glucose. The assigned score will be used to provide clear guidance about when to escalate care and seek additional medical help, both at Middlemore Hospital and at Counties primary birthing units.

The first draft of the NEWS Chart was circulated to key stakeholders in April 2017, and has been revised with the feedback received. A three-day pilot was conducted in June, followed by wide consultation in July. A further large pilot will be conducted in September in Birthing and Assessment, Maternity North and South, and Pukekohe, Papakura and Botany Downs Birthing Units. The NEWS Chart will be implemented in October, following the roll out of an education programme to all maternity staff and lead maternity carers.

The steering group would like to acknowledge the foundation work undertaken by Jonathan Barrett Neonatal CNS.
Kidz First Medical and Surgical Safety Huddles

Kidz First Medical and Surgical commenced trialling safety huddles on 31 October 2016. The overarching principle of these safety huddles is to foster collective situation awareness through establishing shared decision-making with regards to risks and immediate escalation in the anticipated event of deterioration.

Safety huddles are designed with the following specific aims:

- Optimised safety through elimination of avoidable harm.
- Greater empowerment and accountability of all staff.
- Enhanced sense of community and intra-professional trust and respect.
- Improved efficiency and cost savings.

The safety huddles are attended by the nurse in charge, one nurse from each pod who can represent each patient, medical representation where possible, and members of the multi-disciplinary team who have identified patient concerns. These safety huddles follow a structured script of questions and take a maximum of ten minutes.

While the safety huddles were being trialled, they were scheduled for 11am every day in Kidz First Medical and Surgical. In December 2016 these safety huddles were extended to the afternoon shifts (8pm) and the night shifts (3am).

Observational audits were initially trialled during a pilot phase to ensure the process was consistent, followed the scripted format, and became embedded in the day-to-day practice of both Kidz First in-patient areas.

Each ward has developed a method of indicating that the safety huddle has occurred:

- Kidz First Medical sign and initial the three shifts each day on the roster that this has been completed.
- Kidz First Surgical has a ‘tick box’ system on their daily sheet that must be completed when the huddle has taken place.

Safety Huddles are designed with the following specific aims:

- Optimised safety through elimination of avoidable harm.
- Greater empowerment and accountability of all staff.
- Enhanced sense of community and intra-professional trust and respect.
- Improved efficiency and cost savings.

The overarching principle is to foster a collective Situation Awareness for Everyone (S.A.F.E). The Huddle’s primary outcome is to establish shared decision-making for every patient with regards risks and immediate escalation in the anticipated event of deterioration.
Adult Rehabilitation and Health of Older People

Acute Stroke Service
As part of a national priority to improve the management of long-term conditions, CM Health, in conjunction with the wider Auckland region, has developed regional pathways for stroke care. This includes a hyper-acute pathway to ensure all patients have timely access to life and function saving procedures regardless of when symptoms present. Adult Rehabilitation and Health of Older People (ARHOP) have envisioned a model of care that integrates the delivery of acute and rehabilitative care for stroke patients admitted to Middlemore Hospital. Thus, improving patient outcomes and satisfaction by ensuring the delivery of convenient, quality, and timely care.

The first phase of the project started with the opening of Ward 31 (previously the discharge lounge) as a dedicated stroke unit in December 2017. The dedicated stroke unit enables the co-location of all acute stroke patients cared for by the Stroke team. Previously, care for acute strokes was dispersed with only 60 percent of acute strokes were admitted to a ward with specialist stroke expertise. Following the implementation of Ward 31, this indicator has improved to 84.2 percent. This dedicated stroke unit has allowed for the up-skilling of nursing staff to care for highly-dependent patients with neurovascular conditions, and increases capacity of thrombolysis, which requires a high-level of observation in the 24 hours following administration. Improvement in capacity is reflected in an improvement in Counties Manukau’s thrombolysis rates from 15.7 percent (Q2 2016/17) to 9.2 percent (Q3 2016/17).

Challenges have been present with the number and complexity of acute stroke presentations being higher than forecasted. We are progressively increasing the inpatient acute stroke service to accommodate up to 20 beds and will be further developing the stroke model of care aligned to New Zealand Clinical Guidelines 2017.

Further work will be to continue to realise the objective of an integrated acute and rehabilitation ward. The project has been incorporated into the wider System Level Measures Reduction in Acute Bed Days Stroke workstream.
**Health System Integration**

**Clinical Pathways Programme**

**Auckland Regional Healthpathways Programme**

Auckland Regional Healthpathways is a Metro Auckland Region commissioned programme that has been hosted by CM Health since 2013. Improved co-ordination and integration of community and hospital care services is a major health goal of CM Health. As a DHB, we proudly support clinical pathways as a key enabler to drive improvements in quality and efficiency, aiming to avoid duplication thus in turn supporting clinical effectiveness, service sustainability and financial viability.

In 2015 we joined the Healthpathways community alongside 31 other organisations across New Zealand, Australia and the United Kingdom. Healthpathways is, in essence, local agreements between our community, hospital specialist clinicians, allied health teams and NGO colleagues based on evidenced based, best clinical practice. Effective engagement and a collaborative approach to adapting (“localising”) clinical pathways to the local context is essential in creating an integrated approach to person centric service delivery; developing a clearer understanding and response to the increasing diversity of our population contributing to some of the issues related to health equity.

As each clinical pathway is localised, it is subsequently implemented by strongly linking to key strategic priorities that have been identified across the Metro Auckland Region, so that there is a clear integrated ‘line of sight’ between national, regional and local initiatives. This is paramount since the introduction of the National System Level Measures Framework.

The three metro Auckland DHBs value the primary healthcare workforce that is aligned to the needs of our people. Through our enhanced professional development programme we aim to maintain a sustainable workforce development model, putting clinical pathways at the core of all current and future education, building capability across the sector.

Strong IT/IS linkages are developing between the regions, strongly embedding the e-referral platform and Healthpathways. The triaging specialists receiving the referrals will continue to support Healthpathways’ utilisation by referring clinicians to the Healthpathways if the referral is declined or if further information is required. This heightens decision support, consistent quality and delivery of care, reducing risk, and unexplained variation, thus driving quality improvement and patient care delivery.

So far we have:
- 51 percent of the pages localised.
- over 20,000 users since the platform launched.
- steady increases in uptake and ongoing use.

A recent survey of primary care users identified Healthpathways as:

- **94%** Trustworthy  
  *(n=276)*

- **94%** Provides practical guidance  
  *(n=278)*

- **85%** Easy to use  
  *(n=252)*

- **75%** Links were useful  
  *(n=219)*
Primary Care Safety in Practice

Safety in Practice (SiP) Year 3 finished in July 2017, having had 42 practices enrolled across the three Auckland DHBs and six PHOs. In Year 3 we introduced two new care bundles: Reliable System for Managing Cervical Smears and Reliable Management of COPD Patients; these were taken up by a number of general practices. The existing care bundles of Medication Reconciliation, Results Handling, Warfarin Prescribing and Opioids Prescribing were also split well between the practices. A practice participating in their 3rd year of the programme developed an audit care bundle on Cardiovascular Risk Assessment with SiP Clinical Lead, Dr Vikas Sethi.

SiP Year 4 began in August 2017 expanding to approximately 78 practices across the three DHBs and seven PHOs. This year will see Dr Vikas Sethi working with CM Health practices to develop care bundles that align with system level measures; these bundles will include Diabetes, Gout, Polypharmacy and Paediatric Prescribing (anti-microbial). The Cardiovascular Risk Assessment care bundle developed in Year 3 is also being offered as a care bundle going forward.

CM Health, ADHB and WDHB have continued to lead SiP, with programme management and improvement expertise provided by CM Health’s team in Ko Awatea. The programme’s methodology is based on the Institute for Healthcare Improvement’s collaborative approach, and continues to actively involve a wide group of practices, PHOs and DHBs in the development, deployment and evaluation of the programme.

Each clinical area was audited monthly throughout the programme and an overall compliance rate reported. All seven clinical areas have seen marked improvement in compliance. Below is a sample of care bundles overall audit results.
The reconciliation of medication immediately after hospital discharge process increasing from 39 percent to 85 percent – Figure 18.

*Figure 17*

![Medication Reconciliation Overall](image)

Management of the lab results process increasing from 70 percent to 97 percent – Figure 19.

*Figure 18*

![Results Handling Overall](image)
The management of the Warfarin process increasing from 23 percent to 90 percent – Figure 20.

Figure 19

Management of Cardiovascular Risk Assessment increasing from 38 percent to 85 percent – Figure 21.

Figure 20
Primary and Community Health Integration and Localities

Health system integration aims to provide a seamless journey for patients across the system, with care provided in an efficient and high quality way. In order to achieve this, primary and secondary care must coordinate their activities, improve the standard of care provided, and provide services in a way which meets patient demand.

‘Localities’ is a term used to describe an approach to integrating services at a local level to help people better manage their health and stay well at home.

We have been progressively implementing an integrated localities approach since 2012/13. In the new system, patients receive planned and coordinated care via locality based multi-disciplinary teams (MDTs). The MDTs are centred around clusters of general practices but include specialists, community nursing, allied health, pharmacists, and other workers from various organisations and disciplines. Services are designed to work out of locality ‘hubs’.

Planned Proactive Care

The core of the model of care is planned, proactive care for patients with health needs that put them at risk of unplanned hospitalisation. The model includes identifying the patients with the greatest ability to benefit through risk stratification and clinical criteria, an extended consultation with a clinician (often a practice nurse) to undertake an assessment using ‘Partners In Health’, a validated assessment tool, and development of a goal based, patient-centred care plan which includes both medical, eg. ensuring medications and diagnostic tests are consistent with clinical pathways, and psycho-social aspects, eg. referral to health psychology or self-management education.

The care plan is shared electronically so that it can be accessed by clinicians throughout the system when needed, and the MDT can securely access results and message and assign tasks to each other and the patient through the e-shared care system. In the Emergency Department the plan is shown in summary form so that clinicians can quickly see diagnosis, medications, usual vital signs levels, patient goals and their nominated care coordinator contact details (the care coordinator is usually the clinician that completed the plan with the patient, often their practice nurse or GP).
The care process is shown diagrammatically below – Figure 22.

**Figure 21**

*Localities MDT Model of ‘Planned and Proactive’ Care:*

Currently there are 29,801 patients enrolled in PPC. Benefits include:

- Improved patient and population outcomes and improve equity for people with complex health needs including long term conditions.
- Compassionate, culturally sensitive, accessible, and integrated care is provided in a sustainable way designed around consumer needs.
- The model supports improvements in quality of life and access to high quality healthcare for patient, family/whaanau in readiness for them to be competent self-managers.

**Enhanced Primary Care**

As this proactive care coordination role has been progressively implemented in the last couple of years, it has highlighted that core general practice needs to change its business processes so that it has the capability to deliver new care models. We are working in collaboration with PHOs and nine larger general practices to test enhanced ways of operating general practice which improve efficacy and efficiency.

New business processes include:

- Implementation of medical telephone triage resulting in resolution of patient’s issues virtually (without the need for face-to-face consultation).
- Advanced telephony systems and a reduction in dropped calls.
- Rolling out video & email consultations.
- Patient portals for appointments and access to results to increase ‘self-service’.

We are nearing the end of an 18 month pilot phase. Practices that have advanced these new ways of organising their general practices have seen a 20% to 25% increase in their capacity.
Community Health Integration

We have also improved the way that CM Health community nursing and allied health (and mental health) services are delivered to support the new localities MDT approach. These services cover 15,400 patients and 120,000 patient contacts per year. CM Health community teams are being reorganised and refocused as core members of locality MDTs to:

- actively support general practice with proactive planned care coordination & care delivery.
- intervene rapidly to help avoid unnecessary hospitalisation when patients in the community are deteriorating.
- support earlier and safer discharge from hospital and prevent unnecessary institutionalisation by delivering reablement, rehabilitation, and discharge support to patients who have been acutely unwell.

The MDTs are supported by a logistics centre, which we call ‘Community Central’. Community Central is a key enabler for these services as it manages referrals, triage, and resourcing (staff scheduling) and patient tracking across the CM Health teams, and coordinates the contracted providers such as homecare services. Currently 60% of our community workforce is now using mobile computers (tablets). Specialist mental health services are also aligning with locality MDTs and supporting primary care with early intervention.

Urgent and Unplanned Care

Current provision of afterhours and overnight services in CM Health includes one provider of overnight services and four providers of afterhours care providing zero fees for children under 13 years and lower (subsidised) fees for high needs groups. There are a number of other providers of afterhours care in the district that are not currently funded to provide subsidised access to care. The afterhours and overnight services in the Auckland region have been managed through the Auckland Region After Hours Network (ARAHN) with membership from the three DHBs, seven PHOs, providers of subsidised after hours services, ACC and St John. In essence the subsidised afterhours services are for urgent care and not for routine primary care.

In March 2017 the metro Auckland DHBs initiated a procurement process to find the best suited providers to deliver urgent care services, after hours and overnight, within the Auckland region.
The services are aimed at improving access to urgent care for the high needs groups summarised below:

- Zero fees for Under 13s
- Subsidised access for Quintile five, High User Health Card Holders, Community Service Card Holders, and those over the age of 65.

The procurement process aims to improve access by setting a maximum co-payment level across the clinics in the region. In Counties Manukau an additional aim is to increase the number of clinics where subsidised access (and zero fees for Under 13s) is available. We are looking for a maximum of eight facilities delivering urgent care services after hours and two facilities delivering overnight urgent care. The following table (Figure 23 shows the localities where CM Health would ideally like these facilities to be positioned.

**Figure 22**

<table>
<thead>
<tr>
<th>CM Health Procurement Localities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locality</td>
</tr>
<tr>
<td>Manukau</td>
</tr>
<tr>
<td>Franklin</td>
</tr>
<tr>
<td>Maangere/Otara</td>
</tr>
<tr>
<td>East</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

The procurement process aims to achieve best value for money for the required services for the next five years. The Request for Proposals was issued on 6 April 2017 and the closing date for responses was 17 May 2017. The evaluation panel has reviewed the responses and the evaluation report with preferred providers has been approved by the DHBs. Negotiations with the preferred providers are set to start in August 2017, with a proposed service start date of 1\textsuperscript{st} November 2017.

**Ambulatory Services**

To support the localities process and integration of services, we are also working to review ambulatory and outpatient services. This includes a review of the booking, scheduling and call centre functions; follow-up processes; clinic systems; development of a one-stop-shop approach for patients requiring cross-specialty appointments; and consideration of the use of tele-health models. It also will include a review of which services will be amenable to delivery within the locality community hubs.

So far a review has shown that there was 465,000 outpatient appointments across all facilities in 2016; 68\% of this activity was delivered from Manukau SuperClinic and 17\% from Middlemore Hospital. Based on population growth and current models of care, Manukau SuperClinic will need 34 additional clinic rooms over the next ten to 15 years unless services are delivered differently. Work within the locality hubs and challenging new models of outpatient care aims to limit this need.

The first mapping process, problem identification and solutions generation review has been completed, and a change package is in place to improve booking for first specialist appointments.
Mental Health and Addictions Services: Model of Care

System Integration

The mental health and addictions system across Counties Manukau is being redesigned to deliver an integrated approach to the provision of care focusing on improving health outcomes and patient experience. Working alongside primary care as the ‘healthcare home’, the new integrated model of care is supported by three core delivery partners:

1. CM Health specialist mental health services.
2. Community Alcohol and Drugs Service (CADS).
3. Community-based support services provided by the NGO sector.

The key components of change are:

- new community-based, primary care-facing specialist teams (integrated locality care (ILoC)) with a dual purpose of developing and supporting in primary care and providing easier, earlier access to mental health and addiction support closer to people’s homes.
- redesigning specialist mental health community teams to emphasise purposeful, discrete episodes of care (integrated specialist episodic care (ISpEC)).
- an integrated response to mental health and addiction needs, with the CM Health mental health workforce and the WDHB CADS working more collaboratively to respond to individual need.
- a redesign of NGO provision to deliver a comprehensive suite of services in each part of the district.

The model of care diagram below (Figure 24) provides an illustration of the overall system, with ‘Integrated Care’ and ‘Suite of NGO support services’ the focus of the system redesign.

*Figure 23*

![Diagram](image)

Within the model of care, the component parts of the system are characterised as follows:

- **Integrated locality care (ILoC)**
  - Delivered by sector-wide teams including DHB and NGO mental health and addictions.
  - Delivering liaison and brief intervention in primary care settings.
  - Established relationships between primary care providers and named individuals within each locality team.
  - No formal referral required.

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8Team composition supporting a life-course approach, with expertise in child and youth, adults, and older adults
• **Integrated specialist episodic care (ISpEC)**
  - Delivered by sector-wide teams including DHB and NGO mental health and addictions.
  - Delivering specialist episodes of care (both short-term and medium-term episodes of care), utilising a shared-care approach with primary care.
  - Written referral required (with support from ILoC where involved).

• **Acute specialist episodic care**
  - Delivered by cross-sector teams, inc. specialist mental health, specialist addictions and NGOs.
  - Written referral required (with support from ILoC where involved).

The first ILoC team was established in the Franklin Locality in 2016, working with a range of ‘primary care’ providers (general practice, schools, aged-residential care and marae). With a clinical and non-clinical workforce, the team are able to respond to requests from primary care with clinical and/or social advice and brief interventions. Significant effort has been focused on establishing relationships with primary care and understanding how the team can best add value within the primary care model of service provision. Feedback has been positive, with early indications of a positive impact on the number of formal referrals to specialist services.

**Audit and Evaluation**

**Clinical Audits**

There has been a marked increase in the number of clinical audits undertaken in Mental Health Services during 2016/2017 compared with previous years. ‘Medication’ and ‘drug-related monitoring’ audits were the most common clinical audit topics, followed by ‘service processes/requirements’ and ‘documentation/standard operating procedures’. Integrated Care Adult services and SMOs conducted the highest number of clinical audits with nurse-led audits increasing, particularly in Child & Adolescent Mental Health Service (CAMHS) and Acute Adult Services.

**Evaluation**

Two evaluations were completed during 2016/17:

- Awake Overnight Nurse Pilot in Emergency Care Department.
- Intensive Community Treatment (ICT) and Te Puna Oranga (TPO) Pilot Project: Support Service for Females with High and Complex Needs Under the Care of ICT.

The Mental Health Services Clinical Audit and Evaluation Leader role has facilitated:

- targeted promotion of clinical audit and evaluation to Senior Medical Officers, nurses, psychologists and allied health professionals about the value of reflective practice and support available to staff.
- development of an expedited approval process for MHS clinical audits.
- development and launch of the Mental Health Clinical Audit and Research website.
- development of an annual MHS audit programme.
- engagement and collaboration with other DHBs and CM Health departments on audit development and procedures including privacy issues, medication audits, and clinical documentation.

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9 Specialist teams focusing on sub-specialties for Maaori, Pacific, child & youth, adult, older adult
Patient Experience

Patient Experience Year 2017

Improving Experience Everyday, Everywhere, for Everyone
CM Health highlights person-centred care and creating effective partnerships with patients, whaanau and staff as core to its Healthy Together 2020 strategy.

This year our approach has been on raising awareness, understanding, and confidence about the importance of understanding experience and co-design. This has been achieved by showcasing our local CM Health work through a communications approach, including the release of 60+ articles, publications and developing case studies [http://koawatea.co.nz/category/case-studies/](http://koawatea.co.nz/category/case-studies/).

Our aim has been to raise the notion that experience happens in every moment, between patients, whaanau and staff - what experiences do we imprint during those interactions. Experience is the sum of all interactions and reactions to all those moments that create an overall lasting CM Health experience.

As part of this year’s activities we have run several Empathy zones. Simulation gives participants an insight into the loss of control, fear, vulnerability and frustration patients may experience, and helped them to develop awareness and empathy with how these feelings impact on us all, Listening labs to enable students to hear experiences direct from patients and whaanau who have experienced our health and care services. Also hosting several Grand Rounds focused on aspects of co-design and experience.

Building understanding and capability around patient experience and co-design through existing programmes like Emerging Leaders, New Entry to Practise and Leading Quality Care, leading masterclass sessions and supporting projects and teams to build their expertise around engaging patients and whaanau in service development and improvement.
Throughout the year we have been involved in initiatives such as ‘What Matters to You’ Day, which was used to raise awareness around understanding what matters to our patients, whaanau and workforce, and ‘International Hello My Name Is... Day’ recently on 25 July, which follows the ethos of our Al²DET training.

“To be treated with kindness, to be listened to, having things well explained so I understand what is going to happen next.”

Patient
AI²DET

AI²DET was introduced into CM Health in 2011 by Maaori Health following a series of patient complaints. Patients were saying things like: ‘People are talking about us and not to us’, ‘we don’t know who is in the room’, ‘they are rude and don’t greet us’, ‘we feel invisible’. Maaori Health found the tool AIDET from the Studer group in America and adapted it for our organisation.

In 2016, we started introducing Health Literacy into CM Health and I thought about AI²DET as a good tool to support this. BUT the old E = Explanation and that does not fit with Health Literacy. So we refreshed the tool by changing the cartoons to represent our whole community and changed the E to Enquire (ask them what matters to them, what do we need to know to ensure they can do what is required). And Effective Communication by giving the information in a way they understand by using the three steps of Health Literacy (Find out what people know, Build health literacy skills and knowledge and Check you were clear).

AI²DET is a tool to ensure effective communication occurs between staff and the people we work with and care for. By acknowledging people to, build rapport, trust and make connections. Ensuring they know who we are and we have the correct person. Sharing the patient’s information with the person and/or whaanau to keep them informed.

Using effective communication by following the three steps of health literacy principles (Figure 25) ensures the person has understood information and that they are able to do what is required and/or know how to and who to contact when needed.

Figure 24
Consumer Council

The CM Health Consumer Council was established in early 2015 and works at all levels (including strategic and grass roots) to advise on a broad range of subjects including patient experience, whole-of-system initiatives, population health campaigns, and specific services.

The Consumer Council’s key role is: “to represent the interests of consumers and to bring an inpatient and ambulatory consumer and family/whaanau perspective to the development of CM Health plans, policies, publications and operational decisions, and to raise issues that are being identified in the community.”

Figure 25

“They remind us what it is like on the other side”

Staff Member
Health Literacy

During the 2016/17 year, an updated health literacy strategy document was approved and published on the CM Health website as “Building Understanding: Advance on being a health literate system”. This expressed our vision of a health literate organisation and system as one in which:

- everyone in Counties Manukau can find their way into and around the health services they need.
- every interaction builds understanding between patients, whaanau and staff.
- appropriate health education resources and information are used when needed to support understanding.

Three key components of a health literate organisation and system can be summarised as:

- Health literate, culturally competent staff, using the three step process for health literacy:
  1. Find out what people know.
  2. Build health literacy skills and knowledge.
  3. Check you were clear (and if not, go back to step 2), able to recognise that they may have different assumptions from others, and appreciate that it is their responsibility to communicate in ways that patients and whaanau can understand.

- Health literate, culturally competent health education resources, developed with target audience involvement, with appropriate language access (interpreting and translation).

- Supportive systems and processes for ensuring that appropriate resources are available and approved for use within services, and that staff/volunteers are able to easily access and share them with whaanau.

A multi-layered system of staff capability building has been developed to support the development of these three components.

During financial year 2016/17, the number of staff attending in-person training in health literacy, which included the three step process (ranging from a brief introduction to two-hour workshop sessions), was 1,142. Additionally, 15 staff from seven services across the organisation participated in a specially commissioned course designed to support them in the development of health education resources as well as the systems and processes to ensure the availability of such resources within their services. This is being formally evaluated, with results expected in October 2017. Early feedback, however, indicates that the framework used has been useful in helping staff identify and engage with the target audiences for their resources, as well as clarify elements of the systems and processes that need to be in place to ensure that appropriate health education resources are available for use with patients and whaanau when needed.

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Middlemore Hospital RAINBOW Volunteers

From June 2016 to July 2017, our volunteers contributed 9,357.20 volunteer hours to CM Health.

To add to the achievement, The Rainbow Volunteer team were recognised for their contribution to patients and whaanau in our community by being Runners up 2017 Minister of Health Volunteer Awards “Health Care Provider Service Volunteers Team”.

Celebrating success one year on

We have continued to build our community partnerships and had 17 schools from our community participating in our volunteer programme by enrolling their students who were keen on a career in health. We can successfully report that we had five Year 13 students who enrolled in health related degree/ courses after concluding their volunteer work with us at the end of 2016. This validates that our talent pipeline for growing our own future health workforce has merit.

The Rainbow Volunteer Service has also been able to offer return to light duties work for some of Counties Manukau Health employees. Employees who have been injured at work but cannot return to their roles immediately after their injury, but have been cleared for light duties, can volunteer with the Rainbow Volunteer service and help around the hospital. This enables our staff to stay connected to the hospital and feel valued without compromising their recovery. The volunteer service accommodated 16 staff recovering from workplace injury in 2016 (health care assistants, registered nurses, security staff and orderly staff).

Improving patient experience

- Helping at meal times on the wards.
- Taking patients for a walk and helping them get mobile.
- Helping at Kidz First children’s hospital.
- Helping with patient surveys.
- Reading to patients, playing card games or just chatting/visiting them.
- Helping with hand hygiene.
- Reception /way finding.
- Wheelchair assist.
- Admin support.
- Other tasks where appropriate.

For 2017, we have been working on integrating the volunteer team at the Manukau SuperClinic into our Rainbow Volunteer Team. This will help us provide an enhanced, consistent and integrated volunteer service across both our sites. This is an ongoing change process.
**Workforce Development**

**People Strategy**

CM Health’s People Strategy; an enabling strategy to support Healthy Together 2020, continues to provide a focus for the development work for the ‘people’ of our organisation. CM Health, through Ko Awatea, continues to invest in the personal and professional development of staff with a range of development opportunities including focus on improvement, patient safety, communications, diversity, mindfulness, management, leadership and service specific training.

In addition to this, there has been a particular focus on the unregulated workforce through the ‘step up’ programme, which is utilising numeracy and literacy skills development to increase the communication skills of our unregulated workforce. By July 2018 230 staff will have accessed the opportunity.

**Ko Awatea Leadership Academy**

Committed to nurturing health leaders, our Leadership Academy engages leaders from across CM Health to further improve and guide strategy and tactics now and for the future.

Through robust programmes that align leadership behaviours with patient care and excellence in practice, the Leadership Academy develops the organisations capacity for change leadership across the system.

**Doctors as Leaders**

With the successful launch of the Doctors as Leaders programme in 2015/2016 we have further developed the programme to run a second cohort in 2016/2017, a unique part of this programme is that it brings together both general practitioners (GPs) and senior medical officers (SMOs) into a learning environment which helps them to better understand the world in which they work, create contacts and networks and improve the flow of patients across the system.

In addition for the first cohort we have introduced Phase Two Leadership Development (Leadership in Action) as an extension to the original programme. It is designed to support the leadership learning of those doctors choosing to engage in the applied leadership work of designing and implementing an operating model across the DHB.

**Leading Quality Care**

This programme was introduced to CM Health in 2016/2017 - targeting frontline clinical leaders it is designed to further build clinical leader capability, and therefore influence and strengthen performance centred on quality care and patient outcomes. At the heart of CM Health are frontline leaders, who are pivotal in touching a broad scope of people. The aptitude needed to successfully manage and lead wards and other teams is forever increasing and challenging, and therefore vital for our leaders to continually develop in practices that best serve their capabilities. It is designed for those staff who are looking to develop their leadership capability to lead and enable others to improve the patient experience.
**Undergraduate Education**

CM Health offers circa 1,500 placements to students from a variety of healthcare professions. In order to improve the safety of healthcare students whilst on placement at CM Health, an online Ko Awatea Learn orientation module has been developed for all to complete.

The module contains information to prepare students for their clinical placement and orientate them to CM Health. The module includes patient safety training, privacy and occupational health requirements.

**Ko Awatea LEARN**

**Building staff capability through e-learning**

Ko Awatea LEARN has become firmly established as CM Health’s premier e-learning platform and in 2016/2017 grew nationally to include 47,000 users across 15 New Zealand DHBs with an average of 28432 page views, 265 users and 752 sessions per day accessing healthcare development programmes.

Ko Awatea Learn offers over 100 internal e-learning courses across areas such as patient safety, medication safety and systems change and during 2016, CM Health staff completed over 3,100 Patient Safety Training courses, 275 CALM courses, 430 Medication Certification and 260 Drug Calculations courses, ensuring that CM Health have a workforce that is up to date with current learning and regulations. See Figure 27 - Analytics for Ko Awatea Learn below.

*Figure 26 – Analytics for Ko Awatea LEARN*
Medical Council Accreditation

Medical Council Accreditation for prevocational medical training

In late June 2016, a team from the Medical Council of New Zealand visited Middlemore hospital to monitor our performance in relation to the Council’s accreditation standards for training providers. The Medical Council set the standards for the training of doctors in their first years after graduation from medical school. The Council had recently reviewed the curriculum for training and had introduced an electronic system for logging the young doctors’ progress.

In the report written after the visit, the team commented that high standards of medical practice, education and training were key strategic priorities for the District Health Board. The report noted that the DHB was committed to providing a high quality environment for education and training. The team identified the clear and effective leadership of the training programme.

Alongside a number of recommendations and commendations, the team identified four corrective actions. These actions related to:

1. The direct involvement of young doctors in the governance of the training programme.
2. The completion of meetings between the young doctors and their supervisors.
3. The process of young doctors being involved appropriately in obtaining consent from patients for operations.
4. The need for improvement of annual leave applications and approvals.

CM Health has made significant progress towards these actions with the first two issues being resolved. The Medical Council is currently considering the DHB’s progress with regard to the latter two actions.
Facilities Development

Retail Centre Development

In February 2017, CM Health welcomed the opening of the new retail complex, Paataka Place.

Paataka Place is the result of a significant refresh and upgrade of the previous retail outlet at Middlemore Hospital. It offers a much greater range of retail, food and beverage options to the public and staff. Included in Paataka Place is the new Haumanu Pharmacy, which offers a convenient option for patients to collect their medicines, as well as a range of retail products, on their way home from hospital.

There is four retail food and beverage outlets, offering great healthy eating options to patients and families, open from early in the morning until 9pm at night, seven days a week, and 365 days per year. The food retailers are supporting the adoption of the National Healthy Eating Policy, ensuring that CM Health is a leader in offering great healthy food options to our community. There is also an organic grocer, offering convenience and ‘grab and go’ meals for patients, whaanau and staff, as well as a florist providing gift options.

Paataka Place offers a calm and inviting space for patients and whaanau to congregate, with plenty of seating options and a dedicated lounge area to allow visitors a place to relax.

Paataka Place has greatly enhanced the patient and whaanau experience of Middlemore Hospital.
Tiaho Mai: New Acute Mental Health Unit

Progress is well underway on the building of the new Acute Adult Inpatient Unit at Middlemore Hospital. Being built on the same site as the old unit has required a two stage build, with decanting of one ward to the Mani Hospital while the first half of the build is undertaken.

The picture below shows the extent to which the new unit has been rebuilt. The roofed area to the right of the picture will be the high dependency unit HDU. The roofed area to the far left will be the low dependency unit LDU, with the long roofed area to the centre rear housing the social and dining areas for the LDU service users.

The architect’s impression of this area once complete is shown in the picture below.

The planned completion date for the first half of the new unit is currently the end of December 2017/early January 2018.
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Note that this paper was endorsed by the Audit Risk and Finance Committee at their meeting of 15 November 2017 to proceed to the Board meeting of 6 December 2017.

Receive the Finance and Corporate Business Report for September.

Prepared by and submitted by: Margaret White, Chief Financial Officer

Purpose

The purpose of this paper is to provide the Board with an overview of the latest available financial position.

Financial result (YTD September 2017):

Year to date to 30 September 2017 the consolidated result is $0.666m favourable to budget. Performance by division is presented in the table below.

Statement of Performance by Operating Arm for the period ended 30 September 2017

<table>
<thead>
<tr>
<th>Net Result</th>
<th>Month September 17</th>
<th>Year to Date September 17</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act $000</td>
<td>Bud $000</td>
<td>Var $000</td>
</tr>
<tr>
<td>Hospital Provider</td>
<td>3,508</td>
<td>3,161</td>
<td>347</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(3,628)</td>
<td>(3,726)</td>
<td>98</td>
</tr>
<tr>
<td>Ko Awatea</td>
<td>(1,196)</td>
<td>(1,242)</td>
<td>46</td>
</tr>
<tr>
<td>Provider</td>
<td>(1,316)</td>
<td>(1,807)</td>
<td>491</td>
</tr>
<tr>
<td>Funder</td>
<td>522</td>
<td>411</td>
<td>111</td>
</tr>
<tr>
<td>Governance</td>
<td>(350)</td>
<td>(76)</td>
<td>(274)</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(1,144)</td>
<td>(1,472)</td>
<td>328</td>
</tr>
</tbody>
</table>

Provider Arm

Year to Date the Provider Arm produced a $0.912m favourable result against budget, on the backdrop of a busy winter period that has seen unprecedented demand for ED and inpatient care which has impacted on the elective programme. Mitigating this impact was the strong contribution from the ACC arrears programme, favorable movement in creditors and vacancies across the service (partially offset with outsourced personnel).
Funder

Year to date the Funder Arm is $0.071m adverse to budget, attributable to a continued monthly provisioning for anticipated IDF wash-up exposure in Community Pharmaceuticals, Community Laboratory (Rheumatic Fever tests) and Auckland Regional Dental Service (ARDS). This has been mitigated to some extent by the recognition of lower PHO enrolments relative to budget growth assumptions.

Governance

Year to Date the Governance Arm is $0.175m adverse to budget, with a $0.226m September write down of project costs being reviewed and assessed as no longer appropriate to retain as WIP, offset by continued vacancies in Maori Health (2 FTE), Planning and Funding (1 FTE) and Mental Health (1 FTE).

Volume Summary

Year to Date Emergency Department discharges were 3.8% greater than the same period last year. Year to date Acute WIES were 0.4% greater than budget and 2.4% greater than the same period last year of 18,065.

Sustained acute demand over and above the increases already budgeted, compounded by anesthetist vacancies have impacted Elective surgery volumes which continue to track under contract. Year to date Elective WIES were 5.6% adverse to budget and 12.6% less than the same period last year of 4,962.

Statement of Revenue and Expenditure for the period ended 30 September 2017

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act $000</td>
<td>Bud $000</td>
<td>Var $000</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>136,522</td>
<td>133,215</td>
<td>3,307</td>
</tr>
<tr>
<td>Other</td>
<td>2,971</td>
<td>2,880</td>
<td>91</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>139,493</td>
<td>136,095</td>
<td>3,398</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>49,948</td>
<td>51,254</td>
<td>1,306</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>2,218</td>
<td>952</td>
<td>(1,266)</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>5,839</td>
<td>5,781</td>
<td>(58)</td>
</tr>
<tr>
<td>Funder Provider</td>
<td>59,842</td>
<td>57,516</td>
<td>(2,326)</td>
</tr>
<tr>
<td>Payments</td>
<td>Clinical Sup.</td>
<td>10,137</td>
<td>10,080</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>7,190</td>
<td>6,329</td>
<td>(861)</td>
</tr>
<tr>
<td>Operating Exp</td>
<td>135,174</td>
<td>131,912</td>
<td>(3,262)</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>4,319</td>
<td>4,183</td>
<td>136</td>
</tr>
<tr>
<td>Depn.</td>
<td>2,632</td>
<td>2,661</td>
<td>29</td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital Chg.</td>
<td>2,831</td>
<td>2,994</td>
<td>163</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(1,144)</td>
<td>(1,472)</td>
<td>328</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

Crown Revenue

Year to date was $4.524m favourable to budget, reflecting the following:
- favourable unbudgeted $2.608m MoH funding for Disability Support Services Pay Equity (offset in Funder Provider Payments)
- favourable $1.121m accrued funding for System Level Measures paid to PHO’s during the month (offset in Funder Provider Payments)
- favourable $2.247m from the on-going ACC arrears initiative
- unfavourable $0.285m wash-up of Inter District Flows, predominantly due to Tairawhiti DHB deciding to no longer have CMH manage their PHO payments (offset in Funder Provider Payments)
- unfavourable $1.185m due to under delivery of elective programme (funding has been provisioned in the balance sheet for release in line with delivery against the MOH contract for the balance of year)

Other Revenue

Year to Date was $0.055m favourable to budget attributable to:
- favourable $0.361m unbudgeted revenue for After Hours Service provided on behalf of other DHB’s and PHO’s
- favourable $0.168m for additional patient charges for non-residents
- favourable $0.166m bad debt recoveries
- unfavourable $0.646 Pharmacy revenue (offset in infrastructure)

Personnel and Outsourced Personnel

Year to Date net personnel costs were $0.341m favourable to budget, reflecting vacancies across the service as well as delays in approving new roles due to late confirmation of the budget.

Funder Provider Payments

Year to date was $4.564m unfavourable to budget, reflecting the following:
- unfavourable $2.608m accrual for Disability Support Services Pay Equity (offset in Crown Revenue)
- unfavourable $1.121m payments to PHO’s during the month (offset in Crown Revenue)
- unfavourable $0.616m accrual for the current estimate of IDF shortfall for the 17/18 year

Clinical Supplies

Year to Date was $0.454m favourable to budget, reflecting high clinical demand offset by movement in creditors.

Infrastructure

Year to Date $0.455m unfavourable to budget, mostly reflecting Retail Pharmacy Cost of Goods Sold $0.412m (offset in Other Revenue).

Depreciation, Interest and Capital Charge

Depreciation and Capital Charge Year to Date is $0.218m favourable to budget reflecting timing for capitalisation of projects.
Statement of Financial Position as at 30 September 2017

<table>
<thead>
<tr>
<th></th>
<th>Act $000</th>
<th>Bud $000</th>
<th>Var $000</th>
<th>June 2017 $000</th>
<th>Movement $000</th>
</tr>
</thead>
<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>8</td>
<td>8</td>
<td>-</td>
<td>20,894</td>
<td>(699)</td>
</tr>
<tr>
<td>Bank</td>
<td>20,195</td>
<td>8,504</td>
<td>11,691</td>
<td>46,990</td>
<td>7,054</td>
</tr>
<tr>
<td>Trust</td>
<td>885</td>
<td>886</td>
<td>1</td>
<td>883</td>
<td>2</td>
</tr>
<tr>
<td>Prepayments</td>
<td>4,059</td>
<td>2,307</td>
<td>1,752</td>
<td>2,307</td>
<td>1,752</td>
</tr>
<tr>
<td>Debtors</td>
<td>54,044</td>
<td>51,130</td>
<td>2,914</td>
<td>56,294</td>
<td>7,054</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,391</td>
<td>7,484</td>
<td>(93)</td>
<td>7,484</td>
<td>(93)</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>33,743</td>
<td>33,743</td>
<td>-</td>
<td>33,743</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td>120,325</td>
<td>104,062</td>
<td>16,263</td>
<td>112,309</td>
<td>8,016</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>614,550</td>
<td>606,452</td>
<td>8,098</td>
<td>613,311</td>
<td>1,239</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,627</td>
<td>1,627</td>
<td>-</td>
<td>1,627</td>
<td>-</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,100</td>
<td>10,515</td>
<td>(6,415)</td>
<td>4,259</td>
<td>(159)</td>
</tr>
<tr>
<td>Information Software</td>
<td>562</td>
<td>561</td>
<td>1</td>
<td>561</td>
<td>1</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>4,416</td>
<td>4,416</td>
<td>-</td>
<td>4,416</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>837,675</td>
<td>835,991</td>
<td>1,684</td>
<td>836,594</td>
<td>1,081</td>
</tr>
<tr>
<td><strong>Accum. Depreciation</strong></td>
<td>(157,905)</td>
<td>(159,689)</td>
<td>1,784</td>
<td>(151,706)</td>
<td>(6,199)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>679,770</td>
<td>676,302</td>
<td>3,468</td>
<td>684,888</td>
<td>(5,118)</td>
</tr>
<tr>
<td><strong>Work In-progress</strong></td>
<td>45,553</td>
<td>62,082</td>
<td>(16,529)</td>
<td>37,695</td>
<td>7,858</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>725,323</td>
<td>738,384</td>
<td>(13,061)</td>
<td>722,583</td>
<td>2,740</td>
</tr>
<tr>
<td><strong>Investments in Assoc</strong></td>
<td>44,471</td>
<td>41,834</td>
<td>2,637</td>
<td>41,834</td>
<td>2,637</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>890,119</td>
<td>884,280</td>
<td>5,839</td>
<td>876,726</td>
<td>13,393</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>102,429</td>
<td>102,352</td>
<td>77</td>
<td>93,254</td>
<td>9,175</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>9,470</td>
<td>7,964</td>
<td>1,506</td>
<td>6,164</td>
<td>3,306</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>15,199</td>
<td>14,151</td>
<td>1,048</td>
<td>13,324</td>
<td>1,875</td>
</tr>
<tr>
<td>Loans</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>43,746</td>
<td>39,022</td>
<td>4,724</td>
<td>39,008</td>
<td>4,738</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>74,635</td>
<td>76,751</td>
<td>(2,116)</td>
<td>76,250</td>
<td>(1,615)</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>245,479</td>
<td>240,240</td>
<td>5,239</td>
<td>228,000</td>
<td>17,479</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(125,154)</td>
<td>(136,178)</td>
<td>11,024</td>
<td>(115,691)</td>
<td>(9,463)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>644,640</td>
<td>644,040</td>
<td>600</td>
<td>648,726</td>
<td>(4,086)</td>
</tr>
<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>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employee Provisions (non-current)</td>
<td>18,650</td>
<td>18,717</td>
<td>(67)</td>
<td>18,717</td>
<td>(67)</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>900</td>
<td>900</td>
<td>-</td>
<td>898</td>
<td>2</td>
</tr>
<tr>
<td>Insurance Liability - non current</td>
<td>931</td>
<td>931</td>
<td>-</td>
<td>931</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>20,481</td>
<td>20,548</td>
<td>(67)</td>
<td>20,546</td>
<td>(65)</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>399,788</td>
<td>399,788</td>
<td>-</td>
<td>399,788</td>
<td>-</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>283,552</td>
<td>283,552</td>
<td>-</td>
<td>283,552</td>
<td>-</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(59,181)</td>
<td>(59,848)</td>
<td>667</td>
<td>(55,160)</td>
<td>(4,021)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>624,159</td>
<td>623,492</td>
<td>667</td>
<td>628,180</td>
<td>(4,021)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>644,640</td>
<td>644,040</td>
<td>600</td>
<td>648,726</td>
<td>(4,086)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances

- Bank was $11.691m favourable to budget, largely attributable to the receipt of a $3.0m settlement during the month of August (see below), and timing of spend for Fixed Assets.

- Prepayments were $1.752m higher than budget, predominantly $0.972m for insurance prepaid, and $1.2m for pay equity funding received.

- Debtors was $2.914m higher than budget attributable to accrued debtors for System Level Measures (SLM) funding owed by MoH $1.07m and $2.4m for accrued Pharmac rebates.

- Total Fixed Assets were $13.061m lower than budget reflecting timing of spend and capitalisation for major capital projects (KA II, AMHU and HT2020).

- Investment in Associates was $2.637m higher than budget representing the healthAlliance C class shares investment in relation to 2016/17 financial year settled in September.

- Creditors are in line with budget reflecting the following:
  - accrual of $6.09m for slower payments pending rollout of new NGO contracts
  - settlement of $3.0m held pending commencement of the work on a facilities project
  - accrual of $0.344m for IDF wash-up for Community Pharmaceuticals, Community Laboratory and Auckland Regional Dental Services
  - capital spend being $6.6m lower than planned for September, therefore not being carried in Creditors balance

- Income in Advance was $1.506m higher than budget, reflecting Clinical Training Agency funding $1.2m received in August.

- GST and PAYE were $1.048m higher than budget mostly attributable to timing of for PAYE.

- Payroll Accrual & Clearing were $4.724m higher than budget reflecting:
  - September payroll accrued but not yet paid $12.716m, which was $1.774m higher than budget
  - $2.122m timing of payments for payroll provisions
  - ACC Levy provision $0.485m higher than budget

- Employee Provisions were $2.116m lower than budget, and Non-Current Employee Provisions were $0.067m lower than budget, primarily due to a reduction in current leave provision of $1.852m.

- Working Capital $11.024m favourable to budget represents movement in cash $11.691m, of which $13.061m is due to the timing variance in relation to major capital, offset by the additional $2.637m investment in healthAlliance C Class Shares.
Statement of Cash flow for the period ended 30 September 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
</tr>
<tr>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td><strong>Cash flows from Operating activities</strong></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>138,019</td>
</tr>
<tr>
<td>Other</td>
<td>3,388</td>
</tr>
<tr>
<td>Interest rec.</td>
<td>129</td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(92,068)</td>
</tr>
<tr>
<td>Employees</td>
<td>(49,703)</td>
</tr>
<tr>
<td>Interest paid</td>
<td></td>
</tr>
<tr>
<td>Capital charge</td>
<td>1</td>
</tr>
<tr>
<td><strong>Net cash from Operations</strong></td>
<td>(234)</td>
</tr>
<tr>
<td><strong>Cash flows from Investing activities</strong></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(4,483)</td>
</tr>
<tr>
<td>Sale of Asset</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>(2,636)</td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(7,119)</td>
</tr>
<tr>
<td><strong>Cash flows from Financing activities</strong></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td></td>
</tr>
<tr>
<td>Debt</td>
<td></td>
</tr>
<tr>
<td>Other Non-Current Liability</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>(7,353)</td>
</tr>
<tr>
<td>Opening cash</td>
<td>27,556</td>
</tr>
<tr>
<td><strong>Closing cash</strong></td>
<td>20,203</td>
</tr>
</tbody>
</table>

Reconciliation Summary

<table>
<thead>
<tr>
<th>Net Surplus/(Deficit)</th>
<th>Add/(Less) non-cash items</th>
<th>Add/(Less) items Classified as Investing or Financing activities</th>
<th>Add/(Less) Movements in Financial Position items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(1,144)</td>
<td>(1,472)</td>
<td>328</td>
</tr>
<tr>
<td>Add/(Less) Impairment of Intangibles</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depn</td>
<td>2,632</td>
<td>2,661</td>
<td>(29)</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>1,488</td>
<td>1,189</td>
<td>299</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Add/(Less) Movements in Financial Position</th>
<th>Debtors and Other Receivables</th>
<th>Inventories</th>
<th>Creditors</th>
<th>Employee Entitlements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add/(Less)</td>
<td>799</td>
<td>328</td>
<td>471</td>
<td>(8,806)</td>
</tr>
<tr>
<td>Less/(More)</td>
<td>102</td>
<td>-</td>
<td>102</td>
<td>93</td>
</tr>
<tr>
<td>Add/(Less)</td>
<td>(2,868)</td>
<td>14,503</td>
<td>(17,371)</td>
<td>14,354</td>
</tr>
<tr>
<td>Less/(More)</td>
<td>245</td>
<td>392</td>
<td>(147)</td>
<td>3,056</td>
</tr>
<tr>
<td>Net Cash flow from Operations</td>
<td>(234)</td>
<td>16,412</td>
<td>(16,664)</td>
<td>12,604</td>
</tr>
</tbody>
</table>

| Net Cash from Investing                  | (7,119) | (11,102) | 3,983 | (13,303) | (23,784) | 10,481 |
| Net Cash from Financing                  | - | - | - | - | - | - |
| Net Increase / (Decrease)                | (7,353) | 5,310 | (12,663) | (699) | (12,390) | 11,691 |

| Opening Cash                            | 27,556 | 3,202 | 24,354 | 20,902 | 20,902 | 0 |
| **Closing Cash**                        | 20,203 | 8,512 | 11,691 | 20,203 | 8,512 | 11,691 |
Commentary on Major Variances

- YTD cash-flow from Crown Revenue is $2.103m favourable to budget, representing:
  - favourable $2.247m from the on-going ACC arrears initiative
  - unfavourable $0.285m wash-up of Inter District Flows, predominantly due to Tairawhiti DHB deciding to no longer have CMH manage their PHO payments

- Year to Date payments to suppliers were $8.065m adverse to budget, reflecting:
  - unfavourable $3.223m outsourced personnel, together with the increased Funder Provider Payments
  - unfavourable $1.121m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue)
  - unfavourable $1.945m Disability Support service Pay Equity received in June but paid in Q1 of 2017/18

- Employee Payments were $6.103m favourable to budget representing the vacancies across the service together with the $3.129m higher balance in Payroll Accrual & Clearing predominantly due to timing of the payroll.

- Fixed Assets $13.116m favourable to budget representing the timing of spend and capitalisation for major capital projects.

- Investments were $2.637m adverse to budget representing the healthAlliance C class shares in relation to 2016/17 financial year settled in September.
Counties Manukau District Health Board
System Level Measures Quarterly Regional Report and Scorecard

Recommendation

It is recommended that the Board:

Receive the System Level Measures Quarterly Update Report.

Prepared and submitted by: Benedict Hefford, Director Primary, Community & Integrated Care.

Purpose

This scorecard presents regional progress towards meeting the 2017/18 Metro Auckland System Level Measures (SLMs), by District Health Board. Please note that the Infants Living in Smokefree Households and Youth Health measures are developmental for 2017/18.

Introduction

The New Zealand Health Strategy outlines a new high-level direction for New Zealand’s health system over the next ten years to ensure that all New Zealanders live well, stay well, get well. One of the five themes in the Strategy is value and high performance. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health worked with the sector to develop a suite of System Level Measures to provide a system-wide view of performance. Building on the work outlined in the 2016/17 System Level Measures Improvement Plan, in 2017/18 improvement milestones and contributory measures for each of the SLMs have been prioritised in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Counties Manukau (CM) Health and Auckland Waitemata Alliances are firmly committed to including more contributory measures over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Maaori health gain and the elimination of inequity for Maaori.

The steering group and working groups have continued to meet in 2017/18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven Primary Health Organisations and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams and provides oversight of the overall process. Working groups were responsible for drafting contributory measures and identifying the related interventions to be included in the local improvement plans. Each working group is chaired by a Primary Health Organisation lead and supported by a DHB public health physician. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers.

This second improvement plan (2017/18) includes the additional two SLMs:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2017/18. The milestone must be a number that either improves performance from the district baseline or reduces variation to achieve equity.
For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

This report includes the latest available data for each DHB for both the SLMs and their contributory measures. It also outlines each working group’s progress against the improvement activities identified in for each SLM in the Improvement Plan.

**Scorecard**

### 1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2017/18: five percent reduction in rate by June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate per 100,000 domiciled 0-4 year-olds</td>
<td>Auckland DHB (37%)</td>
</tr>
<tr>
<td></td>
<td>5% monthly</td>
</tr>
</tbody>
</table>

**Legend**
- ● Target met / on track
- ○ Improvement needed
- ●● Significant improvement needed

### 2. Acute Hospital Bed Days

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2017/18: 3% reduction for Metro population by June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-standardised rate per 1,000 domiciled</td>
<td>Auckland DHB (3%)</td>
</tr>
<tr>
<td>Region</td>
<td>172%</td>
</tr>
<tr>
<td></td>
<td>3% monthly</td>
</tr>
</tbody>
</table>

### 3. Patient Experience of Care

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2017/18: Aggregated domain score (SDH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB Adult Inpatient Experience Survey</td>
<td>Auckland DHB (8.5)</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

### 4. Amenable Mortality

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2017/18: two percent reduction for single year baseline by June 2018 (90% reduction for each DHB (as 2013 baseline) by June 2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age-standardised rate per 100,000 domiciled</td>
<td>Auckland DHB (71.4)</td>
</tr>
<tr>
<td>Region</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>3% monthly</td>
</tr>
</tbody>
</table>

### 5. Youth Health

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2017/18: Eighty percent of pregnant women aged 15-24 years are screened for Chlamydia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia testing coverage for 15-24 years</td>
<td>Auckland DHB (80%)</td>
</tr>
<tr>
<td>Region</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

### 6. Babies Living in Smokefree Households

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target 2017/18: Six months of age household is not exposed to smoke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of babies for whom smoke-free</td>
<td>Auckland DHB (10%)</td>
</tr>
<tr>
<td>Region</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>6 monthly</td>
</tr>
</tbody>
</table>

 Counties Manukau District Health Board

6 December 2017

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Overall Progress Report

Overarching activities for Q1:

- Final submission and approval of the 2017/18 Improvement Plan to the Ministry
- Q4 reporting for 16/17 approved, with payment processed on 15 September to all Primary Health Organisations without impediment
- Stocktake of existing, new, planned and boosted activity under SLMs, which has been developed into a Regional Action Plan (Implementation Plan), with a plan to present to the Alliance Leadership Teams after Q2
- Consideration of the business-as-usual stage for SLMs, with a plan for operation agreed and preparation in progress
- First steps to business-as-usual, development of a consolidated governance structure: data panel, Primary Health Organisation implementation group and acute hospital bed days working group reporting to steering group, with a view to the permanent home of the other SLM working groups in negotiation
- Formation of quarterly static and on-going dynamic reporting and a formal workshop to launch these reports, explain the process for data requests and discuss the attributes and limitations of SLM related data
- SLMs have become core business for the metro-Auckland Data Sharing Data Stewards during embedding of the data release and governance processes, also presented at Regional Privacy Advisory Group (RPAG)
- Some data has been delivered for almost all milestone and contributory measure data sets. Those that have not been received have been formally requested. There is some lag from Ministry data sets and where there is lag, wait times range from 3 to 6 months
- Several improvement activities requiring data have also had the Metro-Auckland Data Sharing Framework (MADSF) user request completed and have either received data or is in the approval process. Some further improvement activity-related data sets are currently being defined with a view to analysis shortly.

Ambulatory Sensitive Hospitalisations 0-4 year olds

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting.

In New Zealand children, ASH accounts for approximately 30 percent of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

A composite ASH measure is preferred because it gathers up more conditions and aligns with the intention of using measures that operate at a system level rather than ones that focus on a specific condition or service.

In 2017/18, the overall improvement milestone is to achieve a reduction in ASH rates for 0-4 year olds of 5% by June 2018. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported and interrogation of approach to ensure that interventions reduce not worsen inequity. Metro Auckland’s rate is 6,258 per 100,000 for the 12 months to June 2017 (latest results). This is more than a 5% reduction on the results to September 2016 (baseline) of 6,758 per 100,000 population.
Contributory Measures

1. Māori babies fully immunised by 8 months of age
The goal for 2017/18 is to achieve the national target of 95% coverage per quarter. To achieve this goal, the current whole-of-pathway focus of the immunisation programme would continue. For Quarter 1 2017/18, none of the metro-Auckland DHBs met the target overall, with a metro-Auckland result of 88.2%.

Improvement Activities

- Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care).
- Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care.
- Develop links between immunisation All DHBs and Primary Health Organisations continued with business as usual activities throughout the quarter.

Closing the equity gap and targeting high risk children are priorities for DHBs, and scoping activities have begun for in-hospital immunisation monitoring and documentation.

There is activity in each of the named improvement activities, although Well Child/Tamariki Ora immunisers and Whanau Ora service utilisation has not yet been addressed.

The Primary Health Organisation implementation meeting on 6 September addressed the contribution of Primary Health Organisations to this measure, with identification of barriers to immunisation and a set of
Improvement Activities
outreach services and Maori Tamariki Ora providers to improve immunisation coverage for their enrolled children.
• Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation.
• Utilise Whaanau Ora services for immunisation of hard to reach children.
• Promote immunisation in antenatal classes.
• Investigate whether significant numbers of Maori babies are not engaged with general practice, with a view to include improvement activities to connect Maori whaanau into the current newborn enrolment work.

Progress Report
strategies developed to identify and engage high risk children.

2. Skin infections
The goal is a reduction in hospitalisation rates by 5% by June 2018, from a baseline of 907 per 100,000 0-4 population as at September 2016. To achieve this goal, there are a number of targeted activities around promotion of key prevention messages, in various community settings. The latest data is for the 12 months to June 2017 and shows a result of 791 per 100,000 0-4 population, a more than 12% reduction on baseline. However, results are much higher for Maori and Pacific populations and also typically fluctuate between quarters.

Metro-Auckland unstandardised skin infection rate 0-4 year olds to June

<table>
<thead>
<tr>
<th>Year</th>
<th>Other</th>
<th>Maori</th>
<th>Pacific</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>600</td>
<td>800</td>
<td>100</td>
<td>1500</td>
</tr>
<tr>
<td>2013-14</td>
<td>550</td>
<td>750</td>
<td>90</td>
<td>1400</td>
</tr>
<tr>
<td>2014-15</td>
<td>500</td>
<td>700</td>
<td>80</td>
<td>1300</td>
</tr>
<tr>
<td>2015-16</td>
<td>450</td>
<td>600</td>
<td>70</td>
<td>1200</td>
</tr>
<tr>
<td>2016-17</td>
<td>400</td>
<td>550</td>
<td>60</td>
<td>1100</td>
</tr>
</tbody>
</table>

There is ongoing work in this area as detailed in the activities.

There is a Primary Health Organisation implementation meeting scheduled for 15 November to support the activities in Primary Care. Several Primary Health Organisations are taking a lead in this area by working on primary care skin clinics and related identification of higher risk skin infections, which will be treated in primary care, reducing hospitalisations.

The new national pharmacy plan should link this work to interventions in pharmacy shortly.
3. Oral Health

The goal is 95% enrolment with oral health services amongst preschool children. The newly finalised Oral Health Strategy is the basis of the improvement, with SLMs aligning and supporting this work. As at October 2017, the metro-Auckland result shows that around 88% of 0-4 year olds are enrolled with the Auckland Regional Dental Service. This is much lower for Maaori at 70%. Counties Manukau have the lowest rate of enrolment overall at 81.5%, Waitemata the highest at 95%.
### Improvement Activities

- Messaging to align with Raising Healthy Kids National Health Target.
- Increase awareness of free dental services.
- Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes.
- Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services.
- Increased number of extended hours and Saturday dental clinics in appropriate locations.
- Consider a targeted intervention for Pacific and Maaori children to address inequity.

### Progress Report

Early adopters are working toward promotion of lift-the-lip assessments and clarification of the referral pathway.

Many of the activities in this measure are the agreed responsibility of Auckland Regional Dental Service (ARDS) under the Pre-School Oral Health Strategy.

<table>
<thead>
<tr>
<th>Respiratory Conditions Potentially Preventable by Immunisations</th>
</tr>
</thead>
</table>

The goal is to increase flu vaccination coverage by 10% (from a baseline of 13% at December 2016) for children who are hospitalised with a respiratory illness. To achieve this goal, there is a focus on provision of information in a timely manner and improved key messages around flu vaccine for eligible children. This measure is across the calendar year in line with the flu season May to December. So the cohort is established at 1 March and vaccination rates are measured for these children at 31 May, 31 July and 30 September, with the final measure as at 31 December. The rates below are as of 31 July 2017. Rates were highest for Waitemata DHB and lowest for Counties. Maaori and Pacific rates are lowest.

**Flu vaccination rates for children hospitalised with a respiratory condition aged under 5 years - as at 31 July 2017**

<table>
<thead>
<tr>
<th></th>
<th>ADHB</th>
<th>CMDHB</th>
<th>WDHB</th>
<th>2017 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European/Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maaori</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Counts Manukau District Health Board

6 December 2017

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**Improvement Activities**

- Develop the current activity to identify and vaccinate all children aged 0–5 who qualify for the free influenza vaccine.
- Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities.
- Undertake activities in primary and secondary care:
  - **Secondary care**
    - Develop a documented, consistent system for providing lists of hospitalised children to Primary Health Organisations and monitoring through the Influenza season (when the vaccine is available);
    - Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations, and
    - Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations.
  - **Primary care**
    - Immunisation coordinators in Primary Health Organisations provide education to general practice staff on special immunisations while visiting practices, and
    - The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions.
- Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness.
- Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years.
- Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.

**Progress Report**

There has been very good engagement with this measure in both primary and secondary care. It was discussed at the Primary Health Organisation implementation meeting on 6 September and Primary Health Organisations agreed to develop specific queries to determine eligible patients and plan to liaise with NIISG to improve promotional material. DHBs have agreed to provide lists of eligible children as early as possible to facilitate early engagement.

An education programme was agreed for later in the year, with key messages at conferences and on web based platforms to decrease barriers to access.

Conversations about the feasibility of offering influenza vaccination to all children 0-4 years have been postponed until the key actions in this SLM have been undertaken.

Data for pregnancy related immunisation has been requested from the Ministry of Health and is due in November 2017.
Acute Hospital Bed Days Per Capita

Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors, good communication between primary and secondary care, can all help reduce unnecessary acute demand. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day’s per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to Emergency Department (self, provider variation, ambulance etc.). Primary care interventions are key and can have significant impact on hospital admission rates.

The Auckland Metro age standardised acute bed day rate per thousand population was calculated to be 437.7 as at September 2016 with a target set to reduce the rate by:

- 2% for the total population – 428.9 standardised acute bed days/1000 by June 2018
- 3% for the Maaori population – 604.6 standardised acute bed days/1000 by June 2018
- 3% for the Pacific population – 729.6 standardised acute bed days/1000 by June 2018

It must be noted that any new beds opening will need to be adjusted for, as supply side changes will impact this indicator in a stepwise fashion.

When standardised, overall rates are generally declining for all DHBs as they are nationally. The metro-Auckland overall rate is nearing the June 2018 target at 429.1 standardised acute bed days/1000.
However, rates are much higher and more static for Māori and Pacific populations. While Auckland has met target for Māori and Waitemata is better than target, Counties Manukau are some way from the achieving. For Pacific, both Counties and Waitemata are now within the target, but Auckland remains above.

**Contributory Measures**

1. **Emergency Department Presentation Rates.**

Overall reduction in Emergency Department presentations will result in less admissions and bed day use. There is some complexity involved in this measure however it is a good marker due to its correlation with actual admissions and also potentially avoidable admissions. The difficulty will come from wide confidence intervals for the measurement at a practice level. Other measures such as Primary Options for Acute Care utilisation rates are also being developed.

The methodology for calculating this measure has only recently been finalised and approved and a baseline established of 214.3 Emergency Department attendances per 1000 population (standardised), for the 12 months to 30 September 2016. The 2017/18 SLM Improvement Plan set a target of reduction of 2% by June 2018. Data is yet to be released to determine performance.

These rates are per 1,000 of the population and age standardised to the New Zealand population 2013 and presented as a moving 12 month rolling figure. Note that the data will be refreshed retrospectively for each reporting period, so previously reported figures may change.
<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Options for Acute Care activities:</td>
<td>Data definitions have been completed and discussed with Primary Options for Acute Care. These have been approved by the Data Custodians and Steering Group and a source request sent to Primary Options for Acute Care. This data was discussed by the expert group on 19th October.</td>
</tr>
<tr>
<td>• Determine baseline utilisation of Primary Options for Acute Care across the region, including an ethnicity-level and a practice-level analysis.</td>
<td>Practice level reporting is also in development for the region.</td>
</tr>
<tr>
<td>• Identify gaps and areas for potential improvement.</td>
<td>Development of the education programme is scheduled for the Primary Health Organisation implementation meeting to discuss Primary Options for Acute Care on 1 November 2017.</td>
</tr>
<tr>
<td>• Convene expert group to determine and agree consistent interventions.</td>
<td>CMDHB is currently developing an application to show emergency wait times and may give out vouchers to redirect patients should wait times prove lengthy for low acuity.</td>
</tr>
<tr>
<td>• Monitor Primary Options for Acute Care utilisation, intervention rate and impact.</td>
<td></td>
</tr>
<tr>
<td>• Develop and implement an education programme to promote appropriate use of Primary Options for Acute Care.</td>
<td></td>
</tr>
<tr>
<td>• Explore current barriers to general practices using Primary Options for Acute Care.</td>
<td></td>
</tr>
<tr>
<td>• Develop practice-level reports showing Primary Options for Acute Care usage relative to peers.</td>
<td></td>
</tr>
<tr>
<td>• Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.</td>
<td></td>
</tr>
</tbody>
</table>

2. Acute readmission rates at 28 days
Avoidance of readmission to hospital following a recent discharge from hospital. The Ministry of Health have recently changed the methodology for calculating acute readmission rates at 28 days significantly. Therefore the data presented below cannot be compared to previous datasets. The latest Ministry results (to June 2017) for metro-Auckland show performance at 12.1% standardised for the total population. Within this, Auckland DHB has a result of 13%, Counties Manukau 11% and Waitemata DHB 12.8%. There has been little movement across the three data points, though a general decline is evident for all except Waitemata DHB. Only Counties Manukau is below the New Zealand rate.

For both Māori and Pacific, readmission rates for Auckland are highest and lowest for Counties Manukau. Readmission rates for Māori are also generally static though higher than that for the total population, whereas there is a marked decline across the data points for Pacific, except for Waitemata which has increased between this and last reporting period.
### Improvement Activities

- Determine baseline readmission rates by ethnicity, by Primary Health Organisation and across the region.
- Explore the potential of risk stratification to identify patients at highest risk of readmission.
- Review discharge planning processes across the hospital systems.
- At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly.
- Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly.
- Ensure that patients discharged from hospital with a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans are in place, with a focus on initiating them in primary care settings.

### Progress Report

- Awaiting Ministry data using new methodology, first set delivered late September but was returned due to low quality.
- AHBDB working group is creating linkages between the DHBs and their ongoing projects in this area.
- CMDHB has four working groups newly created to address the condition-based issues – specifically, chronic obstructive pulmonary disease, heart failure, stroke and cellulitis.
- ADHB has ‘Using the Hospital Wisely’ programme and a specific consideration of chronic obstructive pulmonary disease.
- WDHB has the TransforMED programme which has a bed day reduction focus, and a frail and elderly emphasis.
- The three programmes above are linking up with the AHBDB working group and sharing ideas and successes.
- Risk stratification is ongoing at CMDHB as part of the Planned Proactive Care model of care.
- A/WDHB are reviewing and focusing on discharge planning.

### Patient Experience of Care

‘Person centred care’ or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

### Measures

1. **DHB Adult Inpatient Survey**

   The nationally applied DHB Adult Inpatient Survey has been conducted quarterly since 2014 and for 2016/17 the SLM milestone for patient experience focused on the Adult Inpatient Experience Survey. This survey captures 4 measured domains - communications, partnership, coordination, physical and emotional needs. The 2016/17 target was to achieve an aggregate score of 8.0/10 across all four domains measured, this has been increased to 8.5/10 for 2017/18.

   Interventions are aimed at improving patient experience scores in the 4 domains along with promoting the survey to improve participation and using the results to improve quality. Individual DHBs need to improve survey participation, particularly with respect to equity and foster greater regional collaboration. This may include working with Maori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

   Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.
### Improvement Activities

- **Individual DHB focus areas via annual planning** will be worked on at a local level. For 2017/18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered.
- **A regional DHB group for patient experience of care** meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group.
- **Develop long-term strategies in response to specific equity challenges** (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients to improve their experience and journey of care.
- **Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.**

### Progress Report

This work is ongoing in DHBs. Regular joining-up occurs, with lessons learnt contributing to initiatives in primary care. The Patient Experience of Care Primary Health Organisation implementation meeting was held on 20 September with contribution from regional and DHB representatives.

### 2. The Primary Health Care Patient Experience Survey

The Primary Health Care Patient Experience Survey) is currently being rolled out across Auckland. In Auckland 5 Primary Health Organisations with a total of 95 practices participated in the August Primary Health Care Patient Experience survey week prior to setting up ongoing survey capability. The survey was conducted in the first week of August. There were some technical issues which meant that around 15 practices set to participate did not have the survey sent to patients. A plan for remediation was made, with the survey week extended for these practices and a technical patch in place.

According to the Health Quality and Safety Commission, this will be implemented in all practices, but it is critically dependent on establishment of the National Enrolment System (NES), which has not yet been implemented in any practices. The 2017/18 target is to ensure 50% of each Primary Health Organisation’s practices (approximately 166 practices) are participating in the Primary Health Care Patient Experience Survey by June 2018.

---

**DHB Adult Inpatient Experience Survey: Aggregated Domain Score (/10)**

<table>
<thead>
<tr>
<th></th>
<th>ADHB</th>
<th>CMDHB</th>
<th>WDHB</th>
<th>NZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep-14</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Dec-14</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Mar-15</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Jun-15</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Sep-15</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Dec-15</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Mar-16</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Jun-16</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Sep-16</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Target</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
<td>8.0</td>
</tr>
</tbody>
</table>

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Counts: 216 216
**Improvement Activities**

- Ensure socialisation of resources and support for practice-related activities, such as, Primary Health Organisations follow Health Quality and Safety Commission/Ministry of Health ‘Getting Started’ resource pack and advice.
- Primary Health Organisations advise Complicity of Primary Health Organisation name and contact for survey, and IT key contact to enable log on via email address.
- Practices are supplied with and follow getting started guide and resources.
- Practices provide Primary Health Organisation with details to appear on survey invitation email, text message and online survey.
- Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled.
- Practices check email addresses of all patients 15 years and over and save preferences.
- Follow up by Primary Health Organisation and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required.
- Once survey is closed, practices and Primary Health Organisations will review the final results of the survey.

**Progress Report**

The survey week was held in the first week of August. There were some technical issues which meant around 15 practices from various Primary Health Organisations were not able to have patients complete the survey. The survey week was extended for these practices in order to overcome the issue.

A further patch of Medtech is expected just before the next survey week in November, and this will need to be implemented quickly, but should solve several technical issues.

We note some Primary Health Organisations did not participate in survey week due to delays in NES completion at their sites.

---

**Contributory Measures**

1. **E-Portals.**

E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).

For 2017/18 the target is that 55% of each Primary Health Organisation’s practices are registered with a portal and 15% of each Primary Health Organisation’s population have access to a portal. The latest (July 2017) results show that only 4 Primary Health Organisations (when split by DHB boundaries) have still to meet the 55% target for having portals in place (noting NHC has only one practice – in Waitemata – with a portal). However, most Primary Health Organisations have yet to meet the 15% target of enrolled patients registered to use portals.
Improvement Activities

- E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via Primary Health Organisations and practices.
- Primary Health Organisation teams will provide support to practices to implement e-Portal enrolment systems.
- Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include:
  - access to clinical data – diagnoses, notes, allergies,

Progress Report

Update of e-portals is now increasing and Primary Health Organisations are generally using a tranche approach to engage groups of practices per quarter.

There is wide variation in the number of practices engaged in e-portals with some Primary Health Organisations having 100% of practices engaged, and some at 0. Those with 0 e-portals have a plan to implement imminently.

The Patient Experience of Care Primary Health Organisation implementation meeting was held on 20 September with discussion on how Primary Health Organisations are implementing the E-portals, techniques to overcome barriers and a commitment from most to meet the target by year end.
Improvement Activities

- Immunisations, lab results;
- Access to communications – messaging to doctor or nurse, repeat prescription, requesting appointments, self-scheduling;
- Access to education – condition specific information, websites with merit, self-management activities, and
- Primary Health Organisations will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.

Amenable Mortality

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75).

For 2017/18 the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease management and smoking cessation.

Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30 was used as baseline:

<table>
<thead>
<tr>
<th>DHB</th>
<th>2013</th>
<th>2009-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>72.9</td>
<td>87.5</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>104.4</td>
<td>113.0</td>
</tr>
<tr>
<td>Waitemata</td>
<td>65.6</td>
<td>74.6</td>
</tr>
<tr>
<td>Metro Auckland</td>
<td>80.2</td>
<td>89.4</td>
</tr>
</tbody>
</table>

The goal is to achieve a 6% reduction for each DHB (on 2013 baseline) by June 2020, noting that changes in rates would generally only be seen over an extended timeframe of at least 3-5 years.

The current level of inequity in amenable mortality indicates the scope for health gain.

Standardised amenable mortality rates per 100,000 by ethnicity: 2010-2014

- Maori
- Pacific
- Non-Maori, non-Pacific
- NZ
Based on five year trends, all three Metro Auckland DHBs show consistently declining rates as per graph below, despite an increase between 2013 and 2014 for Auckland and Waitemata DHBs. Given that there will always be some annual fluctuation and that the target extends to 2020, we should be on track to meet the 6% reduction by 2020.

Note: 2010-2014 and 2014 data are draft/interim

**Contributory Measures**

1. **Cardiovascular Disease Risk Assessment – to increase coverage of Māori to 90%**
   
   As at March 2017, Māori screening rates were slightly below the target with Counties Manukau DHB screening 88.4% of the eligible population, while Auckland DHB had screened 88.1% and Waitemata DHB 86.6%. Results for the quarter ending June 2017 show a small improvement in performance: 89.3% for Counties Manukau DHB, 88.9% for Auckland DHB and 86.7% for Waitemata DHB.

<table>
<thead>
<tr>
<th>Māori</th>
<th>Non-Māori/Non-Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>92%</td>
<td>94%</td>
</tr>
</tbody>
</table>

**Improvement Activities**

- Follow up Primary Health Organisation calls (evenings) for practice generated cardiovascular disease RA recall letters to Māori.
- Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.

**Progress Report**

These activities were discussed in the Primary Health Organisation implementation meeting on 23rd August, with agreement from all Primary Health Organisations to participate in data mining to find Māori patients, and recall.

Several practices are piloting use of the Cobas machines to opportunistically test Māori males on presentation to clinics, with an informal evaluation to follow in early 2018.
2. **Cardiovascular Disease Management - to increase triple therapy by 5% (relative) for those with a prior cardiovascular disease event and for those with a cardiovascular disease risk assessment of ≥ 20%**

Baseline for 2017/18 was set on performance as at the twelve months ended September 2016.

For triple therapy baseline results, Counties Manukau DHB recorded 58.1%, Auckland DHB 52.7% and Waitemata 53.8%. Latest performance (for the 12 months ended March 2017) shows deterioration in results for all DHBs – 52.2% for Auckland, 57.6% for Counties Manukau and 53.1% for Waitemata, with a metro-Auckland rate of 54.4%. Rates are lowest for Asian at 47.5% across the metro-Auckland region, followed by Other ethnicities at 52.8%.

For the twelve months ended September 2016, dual therapy pharmaceuticals dispensed to those with a cardiovascular disease risk assessment score greater than 20% were 41.6% for Auckland DHB, 49.1% for Counties Manukau and 41.4% for Waitemata DHB. Little change in rates for any of the DHBs can be seen in the twelve months ended March 2017, with results recorded as 42.2% for Auckland DHB, 49.4% for Counties Manukau and 41.3% for Waitemata DHB, or 45.2% for the metro-Auckland region. Across metro-Auckland, rates are lowest for Other ethnicities at 40.6%, followed by Asian at 43%.
### Improvement Activities

- Identification of patients at a NHI level who have had a cardiovascular disease event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via Primary Health Organisations.
- Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy.
- Post-event medication counselling and other rehabilitation services in hospital.
- Ongoing medication counselling by community pharmacists.
- Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments.
- Establish a single process to report cardiovascular disease indicators from PRIMARY HEALTH ORGANISATION practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.

### Progress Report

There are regionally agreed definitions and standardised format of reporting for cardiovascular disease dispensed medications is available from the Northern Region Cardiac Network. Primary Health Organisations have given approval to share the aggregated dispensing reports for regional reporting.

All Primary Health Organisations have agreed to identify patients who are not on optimal therapy and feedback these results to GPs.

The Primary Health Organisation implementation meeting on 26th August discussed opportunities to improve in this area, and a tutorial on the reporting was delivered.

Work on the cardiovascular disease indicators is ongoing.

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**3. Increase rate of cessation support provided to enrolled smokers by 10%**

The Auckland Metro DHBs have achieved the Better Help for Smokers to Quit health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. For 2017/2018 the target is an increase in cessation support by 10% disaggregated by ethnicity.

Baseline data, for the quarter ended September 2016 showed rates of cessation support provided to smokers enrolled in Primary Health Organisations was 24.7% for Auckland DHB, 24.4% for Counties Manukau DHB and 32.9% for Waitemata DHB – with a metro-Auckland result of 27%. Latest results show a small improvement in these rates (for the quarter ended June 2017) for Auckland DHB with a result 26.7% and Counties Manukau DHB showing a small increase to 25.6%. However, Waitemata DHB recorded a small decrease to 31.8%. Overall metro-Auckland rate was slightly better at 27.8%. The Ministry of Health is not currently able to provide ethnic specific results. Agreement has been sought from the Primary Health Organisations to provide the data locally from next quarter.

![Enrolled smokers who received cessation support](image-url)
### Improvement Activities

- Analyse reasons for historical low referrals to smoking cessation providers.
- Improve referral pathways to smoking cessation providers.
- Improve feedback to referrers from smoking cessation providers.
- Access aggregated data for Auckland population.
- Establish a single process to report smoking from Primary Health Organisation practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.
- Benchmark ‘access to smoking cessation’ READ codes across Primary Health Organisations: i.e. the number of patients with codes 1, 2 and 3:
  1. ZPSC10 – referral to smoking cessation support;
  2. ZPSC20 – prescribed smoking cessation medication, and
  3. ZPSC30 provided smoking cessation behavioural support.

### Progress Report

Regionally agreed definitions have been developed which have been approved by the data custodian group. These have also been approved by the SLM steering group, with source requests delivered to organisations in late September and the first data upload held on 12 October.

A second data definition for referrals to smoking cessation with data coming from smoking cessation providers is in progress and will be presented to the data custodians in November.

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### Youth Access to and Utilisation of Youth-appropriate Health Services

The Youth Domains are 5 separate areas of youth health which combine to support a positive youth experience of health care. The focus this year is on Sexual and Reproductive Health. The overarching milestone is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.

There is work on-going in the contributory measures to set up other domains in preparation for next year.

#### Chlamydia testing coverage in 2016 by domiciled DHB

![Chlamydia testing coverage in 2016 by domiciled DHB](chart.png)
All Pregnant Women are Screened for Chlamydia
The target for this year is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.

**Improvement Activities**
- Workforce development activities for lead maternity carers.
- Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy.
- Data analysis looking for the potential to report back screening rates to lead maternity carers.

**Progress Report**
- Data definition for this measure is underway and completion is anticipated by March 2018.
### Contributory Measures

1. **Development of Future Sexual and Reproductive Health Contributory Measures**

   The target for this year is to establish a baseline in this measure.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analysis of SLM data by age, ethnicity, and Primary Health Organisation.</td>
<td>• The data definition for the SLM has been completed, as has analysis.</td>
</tr>
<tr>
<td>• Identify gaps and potential areas for improvement.</td>
<td>• There is ongoing work to identify gaps and promote improvement, particularly</td>
</tr>
<tr>
<td>• Review the literature to identify options for improving access to chlamydia testing</td>
<td></td>
</tr>
<tr>
<td>for Māori and Pacific youth including school-based services, pharmacy, community</td>
<td></td>
</tr>
<tr>
<td>laboratories, primary care, outpatients, justice systems, and other opportunistic</td>
<td></td>
</tr>
<tr>
<td>settings.</td>
<td></td>
</tr>
</tbody>
</table>

2. **Chlamydia Burden of Disease**

   The target for this year is to establish a baseline in this measure.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.</td>
<td>• This data definition is in progress and has been approved by the Data</td>
</tr>
<tr>
<td></td>
<td>custodians in September. The SLM Steering Group approved this data request</td>
</tr>
<tr>
<td></td>
<td>in September, and the user request form was submitted in late September.</td>
</tr>
<tr>
<td></td>
<td>• It is anticipated that data for this measure be released and analysed by</td>
</tr>
<tr>
<td></td>
<td>early 2018.</td>
</tr>
</tbody>
</table>

3. **Healthcare Utilisation by 15-24 year olds**

   The target for this year is to complete the analysis detailed in the activities.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Explore the availability of data across services potentially accessed by youth and</td>
<td>• A baseline analysis is anticipated by June 2018.</td>
</tr>
<tr>
<td>the feasibility of data linkage to explore systems-wide youth health service</td>
<td></td>
</tr>
<tr>
<td>utilisation and identify gaps.</td>
<td></td>
</tr>
<tr>
<td>• Baseline primary health care enrolment and utilisation.</td>
<td></td>
</tr>
</tbody>
</table>

4. **Participation in the Child and Adolescent Mental Health Services Marama Real-Time Survey**

   The target for this year is to establish a baseline in this measure.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analysis of SLM data.</td>
<td>• A baseline analysis is anticipated by end June 2018.</td>
</tr>
<tr>
<td>• Engage with Mārama, the regional child and adolescent Mental Health Service group,</td>
<td></td>
</tr>
<tr>
<td>and service providers to identify gaps and potential areas for improvement.</td>
<td></td>
</tr>
</tbody>
</table>
5. Development of Baseline Data for Youth Domains:
   a. Alcohol and Other Drugs
   b. Access to Preventative Services
   c. Mental Health and Well-being

The target for this year is to establish a baseline in these domains.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Analysis of SLM data by age, ethnicity, and PRIMARY HEALTH ORGANISATION.</td>
<td>- A baseline analysis is anticipated by end June 2018. The Ministry has signalled data will be available from March 2018.</td>
</tr>
<tr>
<td>- Identify gaps and potential area for improvement.</td>
<td></td>
</tr>
</tbody>
</table>

Proportion of Babies Living in Smokefree Homes at 6 weeks postnatal

Baseline data from Well Child Tamariki Ora providers suggests that 98% of babies lived in a smokefree household at 6 weeks post-partum during Q1-2 of 2016/17. Given current smoking prevalence this is unlikely to be accurate. In addition, nearly 1 in 5 babies in Metro Auckland did not have smokefree household data recorded. Therefore, Well Child Tamariki Ora activities in the 2017/18 plan focus on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term.

Caution should be taken when drawing conclusions from this data. Data quality is questionable. The data below covers the period July – December 2016. Data prior to this time period is not of sufficient quality to include. While the percentage of babies living in smokefree households appears to be quite good, there are a significant proportion of instances where the question has not been asked, the field is blank or the response recorded is ‘unknown’, particularly for Counties Manukau DHB domiciled patients.

The milestone target for this measure is to reduce missing smokefree household data to <10% by June 2018.
Contributory Measures

1. Maternal Smokefree Services

The target for this year is to establish a baseline in this measure.

<table>
<thead>
<tr>
<th>Improvement Activities</th>
<th>Progress Report</th>
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</thead>
<tbody>
<tr>
<td>• Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored.</td>
<td>• The Primary Health Organisation implementation meeting on 4 October focused on smoking cessation with activities in primary care identified as: further promotion of the referral pathway and promotion of optimal pharmacological interventions for smoking cessation. Continued prioritisation of Māori and Pacific was discussed, as were opportunities for more consistent reporting from referrers.</td>
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<tr>
<td>• Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women.</td>
<td>• Smoking cessation incentives programmes are close to starting.</td>
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<tr>
<td>• Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women.</td>
<td>• A meeting with regional Midwifery representatives has been organised for 10 November to begin conversations about increased communication between primary care and midwifery.</td>
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<td>• Facilitate early enrolment of pregnant women with lead maternity carers.</td>
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<td>• Provide lead maternity carers and GP training on smoking cessation.</td>
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<td>• Provide feedback to lead maternity carers on their referral rates.</td>
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<td>• Provide pregnancy SSS incentives programme.</td>
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<td>• Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific).</td>
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<tr>
<td>• Explore innovative ways of engaging pregnant smokers to quit, with a focus on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.</td>
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</table>
### 2. Household Smoking Cessation

The target for this year is to establish a baseline in this measure.

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<tr>
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<tr>
<td>• Well Child Tamariki Ora Data Quality Improvement: Review and align data collection processes for SLM measure across Well Child Tamariki Ora providers and provide SOPs for data collectors.</td>
<td>• The Ministry have notified this working group that they will undertake data collection improvement nationally</td>
</tr>
<tr>
<td>• Provide Well Child Tamariki Ora providers feedback on missing smokefree data rates.</td>
<td>• The first data set has been received, however, the quality of the data is poor and the collection time frame is not current</td>
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<tr>
<td>• Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes.</td>
<td>• The data has been socialised with Well Child Tamariki Ora providers at various Well Child Tamariki Ora forums regionally to explain the connection and seek engagement.</td>
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<tr>
<td>• Explore opportunities to offer smoking cessation support to whaanau of newborn inpatients and outpatients, and paediatric ED attendances.</td>
<td>• We anticipate some further data in March 2018</td>
</tr>
<tr>
<td>• Explore additional ways of offering smoking cessation support to whaanau of young children, e.g. pharmacy initiatives, Well Child providers.</td>
<td>• The Primary Health Organisation implementation meeting on 4 October focused on smoking cessation.</td>
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<tr>
<td>• Support the work undertaken in the Amenable Mortality SLM.</td>
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</table>
Counties 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>
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<tbody>
<tr>
<td>1. Confidential Minutes of 25 October/Actions</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<tr>
<td>2. Draft Minutes of the Community and Public Health Advisory Committee and Audit Risk &amp; Finance Committee</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>3. Turnaround Plan</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>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. [Official Information Act 1982 S9(2)(i)]</td>
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<tr>
<td>4. Facilities Master Planning Update</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Communication with the Sovereign The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)(i)]</td>
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<td>5. Scott Building Recladding Works Contract</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 Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry</td>
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<td>6.</td>
<td>MRI Service in Harley Gray Building-Construction Contract</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td>7.</td>
<td>Specialised Rehabilitation Centre Investment</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td>8.</td>
<td>Community Referred Laboratory Services</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>
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<tr>
<td>9. Ko Awatea Review</td>
<td>Negotiations</td>
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<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>Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage the DHB if made public at this time.</td>
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<thead>
<tr>
<th>10. NZHIH Update &amp; Future Direction</th>
<th>Privacy</th>
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<tr>
<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>The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons.</td>
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<tr>
<th>11. Integrating Governance, Leadership and Planning Arrangements for Maori Health</th>
<th>Commercial Activities</th>
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<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>Information contained in this report is related to commercial activities and the DHB would be prejudiced or disadvantaged if that information was made public.</td>
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<tr>
<th>11. Integrating Governance, Leadership and Planning Arrangements for Maori Health</th>
<th>Protect Confidentiality of Advice Tendered by Officials/Free and Frank Expression of Opinion/Negotiations</th>
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<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>The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials; maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation of officers and employees of any department or organisation in the course of their duty; information contained in this report is related to commercial negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.</td>
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**NZPH&D Act 2000 Schedule 3, S32(a)**

**Official Information Act 1982 S9(2)(i)**

**Official Information Act 1982 S9(2)(j)**

**Official Information Act 1982 S9(2)(a)**

**Official Information Act 1982 S9(2)(j)**
<table>
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<tr>
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<th>Description</th>
<th>Details</th>
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<tr>
<td>12.</td>
<td>Finance &amp; Corporate Business Report</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td>13.</td>
<td>Risk Management</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td>14.</td>
<td>Social Investment Board Update</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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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</table>

**Commercial Activities/Negotiations/Commercial Position**

Information contained in this report is related to commercial activities and negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.

[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(ii)]

**Confidentiality of Advice Tendered by Officials**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials.

[Official Information Act 1982 S9(2)(f)(iv)]

**Communication with the Sovereign**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative.

[Official Information Act 1982 S9(2)(f)(i)]