MEETING OF THE BOARD
13 September 2017

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

CMDHB BOARD MEMBERS
Rabin Rabindran – Acting Chair
Colleen Brown – CMDHB Board Member
Catherine Abel-Pattinson – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
Mark Darrow – CMDHB Board Member
Ashraf Choudhary – CMDHB Board Member
Reece Autagavaia – CMDHB Board Member
George Ngatai – CMDHB Board Member
Lyn Murphy – CMDHB Board Member

CMDHB MANAGEMENT
Gloria Johnson – Acting Chief Executive
Margaret White – Chief Financial Officer
David Hughes – Deputy CMO
Jenny Parr - Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Lyn Butler - Board Secretary

APOLOGIES - Lester Levy, Katrina Bungard, Vanessa Thornton

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?

PART 1 – Items to be considered in public meeting

AGENDA

1. AGENDA ORDER AND TIMING

2. BOARD MINUTES
  2.1 Confirmation of Minutes of the Meeting of the Board – 13 September 2017
  2.2 Actions arising from previous meeting
  2.3 Draft Minutes of Community Public Health & Advisory Committee (26 July 2017)
  2.4 Draft Minutes of Disability Advisory Committee (16 August 2017)
  2.5 Draft Minutes of Hospital Advisory Committee (23 August 2017)

3. EXECUTIVE REPORTS
  3.1 Chief Executive Officer’s Report (including Patient Story) (Gloria Johnson)
  3.2 Health and Safety Report (Elizabeth Jeffs)
  3.3 Communications Report (Jason Ranston)

4. DECISION ITEMS
  4.1 Approval of Granting Agency in favour of healthAlliance (FPSC) Limited (Margaret White)
  4.2 Northern Region Hyper Acute Stroke Pathway Treatment Benefits (Dana Ralph-Smith)

5. PERFORMANCE REPORT
  5.1 2016/17 Financial Result (Margaret White)

6. RESOLUTION TO EXCLUDE THE PUBLIC
## Board Member Attendance Schedule 2017

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<tr>
<th>Name</th>
<th>Jan</th>
<th>15 Feb</th>
<th>29 Mar</th>
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<th>13 Sept</th>
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<td>Dr Ashraf Choudhary</td>
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* Attended part meeting only
## BOARD MEMBERS’ DISCLOSURE OF INTERESTS

**September 2017**

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</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  
• 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  
• Chair, IIMuch Trust  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group |
<table>
<thead>
<tr>
<th>Name</th>
<th>Positions and Memberships</th>
</tr>
</thead>
</table>
| Dr Lyn Murphy          | • Member, ACT NZ  
                           • Director, Bizness Synergy Training Ltd  
                           • Director, Synergex Holdings Ltd  
                           • Trustee, Synergex Trust  
                           • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
                           • Member, New Zealand Association of Clinical Research (NZACRes)  
                           • 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.  
                           • Vice President, National Council of Women of New Zealand  
                           • Justice of the Peace  
                           • Member, Pacific Women’s Watch (NZ)  
                           • Member, Auckland Disabled Women’s Group |
| George Ngatai          | • 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  
                           • Husband, Director, Blackstone Partners Ltd  
                           • Husband, Director, Bspoke Ltd |
<table>
<thead>
<tr>
<th><strong>Mark Darrow</strong></th>
<th><strong>Dr Ashraf Choudhary</strong></th>
<th><strong>Katrina Bungard</strong></th>
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<tbody>
<tr>
<td>• Husband, Director, 540 Great South Ltd</td>
<td>• Board Member, Otara-Papatoetoe Local Board</td>
<td>• Chairperson MECOSS – Manukau East Council of Social Services.</td>
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<tr>
<td>• Husband, Director, Barclay Suites</td>
<td>• Member, NZ Labour Party</td>
<td>• Deputy Chair Howick Local Board</td>
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<td>• Husband, Chairman, Lifetime Design</td>
<td>• Chairperson, Advisory Board Pearl of Island Foundation</td>
<td>• Member of Amputee Society</td>
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<td>• Husband, Director, various single purpose property owning companies</td>
<td>• Co-Patron, Bharatiya Samaj Charitable Trust</td>
<td>• Member of Parafed disability sports</td>
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<td>• Chairman, Primary Industry Training Organisation Incorporated (ITO)</td>
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<td>• Member of NZ National Party</td>
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<td>• Chair, Remuneration Committee, Primary ITO</td>
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<td>• Ex officio, Finance and Audit Committee, Primary ITO</td>
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<td>• Independent Director, Motor Trade Association</td>
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<td>• Chair, Investment Committee, Motor Trade Association</td>
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<td>• Director, New Zealand Transport Agency (NZTA)</td>
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<td>• Chair, Finance and Audit Committee, NZTA</td>
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<td>• Independent Director, Balle Bros Group</td>
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<td>• Chair, Finance and Audit Committee, Balle Bros Group</td>
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<td>• Member, Investment Committee, Balle Bros Group</td>
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<td>• Director, Advisory Board, Courier Solutions Ltd</td>
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<td>• Chairman, The Lines Company Ltd</td>
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<td>• Chairman, Armstrong Motor Group (Advisory Board)</td>
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<td>• Director, MCD Capital Ltd</td>
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<td>• Chairman, Signum Holdings Ltd</td>
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<td>• Trustee, Tudor Park Trust</td>
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<td>Director having interest</td>
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<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>
</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>
</tr>
<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>
</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>
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</tbody>
</table>
Minutes of Meeting of the Counties Manukau District Health Board

Wednesday, 2 August 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 (Chair)
Rabin Rabindran
Colleen Brown
Catherine Abel-Pattinson
Dianne Glenn
Katrina Bungard
Mark Darrow
Ashraf Choudhary
Reece Autagavaia
George Ngatai
Lyn Murphy

ALSO PRESENT

Margie Apa (acting Chief Executive)
Margaret White (Chief Financial Officer)
Vanessa Thornton (acting Chief Medical Officer)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Elizabeth Jeffs (Director Human Resources)
Sarah Baddeley (GM Corporate Affairs and Communications)
Dinah Nicholas (acting Board Secretary)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Emily Ford, Manukau Courier
Fiona Thomas, NZ Doctor
Holly Nielson, Coordinator Maternity Consumer Council

APOLOGIES

Gloria Johnson

WELCOME

The Board Chair welcomed those present.
DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

No specific interests were noted.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Minutes of the Meeting of the Board – 21 June 2017

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

That the Minutes of the Board Meeting held on 21 June 2017 be approved.

Carried

Actions Arising from Previous Minutes

Page 9 Chief Executive’s Report, last paragraph- should read ‘She advised that Auckland is the only Council that does not have a local alcohol policy’.

Page 12 SLM Framework, Comments from the Board, 3rd paragraph - should read ‘Maaori life expectancy gap is reducing’.

2.2 Actions Arising from Previous Meeting

Draft Delegated Authority Policy – it was confirmed that the redrafted Delegated Authority Policy will be aligned with Waitemata and Auckland DHBs and will reflect a reduction in a number of areas of delegated financial authority at CM Health as some thresholds are inappropriately high and currently out of alignment with the other DHBs.

2.3 Draft Minutes of the Community Public Health and Advisory Committee (14 June 2017)

Colleen Brown highlighted two issues:

There is a lot of data being collected by CM Health and we are starting to question how well it is all aligned, collated and fed back into the system (ie) the school nurses are operating very effectively within schools but where does that information go, who is using it and what are we doing with the information. There are several areas that the Committee want to identify and work with CM Health staff on, in particular child health.

ARPHs had recently identified that Fiji does not provide MMR as part of their vaccination regime. This is an issue that will impact our population and the Committee will be following up with ARPHs in relation to what they are doing to alert GPs to this.
2.4 Draft Minutes of the Hospital Advisory Committee (12 July 2017)

Lyn Murphy highlighted the increased demand on our hospital services. The Committee concluded that long term, a regional approach will be needed to look at how we are going to meet increased demand and capacity.

3. EXECUTIVE REPORTS

3.1 Chief Executive’s Report

Jenny Parr presented a story about a patient who had been transferred to Middlemore Hospital from another DHB and the patient’s comparisons between the two.

Margie Apa, acting Chief Executive, introduced Elizabeth Jeffs, the new Director Human Resources.

The report was taken as read with Margie Apa highlighting the following areas:

Winter demand – the short term concern is to ensure that we are well prepared for a mid-August peak. June and July were particularly difficult months with the organisation not achieving the ED 6-hour wait time target. The Auckland-metro DHBs have met to discuss how they would enact an ‘incident response’ if all three hospitals were all very full at the same time. An incident response would enable the DHB to do other things that we would not ordinarily do in every day practice. The Chair advised that although there are consequences to doing that, there should be a low threshold for doing that. He further advised that if it is impending, we will want to be doing it earlier rather than later because of the multiplier effect.

Ko Awatea – In addressing Ko Awatea the Acting Chief Executive noted that they are working to reorientate their resources. As a DHB-funded team, their purpose is to support the organisation and they have been asked to review their current work programme in order to do this. In this frame of reference they will be considering which activities should be continued because they are critical to the core business, but also to identify the areas for potential de-prioritisation. A plan is expected to be presented to ELT in September revealing the priorities and focus on our population. This will be presented to Board in October.

Maaori Child Health Indicators – MHAC had undertaken a deep dive into Maaori child health indicators at their last meeting and one of the conclusions of that work was around data - significant data is collected, but not correlated. A recommendation from the meeting was to commission work to determine the underlying meaning derived from the data. A report will come back to MHAC with more detailed insight on the indicators.

Colleen Brown asked if this work could look at the locality areas by neighbourhood.

The Chair asked if the work could also look into why the 8-month rates are much better than 24-month rates.

Comments from the Board as follows:

• The Chair noted that he had advised the Minister that given the DHB’s current circumstances its priority is the safety of its patients and staff wellbeing. The environment is very challenging and where necessary targets may be deprioritised and budget expenditure made to ensure a safe environment. A supportive response was received and
it was reiterated that targets are a means to an end – targets are important, but the DHB has to manage and lead to context.

- A reference was made to the comments on page 36 in relation to a late handover of a baby from LMC to WCTO and that this is higher in Māori and Pacific babies and means that the DHBs highest risk babies may not get WCTO support to start their immunisation plans at 6 weeks. Ms Apa advised that some women do not engage with ante-natal care and that there are a mix of reasons why mothers choose not to have their babies immunised. To ensure engagement with these mothers the DHB needs to provide a positive experience.

- Page 38 – the third bullet point under Provisional Local Alcohol Policy refers to the endorsement of a priority overlay concept, providing 23 high deprivation suburbs with ‘extra protections’. In response to a question about the what the ‘extra protections’ are and the impact they may have on CM Health, Ms Apa advised that they allow local decision makers to restrict the supply of alcohol and the number of public places people can drink. It will depend on the local boards having some rigour around these recommendations.

3.2 Health and Safety Report (Elizabeth Jeffs)

The report was taken as read.

Elizabeth Jeffs highlighted the following:

A key priority will be conducting her own due diligence on the health and safety framework policy and what is occurring at CM Health to gain assurance, which will be reported to ELT and the Board.

Ms Jeffs advised that she is currently working through the Gavin Johnson report’s eight areas of focus for business plans to ensure they are properly resourced and the plans and mitigation strategies will actually achieve a safer experience for our staff. The report also highlights that the organisation could improve in the investigation of incidents and she will be working with the team to understand the current investigation process and how it can be improved.

The first Executive Health and Safety Committee meeting is scheduled next week with a larger more formal meeting in September.

There are a number of Board action items that have been highlighted and these will be reported to the Board at its next meeting.

Work is ongoing on metrics with the Director Hospital Services and the acting Director Ko Awatea to understand the facilities, falls and slips and working together as an executive to ensure the resources and priorities are in the right places.

Comments from the Board as follows:

- 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. The Chair suggested
that it would be beneficial for CMDHB to also hold a workshop, which would also test the conclusion reached at ADHB.

The current Health and Safety reports are ambiguous in these areas.

It was noted that the Board expects complete compliance with the Act across every dimension. This is an area that the Board has serious responsibilities in and it expects to have unfettered access to all information and to participate in decision making that is critical to ensure it can demonstrate that it has (a) undertaken due diligence and (b) turned its mind to issues. The Board is not comfortable just ‘receiving’ information, it needs to be a lot more integrated.

- Hazard Substances Audit in the Gavin Johnson report – there are significant deficiencies in many areas and the list in the report is a serious concern that things are not being done right. If a satisfactory programme was in place there would not be as many comments from external audit.

- 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 requested that the Committee’s minutes be submitted to the Board for information.

- It was noted that the Health and Safety report does not report on near misses and that as much can be learnt from near misses as from incidents. Elizabeth Jeffs advised that the organisation does record both near misses and incidents, but they are not distinguishable and need to be manually extracted. This will be worked on over the coming months.

- CM Health needs to evaluate health and safety a lot more and quickly.

- It was noted that the DHB utilises a lot of bureau nurses and it is important that they are well informed with the DHB’s health and safety processes.

- Aggression and Violence – the Board requested information showing that the training and risk mitigation programmes are having a positive impact and that these incidents are diminishing. Consideration needs to be given to other control measures that might be needed to keep people safe. Robust policies need to be in place, CM Health is under-developed in this area and needs improved processes for policy review/sign-off.

### 3.3 Communications Report (Sarah Baddeley)

The report was taken as read.

Sarah Baddeley summarised a few areas:

The Communications team has been busy working to support the Emergency Department with proactive media services (targeting local media) and social media campaigns to support improved awareness of where to go to access healthcare. This social media post reached 16,214 in a 12 hour period, with a large amount of positive sentiment.

Development and roll-out of the new Intranet went live last Sunday. Analytics are now being obtained and reinforce that clinicians are the main users.
At the previous meeting, Board members enquired about the success of the LinkedIn channel in terms of recruitment outcomes. It was noted that due to costs the DHB does not actively use the site for recruitment. The channel will continue to be monitored in the coming months to determine further insights.

4. DECISION ITEMS

4.1 2017/18 Māori, Pacific and Asian Health Plans

Population estimates for 2017 tell us there are 338,200 people of Māori, Pacific and Asian ethnicity, which comprises 62% of the total Counties Manukau population. These plans represent the key health gain commitments made by CM Health for these residents.

The plans have received significant regional contribution and have linkages to the 2017/18 metro-Auckland SLM Improvement Plan and 2017/18 Annual Plan equitable outcome actions. All the plans have a strong focus on children and long term conditions for adults.

There is a commitment to work on a three-year regional plan for Māori Health with the aspiration to have one single regionally aligned plan.

Work is underway on a one-page ‘dashboard’ that will include all three plans.

The Board commented as follows:

- That the DHB, like most health organisations, has many priorities and could these be better applied if there were fewer and with a more defined focus on areas for improving Māori health. Greater focus is needed as well as a discussion around the priorities to capture the DHB’s ‘strategy on a page.’ The health plans are important and it needs to be clear that the DHB has specific Māori, Pacific and Asian plans that are meaningful and matter.

- 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.

Resolution (Colleen Brown/George Ngatai)

The Board:

Received the final 2017/18 Māori, Pacific and Asian Health Plans.

Noted that the draft 2017/18 Māori Health Plan was endorsed by the Māori Health Advisory Committee 26 April 2017 and the Board 10 May 2017, subject to requested updates.

Noted that the draft 2017/18 Pacific and Asian Health Plans were approved by the Community Public Health Advisory Committee 3 May 2017 for Board approval.

Noted that the final 2017/18 Māori, Pacific and Asian Health Plans were approved by the Executive Leadership Team 11 July 2017 for forwarding to the Board for publication approval.
Approved the final 2017/18 Maaori, Pacific and Asian Health Plans for publication on the CM Health website.

Carried

5. PERFORMANCE REPORT

5.1 Financial Performance (Margaret White)

The May report was presented to the Board.

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.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Mark Darrow/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:
<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 1. Confidential Minutes of 21 June 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. | Confirmation of Minutes  As per the resolution from the public section of the minutes, as per the NZPH&D Act.  
[NZPH&D Act 2000 Schedule 3, S32(a)] |
| 2. Draft Minutes of the Community and Public Health Advisory Committee, Hospital 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.  
[NZPH&D Act 2000 Schedule 3, S32(a)] |
| 3. Final Draft 2017/18 Annual Plan | 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  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)] |
| 4. Refurbishment and Extension of Scott Dialysis Unit Business Case | 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)] |
| 5. University of Otago Dental Business Case | 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)] |
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<th><strong>6. Implementation of MRI Service – Harley Gray Building Business Case</strong></th>
<th><strong>Commercial Activities</strong>&lt;br&gt;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.</th>
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<td><strong>7. WAI Auckland Business Case</strong></td>
<td><strong>Commercial Activities</strong>&lt;br&gt;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.</td>
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<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td><strong>8. Urgent Care Services</strong></td>
<td><strong>Commercial Activities</strong>&lt;br&gt;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.</td>
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<td><strong>9. Contributions to Cost Pressure Agreement</strong></td>
<td><strong>Communication with the Sovereign</strong>&lt;br&gt;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>
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| 10. SWIFT Strategic Relationship Agreement | 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
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[NZPH&D Act 2000 Schedule 3, S32(a)]

[Official Information Act 1982 S9(2)(j)]
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| 11. MoH Medical and Allied Health Training Agreement Contract Variation | 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
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[NZPH&D Act 2000 Schedule 3, S32(a)]

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| 12. Specialised Rehabilitation Services Investment | 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
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[NZPH&D Act 2000 Schedule 3, S32(a)]

[Official Information Act 1982 S9(2)(i)]

Negotiations
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[Official Information Act 1982 S9(2)(j)]
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<th>No.</th>
<th>Agenda Item</th>
<th>Confidential Reason</th>
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<tr>
<td>13.</td>
<td>Chief Executive’s Report</td>
<td>Communication with the Sovereign&lt;br&gt;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>
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<td>[Official Information Act 1982 S9(2)(f)]</td>
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<td>14.</td>
<td>Northern Region Long Term Investment Plan</td>
<td>Commercial Activities&lt;br&gt;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.</td>
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<td>[Official Information Act 1982 S9(2)(i)]</td>
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<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. The Chair suggested that it would be beneficial for CMDHB to also hold a workshop, which would also test the conclusion reached at ADHB. 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 requested that the Committee’s minutes be submitted to the Board for information. Aggression and Violence – the Board requested information showing that the training and risk mitigation programmes are having a positive impact and that these incidents are diminishing. Consideration needs to be given</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 IDFs 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>
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<td>2 August</td>
<td>2017/18 Maaori, 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>
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<td>2 August</td>
<td>Chief Executive’s Report</td>
<td>Maaori Child Health Indicators – MHAC had undertaken a deep dive into Maaori child health indicators at their last meeting and one of the conclusions of that work was around data - significant data is collected, but not correlated. A recommendation from the</td>
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<td>meeting was to commission work to determine the underlying meaning derived from the data. A report will come back to MHAC with more detailed insight on the indicators.</td>
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<td>Colleen Brown asked if this work could look at the locality areas by neighbourhood.</td>
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<td>The Chair asked if the work could also look into why the 8-month rates are much better than 24-month rates.</td>
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<td>21 June</td>
<td>CE Report</td>
<td>Immunisation rates for Maaori 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>
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20
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 26 July 2017 at 9.00am
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)
   Ashraf Choudary
   Dianne Glenn
   George Ngatai
   Katrina Bungard
   Rabin Rabindran
   Apulu Reece Autagavaia

ALSO PRESENT

   Matt Hannant (for Benedict Hefford)
   Doone Winnard (for Margie Apa)
   Annelize 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, Benedict Hefford, Margie Apa, Jenny Parr and Katrina Bungard (for lateness).

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:

   George Ngatai – Board Member, Manurewa Marae – delete; Member Counties Rugby League Board – add.
There were no Specific Interests in regards to any items on today’s agenda.

1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 14 June 2017.

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

That the minutes of the Community and Public Health Advisory Committee meeting held on 14 June 2017 be approved.

**Carried**

**Matters Arising from the Minutes**

Page 7 Healthy Mums and Babies – ‘Ms Scott was asked whether she could provide both sets of information to the Committee in future reports (ie) one set pertaining to the women registered with an LMC and another set pertaining to the women registered with a DHB midwife’. Dianne Glenn expressed concern that as the Ministry won’t be changing the national definition it will be important for the DHB to be consistently reporting both the national data and our local picture. The Committee asked that every time the national targets are published, they also receive a local picture.

Page 9 The Mumps Outbreak – ‘Fiji does not provide MMR as part of their vaccinations regime. MoH will liaise with the World Health Organisation (WHO) who will work with the Fiji Government in regard to making Mumps part of their immunisation regime. A question was raised in relation to what information is provided to immigrants around immunisations and its availability and it was suggested that perhaps this information could be provided on the ARPHS website. Mr Hefford also suggested that an update could be provided in the next Primary Care e-mailout’.

Dr Winnard advised that she is aware that the Ministry of Health is working with the World Health Organisation in terms of international health regulations and what happens across borders and agreed to follow up with them and report back to the Committee.

Matt Hannant was asked to follow up to ensure that something is being put in the next Primary Care e-mailout in relation to this issue.

**Action Items Register**

Noted.

3. **BRIEFING PAPERS**

3.1 **Otara/Mangere Locality Briefing**

Sarah Marshall provided a presentation to the Committee highlighting the following:
**Estimated resident population** – high Pacific population, a good number of Māori, Asian and European/Other so is a diversely ethnic community. The ethnicity figures on page 19 were taken from the 2013 census and extrapolated by the DHB on the basis that people will still be living in the same kind of distribution as they were at the time of the 2013 census - this does make a lot of assumptions.

Doone Winnard advised that a paper has been through the ELT and ARF meetings that will be sent to the Ministry of Health advising that according to the DHB health records, we have an additional 25,000 people living here at a particular point in time than the Stats NZ records show. If the PPBF funding share were done according to the people that our health records tell us are living in our area and we are providing services for rather than an estimate, we would funded better. There is an opportunity with Stats NZ for the next census, to try and really count our population properly. We will still run into the problem of people not recording the actual number of people living at a residence (ie) confirming 3 people live there when in fact there are 12.

*Localities by prioritised ethnicity* – it was noted that Health is the only government department that groups European & Other (African/Middle Eastern) together. In terms of the health profile they are more akin to Asian rather than European. Doone Winnard advised that we could certainly raise this nationally with the Ministry and express concern about it.

*Mangere/Otara Strategy* - it was felt that the strategy would benefit from having the joint initiatives with the Social Investment Board highlighted (ie) Maternal & Child Nutrition. It was also noted that the strategy has no outcomes for disability and could be strengthened in this area. Because the Mangere/Otara locality has a high Pacific population, would there be any benefit in having a Pacific-led localities programme that would focus on Pacific issues and what is best for them. We have to find better and more innovation ways of engaging with high needs communities.

*Locality Leadership Team* – Māori Health leadership has been identified as a gap and needs strengthening because it is a priority of the LLT to focus on particular communities. If there are issues with Māori or Pacific representation, as a DHB we should find resources to fill those gaps if we really want to address specific issues. It is not the responsibility of the Māori Health team to fill this gap, it is the responsibility of the DHB to fill the gap. Equity is actually everyone’s business and is mainstream for our DHB. Now is the time for us to sit down and focus on what the important issues are - making a 10% improvement in 60,000 families would be huge.

*Service delivery* - there was discussion about whether there needed to be specific Māori-focused and Pacific-focused locality strategies, with acknowledgement that delivering for Māori and Pacific communities is everyone’s business, not just Māori and Pacific providers. The Committee were concerned about the lag in being able to deliver to the Māori & Pacific communities at a grassroots level. They are also sufficiently concerned about the ratio between specific targeted community services for Māori & Pacific and those which are mainstream and would like a re-examination and explanation about how this ratio is determined, why it is done this particular way, what the outcomes are and have we got the ratios right. Concern that our current service design isn’t reaching individuals and families who are most vulnerable. The Committee felt that this was a wider issue for the Board to consider.

(Katrina Bungard arrived at 10.00am)

**Resolution** (Moved: Colleen Brown/Seconded: George Ngatai)

The Community and Public Health Advisory Committee recommend that the Board examine the community funding ratio against mainstream delivery for Māori and Pacific as separate entities.

**Carried**
The Chair thanked Sarah for her presentation which gave the Committee a deeper understanding of what is going on and congratulated Sarah on the significant achievements the Mangere/Otara locality have undertaken. Localities are a total community investment and a long term plan.

4. **RESOLUTION TO EXCLUDE THE PUBLIC**

Resolved (Moved: George Ngatai /Seconded: Katrina Bungard)

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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<tr>
<td>2.1 Minutes of CPHAC Public Excluded meeting 14 June 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>
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<td>3.1 Self-Management Support in Counties Manukau</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>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.</td>
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Carried

The meeting concluded at 10.42am.


Colleen Brown, 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 down 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
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Wednesday, 23 August 2017 at 2.35pm
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

There were no public or media present at this meeting.

APOLOGIES

An apology was received and accepted from Jenny Parr.

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 12 July 2017

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

That the minutes of the Hospital Advisory Committee meeting held on 12 July 2017 be approved.

Carried

2.2 Action Item Register

Noted.

3. PROVIDER ARM PERFORMANCE REPORT

Phillip Balmer introduced the report.

3.1 Deep Dive into Demand Pressures for Medicine and Surgery

This item was discussed in the Public Excluded section of this meeting.

3.2 Emergency Department, Medicine and Integrated Care

Discharge Lounge – the 11am discharge rates have improved and been sustained over the last three months. Overall, the trend indicates a steady move towards the target. 3pm rapid rounds and nurse facilitated discharges are strategies currently being used. Doctor roster changes will also result in timely decision making to support early discharges.

3.3 Surgery, Anaesthesia and Perioperative Services

The report was noted and taken as read.

3.4 Executive Summary

Women’s Health & Kidz First – in line with our strategic goal of reducing inequities and adding life years, the division’s achievement in reducing Sudden Unexplained Death in Infants (SUDI) for Maaori babies through their implementation of the regional SUDI Safe Sleep programme of work is a standout success worth celebrating.

3.5 Initiative Programme Update

Savings achieved from planning 2016/17 initiatives totalled $12.4m against a target of $14.7m for the year. This represents a delivery result of 85% against target. There is a commitment to continuous improvement and to carry these projects through to 2017/18 along with new initiatives.
3.6 **Balanced Scorecard**

*Lines 12 & 13 June 2017 – errors in the figures were noted and will be amended next month.*

3.7 **Finance (Margaret White)**

Important to note that the Provider Arm came through $2.9m favourable to budget for the year. That was in response to a request from the organisation that the Provider Arm share the pain as we had some unfavourable positions within the Funder late 2016 so this was a good demonstration of working collectively.

There are some particularly big movements in the month of June which characterised our year adjustments.

One area continuing to see pressure is nursing staff, we need to make sure we have a clear strategy to address this when we think about resourcing going forward.

3.8 **Central Clinical Supplies**

*Radiology* – workforce pressures are creating challenges in terms of providing timely access with services prioritising acute work which means that some of the GP referrals and others are not being delivered in the same way as we have in the past. Turnover has dropped back in the last few months but inevitably, this workforce pipeline and using the facilities we have is an important challenge going forward.

3.9 **Women’s Health & Kidz First**

*MCIS* – we have been working very closely with MCIS and the Ministry although not really progressed very far with them. We are hoping to get a commitment from the Ministry that we will get support to improve the MCIS. It is important to be aware that this is a system that is causing a lot of clinical concern. At the moment we are trying to persist with improving the electronic system because backing out completely would also cause a lot of problems for the organisation. It is an area that has been very slow moving and we are anticipating that the upcoming election will slow things down even further.

*Midwifery* – a provisional report on the current midwifery shortage (national and by DHB) reflects a large shortage and will likely require a new strategy for training and retaining this workforce. CM Health has shortages in our employed senior midwifery positions as well as LMC shortages. The Directors of Midwifery met late July to start to develop an urgent retention strategy.

*Caesarean Section Rate* – the organisation’s CS rate for June was 28%, compared to YTD rate of 26% against 23% last year. Our rates remain significantly lower than other DHBs across the region and this is because we will only do Caesarean Sections for medical reasons, rather than patient choice. Complications have increased particularly morbid obesity, older mothers and diabetes in pregnancy.

3.10 **Adult Rehabilitation and Health of Older People**

*Spinal Inpatient ACC Revenue* – it was noted that the ACC revenue for June was slightly lower than projected due to a lower number of patients coming through which is predominantly because of seasonal variation, we see a lot more patients in summer. Some of the ACC
patients are also in our system for 4-6 week and are not coded until discharge so often the revenue won’t come through until the next month.

3.11 Mental Health and Addictions

Mental Health Measure Action Item Response – it was noted that a further update will be provided to the Committee on 15 November.

Maternal Mental Health Model of Care - the Committee noted that the Maternal Mental Health team recently received the Mental Health Nursing Service Award for the work the team have completed to develop a clear and contemporary model of care. The team have worked in collaboration with their NGO partner and now have improved access to Maternal Mental Health support for women when pregnant or with a new baby. This work was undertaken as a result of the Counties Manukau Maternal Mental Health service review completed in 2015. The Committee agreed to send a letter of congratulations to the team.

NZ HR Award to Mental Health Nursing Education Team - the Mental Health Nurse Education Team were recently awarded the NZ HR Award for ‘Learning and Development Capability in the Public Sector’ for the development of the National Safe Practice Effective Communication training package. The Committee agreed to send a letter of congratulations to the team.

3.12 Facilities

Galbraith Building – there are currently a number of reviews being undertaken by BECA Consulting in relation to the Galbraith Building:

1. A detailed seismic review against the new earthquake standards that will come up with a set of recommendations of what our options are for improving its seismic rating.
2. A critical infrastructure site survey - all the hospital main gas, oxygen, water etc comes through the Galbraith building. The site survey is to develop a plan that would enable us to either move those services or to protect them so they were not damaged in the event of an earthquake.
3. An asbestos review (BECA Consulting with an independent agent providing oversight) starting with Galbraith with the intent to undertake a full survey across all our sites.

We need to know what strengthening work needs to be done, how good that will make the building and how quickly it can be done. We also need to ensure that any strengthening won’t disturb any asbestos or will require decanting of patients and/or staff. The BECA reports will come to Gloria, Phillip and Rabin Rabindran who will okay what work will be undertaken.

Recladding – Mr Balmer to bring back a Facilities Stocktake paper to the next HAC meeting (4 October) which will reflect which buildings appear to have potential weather seal, build and/or passive fire protection issues with an indication of costs to remediate.

3.13 Middlemore Central

Mr Balmer to bring the headlines from the 2017 Winter review plan to the next HAC meeting (4 October).
4. CORPORATE REPORTS

4.1 Director Patient Care, Chief Nurse and Allied Health Professions Officer

The Committee agreed that a letter of congratulations be sent to Akshat Shah, a Middlemore-based Speech Language Therapist who recently won the University of Auckland 3-minute Thesis Masters Final. Akshat spoke on the effectiveness of a workshop to improve community speech language therapists’ ability to assess and provide appropriate intervention for children with cleft palate speech disorders. Akshat will now represent the UoA at the Masters 3MT Inter-University Challenge to be hosted by Victoria University on 24 August.

Diversity Ball – the Committee asked that next year a Board table be reserved at the Diversity Ball.

4.2 HR Report

The report was taken as read.

4.2 Q4 Non-Financial Summary Report

The report was taken as read.

The Chair thanked everyone for their contributions to today’s meeting.

The meeting closed at 3.45pm


Lyn Murphy, Committee Chair
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

1. News and Events Summary

Since the last Board meeting, the high acute demand for services has remained our most pressing and prominent issue. This has attracted some media interest, as Board Members are aware.

We continued to experience extremely high levels of occupancy and frequent ‘Dot Days’ until late August, with associated delays in admitting patients from the Emergency Department (ED), and impaired performance against the 6 hour target for length of stay in ED. This has, of course, placed significant stress on our facilities and staff. Fortunately, there has been a marked improvement in the second half of August – after 8 ‘Dot Days’ in the first half of the month, there have been none since 16 August. Consequently, performance on the ED length of stay has lifted to exceed the 95% target.

Analysis indicates that the high occupancy has been driven by both medical and surgical demand and it is not simply a reflection of this year’s influenza season. Required beds are much higher than those forecast on the basis of historical growth and given the diagnostic diversity, seems likely to reflect accelerating population growth and aging.

It is clear that we require additional capacity to meet the sustained rise in combined acute surgical and medical demand this year, and we are actively considering options to increase wards and theatres/procedure rooms. The planning and decision making have to be completed with some urgency as implementation will require both facilities development and workforce recruitment, each of which will take several months to complete. A Facilities Master Planning project team has been set up to support urgent completion of a facilities stocktake and clarification of both building issues and capacity requirements. Full seismic evaluation of the Galbraith building is being undertaken to inform remediation and refurbishment options but this preliminary step will take several weeks. Options will be brought to the Board for consideration once they have been worked up.

District Annual Plan

Work on the plan for the 2017/18 year is largely complete. The final draft has been reviewed by the Audit Risk & Finance Committee and is now awaiting approval from the Chair before submission to the Ministry of Health for consideration. In the meantime, the process for ongoing review of progress against the plan is underway, overseen by the Investment and Change Steering Group.

Influenza Vaccination Programme

By the end of August, this had achieved an overall rate of 67%. It is pleasing that the highest rates were in clinical workforce groups (nursing, allied health and medical, all 68-69%). Midwifery rates were still low at 44%, and this is an ongoing challenge.
The peer vaccinators who were instrumental in achieving the improved performance, were thanked at an awards ceremony on 30 August. Our top vaccinator was Helen Bretherton, who vaccinated over 162 staff. Top teams were Middlemore Central and the Emergency Department. Overall, 4,567 vaccines were given to staff, and in addition, 792 students and contractors were vaccinated.
Now Live wards 34 East and 7 Middlemore Hospital

eVitals is now live on wards 34 East (General Surgery/ General medicine) and ward 7 (General medicine). The eVitals project introduces Patientrack for electronic capture of patient observations, like blood pressure and heart rate, and patient assessments like the patient’s fluid balance. The first electronic charts available are patient observations, neurological assessment, fluid balance, bowel, peripheral IV Line insertion, weight and smoke free assessments.

CMH is also trialling the new national Early Warning Score (EWS) that replaces CMH’s Physiologically Unstable Patient (PUP) score. EWS is automatically calculated as patient observations change prompting staff to action care. Automated notification of the EWS to the Patient At Risk team is a planned next step.

Nurses agree that eVitals has given greater visibility of critically ill patients on the ward, and that there is greater collaboration within the team as they can see if a colleague needs help with activities. They expressed excitement at having more charts added as soon as possible to reduce the paper load.

Patients are also enjoying seeing nurses with ipads and have asked why it has taken so long. Some are enjoying being shown their information on the ipad and appreciate that it is really clear.

Medical staff are adjusting to having Computers on Wheels (COWs) on their ward rounds and realising the benefits of Concerto at their fingertips at the patient’s bedside. Doctors agree that introducing electronic systems to capture this information is critical but acknowledge that it can take time to adjust to new ways of working.

One of our Radiologists commented that eVitals has already shown its worth when he received a late night phone call regarding a sick patient who may have needed an invasive procedure during the night (refer to the box).

“I was able to view the images, blood results and now vital signs offsite via Citrix and Concerto! It enabled me to advise that since the vital signs had improved over the previous 12 hours we should continue to observe and reassess today. Not only did it benefit the patient who might have had an unnecessary procedure with some risk, but also a financial saving as our nurse and MRT would have been called in and this would have incurred a call back component.”

Clinical coaches continue to be available 7 days a week to assist staff with training and to support them with any issues they may face.

The early adopter wards will use eVitals for the next 6 weeks. This settling period enables staff to identify any patient safety issues, additional process and workflow changes or technical issues. It will be implemented to all medical, surgical and ARHOP inpatient wards over the next 8 months.

More information

Sally Dennis (sally.dennis@middlemore.co.nz) - eVitals Clinical Nurse Lead, or healthytogethertechnology@middlemore.co.nz

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Diversity Ball
This was a night to remember, as over 720 people attended the annual CMH Diversity Ball. Hollywood vs Bollywood came alive as people enjoyed great entertainment, food and company.

2. Future Focus

Trends in hazardous alcohol use and burden of alcohol-related harm

Background
Hazardous alcohol use and alcohol-related harm cause large health, social, and economic burdens in Counties Manukau and are key drivers of inequities. Alcohol is an addictive psychotropic drug, a carcinogen, an intoxicant, a leading cause of violence and injury, a contributing factor to many mental health problems, and a component cause of more than 200 disease conditions, including alcohol dependence, liver cirrhosis, cardiovascular disease, and cancers. Alcohol-related problems affect many people and communities in Counties Manukau and touch most departments/services with the CM Health system, as well as sectors outside health.

A complete picture of trends and burden of alcohol-related harm is not currently available, particularly at a local level. This is due to two main problems: 1) a lack of systematically-collected data related to alcohol (e.g. lack of data on alcohol-related presentations to ED – improving this is a current focus at CM Health) and 2) existing sources which underestimate the problem (e.g. data on alcohol-related hospitalisations describes hospitalisations that are ‘wholly attributable’ to alcohol, which is a subset of the total burden and does not include all conditions and injuries to which alcohol may have contributed). However, the New Zealand Health Survey (NZHS) provides a useful population-level picture of hazardous alcohol use, and is presented below.

National trends & burden
Trend data from the NZHS\(^1\) between 2006/07 and 2015/16 show that the percentage of adults (age 15+) with hazardous drinking patterns fell in the 2011/12 survey, but subsequently increased (18% in 2006/07, 15% in 2011/12, 15% in 2012/13, 16% in 2013/14, 18% in 2014/15, 19% in

\(^1\) Ministry of Health. 2016. Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health
Over the decade, statistically significant increases in hazardous drinking were seen among 35-74 year olds, Māori women, and the European/Other ethnic groups. Statistically significant decreases were seen among 15-24 year olds.

Alcohol-related burden in NZ is substantial. It is estimated that 5.4% of all deaths of people under 80 years of age (2007 data) and 6.5% of all healthy life years lost among 0-79 year olds (2004 data) are attributable to alcohol consumption. One in three New Zealanders who consume alcohol have reported being harmed by their own drinking in the past year. The New Zealand Burden of Diseases, Injuries and Risk Factors Study reported that alcohol ranked 6th in the list of leading risk factors (2006 data). There were marked ethnic inequities: on a relative scale, the burden of alcohol was three times greater for Māori than for non-Māori; on an absolute scale, alcohol accounted for 11% of the ethnic inequity in health loss. Also of concern, but not well quantified, are the substantial harms to people (including unborn babies) from other people’s alcohol use. Foetal Alcohol Spectrum Disorder (FASD) is recognised as a leading preventable cause of intellectual and developmental disabilities.

Counties Manukau trends & burden
Trend data from the NZHS, describing hazardous alcohol use by DHB region, are available for 2006/07 and 2011-14, and show that the percentage of adults (age 15+) with hazardous drinking patterns in Counties Manukau has stayed about the same at 13%. Among the Counties Manukau Māori population, the percentage of adults with hazardous drinking patterns is much higher at 29%.

It is estimated that there are approximately 50,000 Counties Manukau adult residents aged 15+ with hazardous, harmful, or dependent drinking. By Locality, approximately 19,300 hazardous drinkers live in Manukau Locality, 12,700 in Eastern Locality, 10,400 in Mangere/Otara Locality, and 7,500 in Franklin Locality. Approximately 8,000 people (2% of 15+ years Counties Manukau population) accessed Counties Manukau Alcohol and Drug Team services or CADS (Community Alcohol and Drug Services) in 2014.

A two-week study (5th-19th December 2016) of alcohol-related presentations to MMH ED has demonstrated the significant impact on patients, staff and healthcare resources. Of the 4363 total presentations to the ED during the study period, 87.8% (n=3843) were assessed as to whether the presentation was associated with alcohol. In adult patients aged 15+, 9% of presentations were alcohol-related. Alcohol-related presentations were more common on weekends, with night shifts most affected. Male patients, those aged 15-29 years, and Māori or European & Other ethnic groups had the highest percentage of alcohol-related presentations. Alcohol-related health harms were broadly categorised as: injury related (51%), acute intoxication (24%), chronic alcohol intake (15%) and self-harm related (9%). Cost associated with alcohol-related presentations over the two-week study period was approximately $580,000.

Counties Manukau Health Alcohol Harm Minimisation Programme
CM Health has developed and is in the early stages of implementing a new Alcohol Harm Minimisation Programme. The programme is collaborative, whole-of-system, underpinned by an equity approach and closely aligned with the equity goal of the ‘Healthy Together’ Strategic Plan and the vision of Healthy Communities. It takes a primary and secondary prevention focus. Key components are 1) implementation of the Alcohol ABC Approach (also known as Screening, Brief

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3 Meiklejohn J et al. One in three New Zealand drinkers reports being harmed by their own drinking in the past year. NZMJ 2012, 125(1360):28-36
5 CM Health analysis
6 CM Health analysis
7 CM Health analysis
Intervention & Referral to Treatment [SBIRT]) in three key settings (i.e. general practice, community/locality, and ED), 2) strengthening of integration between Alcohol ABC Approach providers and Alcohol and Other Drug services, and 3) focussed collaborative projects with communities and health and social sector partners.

Priorities for 2017-18 are:
- Contracting with PHOs for ABC Alcohol Approach data collection, recording, and reporting capability development, and linked Quality Improvement Plans in General Practices.
- Emergency Department ABC Alcohol Approach project, with a focus on sustainable data collection on alcohol-related presentations, and designing & implementing a model for ABC Alcohol delivery in ED with spread of learning to inpatient wards.
- Development of a new Alcohol Harm Minimisation Advisor role for Middlemore Hospital.
- Planning and implementing ABC Alcohol Approach with community-based providers.
- Youth-focussed project (co-design of an intervention approach for the youth peer crowd at highest risk of alcohol-related harm).
- Improving and refining CM Health data and information on hazardous alcohol use and alcohol-related harm.

This will also be complemented by a Social Investment Board South Auckland funded test to trial Brief Interventions and direct referral to interventions by the social sector. It is mostly the social sector who may see patterns of alcohol harm (e.g. Police, Tenancy Managers, MSD case workers) before people seek health interventions.

Annual Women’s Health and Newborn
The “Women’s Health and Newborn Annual Report” will have been submitted to the Ministry of Health by the time the Board meets. This will be the fifth annual report produced on maternity and infant care funded by the Ministry of Health. All DHBs are required to produce an annual Maternity Quality and Safety Annual Report. CM Health have extended our local report to include gynaecology, newborn initiatives and neonatal care data. The highlights of issues topical to past Board are summarized here:

- **Overall Births:** There were 8,051 births in the 2016 calendar year, 83% of whom birthed at CM Health facilities. 1,227 CMDHB women birthed at ADHB and a further 145 birthed at WDHB and other DHBs. Of those who live and birthed in CM Health, 27.9% were Pacific, 26.3% were NZ European, 19.8% were Maaori and 11% were Indian, 8.6% Chinese. The trajectory of births in CM Health has been trending down.

- **Mums under 20 yrs:** The number of teen mums has also been trending down since 2012 with 403 women giving birth in 2016. The rate has significantly dropped for Maaori young mums from a rate of more than 80/1000 in 2012 to less than 50/1000 in 2016;

- **Workforce shortages:** Although there are workforce shortages that persist in midwifery, a concentrated effort on growing Maaori and Pacific midwives has generated significant improvement. Thanks to the Tindall Foundation, programmes like Pu Ora Matatini have contributed to an increase in Maaori midwives graduating and working in CM Health. Since 2012, Pu Ora Matatini has contributed to (provides financial and pastoral support to students) graduating 15 Maaori midwives – 6 are employed by CMDHB, 6 are self employed LMCs and 1 is employed by WDHB. Helped by AUT moving their midwifery programme to South Auckland from 2014, the pipeline offers much hope – there are 58 Maaori students enrolled in the AUT Midwifery Programme in 2016, out of a total group of 255. CM Health has also funded scholarships for Pacific midwives, of which 8 graduated in March and are now registered midwives – 6 are all practicing at CM Health, 1 is on maternity leave herself and 1 is working in Northland as a midwife. There are 26 Pacific midwives enrolled at AUT in 2017.
• **Baby Security System:** Following the unauthorized absence of a baby in 2014, a system to monitor baby security was tested in 2016 (proof of concept) and is now being implemented. The system is in the process of being tested for full implementation at Middlemore (including neonatal intensive care), Botany, Papakura and Pukekohe Birthing Units since February 2017. The system involves a special tag in a baby’s ID bracelet which is seen by receivers installed in facilities. This provides an approximate location on an App that can view baby’s location on a map. The alert displays and sounds an alarm on an iPhone carried by the person in charge on the ward and on two iPads placed at fixed stations on the ward. If a serious situation arises, the App can directly alert the Security Services and escalate to Police. Monitors are also installed outside in the hospital grounds (e.g. near certain stairwells, lifts, corridors and exits) to provide information on where that baby is heading. Full implementation is due during 17/18.
### 3. Performance and Outcomes Priorities

**Health Target Summary – 2017/18**

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Results</th>
<th>Status by 30 June 2018</th>
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<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>
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<td><strong>July result:</strong> 83%</td>
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<td><strong>Note:</strong> Volumes over the winter quarter have presented a significant challenge. During July, ED presentations totaled 10,294, a 4.1% increase over July 2016 volumes. Year-to-date (YTD) presentations are 20,629 which represents a 7% increase from YTD volumes last year. Higher patient volumes across the system have impeded patient flow throughout the hospital, which in turn has meant our ED has been unable to process patients within the target timeframe. A range of initiatives are underway to address underlyng system challenges and manage demand.</td>
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<td><strong>Elective Surgery</strong></td>
<td>Elective surgery will increase by an average of 4,000 discharges per year</td>
<td>ACHIEVED</td>
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<td><strong>June 2017 (confirmed end of year result):</strong> 107%</td>
<td>(at 30 June 2017)</td>
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<td></td>
<td><strong>ESPI2:</strong> 0 FSA breaches for June (confirmed result)</td>
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<td></td>
<td><strong>ESPI5:</strong> 13 treatment breaches for June (confirmed result)</td>
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<td></td>
<td><strong>July results not yet available as measure reported one month in arrears.</strong></td>
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<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>ACHIEVED</td>
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<td><strong>July 2017 (individual month result – indicative only):</strong> 93%</td>
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<td><strong>Note:</strong> As of 1 July 2017, the target has increased from 85% to 90%; however, the definition at this time has also changed. Previously, breaches could be attributed to patient choice, clinical consideration, or capacity constraints. Now that the new target definition is in place, only those relating to capacity constraints will be counted as breaches. Accordingly we expect our performance against the target to improve in 2017/18, despite the increase to 90%. In July there were two capacity constraint breaches (from a total of 32 FCT patients).</td>
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<td><strong>Immunisation</strong></td>
<td>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 Maaori and Pacific population groups).</td>
<td>ON COURSE</td>
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<td><strong>July 2017 (individual month result):</strong> 94% for total population (Maaori coverage: 89%, Pacific coverage: 96%)</td>
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<td><strong>Note:</strong> A further 20 babies were required to be immunised on time by 30 July 2017 in order to have met the 95% total population target.</td>
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<td><strong>Raising Healthy Kids</strong></td>
<td>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)</td>
<td>ACHIEVED</td>
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<td></td>
<td><strong>July 2017 (individual month result):</strong> 99% total population (Maaori: 98%, Pacific: 99%)</td>
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<td>Tobacco</td>
<td>Primary</td>
<td>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</td>
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<td><strong>July result (individual month result):</strong> 85% total population (Maaori: 83%, Pacific: 85%)</td>
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<td></td>
<td></td>
<td>As expected there has been a drop in performance against the Better Help for Smokers to Quit Health Target in July. At the start of the new quarter, all enrolment changes for Primary Health Organisations (PHOs) in the previous quarter are registered (changing the PHO denominator), which usually negatively impacts results.</td>
</tr>
<tr>
<td>Maternity</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>June 2017 (confirmed end of year result):</strong> 92% (Maaori 90%, Pacific: not reported)</td>
</tr>
</tbody>
</table>

**Achieved:** Already meeting target / will meet target by 30 June 2018.

**On Course:** Expected to meet target by 30 June 2018.

**At Risk:** Risk that target will not be met by 30 June 2018 unless performance improves.

* Performance against the Elective Surgery target is reported one month in arrears.

** Data provided from the MOH quarterly (for previous 6 months). Result reflects percentage of children identified as obese for whom a referral has been sent and that referral has been acknowledged.
Hospital Services continues to track performance against the contributory measures they committed to as part of the overarching SLM programme of work. The dashboard shows sustained performance against the discharges by 11am measure, as well as ongoing improvement in the number of referrals to the Reablement Service. Performance against our LOS measure is symptomatic of both the increase in demand and the increase in acuity of our patients. Efforts to develop, capture, and measure the patient journey through a patient-flow dashboard are progressing well – this will enable us to identify and address pressure points and barriers within the system. A targeted initiative to identify stranded patients and facilitate their timely return to the community is also underway.
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 July 2017.

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

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</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>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>EM&amp;IC</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>

Appendices:
A: Board Charter
B: Executive Health and Safety Committee Agenda and Minutes
C: Compliance Tracker

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
It is recommended that CM Health adopt the attached Board Charter (Appendix A).

The Executive Health and Safety Committee has been established and minutes attached (Appendix B).

There were no notifiable events for July 2017 and the profile of incidents is similar to previous months. This is a good outcome given the demand on the organisation in July.

The DHB has established a compliance tracker to monitor actions to remediate the actions noted in the audits (Appendix C available in Diligent).

Board Charter
A Health and Safety Marker Self-Assessment was completed in March 2016 to ensure compliance with the new legislation. The “Health and Safety Guide: Good Governance for Directors” published by the Institute of Directors and WorkSafe New Zealand was used as a benchmarking framework for this assessment.

The improvement opportunity was to develop a Board Charter to describe Board / Director roles including what is required from management and detailed structures and processes to be used to plan, deliver, monitor and review leadership of health and safety.

Action Point: Attached is a Charter for the Board to consider, discuss and accept. (Appendix A).

Work Place Observations
A work place observation will take place after the Board Meeting on 13 September. The work area to be observed is the AMHU construction site. The Executives visiting the work site will be hosted by the Ebert’s Construction onsite H&S Coordinator, with support from the CM Health Manager Capital Works.

Executive Health and Safety Committee August 2017
The Executive Health and Safety Committee has been established and minutes for the August meeting are attached (Appendix B).

The Committee confirmed its terms of reference, accepted that the two key safety policies remain valid (Health and Safety Policy and the Injury Management Policy) and accepted that the Health and Safety Assessment Report of March 2017 will form the basis for the work of the team for the 17/18 year.

The Committee has requested that a Violence and Aggression workgroup be established to provide assurance that all actions are being taken in a co-ordinated manner to ensure that staff remain safe from risks of this nature.
Performance Scorecard

### Lagging Indicators

<table>
<thead>
<tr>
<th>Number of Reported Incidents</th>
<th>Actual July</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>104</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>5</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Visitor</td>
<td>3</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

| Number of Injury Claims     | 20          | <35    |       |
| Lost Time Incidents         | 2           | <5     |       |
| Cost of Injury Claims       | $8,366      | -      |       |

### Leading Indicators

<table>
<thead>
<tr>
<th>Scorecard Comments</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at Health and Safety Orientation 93%</td>
<td>104 Welcome Day attendance bookings were made with 97 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>
<td>The aim is to have 190 fully trained Health and Safety Reps by March 2018.</td>
</tr>
<tr>
<td>Pre-employment health screening completed prior to commencement</td>
<td>New hires and transfers that commenced to the on-boarding phase in July.</td>
</tr>
<tr>
<td>Staff flu vaccination uptake</td>
<td>The actual herd-uptake figure for July does not include staff that had vaccinations done at their own medical providers, students and contractors.</td>
</tr>
<tr>
<td>Lost time Injuries</td>
<td>The injuries that resulted in lost time were due to: Patient handling resulting in a back sprain Awkward stepping motion resulting in an ankle sprain Both these injuries were sustained in the Nursing / Midwifery work group within PHCS and SAP</td>
</tr>
</tbody>
</table>

### Notifiable Events

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

**Staff incidents (IRS)**

Staff are being encouraged to report all incidents, including near misses. It is pleasing to note that staff incident reporting is increasing for the rolling 12 month period, which provides an improved risk identification and mitigation process.

**Pre-employment Screening**

Pre-employment screening rose gradually over the rolling 12 months, with a peak in November and December 2016, and again in April and May 2017 due to a large number of new intakes of staff for those periods.

**Attendance at H&S Orientation**

94 employees attended the Welcome Day inductions in July. This is an increase from the 84 attendees in June. H&S Orientation attendance indicates an upward trend for the past 6 months.

**Number of injury claims**

Injury claims rose steadily over the rolling 12 month period due to high moving and handling, slips/ trips/ falls and aggression and violence incidents reported in March, May and June 2017.

**Health and Safety Representative Training**

50 representatives and 30 Champions have undertaken the new health & safety training to date. Workshops are scheduled monthly for the remainder of 2017.

**Key**

- Increased performance
- Steady performance
- Decreased performance
Reported Incidents

Summary
The incident profile remains consistent with the exception of Stress and Fatigue that features among the predominant incident types for July.

The incident profile consists of the following top 4 injury types for July 2017:
- Aggression and Violence: 25
- BBFE: 24
- Moving and Handling: 13
- Psychological: 12.

Slips, trips, and falls decreased for this period and may be attributed to increasing awareness and the umbrella baggers placed at the entrances during wet weather.

The incidents defined as ‘Other’ relate to minor incidents such as insect bites, minor burns, dust particle in an eye, noise and glare. These incidents are followed up with the relevant manager of the work area.
Reported Incidents

Rolling year-on-year monthly average comparison:
Previous 12 months – 106.25
Current 12 months – 105.91

The number of reported incidents being both events and near misses is very similar month on month.

Environmental factors with no injury impact, but which have been notified are included in the ‘Other’ category. These are 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:
112 incidents were reported in July 2017.

The incident profile changed slightly from other reporting periods with Stress and Fatigue slightly more prevalent than slips/ trips and falls.
Reported Incidents - Aggression and Violence

**Rolling year-on-year monthly average comparison:**

Previous 12 months – 21
Current 12 months – 20.5

The trend for assaults and aggression remain steady for the rolling year.

**Current Period:**

24 aggression and violence incidents aimed at staff were reported in July with the following incident types recorded:

- 17 Physical assaults
- 4 Exposed to threatening and violent behaviour
- 2 Hit by patients
- 1 Verbal abuse
- 1 Exposed to inappropriate behaviour

Incidents remain high in the Mental Health Division. Most incidences in Mental Health occurred in Ward 35 East. According to our records no injury claims were lodged.

Most incidents in ARHOP occurred in Ward 23 (AT&R) and resulted in minor and moderate injuries with one claim lodged for treatment. 4 incidents reported were caused by one patient.
Reported Incidents -BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly average comparison:

Previous 12 months – 21.9
Current 12 months – 22.7
There is a slight increase in the number of reported BBFE incidents for the rolling 12 months.

All BBFE notifications are followed up with a detailed investigation by the Occupational Health clinical team to determine if the incident was an actual or near-miss 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:

24 BBFE incidents were reported in July. This includes all incidents logged and were all investigated by the Occupational Health nurses.

Causation profile:

Unnecessary Haste: 4
Acts of others: 4
Not true BBFE: 4
Job Factor: 3
PPE not Used: 3
Improper Work Techniques: 2
Patient Condition: 2
Policy/Safety Rule Violation: 1

Occupational group of BBFEs:

Nursing/Midwifery: 10
Medicine: 9
Allied Health: 3
Health Care Assistant: 1
Medical Student: 1
Reported Incidents - Moving and Handling

Rolling year-on-year monthly average comparison:

Previous 12 months – 23
Current 12 months – 19

Moving and Handling injuries continue to be closely monitored and investigated.

Reported incidents has decreased over the past 12 months rolling.

A steering group has been appointed to manage this risk in the organisation.

Current period:

No major injuries resulted from the incidents reported in July. All injuries were rated as minor or minimum.

8 Injuries resulted from moving patients.

5 Injuries resulted from moving objects.
Reported Incidents - Psychological

Rolling year-on-year monthly average comparison:

Previous 12 months – 6.3
Current 12 months – 7.5

Psychological incidents are defined as Stress and Fatigue for this reporting period. These incidents has gradually increased since November 2016 and appear to be changing the predominant injury profile.

Current period:

The incidents notified in ARHOP and EM&IC were attributed in the reports to understaffing in these areas.

The incident notification comments indicated that understaffing was the primary causation, which had also attributed to 3 patient falls. Additional comments in the report indicated that staff could not meet the requirements of the ward and could not take any breaks as they had patients that were vulnerable and could not be left alone.
Reported Incidents – Workforce and Division

Reported Incidents Summarised by Category and Workforce for the period July 2017

Reported Incidents Summarised by Division & Category for the period July 2017
Key Health and Safety Risks and Actions to Remediate

CM Health Health and Safety Risks are categorised into 3 main categories:
- Compliance Risks
- Occupational Health and Safety Risks
- Wellness Risks.

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

<table>
<thead>
<tr>
<th>Risk: Occupational Health and Safety - Aggression and Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Status / Issues</strong></td>
</tr>
<tr>
<td>The incident profiling of aggression and violence incidents directed at workers from patients and visitors continues to primarily occur in Mental Health and the Emergency Department.</td>
</tr>
<tr>
<td>There are 11 different classifications of Aggression and Violence in the Incident Reporting System. Work has progressed to redefine the incidents into consequence ratings for reporting purposes i.e.:</td>
</tr>
<tr>
<td><strong>Rating</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td><strong>Action</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Original Risk</th>
<th>Residual Risk</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Risk: Occupational Health and Safety - Community Health Work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Status / Issues</strong></td>
</tr>
<tr>
<td>The Community Health, H&amp;S Induction handbook is being reviewed, given the focus on this risk. The aim is to ensure that the information remains current and up-to-date. The issue around P-labs has been included and specialist opinion sought to address employee exposure to fumes. At CMH there are several courses that focus on safety within a community setting Mental Health have a suite of trainings under the Safe Practice and Effective Communication (SPEC) umbrella • Four Day SPEC for all new employees working</td>
</tr>
<tr>
<td><strong>Action</strong></td>
</tr>
<tr>
<td>Current Status / Issues</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Incidents of slips/ trips and falls decreased for this month. The umbrella baggers have proved to be very effective during the winter weather.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk has decreased following operational interventions by Facilities and the Cleaning teams. The overall risk remains the same due to the ongoing occurrence of events. 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>A teleconference has been scheduled with Michael Frey (United Kingdom) and Anne McMahon (WDHB) to assess the suitability of the Trophi risk assessment tool.</td>
</tr>
<tr>
<td>Involvement of CMDHB Workforce Capability Team to develop training resources has been confirmed.</td>
<td>Once the risk assessment has been completed, consideration will be given to the roll out of training and resources across CMDHB.</td>
</tr>
<tr>
<td>Training resources have been identified by Ko Awatea to support the Moving and Handling initiative.</td>
<td></td>
</tr>
</tbody>
</table>

**Original Risk:** The residual risk remains the same at present.
### 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 80 participants trained to date. Currently there are 50 employees working through the unit standard to achieve the above. The aim for 190 Champions to be trained by date</td>
<td>OHSS will present the new “Risk Management Review” to the JCCs forums to ensure unions are informed and consulted as appropriate and as required. No formal consultation is being undertaken currently.</td>
</tr>
<tr>
<td>Tutorials for the Health &amp; Safety Representative unit standard assessment are conducted twice monthly. Risk Management training for managers has been implemented and uptake has steadily increased over the last three months, with 43 managers trained.</td>
<td>The training plan and program will be communicated to provide a selection of dates for managers for the balance of 2017. The aim is to target every manager who is responsible for maintaining and updating a work area risk register in the future.</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 projects are fully compliant has an active assurance regime, is monitored, measured and validated by third party H&amp;S auditors. Facilities are assured of compliance. The Hospital and Facilities Contractor management process is currently immature and requires review and resource to attain the level of H&amp;S assurance required under the legislation.</td>
<td>An external audit of H&amp;S Management systems and compliance requirements is continuing to be undertaken by an external H&amp;S Risk Specialist. This audit is being undertaken in partnership with Facilities and the evaluation is due for completion by October due to the complexity and diversity of the scope.</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: Wellness - Employee Wellness

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Flu Campaign: The current uptake is 67% and is the highest outcome CM Health has achieved to-date.</td>
<td>The Flu Campaign will cease on the 31st August due to the deadline of reporting to the Ministry of Health in early September. The vaccination will still be available through OHSS after the formal program has ceased.</td>
</tr>
<tr>
<td>528 Students and contractors have been vaccinated in addition to the uptake figure.</td>
<td>The Wellness Survey results will be evaluated with recommendations to be scoped in November.</td>
</tr>
</tbody>
</table>

Employee Wellness is the focus of a Capstone Project which is part of the Emerging Leaders Course through Ko Awatea and University of Waikato. The project has been sponsored by the OHS Manager and supports the Wellness strategy drafted in 2016. The 2017 survey follows a survey that was done in 2016 and which supported the Healthy and Well Together programme.

The survey goal is to undertake a gap analysis of current wellness initiatives at CM Health. In addition, by engaging our people to partner with this initiative it will clarify how staff want to access any future initiatives.

## 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 459. This includes training on both the old and new modules. Those who have had the training based on the old module (old legislative requirements) are being followed up to retrain on the new module.</td>
<td>To increase the level and frequency of communication channels with these H&amp;S Representatives.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Original Risk</th>
<th>Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>Extreme</td>
</tr>
<tr>
<td>Moderate</td>
<td>Major</td>
</tr>
<tr>
<td>Major</td>
<td>Extreme</td>
</tr>
</tbody>
</table>
Assurance Activities

Workplace Inspections Conducted

For the May - June 2017 inspection cycle, OHSS received 98% (120) of the total (122) expected submissions showing a very high response rate across the organisation. Follow-up was given to the areas who did not submit their inspections and which were due to other work conflicts during a busy period. These inspections are undertaken by H&S Representatives who are volunteers and undertake them over and above their normal work duties.

The purpose of the Workplace Inspections is to identify the hazards around the workplace, assess the risk and have a plan to manage the risk. Feedback from the Inspections shows 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 August 2017.

![Workplace Audits Conducted to June 2017](chart.png)
### Glossary for Monthly Performance Scorecard and Report

<table>
<thead>
<tr>
<th>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><strong>Lost time injury Frequency Rate</strong></td>
<td>No of lost time Injuries per million hours worked.</td>
</tr>
<tr>
<td>LTIFR (Lost Time Injury Frequency Rate)</td>
<td>((\text{Number of Lost Time Injuries} / \text{Hours Worked}) \times 1,000,000.)</td>
</tr>
<tr>
<td><strong>Injury Severity Rate</strong></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)</td>
<td>((\text{Number of Lost Hours} / \text{Hours Worked}) \times 1,000,000.)</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 zoonoses) 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 |
Counties Manukau District Health Board’s Health and Safety Charter
Contents

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Responsibilities of Managers 04
Responsibilities of Staff 04
Health and Safety Training 04
Employee Participation and Consultation 04
Meetings 04
Introduction

This Charter is approved by the Board to assist Counties Manukau Health (CM Health) to fulfil its governance responsibilities in relation to Health and Safety. This Charter will be reviewed after 12 months.

At all times, the Charter seeks to support the organisational promise of:

“Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Māori, Pacific and communities with health disparities by 2020.”

This will be achieved through living the organisational values:

- Valuing everyone – we make everyone feel welcome and valued
- Kind - we care for other people’s wellbeing
- Together – we include everyone as part of a team
- Excellent - we are safe, professional and always improving

Policy Statement

1. The Board is committed to ensuring a safe environment for its people (employees and contractors), patients, families and other people for whom we are responsible in the vicinity of the organisation’s places of work.
2. The Board recognises that it has a critical role to play in the implementation of health and safety, and the health and safety culture of the organisation.
3. The Board will fulfil its role by ensuring that appropriate policies and procedures are adopted and implemented by reviewing and monitoring the identification, reporting, culture and management of health and safety hazards and risks.
4. The Board is committed to an aspiration of zero harm
5. All directors will familiarise themselves with their obligations under the relevant legislation (including any amendments) and their obligations as directors and ensure the appropriate policies and processes are in place to meet those obligations.

Responsibilities of the Board

The health and safety responsibilities of the Board will include:

1. Considering, approving and making changes to all major health and safety strategy, policy and procedures including the organisational Health and Safety Management System;
2. Setting health and safety indicators, together with the Chief Executive, and assessing performance in accordance with available resources against those indicators;
3. Ensuring the Board and its Directors are properly and regularly informed and updated on matters relating to health and safety governance, performance, and compliance;
4. Reviewing the adequacy of the organisation’s systems for monitoring compliance with both relevant applicable law and the organisation’s policies;
5. An annual assessment/audit of the organisation’s health and safety risk profile and compliance and control processes;
6. Obtaining regular reports from management on the operation of the organisation’s risk management, compliance, and internal control processes as they relate to health and safety;
7. Evaluating the adequacy of the organisation’s relevant systems for the reporting of actual or potential incidents and breaches, subsequent investigations, and remedial actions. This shall include reviewing all health and safety incidents that meet the definition of Notifiable Events under the Health and Safety at Work Act 2015, occurring across the organisation’s operations, and considering the appropriateness and efficacy of any identified corrective actions to minimise the risk of recurrence.

**Responsibilities of Managers**

1. All managers have a responsibility to ensure that a safe and healthy work environment is achieved and maintained.
2. Managers are accountable for integrating CM Health’s health and safety system and policies into their work areas, for themselves, their employees, students, volunteers, contractors and visitors.

**Responsibilities of Staff**

All employees have a duty and responsibility, to maintain their own health, safety and wellbeing and to ensure that no action or inaction on their part causes themselves or another person harm.

**Health and Safety Training**

Training starts at induction, with employees understanding their responsibilities and how they can contribute to a healthy and safe environment, and ensure compliance with CM Health’s vision and statutory requirements. All relevant health and safety training will be made available to all CM Health employees.

**Employee Participation and Consultation**

1. CM Health will ensure that all employees have ongoing opportunities to be involved and to have their interests represented in the development, implementation and evaluation of safe workplace practices.
2. This includes management proactively engaging employees, their H&S Representatives and the Union, through their organisers and members.
Meetings

At all Board meetings, the Board will receive a report on CM Health’s health and safety systems. The report will contain a comprehensive summary of health and safety activity across the organisation. The Board will review the report and respond to recommendations as appropriate, and/or provide any feedback and direction as required. Board workshops or meetings dedicated to health and safety will be scheduled twice a year. These meetings will comprehensively review the organisation’s Health and Safety strategy and its health and safety performance against the relevant indicators and targets and make any adjustments to the strategy, indicators or targets as necessary. The Board may arrange to visit any site managed by or for CM Health. Such visits will be arranged and co-ordinated via the Chief Executive.
Executive Health, Safety and Wellbeing Committee Minutes  
10 August 2017, 1.00pm – 2.00pm  
Executive Management 1 Meeting Room  
Lvl 5, Galbraith Building

<table>
<thead>
<tr>
<th>#</th>
<th>Agenda Item</th>
<th>Action</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Opening of Committee, discussion on context, purpose etc</td>
<td>Elizabeth</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Terms of Reference</td>
<td>ToR approved with following updates required: Required Committee Members list to be reviewed. Update frequency to 6 weekly initially and move to quarterly in 2018</td>
<td>Bev</td>
</tr>
<tr>
<td>3</td>
<td>Approval of following policies:</td>
<td>The terminology used within the documents to be run past Communications team to ensure the policies have a consistent Counties Manukau voice. Bev to send updated documents to Director HR for CE sign off.</td>
<td>Bev</td>
</tr>
<tr>
<td></td>
<td>• Health and Safety Policy</td>
<td>nten</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Injury Management Policy</td>
<td>nten</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Confirmation of Gavin Johnson’s H&amp;S Assessment Report and Recommendations</td>
<td>It was noted that the recommendations in the report are endorsed by the board and will be referenced to for the Occupational Health and Safety 2017/2018 workplan.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Aggression and Violence Steering Group</td>
<td>To review ADHB and WDHB ToR for Aggression and Violence Steering Groups. Phillip to review the membership of group at CHMIT. Vanessa Thornton nominated as lead for steering group.</td>
<td>Bev / Phillip</td>
</tr>
<tr>
<td>6</td>
<td>Learning Lab Opportunities</td>
<td>Gloria advised that interested staff from the committee have an open invitation to attend the leadership H&amp;S training held at WDHB. Elizabeth to contact Fiona for more details ie; who attends, frequency, topics covered etc</td>
<td>Elizabeth / All</td>
</tr>
<tr>
<td>7</td>
<td>Additional item: Risk Pro</td>
<td>Discussed and confirmed that RiskPro is to be used for all clinical and nonclinical risks. Training proposed for staff entering risks to ensure sensible report.</td>
<td></td>
</tr>
</tbody>
</table>

Meeting end 1.40pm
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 14 July to 30 August 2017.

Prepared and submitted by: Jason Ranston 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 14 July to 30 August 2017.

Major Issues or Events

Support to the management of winter demand

Support for the organisation in response to winter demand eased toward the latter half of the reporting period. Extensive media coverage continued to occur nationally in light of pressure being faced by DHBs including potential impact on elective surgery rates.

There was a high degree of media interest in the spike in presentations of patients following consumption of synthetic cannabis. Support was provided to Dr Chip Gresham, CM Health toxicologist, to alert the public to the effects of consumption. We also worked closely with regional colleagues and emergency services to coordinate efforts.

'Whatever’s out there is bad' - doctor treating life-threatening seizures caused by synthetic cannabis

New cases of life-threatening seizures caused by synthetic cannabis are being reported by emergency doctors at Auckland’s Middlemore Hospital.
The new intranet, Paanui, went live with a large degree of positive feedback. The dynamic platform with enhanced search function and delegated content management is a step change in terms of the outdated unsupported functionality of the previous platform.

With a modern analytics platform embedded in the system, we are now able to deep dive site usage information and optimise the experience for users. Statistics such as the number of average users per day (3700), the percentage of mobile iPad users 24%, or that in a typical hour we see around 200 outbound links clicked, are all within easy reach.

Media and Email Enquiries
Approximately 134 media enquiries were received over the period with a lower proportion than normal (15%) relating to patient condition updates. This is more of a function of a higher degree of media scrutiny on other activities.

The Group also manage a generic communications email box responding to all emails and connecting people to departments. For this period 194 emails were received. 103 were not related to communications issues and, where appropriate, were referred to other departments and services at 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. In addition, one special advisory for Primary Care was issued, to offer further guidance around referrals, as the hospital approached capacity.

The MedIntel portal is currently being rolled out at WDHB and we are working with Healthpoint to receive feedback from PHOs and GPs in our district. Preliminary feedback on the functionality is positive. A decision on whether to progress this will take place in late October/early November.
Key activities

- **Supporting employees when hospital is at capacity:** Increased visibility of “Dot Days” on Paanui. Recognition from CEO and Director of Hospital Services that people are working hard and that action is being taken. Continuing to highlight stories of our values in action.

- **General election:** Reminding staff of the State Services Commission guidance on the pre-election period and our media policy.

- **Social media:** Revising our social media policy and creation of social media guidelines. New Policy and guidelines to be presented to ELT 29 August.

- **Paanui:** Communications support provided for pre-launch, launch and post-launch of new Intranet. On-going content (videos/stories) scheduled.

- **Connect+:** Editorial meeting and planning underway for the employee magazine. As part of a value for money initiative, Connect+ will now be produced quarterly.

- **Employee Value Proposition:** Work underway with the new Director of HR, Elizabeth Jeffs, on employee value proposition that complements our recruitment brand as well as supports internal engagement.

- **Cook Islands Language Week, 30 July – 5 August 2017:** Three video clips featuring CMH Cook Islands orderlies and nurses celebrating their culture were posted to the CMH Facebook page during the week. These posts were shared on the Healthy Together Facebook page along with posts promoting local Cook Islands events held in the Counties Manukau area during the week.

- **The Women’s Health and Newborn Annual Report 2016-2017** (previously the Maternity Quality and Safety Programme Report) has been submitted to the Maternity, Quality and Safety Group and the Executive Leadership Team for final sign-off. The report will be launched on 20 September 2017.

- **Team Counties blogs:** There were four TC Blogs published this month: (Health Targets, Extra-ordinary efforts during Extra-ordinary times, celebrating diversity, diabetes register first of its kind to improve diabetes screening after pregnancy).

Campaigns in Development

- **Support to Pacific Community (Patient Flow)** – work is well progressed on communications to support Pacific people better understand the patient flow and triage process in the Emergency Department. This has involved a co-design element which has been very useful in understanding how to make our communication more relevant and accessible. A new patient flow communication, derived from the ADHB approach, is to be placed in the Emergency Department, informed by this feedback.
• **Smokefree** – the Smokefree social media channel has been refreshed informed by community feedback and co-design. The new tag line is “Hang Tuff Don’t Puff” and is rich in personal stories of people who have been successful in stopping smoking. Early evidence is of strong engagement that is flowing through positive programme enrolment and to cessation rates.

![Image of Smokefree campaign](image)

**Digital Channels**

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

With a recent update to the analytics platform, we have been able to expose more details of our site usage. While the site has remained consistent, we have found that some of this usage has been at obscure times of the day (such as the 2am spike seen below). While not entirely clear, we are working to identify the events that have led to this and what external factors may have been involved. This identification process fits into the wider strategy of digital data consolidation and consumer usage, which will inform the function of the site going forward.

![Diagram of website data metrics](image)

**Figure 1 Web Site Data Metrics from Google Analytics**

**Social Media**

This period had steady growth on average, with the CM Health Facebook page being the standout again. Overall, our post volume was down and this did correspond with our impression volume dropping also, but we still maintained follower growth and had solid engagement with what was posted.
<table>
<thead>
<tr>
<th></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>5,834</td>
<td>9.99%</td>
<td>36</td>
<td>238,149</td>
<td>6,615</td>
<td>3,733</td>
<td>103.7</td>
<td>236</td>
</tr>
<tr>
<td>Healthy Together</td>
<td>8,233</td>
<td>0.70%</td>
<td>22</td>
<td>42,843</td>
<td>1,947</td>
<td>436</td>
<td>19.8</td>
<td>45</td>
</tr>
<tr>
<td>Facebook</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,389</td>
<td>0.97%</td>
<td>134</td>
<td>34,967</td>
<td>261</td>
<td>103</td>
<td>0.8</td>
<td>23</td>
</tr>
<tr>
<td>CM Health LinkedIn</td>
<td>4,369</td>
<td>1.53%</td>
<td>17</td>
<td>44,201</td>
<td>2,600</td>
<td>627</td>
<td>36.9</td>
<td>414</td>
</tr>
</tbody>
</table>

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

Audience Growth Metrics:

<table>
<thead>
<tr>
<th></th>
<th>Totals</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fans</td>
<td>20,825</td>
<td>+3.4%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>527</td>
<td>+4.4%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>23</td>
<td>+1.00%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>66</td>
<td>+1.5%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>616</td>
<td>+3.4%</td>
</tr>
</tbody>
</table>

Figure 7 Audience Growth Overview by social media channel
CM Health Facebook
This channel was again strong with 10% growth and over 230,000 impressions of our content. It also had over 15,000 views of its videos, none of which were boosted through paid advertising. Of note here is that we improved our viral impressions with a total 89,935, all gained through the sharing of our materials through our ever growing follower base.

Top 4 Posts by Reactions:

<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>579</td>
<td>80</td>
<td>12.3%</td>
<td>12,732</td>
</tr>
<tr>
<td>&quot;It's Cook Island Language Week, so why not use some of these everyday &quot;Cook Island&quot; phrases you can use in conversations with your Cook Island patients. #cookislandlanguageweek #klaorana&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) July 31, 2017 8:06 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>329</td>
<td>48</td>
<td>10.8%</td>
<td>9,358</td>
</tr>
<tr>
<td>As the celebration of Cook Island language week continues, here's some phrases you can use in conversations with your Cook Island patients. #cookislandlanguageweek #klaorana&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) August 02, 2017 10:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>241</td>
<td>27</td>
<td>7.6%</td>
<td>8,248</td>
</tr>
<tr>
<td>Today on our walk round of Ward 7, It was great to see the #hellosynonymels Initiative in action! We received some positive feedback from whanaau saying every staff member introduced themselves saying “hello my name is…” #hellosynonymels #excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) August 10, 2017 3:03 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>233</td>
<td>18</td>
<td>11.1%</td>
<td>7,474</td>
</tr>
<tr>
<td>Klaorana! It’s nearing the end of Cook Island Language Week, but the celebrations are still continuing! Here is some of our awesome orderlies, Solomone Efikana, higa Allen and Motz Tennott, serenading you into the weekend. #CILW2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) August 04, 2017 11:35 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Healthy Together Facebook
With localised content being the new standard, this channel was constant in its growth, even with 43% less posting. The videos that we have released totalled 4,000 views, with our strategic use of the autoplay feature being leveraged to provide a 99% play result. Of note is that women between the ages of 25-34 appear to be the leading force among our fans.

Top 4 Posts by Reactions:

<table>
<thead>
<tr>
<th>Post</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>50</td>
<td>3</td>
<td>4.3%</td>
<td>1,917</td>
</tr>
<tr>
<td>&quot;...the combination of using pol and swaying it to the rhythm of waiata kept her, and her friends, healthy.&quot; Awesome story waiata about how a University of Auckland study has found positive health benefits for people over 90 years old who use pol. #lovekipapuha ta.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Top health benefits equal tal chi - study</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) July 28, 2017 2:23 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>24</td>
<td></td>
<td>4.4%</td>
<td>1,047</td>
</tr>
<tr>
<td>Our Te Rito Ora team did an awesome display in the office for World Breastfeeding Week! The kaupapa for this year is &quot;Sustaining Breastfeeding Together&quot; - highlighting how we all need to work together so mothers can breastfeed. Te Rito Ora is a free community-based service that helps Mums and whānau with breastfeeding and feeding their baby or toddler. If you or your whānau need support in breastfeeding, message us to get in touch.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) August 1, 2017 4:57 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>22</td>
<td></td>
<td>4.8%</td>
<td>1,214</td>
</tr>
<tr>
<td>A couple of weeks ago was the Big Latch On - a fun event where breastfeeding women and whānau gather around Aotearoa. One of the events was at Turuki Health Care. They had an awesome turnout from the community, as well as whānau who are currently working with our Te Rito Ora team. Great man around supporting our whānau and their whānau.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) August 16, 2017 10:28 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>22</td>
<td></td>
<td>3.3%</td>
<td>2,219</td>
</tr>
<tr>
<td>Want to learn how to cook healthy, delicious food on a budget whānau? Are you a mum-to-be or have children under two-years-old? Sign up to Mum's Kitchen Rules! It's FREE! Childcare is available, and at the end of each workshop you have an amazing meal for you and your whānau. The next workshop starts 5 September. Check out the poster below to register or message us #COUNTIESMKR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Post) August 14, 2017 11:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 9 Top 4 Healthy Together Posts by Reactions
CM Health Twitter

This was a relatively quiet period for the channel with only 1% growth overall. What was noticeable was the number of impressions per Tweet increased by 8.9% since previous date range; this tends to indicate that the channel itself is slowing in growth and thus our visibility to our current followers is increasing. Another point of note are that Twitter Audience Demographics, which point to 55% of our users being between the ages of 35-44.

Top 5 Posts by responses:

<table>
<thead>
<tr>
<th>Tweet</th>
<th>Reach</th>
<th>Responses</th>
<th>Clicks</th>
<th>Retweets</th>
</tr>
</thead>
<tbody>
<tr>
<td>cmdhb: We have a special opportunity for someone seeking to work as a Chronic Pain Specialist in a part time role... <a href="https://t.co/b8PpBQd3jG">https://t.co/b8PpBQd3jG</a></td>
<td>5,618</td>
<td>2</td>
<td>--</td>
<td>2</td>
</tr>
<tr>
<td>(Tweet) August 16, 2017 12:45 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cmdhb: Rain/Wind today! With a high of 18C and a low of 12C. #Aucklandweather</td>
<td>4,706</td>
<td>1</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>(Tweet) August 27, 2017 8:15 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cmdhb: Thanks for following cmdhb. <a href="https://t.co/IeUqIJLcxy">https://t.co/IeUqIJLcxy</a></td>
<td>2,396</td>
<td>1</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>(Tweet) August 19, 2017 5:42 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cmdhb: Thanks for following cmdhb. <a href="https://t.co/rsO3npAxUT">https://t.co/rsO3npAxUT</a></td>
<td>2,405</td>
<td>1</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>(Tweet) August 06, 2017 5:03 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cmdhb: Breaking down the barriers to #ICT excellence <a href="https://t.co/h3itMogELJ">https://t.co/h3itMogELJ</a></td>
<td>2,722</td>
<td>1</td>
<td>--</td>
<td>1</td>
</tr>
<tr>
<td>(Tweet) August 08, 2017 9:10 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 10 Top 5 Tweets by responses
CM Health LinkedIn
This was another small month of growth for this channel, with a follower increase of 1.5%. What is interesting to point out here is that this is exactly the same as our last period, but was done with 26% less post volume. This however, did correspond with 30% less engagement and 32% less impressions - overall reaching 20,089 users and averaging 961 impressions per day.

Top 4 Posts by Engagement:

<table>
<thead>
<tr>
<th>Post</th>
<th>Impressions</th>
<th>Engagement</th>
<th>Clicks</th>
<th>Likes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counties Manukau Health</td>
<td>3,100</td>
<td>2.6%</td>
<td>61</td>
<td>21</td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>2,468</td>
<td>2.0%</td>
<td>31</td>
<td>18</td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>2,385</td>
<td>1.9%</td>
<td>33</td>
<td>11</td>
</tr>
<tr>
<td>Counties Manukau Health</td>
<td>2,162</td>
<td>1.8%</td>
<td>24</td>
<td>16</td>
</tr>
</tbody>
</table>

Figure 11 LinkedIn Top 4 Posts by engagement
Counties Manukau District Health Board
Approval of granting agency in favour of healthAlliance (FPSC) Limited

Recommendation

It is recommended that the Board:

Note that the current agency agreement granted by the Board in favour of healthAlliance (FPSC) Limited in relation to supply agreements which are in the DHB’s name (“Agency Contracts”) ends with the transition of National Procurement to New Zealand Health Partnerships.

Endorse healthAlliance (FPSC) Limited to continue as the DHB’s agent in respect of the Agency Contracts in order to:

- Performance manage suppliers;
- Make decisions and notify suppliers in relation to contract renewals, price reviews and other matters under the Agency Contracts; and
- Terminate Agency Contracts where that contract is replaced by a new contract for the same or equivalent products or services entered into by hA (FPSC) for the benefit of the DHB or the Northern Region DHBs.

Note healthAlliance (FPSC) will not have authority as agent to purchase, requisition or make any other form of order of goods or services on behalf of the DHB unless expressly agreed in writing.

Note the scope of the local and regional procurement service to be provided by healthAlliance (FPSC) will be described in a Service Level Agreement which will be agreed by Chief Financial Officers of the Northern Region DHBs and it is anticipated that the Agreement will be finally approved by the Regional Governance Group in October 2017.

Note that this paper was presented to ELT at its meeting of 8 August 2017 and the Audit Risk and Finance Committee meeting of 23 August 2017. The paper was endorsed to proceed to the Board meeting of 13 September 2017 with a request that a clause be included within the contract to reserve to right to withdraw at any time.

Note that the agency appointments contemplated under this letter will commence on the Effective Date (13 September 2017) and continue until terminated by the DHB.

Approve the Board to appoint healthAlliance (FPSC) Limited to continue to act as agent on behalf of the DHB in respect of the limited number of supply agreements which are in the DHBs name.

Approve the Chair and one other Board Member, to sign the letter appointing healthAlliance (FPSC) as agent under procurement contracts.

Prepared and submitted by: Pauline Hanna, Executive Project Director and endorsed by Margaret White, Chief Financial Officer

Purpose

The purpose of this paper is to ask for the Board to approve healthAlliance (FPSC) Limited to continue to be the Board’s agent in respect of the limited number of supply agreements which are still in the DHB’s name (Agency Contracts). Such contracts are a small subset of the contracts which healthAlliance (FPSC) manages in the course of providing the DHB a procurement service.
Background
In June 2014 the DHB appointed healthAlliance (FPSC) Limited to act as its agent in respect of Agency Contracts as part of the set-up of the national procurement service that was being provided to all DHBs. From 1 May the national procurement service will be provided by New Zealand Health Partnerships and healthAlliance (FPSC) will provide the local and regional procurement service to the Northern Region DHBs.

The agency granted in June 2014 will end with the termination of the Shared Services Agreement for national procurement and in order for healthAlliance (FPSC) to continue to manage the Agency Contracts a new agency agreement is required.

The agency relates only to a small subset of the contracts managed by healthAlliance (FPSC) (most of which are managed by way of healthAlliance (FPSC) entering into contracts in its own name, as principal rather than as agent for the DHBs) and does not allow healthAlliance (FPSC) to make any financial decisions on behalf of the DHB. Rather it is a mechanism to allow contract management activity to be undertaken in accordance with the procurement plan agreed with the DHB management.

Only the Board has the appropriate delegation to grant the proposed agency which is attached as Appendix A.

Service Level Agreement
Currently healthAlliance (FPSC) is working with the DHBs to describe the scope of the local and regional procurement service to be provided by healthAlliance (FPSC). It is envisaged that a recommendation as to the scope of healthAlliance (FPSC) Procurement will be reviewed by the Chief Financial Officers of the Northern Region DHBs in September prior to the healthAlliance (FPSC) Board in late September, following which the final version of the draft of the Service Level Agreement will go to the Regional Governance Group October. It is essential for the DHBs to agree on the scope of the services to be provided to avoid duplication of services within the DHBs and maximise benefits of a regional procurement service.

Appendix 1:
Draft – Letter of Appointment as Agent under Procurement Contracts
13 September 2017

Myles Ward
Chief Executive
healthAlliance (FPSC) Limited
Private Bag 92801
Auckland

E-mail: Myles.Ward@healthalliance.co.nz

Dear Myles

DHB - appointment as Agent under Procurement Contracts

Pursuant to the terms of a transition agreement between healthAlliance (FPSC) Limited (hA (FPSC)) and New Zealand Health Partnerships Limited (NZHP), certain national procurement functions (and contracts relating to those functions) will be transferred from hA (FPSC) to NZHP with effect on and from 13 September 2017 (the Effective Date).

As a consequence of this transfer the Shared Services Agreement in respect of national procurement will end and the appointment by the DHB of hA (FPSC) as its agent made in or about June 2014 will cease.

In order for hA (FPSC) to continue to provide a local and regional procurement service (to be more particularly described in a Service Level Agreement to be agreed by Chief Financial Officers of the Northern Region DHBs), in relation to supply agreements which are in the DHB’s name (Agency Contracts), the DHB agrees that without limitation, hA (FPSC) will continue to have responsibility as agent for the DHB, for:

(a) performance management of suppliers;

(b) making decisions and notifying suppliers in relation to contract renewals, price reviews and other matters under the Agency Contracts; and

(c) any decision to terminate an Agency Contract where that Agency Contract is replaced by a new contract for the same or equivalent products or services entered into by hA (FPSC) for the benefit of the DHB or the Northern Region DHBs.

To avoid doubt, hA (FPSC) will not have authority as agent to purchase, or requisition or make any other form of order of, goods and services on behalf of the DHB unless expressly agreed otherwise in writing.
The agency appointments contemplated under this letter will commence on the Effective Date and continue until terminated by the DHB.

hA (FPSC) acknowledges that the consideration for acting as the DHB’s agent is included in the funding DHBs will provide hA (FPSC) for procurement services.

In acting as the DHB’s agent, hA (FPSC) will:

(a) use reasonable diligence and care;
(b) act within the limits of its authority as agent; and
(c) report to the DHB on terms agreed by hA (FPSC) and the DHB (acting reasonably).

By signing a duplicate copy of this letter, hA (FPSC) accepts the appointment as agent on behalf of the DHB and agrees to fulfil its responsibilities as set out in this letter.

Yours sincerely

[Relevant Board Member]
Board Member

[Board Chair]
Chairperson

Accepted by and on behalf of healthAlliance (FPSC) Limited by:

________________________________________
Signature

________________________________________
Name

________________________________________
Title
Counties Manukau District Health Board
Northern Region Hyper-acute Stroke & Clot Retrieval Proposal

Recommendation

It is recommended that the Board:

Receive the Northern Region Hyper-acute Stroke and Clot Retrieval Proposal.

Note that this paper was approved by the Executive Leadership Team on 8 August 2017 and the Audit Risk and Finance Committee meeting on the 23 August 2017.

Note the proposed development of a formal 24/7 Clot Retrieval Service for the Northern and Midland region populations from July 2017 and phased introduction of the afterhours hyper-acute service.

Note that the model will be rolled out for CM Health from July 2018, following a period of monitoring and evaluation during first phase, during 2017/18.

Note based on the assumptions and information in the financial modeling, the incremental financial impact for CM Health is estimated as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Clot Retrieval</th>
<th>Hyper-acute Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>$384k</td>
<td>$12k</td>
</tr>
</tbody>
</table>

and that these costs have been included in the 2017/18 budget

2018/19 Clot Retrieval – no change between 17/18 and 18/19 as volumes assumed the same

2018/19-Hyper-acute stroke@ average WIES of 0.81 = 211 WIES ($1.059Mn)

Hyper-acute Stroke $1.059m

Note ADHBs commitment to open book transparency regarding actual costs of the new service models and agreement that funders will pay for actual costs.

Approve the 2017/18 and 2018/19 funding from CM Health for the proposed 24/7 Clot Retrieval and Hyper-acute Stroke Service for the Northern and Midland region populations from July 2017 and phased introduction of an afterhours hyper-acute service from 2018/19.

Prepared and submitted by: Dana Ralph Smith, General Manager ARHOP, endorsed by Margaret White, Chief Financial Officer

Background

Stroke is the third most common cause of death in New Zealand and is a major cause of long term adult disability. Effective early intervention is required to promote maximum recovery, prevent costly complications, improve independence and therefore reduce the stroke burden in the community. Until recently thrombolysis was the only treatment shown to open blocked brain vessels and improve clinical outcomes following ischemic stroke, however in 2015 five landmark clinical research studies, reported superior outcomes of clot retrieval treatment over the standard treatment of thrombolysis (see section 7.3).

Over the last 24 months the Northern region has been engaged in a substantive regional programme of work (refer appendix 1), led by the Regional Stroke Network, to improve access to high quality stroke services and improve clinical outcomes for all Northern region populations. Although there have been
improvements in stroke care in the Northern region in recent years, there are inconsistencies in the level of care available at each DHB, and differences in the management of acute stroke care is evident in the differing rates of thrombolysis at each DHB and each DHB’s hospitals. The primary focus of the work to date has been the coordinated development of new service models for the Hyper-acute stroke care and Clot Retrieval services supported by the Pre Hospital Acute Stroke Triage in Auckland (PASTA) assessment tool (refer appendix 2).

Over the next three years, the Regional Stroke Programme seeks to achieve a Thrombolysis rate of 15%, and a Clot Retrieval rate of 5% in ischemic stroke. The proposed changes seek to set up two acute time sensitive pathways, a formal clot retrieval service and after-hours access to a specialist led thrombolysis service. Until now, specialist led thrombolysis service at CM Health has been an ‘in hours only” service and while there have been improvements to our thrombolysis rates (15% May, 27.3% June and 18.8% in July 2017) it is not financially or human resource wise feasible or sustainable to deliver the thrombolysis service after hours with our small stroke specialist team. ADHB has the specialist expertise to provide the clot retrieval service and with their Neurology SMO workforce can also effectively and efficiently provide the after-hours thrombolysis service.

There has been extensive engagement with a range of stakeholders including consumers, St John Ambulance, NZ Stroke Foundation and specialist services from all DHBs’ across the Northern region.

Throughout the regional process, direction has been provided by the Regional Service Review Advisory Group, and where needed to inform the development of the preferred models decisions have been made by the Regional Executive Forum (REF) or Regional Governance Group (RGG).

The final proposal (resulting from a 22 month project to develop a regional stroke hyper-acute and thrombectomy model of care) was considered by REF and RGG at their combined meeting in April 2017. Key points from the proposal and following REF/RGG discussion were:

1. Endorsement of a phased implementation of the Centralised Hyper-acute Stroke Care commencing 24 July 2017 with approximately 2-3 patients from West Auckland diverted to Auckland City Hospital after hours. This coincides with a second national public awareness campaign for the FAST message.

2. A full roll-out commencing 1 July 2018 following evaluation and refinement of the initial phased implementation. Roll-out for the total metropolitan population will extend to a further 15 patients per week diverted to Auckland City Hospital after hours. Patients from Counties Manukau DHB have been estimated at 8-9 patients per week (of a total 17 patients across metropolitan Auckland).

3. The model of care for patients to be treated at ACH has been agreed via a combined Hyper-acute/Thrombectomy Pathway, following extensive design and consultation by the Northern Region Stroke Project Working Group, Stroke Executive Network & Service Performance Review Advisory Group. CM Health clinicians and management representatives were active participants on these groups.

4. The detailed implementation plan for Phase 1 includes; recruitment at ACH, communication to the community and DHB staff, survey.

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1 The proposal included Thrombectomy plus one of the two options previously endorsed by RGG; Centralised Hyper-acute Stroke Care, After Hours Only (a.h. only) for the three metropolitan DHBs. The second option; Telestroke, needs to be approved by NDHB prior to progressing through to RGG.
5. A regional workshop (with wider stakeholder representation) planned for May, to identify further projects across the stroke continuum, over the next two years. This has now taken place with a further programme of work proposed.

6. Formal engagement will be initiated with the Midland region following the outcome of the Northern Region REF and RGG consideration of this paper. Discussions have now commenced with senior management and clinician representing the five Midland DHBs.

7. A directive from REF/RGG; that additional 2017/18 costs identified in the proposal for each Northern Region DHB, will require formal approval from their respective Boards to proceed to formal implementation.

The proposed implementation approach is to establish a new Hyper-acute stroke service at Auckland DHB that will provide after-hours access to thrombolysis services for the Auckland metropolitan region, with a phased introduction of the after-hours Hyper-acute stroke service starting with the population of West Auckland from July 2017, and a formally rostered Clot Retrieval service for the Northern (and Midland) region also commencing from July 2017. The North Shore and Counties Manukau DHB populations are expected to access the after-hours Hyper-acute stroke service in the second phase of implementation from July 2018 following a period of monitoring and evaluation of the first phase of the new service development during 2017/18.

During Phase 1, planning for NSH and CM Health will commence and run alongside a 6 monthly evaluation of a suite of key performance metrics. Phase 2 implementation planning over the 12 month period will include; recruitment of shared DHB appointments, training and education (with opportunities for observation/short secondments at ACH), and media messages for the community and general DHB staff.

The key areas/KPIs which will be evaluated are provided in appendix 4. There will be four evaluation periods (over the 24 month implementation), starting with a set of baseline measurements and then evaluating against these, at six monthly intervals. Proposed timelines are:

- July 2017 Determine baselines
- February 2018 Evaluation 1 Report
- August 2018 Evaluation 2 Report
- February 2019 Evaluation 3 Report (of full metropolitan implementation)

Local, Regional and National Alignment

Local
An extensive multidisciplinary and multi-specialist team process within Auckland DHB has resulted in the development of the Auckland region After Hours Hyper-acute Stroke model, a supra-regional (Northern and Midland) “Anytime” thrombectomy model and Pre Hospital Acute Stroke Triage in Auckland (PASTA) guidelines. This involved clinicians and operational managers from Emergency Department, Neurology, Radiology, Medicine, Anaesthesia and Rehabilitation services. CM Health Stroke physicians and nurse specialists collaborated with WDHB and ADHB stroke specialists in the development of these new regional service models. The process included robust internal peer review of the level of resources needed in each service to implement the service models and this process ensured resources were not understated or overstated.

Regional
The Auckland DHB clinical service models and the level of clinical resources required to support these models have been substantively peer reviewed by clinical, management, financial and funding colleagues from the four Northern Region DHBs. There is support for the approach taken by Auckland DHB to quantify the costs of the new services and the recommended approach to funding the new service arrangements. There has been informal dialogue between some stakeholders from the...
Northern Region Stroke Network and the Midland Stroke Network regarding the development of Clot Retrieval services at Auckland DHB. The Auckland DHB Clot Retrieval service is expected to be available to populations of both the Northern and Midland regions and this scale provides for a more cost effective and sustainable service for all DHBs. Formal engagement with the Midland Stroke Network and Midland DHBs is expected to be initiated following Northern region endorsement of the implementation approach being considered at the April Regional Executive Forum and Regional Governance Group combined meeting.

National
In 2016 the National Stroke Network (NSN) convened a national working party to develop a New Zealand Strategy for Endovascular Clot Retrieval; this was published in November 2016. There was significant representation from the Northern Region on this national working group. The NZ Strategy identified the need for three NZ centres including Auckland DHB and the proposed Hyper-acute Stroke model and the Northern/Midland Clot Retrieval model have been developed in accordance with the requirements of the NZ Strategy for Endovascular Clot Retrieval.

Impact on Equity
Stroke disproportionately affects Māori and Pacific patients who experience significantly higher incidence and mortality rates. They are of a younger age when affected, and inequalities in 30 day survival have been widening over time. While the incidence of stroke is declining overall, the rate is now increasing in younger patients, with the rate of increase fastest for Pacific patients. This is particularly the case in the CM Health population.

In principle, investment in services which disproportionately affect deprived populations should lead to reductions in health inequalities if access to those services is equitable. However, as with many effective innovations in healthcare, there is a risk that differential access or uptake of the service could lead to worsening inequalities in outcomes. This may be avoided as the service is designed with careful consideration given to the needs of deprived populations.

In this specific case, where the health impact of the intervention is highly time-dependent, there is a risk that those populations living furthest from the point of service delivery will not benefit to the same extents as those living closer. Since Māori and Pacific tend to live further from the point of service delivery at Auckland City hospital they will tend to experience longer travel times. However, this disadvantage will be addressed by the proposal to implement the service in West Auckland in its first phase and the learning and improving of processes to mitigate access barriers will inform the second phase roll out to CM Health. The PASTA Guidelines will ensure rapid transfer to Auckland City Hospital of those patients potentially eligible to receive thrombectomy.

A potential equity gain from this service will be the increased scrutiny given to patients with hyper-acute stroke which will contribute to more standardised care, including the use of thrombolysis. From an equity perspective it will be important to combine the new service with an effective communications programme that ensures widespread community awareness of common symptoms and signs of stroke, and the importance of obtaining rapid assessment and treatment where stroke is suspected.

Benefits
There are a range of benefits associated with the proposed development of Auckland metro and Northern (and Midland) regional models for Hyper-acute stroke and clot retrieval services:

- There is substantial evidence that improved timeliness to assessment, diagnostic, treatment and rehabilitation services for patients presenting with stroke, results in better outcomes leading to reduced disability and dependency on lifelong health and disability services. Further detail on the health outcome benefit for clot retrieval (thrombectomy) is detailed in appendix 3.
- Improved timeliness to treatment services during the Hyper-acute phase of stroke presentation (4-6 hours from onset of symptoms) ensures patients who meet the criteria for stroke service interventions are rapidly assessed and transferred to the right service for immediate treatment.

- The development of a single hyper acute stroke service (after hours) for the Auckland region and a single clot retrieval service for the Northern (and Midland) region provides sufficient critical mass to ensure specialist skills are maintained and consistently available 24/7 to meet the needs of all participating DHB populations.

- The regional hyper acute stroke service is of sufficient scale to be expected to breakeven from year two without the need for additional funder co-payments above national price.

By achieving the regional Hyper-acute targets of a 15% Thrombolysis rate and 5% Clot Retrieval rate, the Northern region can expect the following annual additional patient outcomes (benefits):

<table>
<thead>
<tr>
<th>Northern region Hyper-acute pathway benefits</th>
<th>Reduced disability</th>
<th>Full/near full recovery</th>
<th>Lives gained</th>
<th>Severe disability reduction</th>
</tr>
</thead>
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<td>CMDHB</td>
<td>25</td>
<td>12</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>43</td>
<td>10</td>
<td>24</td>
</tr>
</tbody>
</table>

Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding is approved for the new service models as outlined in the financial modelling but the costs of the service are greater or less than expected.</td>
<td>Detailed analysis of available costing information has been completed and forecasting assumptions have been treated conservatively to ensure neither overstatement nor understatement of expected resource use. Six monthly regional audits of actual costs are scheduled to occur for a minimum period of two years to track and monitor costs associated with the new models. Auckland DHB has committed to an “open book” transparency of actual costs of the new service models to ensure the service is neither over funded nor underfunded, and a formal funding agreement with all funders will support payment of all actual costs only. Auckland DHB services will establish new resources in accordance with the regionally endorsed, and Auckland DHB Executive approved, staffing model.</td>
</tr>
<tr>
<td>There are less patients referred for Clot Retrieval than estimated in 2017/18 (n = 93, increased from 40 in 2016/17) resulting in increased costs per patient for funders.</td>
<td>All DHBs and St John Ambulance services will implement new ways of working from July 2017 to ensure more patients receive timely thrombolysis treatment enabling more patients to be considered for Clot Retrieval. Standardised measures (refer appendix 4) will be introduced at all DHBs in the Northern region to enable regular monitoring of improvements. Increased resources formally implemented at Auckland DHB as a result of the new investment will ensure there is a clinical team available to respond to increased referrals for Clot Retrieval 24/7.</td>
</tr>
<tr>
<td>There are more patients referred to Careful monitoring of volumes and capacity of after-hours service</td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>Mitigation</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>after-hours service than ADHB can manage in the timeframe constraints</td>
<td>during the implementation of the WDHB/ADHB phase one will need to occur with further planning and mitigation planning prior to CMDHB/ADHB phase two roll out. Midland Region may have to developing services regionally if Auckland becomes unable to manage volumes/growth</td>
</tr>
<tr>
<td>Midland DHBs do not refer patients to the Clot Retrieval service at an equitable rate resulting in less than the forecast volume of Midland patients in 2017/18 and this results in increased costs to Northern region funders.</td>
<td>Following Northern region endorsement of the implementation approach, the Northern stroke network will initiate discussions with the Midland stroke network to advance planning within the Midland region to enable access to the 24/7 Clot Retrieval service.</td>
</tr>
<tr>
<td>New service models are unable to be implemented at Auckland DHB due to a lack of agreement to the additional funding needed to provide improved access to stroke services including thrombolysis and clot retrieval.</td>
<td>The Northern region programme of work leading to the development of the new hyper-acute models has been supported to date by the Regional Executive and Regional Governance forums. Northern Regional DHBs have agreed to phased roll out and initial financial modelling assumptions with agreement that measurement and monitoring of assumptions occurs and re-estimations may be required during phase one of the after-hours hyper-acute service implementation.</td>
</tr>
<tr>
<td>CM Health or Waitemata DHB residents receiving Hyper-acute stroke services at Auckland DHB receive a better standard of care than patients receiving services locally</td>
<td>All Northern region DHBs will report a range of new indicators from July 2017 to monitor the quality of services being provided at each DHB. This will include monitoring ambulance time and access to stroke services particularly for patients from CM Health and WDHB domiciles CM Health is in the process of implementing a dedicated hyper-acute stroke service and integrated inpatient and community stroke rehabilitation system using improvement science and patient co-design methodology</td>
</tr>
</tbody>
</table>

**Financial Impact Analysis**

**Additional Staffing Resources**

The new Hyper acute stroke model at Auckland DHB requires the development of a 24/7 Stroke on call team that includes specialist neurologists, registrars and designated stroke nurses on duty 24/7. Additional physiotherapy and speech language therapist staff resources are integrated in the new service model.

The Clot Retrieval service model requires the establishment of a formal 24/7 roster requiring two Interventional Radiologists to be on call at all times and the development of a standalone anesthetic roster including Anesthetists and anesthetic technicians (developed along the same lines as the transplant programme anesthetic roster). The critical timelines for treatment require the on call Clot Retrieval team to be available within 20 minutes of the referral to treatment.

Additional radiographer and nursing resources, available on call, are also essential new elements of the service. Costs of accommodation in close proximity to Auckland Hospital are included in the total costs of the service for those staff who live more than 20 minutes away from the hospital.

In order to provide responsive and sustainable Hyper-acute stroke and clot retrieval services with appropriately trained staff, and an increase in clot retrieval discharges from 40 to 93 in 2017/18, the additional cost to the Northern and Midland region, when compared to the 2016/17 cost, is $4.67m.
Revenue Implications
The table below shows the Weighted Inlier Equivalent Separations (WIES) cost expected in 2017/18 and the level of co-payment share needed for both the Hyper-acute service and the clot retrieval service to cover the expected annual costs of the new service models at Auckland DHB, and identifies the additional cost in 2017/18 when compared to the 2016/17 forecast. The share of increased costs for clot retrieval has been modelled on the assumption that all populations of the Northern and Midland region will have access to this service on an equitable basis and a Population Based Funding (PBF) share has been used to calculate these DHB costs.

The CM Health Funder share of the 2017/18 estimated costs are $396k, $12.4k associated with the implementation of the new Hyper-acute service and $383k associated with an increased volume and additional cost of clot retrieval.

Financial modeling of Hyper-acute service costs associated with increased numbers of patients after hours from North Shore and Counties Manukau Health from July 2018 shows the full costs of the service will be met by the WIES funding alone associated with an expected additional 740 presentations to ADHB. Assuming there is no change to the tertiary adjustor paid to ADHB and no change to the average WIES associated with the hyper acute stroke presentations, CM Health will not need to fund a co-payment for the Hyper-acute stroke service in 2018/19.

The CM Health Funder has made financial provision for this cost in 2017/18 subject to formal approval by the Board and this proposal will be prioritised from additional demographic growth funding subject to the Funding Envelope.

2017/18 Northern Region Hyperacute Stroke & Thrombectomy Model

Based on the assumptions and information in the financial modeling reviewed and provided to CM Health from ADHB, the 18/19 impact for CM Health would be as follows:

- Estimated Volumes Clot retrieval – no change between 17/18 and 18/19 as volumes assumed the same
- Estimated Volumes Hyper-acute stroke
  - New IDFs into ACH in 2018/19 = 581
  - CMDHB share of WDHB/CMDHB total = 45%
  - CMDHB anticipated numbers is 261
  - @ average WIES of 0.81 = 211 WIES

Please note: these numbers are based on the assumptions in the financial modelling. There will be quarterly financial reviews (in arrears) to assist understanding of any volume changes. Clot retrieval
numbers for 16/17 are already very close to the 17/18 assumed volumes, so will be closely monitoring the trends. It is challenging to model beyond 17/18 because of the uncertainty around volumes.

**Conclusion**

There has been a substantial regional programme of work resulting in the development of new models of care for Hyper-acute Stroke services and Clot Retrieval services. The clinical benefits for the CM Health population of the implementation of these new services are widely understood and accepted, and it is recommended that CM Health allocates $396k funding to these services in 2017/18.

The expected cost of these services for the CM Health population is expected to increase in 2018/19 in line with the implementation of the regional model, however further work will be undertaken during and following six months of implementation to reassess these ongoing costs for CM Health.
Appendix One: Regional Stroke Programme Timeline

May-Dec 2015
- Northern Region Stroke Clinical Pathway Development Programme commences, following RGG approval
- Project team formed; Clinical Lead, Programme Manager & Consumer
- Regional Stroke Working Group formed; DHB clinicians/managers, St John, NZ Stroke Foundation, & consumer representative
- Consumer survey sent to 500 recipients

2016
- Consumer forums attended by approximately 200 people with experience of stroke
- Models of Care identified & reviewed
- Volume model finalised

Oct 2016
- Strategic options confirmed & endorsed

Apr 2017
- Resource model finalised
- Cost/Funding model finalised

Jul-Dec 2017
- Implementation of Phase 1 commences 1 July 2017
- Afterhours hyperacute stroke service for Waitakere domiciled patients
- Clot retrieval service 24/7 for Northern & Midland Regions
- Inpatient/Rehabilitation/Community Projects commence

2018
- Telestroke commences January at NDHB
- Financial review January 2018
- Financial review July 2018
- Implementation of Phase 2 for all metro-Auckland domiciled patients commences 1 July 2018
- Inpatient/Rehabilitation/Community Strategic Analysis

2019
- Implementation Inpatient/Rehabilitation/Community Strategic Options
Appendix Two: Pathway & PASTA Tool

Northern/Midlands
Anytime Thrombectomy

Auckland Region
After-hours Hyperacute Stroke

Principles
- Specificity > Sensitivity
- Transfer stroke/hyperacute candidates
- Avoid transferring those unlikely to benefit

Key
- Action
- Decision
- TS Location
- Person
- Pathway
Appendix Three: Benefits

Benefits:
1. For thrombolysis, the benefits of treating 100 people:
   a) Reduced disability (unlikely to require residential care) – 30 additional people
   b) *Minimal or no disability – 13 additional people
   c) Mortality – no change
   d) Severely disabled – 8 fewer people
2. For clot retrieval, the benefit of treating 100 people:
   a) Reduced disability – 40 additional people
   b) *Minimal or no disability – 20 additional people
   c) Alive – 10 additional people
   d) Severely disabled – 12 fewer people

*=subset of a.

Benefiting patient numbers:
By achieving the regional Hyper-acute targets we can predict the following annual additional patient outcomes:

<table>
<thead>
<tr>
<th>Hyperacute pathway benefits</th>
<th>Reduced disability</th>
<th>Full/near full recovery</th>
<th>Lives gained</th>
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Severe disability is defined as a Rankin score of 4 or 5. This means dependent on others for all activities of daily living (i.e., all self-cares) or worse. Such individuals are usually in hospital level long term care at a cost to the DHB of $50,000 per annum for each person.

Cost benefits:

Hospital costs:
- Thrombolysis - Economic evaluations of generally show a marginal in-hospital treatment cost benefit based on reduced average in-patient rehabilitation use.
- Clot retrieval - economic evaluation of clot retrieval in the Australasian trial indicated marked reduction of average hospital stay (of the first 90 days post stroke, treated patients spent an average of 73 days at home vs 15 days for the standard care group). Overall average hospital costs were $4000 less per person for the clot retrieval group. While the additional resource use is incurred at the treating site (and recovered via inter-district flows), the benefit of reduced hospital use accrues to the domicile DHB.

Disability costs:
- The reduction of 24 cases of severe disability would equate to $1.2 million of cost saving in residential care subsidies per annum across the Northern Region. With life-expectancy of > one year for most patients, this will accumulate year on year.
- The cost benefit of reduction in moderate disability has not been quantified.
Socioeconomic costs:

- The outcome of full or near full recovery equates to an individual being able to do all activities that they were doing prior to stroke onset including work. For younger people, this means not being dependent on benefits and maintaining employment. The advantage of this has not been quantified.
## Appendix Four: Evaluation Questions

<table>
<thead>
<tr>
<th>KEY QUESTIONS</th>
<th>PROPOSED MEASURES / COMMENT</th>
</tr>
</thead>
</table>
| 1. Effective assessment by Emergency Management Service (EMS)? | • % of mimics screened by EMS  
• % of mimics taken to DHB by EMS  
• Number of walk-ins (to Waitakere Hospital) transferred to ACH |
| 2. Timely bypass / transfer (to ACH) by EMS? | • Average Call time (EMS to ACH) to time of Arrival (at ACH)  
• Average Call (for ambulance) time to Arrival time |
| 3. Is Auckland City Hospital efficient & safe? | • Average Door to CT time  
• Average Door to Needle time  
• Average Door to Groin time  
• % Protocol violations |
| 4. Is there equitable and efficient stroke care across all DHBs? | • Average Door to CT time  
• Average Door to Needle time  
• Average Door to Groin time  
• % Protocol violations |
| 5. Is there sufficient stroke beds capacity? | • % returned within 24 hours to DHB of domicile  
• Average transfer time from ACH to DHB of domicile  
• Number of out of domicile patients that are receive assessment and treatment from SLT in ADHB prior to transferring back to home DHB  
• Number of out of domicile patients that are receive assessment and treatment from PT in ADHB prior to transferring back to home DHB |
| 6. Are people being transferred to ACH without stroke? | • % of stroke mimics at ACH from Waitakere |
| 7. Are self-presenters missing out? (self-presenters cf. ambulance) | • Number of self-presenters at Waitakere  
• Average Door to CT time  
• Average Door to Needle time |
| 8. Are resources appropriate? | • Access to Auckland CT (as measured by Door to CT time)  
• Financial review 6 months post implementation  
• Nursing resources required to escort transport between ADHB and to/from local DHB for clot retrieval and after hours hyper-acute services |
| 9. Are consumers satisfied? What are consumers’ experiences of care? | • Patient/whanau survey (to be developed with consumer) |
| 10. What is the staff feedback? | Qualitative survey of the following staff groups:  
• St John  
• ACH staff:  
  – Neurology  
  – Imaging/ radiology  
  – Acute Stroke Unit  
  – Emergency Department  
• Waitakere staff:  
  – Emergency Department  
  – Acute Stroke Unit |
Counties Manukau District Health Board
2016/17 Financial Result

Recommendation

It is recommended that the Board:


Prepared and submitted by: Margaret White, Chief Financial Officer

Purpose
The purpose of this paper is to provide an overview of the final 2016/17 financial result.

2016/17 Year End Update
Despite our best efforts, CM Health posted a year end deficit of ($12.886m) against a planned surplus of $4.5m surplus for the 16/17 financial year. The variance represents a number of one off adjustments for which budget provision was not adequately adjusted for during the year. The significant variations that were material to our position are outlined in the table below:

<table>
<thead>
<tr>
<th>Significant variances:</th>
<th>Implication for 2017/18:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDF wash up not budgeted - adjustments booked April - June 2017</td>
<td>17/18 budget has been adjusted to reflect current trends. IDF flows are reviewed monthly ($11.800m)</td>
</tr>
<tr>
<td>Impairment of previously held SWIFT investment – detailed assessment as part of year end process concluded that previously capitalised values should be written off impacting on operating expenditure</td>
<td>Fully written off as at 30 June 2017 ($5.562m)</td>
</tr>
</tbody>
</table>

The Finance team have been working proactively with the Ministry of Health to ensure officials understand the key drivers of the deterioration in the organisation’s financial position.

Our ELT has committed to a recovery plan that will return our organisation to a breakeven position by 19/20 and refocus all our resources to those functions that deliver evidence based care to our communities. This will be assisted by the Ministry of Health who will be working with us. As part of developing our recovery plan, we will be revisiting our investments in the context of long term regional planning and exploring other opportunities to do more regionally where there are benefits. Updates will be brought back to Audit and Finance Committee meetings.

We want to acknowledge our very hard working frontline staff and support services including community based providers who do their best every day to meet the healthcare needs of CMDHB populations.

We commit to ensuring that the changes we make in our decision making approach will be transparent and focus on those priorities that matter to our workforce, communities and the Government.
**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>
</tr>
</thead>
</table>
| 1. Confidential Minutes of 2 August 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. | 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 Maori Health Advisory Committee, Community Public Health Advisory Committee, Hospital Advisory Committee, 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. |
| 3. Appointment of Asian Representative to CPHAC | 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. | 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. [Official Information Act 1982 S9(2)(a)] |
| 4. Mental Health and Addiction Community-based Support Services Procurement Plan | 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)] |
| 5. ICT Operations Assurance Plan | 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, | Protecting Health or Safety of Public
The disclosure of information would not be in the public interest because of the greater need to enable the Board to avoid prejudice to measures protecting |
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<th>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)]</th>
<th>the health or safety or members of the public. [Official Information Act 1982 S9(2)(c)]</th>
</tr>
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<tbody>
<tr>
<td><strong>6. 2016/17 Annual Plan Update</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td><strong>Communication with the Sovereign</strong> 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)]</td>
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<tr>
<td><strong>7. Risk Management Update</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td><strong>Communication with the Sovereign</strong> 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)]</td>
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