MEETING OF THE BOARD
28 February 2018

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

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

CMDHB MANAGEMENT
Gloria Johnson – 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
Dinah Nicholas – acting Secretariat

APOLOGIES

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

PART 1 – Items to be considered in public meeting

AGENDA

<table>
<thead>
<tr>
<th>9.45am</th>
<th>1. AGENDA ORDER AND TIMING</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>BOARD MINUTES</td>
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<tr>
<td>9.45am</td>
<td>2.1 Confirmation of Minutes of the Meeting of the Board – 6 December 2017</td>
<td>7-19</td>
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<td>9.50am</td>
<td>2.2 Actions arising from previous minutes</td>
<td>20-22</td>
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<tr>
<td>10.00am</td>
<td>2.3 Minutes Community and Public Health Advisory Committee – 29 November 2017 (Colleen Brown)</td>
<td>23-27</td>
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<td>10.05am</td>
<td>2.4 Minutes Disability Support Advisory Committee (draft) – 22 November 2017 (Colleen Brown)</td>
<td>28-32</td>
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<tr>
<td>10.10am</td>
<td>2.5 Minutes Hospital Advisory Committee – 15 November 2017 (Lyn Murphy)</td>
<td>33-37</td>
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Morning Tea Break (10.15 – 10.25am)

3. EXECUTIVE REPORTS

| 10.25am | 3.1 Chief Executive Officer’s Report (including Patient Story) (Gloria Johnson) | 38-43 |
| 10.40am | 3.2 Health and Safety Performance Report (Elizabeth Jeffs) | 44-65 |
| 10.50am | 3.3 Corporate Affairs and Communications Report (Donna Baker) | 66-74 |

4. PERFORMANCE REPORTS

| 11.00am | 4.1 Finance and Corporate Business Report (Margaret White) | 75-84 |

11.10am 5. RESOLUTION TO EXCLUDE THE PUBLIC 85-89
## Board Member Attendance Schedule 2018

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>28 Feb</th>
<th>Mar</th>
<th>4 Apr</th>
<th>16 May</th>
<th>27 Jun</th>
<th>July</th>
<th>8 Aug</th>
<th>19 Sep</th>
<th>31 Oct</th>
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<th>12 Dec</th>
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<td>Dianne Glenn</td>
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<td>Catherine Abel-Pattinson</td>
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<td>Mark Darrow</td>
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<td>Dr Ashraf Choudhary</td>
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* Attended part meeting only
# BOARD MEMBERS’ 
## DISCLOSURE OF INTERESTS
### 28 February 2018

*New items in red italics*

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Rabin Rabindran, Chair        | • Chairman, Bank of India (NZ) Ltd  
• Director, Solid Energy NZ Ltd  
• Director, Swift Energy NZ Ltd  
• Director, Swift Energy NZ Holdings Ltd  
• Director, Kowhai Operating Ltd  
• Director, NZ Liaoning International Investment & Development Co Ltd  
• Director, New Zealand Health Partnerships  
• Singapore Chapter Chairman – ASEAN New Zealand Business Council                                                                 |
| Dr Ashraf Choudhary           | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust                                                                 |
| 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  
• Husband, Director, 540 Great South Ltd  
• Husband, Director, Barclay Suites  
• Husband, Chairman, Lifetime Design  
• Husband, Director, various single purpose property owning companies                                                                 |
| Colleen Brown                 | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group  
• District Representative, Neighbourhood Support NZ Board                                                                 |
<table>
<thead>
<tr>
<th>Name</th>
<th>Roles and Accomplishments</th>
</tr>
</thead>
</table>
| Dianne Glenn         | • Member, NZ Institute of Directors  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Member, National Council of Women of New Zealand  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group |
| George Ngatai        | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Huakina Development Trust (Partnership Clinic)  
• Community Organisation Grants Scheme (Auckland)  
• Lotteries Community (Auckland)  
• Board Member, Counties Manukau Rugby League Zone |
| Katrina Bungard      | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed disability sports  
• Member of NZ National Party |
| 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 |
| 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 |
| Mark Darrow | • Chairman, Primary Industry Training Organisation Incorporated (ITO)
• Chair, Remuneration Committee, Primary ITO
• Ex officio, Finance and Audit Committee, Primary ITO
• Independent Director, Motor Trade Association
• Chair, Investment Committee, Motor Trade Association
• Director, New Zealand Transport Agency (NZTA)
• Chair, Finance and Audit Committee, NZTA
• Independent Director, Balle Bros Group
• Chair, Finance and Audit Committee, Balle Bros Group
• Member, Investment Committee, Balle Bros Group
• Chairman, Advisory Board, Courier Solutions Ltd
• Chairman, The Lines Company Ltd
• Chair, Remuneration Committee, The Lines Company Ltd
• Chairman, Armstrong Motor Group (Advisory Board)
• Director, MCD Capital Ltd
• Chairman, Signum Holdings Ltd
• Chairman, Toloda Properties Ltd
• Trustee, Tudor Park Trust
• Director, Tudor Park Farm Ltd
• Justice of the Peace |
**BOARD MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS**

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 28 February 2018

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rabin Rabindran</td>
<td>BNZ Bank Transitioning</td>
<td>Rabin Rabindran declared a specific interest as Director of New Zealand Health Partnerships.</td>
<td>25 October 2017</td>
<td>That Rabin Rabindran’s specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Apulu Reece Autagavaia</td>
<td>Transform Manukau Puhunui Stage 1</td>
<td>Apulu Reece Autagavaia declared a specific interest, being a Member of the Otara-Papatoetoe Local Board.</td>
<td>25 October 2017</td>
<td>That Apulu Reece Autagavaia’s specific interest be noted.</td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td>Transform Manukau Puhunui Stage 1</td>
<td>Mrs Glenn declared a specific interest, being the President of Friends of Auckland Botanic Gardens and Chair of the Friends Trust.</td>
<td>25 October 2017</td>
<td>That Mrs Glenn’s specific interest be noted but not seen as a conflict of interest.</td>
</tr>
<tr>
<td>Reece Autagavaia</td>
<td>RMO Industrial Action</td>
<td>Mr Autagavaia declared a specific interest in relation to this item, in that his brother is a Junior Doctor at Middlemore Hospital.</td>
<td>15 February 2017</td>
<td>That Mr Autagavaia’s specific interest be noted.</td>
</tr>
<tr>
<td>George Ngatai</td>
<td>Community Services Pharmacy Funding Policy</td>
<td>Mr Ngatai declared a specific interest in terms of their GP Service being likely to use a local Pharmacy.</td>
<td>13 August 2014</td>
<td>That Mr Ngatai’s specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
</tbody>
</table>
Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 6 December 2017

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

PART I – Items considered in public meeting

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

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

PUBLIC AND MEDIA REPRESENTATIVES
Pauline Proud, Auckland Women’s Health Council
Dr Colin Thompson, CM Health

APOLOGIES
Reece Autagavaia
George Ngatai (for early departure)

WELCOME
The Chair welcomed all those present.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
Rabin Rabindran - delete Director, Auckland Transport.

Dianne Glenn – delete Specific Interest in relation to the District Licensing Trust.
AGENDA ORDER AND TIMING
Items were taken in the same order as listed on the Agenda.

BOARD MINUTES

2.1 Minutes of the Meeting of the Board – 25 October 2017

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

That the Minutes of the Board Meeting held on the 25 October 2017 be approved.

Carried

2.2 Actions Arising from Previous Meetings

The Deep Dive on Childhood Immunisations was noted.

2.3 Draft Minutes of Community Public Health & Advisory Committee (18 October 2017)

The minutes were taken as read.

Before School Checks – Colleen Brown confirmed that a comprehensive list of regional concerns was sent to the Ministry of Health which have been acknowledged. This will continue to be an area of focus for CPHAC next year.

Priorities for 2018 - Colleen Brown and Gloria Johnson to discuss specific priorities and focus areas for CPHAC next year.

2.4 Draft Minutes of Hospital Advisory Committee (4 October 2017)

The minutes were taken as read.

Lyn Murphy advised that there had only been two responses to the advertisements to fill the community positions on the Committee earlier in the year, both of which were unsuitable. She queried whether the current Terms of Reference of the Committee could be amended so that the reference to community representatives could be replaced with Board Members. The Chair recommended submitting a Resolution for Board consideration in the New Year.

2.5 Draft Minutes Disability Support Advisory Committee (16 August 2017)

The minutes were taken as read.

Deaths of Intellectually Disabled People – Colleen Brown advised that across the whole of New Zealand, during 2014, there were 45 primary cases of death related to a disability – 25 attributable to Cerebral Palsy; 15 attributable to Down syndrome; 4 attributable to unspecified mental retardation and 1 attributable to chromosomal abnormalities. This is in her view totally unacceptable and is something that the Committee will be following up and advocating for change in the New Year.
2.6 Establishment of Executive Committee of the Board

The paper was taken as read.

The final scheduled meeting of the Board for the year is today, 6 December 2017. The next meeting is on 21 February 2018. There might be some items of business requiring approval at Board level that need to be processed during this period. Under the NZPH&D Act (Schedule 3 Clause 38) there is provision for the Board to establish one or more committees for a particular purpose or purposes.

Resolution (Moved: Mark Darrow/Seconded: George Ngatai)

That the Board:

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

Agreed membership of the Executive Committee will comprise the Board Chair, the Deputy Board Chair (Rabin Rabindran), Mark Darrow, Dianne Glenn, George Ngatai and Colleen Brown with a quorum of four members (the Chair or Deputy Chair to be one of the four members).

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

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

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

Carried

3 EXECUTIVE REPORTS

3.1 Chief Executive’s Report

Jenny Parr played a video entitled Colin’s Story for the Board.

The report was taken as read and the acting Chief Executive summarised the following key areas:

Finance Forum – this forum was extremely positive and helped people understand the DHB’s financial situation better.

Community Nurse Prescribing – 33 nurses have just completed the inaugural Registered Nurse Prescribing in Community Health: Trial and Evaluation. These nurses are now authorised to
prescribe from a limited list of medications using Auckland Regional Health Pathways as clinical
decision support for common skin, ear and sore throat conditions as well as over the counter
medicines.

LTIP – a presentation was given to the national Capital Investment Committee on 13 November
outlining key aspects of the draft Northern Region Long Term Investment Plan. This was well
received and a final version will come back to the Board for final sign-off early in the New Year. It
is expected the LTIP will migrate into a regional health plan which Dale Bramley and Gloria
Johnson will continue to be the sponsors of.

Alcohol Position Statement - the Executive Leadership Team endorsed a CM Health alcohol-
related harm position statement in November. This has been provided to Auckland/Waitemata
DHBs and Northland DHB as it was thought they might like to have similar statements. The Board
asked for regular updates to show the reduction of harm as a result of this Position Statement.

Health Targets – it is becoming more of a challenge to meet some of these targets for a variety of
reasons but particularly when the DHB is facing a combination of resource constraints and rising
demand. There is no financial penalty for not meeting these targets however, there is for non-
compliance of the ESPI targets – these targets are on track currently.

Resolution  (Moved: Lester Levy/Seconded: Dianne Glenn)

That the Board received the Chief Executive’s Report.

Carried

3.2 Health and Safety Report (Elizabeth Jeffs)

The report was taken as read.

The report is undergoing review by Deloitte and going forward will also encompass a well-being
perspective and include measures and critical risks and information on the occupational health
service at CM Health.

There were no Notifiable events for October.

An audit of the DHBs injury management practices was completed in November as part of audit
requirements. The report indicates that the DHB has strong systems and does a good job along
with Well NZ in managing injury and wellness of staff.

An acting Health & Safety Manager has been appointed from within the HR team, Marie
Townsley, who is an experienced Health & Safety Manager from Todd Corporation. She will lead
the team for the next 3-6 months whilst a permanent appointment is sought.
Board comments:

- Annual Leave - it was noted that 70% of people had not taken a 2-week continuous holiday in the last 12 months. Elizabeth confirmed that staff may be taking 7-10 days off but not a continuous 2-week break. Elizabeth will be investigating this further and will report back to the Board in the New Year.

- Aggression & Violence – it was noted that there is an upward trend in aggression and violence incidents year on year. Elizabeth confirmed that most of the incidents reported are not the high level incidents that are truly aggression and violence, but the things that are behaviours of concern that our staff see on a day to day basis are under-reported. Dr Eagleton is undertaking a piece of work encouraging staff to file Risk Pro reports in order to get a better picture of exactly what staff are experiencing.

- DHB Vehicles – in response to a question about whether there is any monitoring and reporting in relation to speeding tickets and parking fines that staff receive, Elizabeth confirmed that the organisation has a two-strike rule and drivers are expected to pay their own speeding fines. The Chair advised that there should be zero tolerance of speeding fines and asked that the relevant DHB policies are made available to the next Board meeting.

- Executive Health & Safety Wellbeing Meeting – Mark Darrow expressed disappointment in the commitment from the Executive to something that is so important, only 2 out of 6 attended the last meeting. He also felt that the Committee needs wider representation. Elizabeth confirmed that they are looking to invite a PSA representative to join the Committee and meetings for 2018 will be set in the Executive’s calendar to ensure maximum participation. The Chair emphasised that safety trumps everything else, we need to move toward achievement of zero harm and if this is a priority, everything else needs to be de-prioritised.

- Wayfinding – the Middlemore campus is a very muddled site and appears to have been developed without any sense of safety in place. There is a bigger picture around health and safety and workplace safety that needs to be addressed. For example, the lighting is not adequate when accessing the hospital at night, it is difficult at night to work out exactly where the main entrance to the hospital is, the signage overall is pretty average. The Board asked that a review of the site be undertaken by a traffic/transport management expert.

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

That the Board:

Received the Health and Safety Report for the period ending 31 October 2017.

Carried

3.3 Corporate Affairs and Communications Report (Janet Haley)

The report was taken as read. Janet Haley summarised the report noting:

Mumps – due to an increase in Mumps cases in South Auckland (399), a targeted communications campaign was undertaken in October and November to raise awareness of the signs and symptoms of Mumps.
Pay It Forward Week – this is being driven by a group of young doctors who want to encourage people to be kind to one another. A range of activities are planned starting in early December. There is a board at the main entrance of the hospital which has been covered in comments from patients, visitors and staff. Janet to take a snapshot of this to send to the Board.

New GM Communications – Donna Baker has been appointed as the GM Communications & Engagement and commences on 22 January 2018.

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

That the Board:

Received the Corporate Affairs and Communication Report for the period ending 31 October 2017.

Carried

DECISION ITEMS

4.1 IRD Executive Officer Holder Nomination (Margaret White)

The paper was taken as read.

Currently Counties Manukau DHB IRD tax filing is completed manually and Management would like to move to electronic filing which is more efficient.

IRD offers a role called the Executive Office Holder (EOH) who acts as the super user for an organisation. This could be for filing tax returns electronically (e.g. GST, PAYE and especially the payroll files for earnings) or for secure email to IRD if there is something needing communication with them.

Resolution (Moved: Rabin Rabindran/Seconded: Lyn Murphy)

That the Board:

Received the paper on the IRD Executive Officer Holder Nomination.

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

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

Agreed the Chair of the Audit Risk and Finance Committee signs the IRD Executive Office Holder Nomination Form.

Carried
4.2 Environmental Regeneration at CM Health (Pauline Hanna, Dr David Galler, Andrew Kerr and Debbie Wilson)

The paper was taken as read.

CM Health has a proven track record in environmental sustainability, being a certified member of the Certified Emissions Measurement and Reduction Scheme (CEMARS) programme since 2012.

In October 2017, the annual measurement of carbon emissions at CM Health was undertaken and the DHB reach 21.2% exceeding the target of 20%.

It is now timely to refresh the strategy, firstly by reframing the programme as one of Environmental Regeneration as the next evolution from environmental sustainability with a proposed vision of being carbon-neutral by 2050.

The Chair noted that we are collectively going to have to be bolder about making decisions more quickly, for example, moving our fleet of vehicles to electric. The Board would be very supportive of initiatives such as this.

Resolution (Moved: Lester Levy/Seconded: Colleen Brown)

That the Board:

Received the paper entitled Environmental Regeneration at Counties Manukau Health Strategy 2017-2050.

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

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

Carried

4.3 Quality Accounts (Jo Rankine)

DHBs are asked to publish an annual Quality Account and make this available to the HQSC. The Accounts are a supplementary document to the CM Health Annual Report, they attract a wide and diverse audience including media, politicians, other DHBs and our own staff and patients/whaanau. The Accounts makes visible to the CM Health’s community the organisation’s commitment to quality, accountability and transparency.

The Board asked that Jo Rankine work with the Communications Team to come up with a communications plan to feed 12 key elements from the Accounts out into the community over the next year.
The Audit Risk & Finance Committee could provide a quality assurance review of the Accounts next year.

Resolution  (Moved: Ashraf Choudhary/Seconded: George Ngatai)

That the Board:

Received the 2016/17 Quality Accounts.

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

Carried

5 PERFORMANCE REPORTS

5.1 Finance and Corporate Business Report (Margaret White)

The report was taken as read.

The Chair noted that whilst the organisation is predicting a deficit, it is performing quite well against budget and this is very commendable considering how busy the hospital is.

The Savings Programme is slightly behind target but is being closely reviewed by the Executive Leadership Team regularly.

Elective performance low YTD however, within the next two months this will start to turn relatively quickly and the elective target will be met by year end.

Mark Darrow noted that it is costing $300k per week to run Ko Awatea. Margaret White confirmed that Ko Awatea is an umbrella division that manages a variety of core services that were taken out of the business and consolidated under Ko Awatea (ie) decision support, research, education, workforce; it is not just the running costs of the facility.

Resolution  (Moved: Lester Levy/Seconded: Colleen Brown)

That the Board:

Noted that this paper was endorsed by the Audit Risk and Finance Committee at their meeting of 15 November 2017 to proceed to the Board meeting of 6 December 2017.

Received the Finance and Corporate Business Report for September.

Carried
5.2 System Level Measures Performance Scorecard (Gloria Johnson)

The paper was taken as read.

The scorecard is hard to read and hard to make sense of. It shows all DHBs not performing well and it remains to be seen how much progress is made.

The scorecard needs a balancing set of metrics alongside, it doesn't give a sense of where we are tracking. Needs to be meaningful - all the DHBs have different targets.

The Board asked that Benedict Hefford provide some regional feedback to the Ministry of Health on the System Level Measures Scorecard.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: Mr Rabin Rabindran)

That the Board:

Received the System Level Measures Quarterly Update Report.

Carried

6 RESOLUTION TO EXCLUDE THE PUBLIC

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

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>
<tbody>
<tr>
<td>1. Confidential Minutes of 25 October/Actions</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(ii)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<td>2. Draft Minutes of the, Community and Public Health Advisory Committee and Audit</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)(ii)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<td>Risk &amp; Finance Committee</td>
<td>information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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| 3. Turnaround 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. [NZPH&D Act 2000 Schedule 3, S32(a)] | 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)] |
| 4. Facilities Master Planning Update | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Communication with the Sovereign  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)(i)] |
| 5. Scott Building Recladding Works Contract | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | 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)]  
Negotiations  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S9(2)(j)] |
| 6. MRI Service in Harley Gray Building | Construction Contract | 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. |
|                                          |                           | **Negotiations**  
Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. |  |

| 7. Specialised Rehabilitation Centre 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**  
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. |
|                                          |                           | **Negotiations**  
Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. |  |

| 8. Community Referred Laboratory Services | 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**  
Information contained in this report is related to commercial activities and the DHB would be prejudiced or disadvantaged if that information was made public. |
|                                          |                           | **Negotiations**  
Information relating to commercial and/or industrial negotiations in progress is incorporated in this report |  |
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| 9. Ko Awatea Review | 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. |
|   |   |   |
| 10. NZHIH Update & Future Direction | 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  
Information contained in this report is related to commercial activities and the DHB would be prejudiced or disadvantaged if that information was made public. |
|   |   |   |
| 11. Integrating Governance, Leadership and Planning Arrangements for Māori Health | 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. | Protect Confidentiality of Advice Tendered by Officials/Free and Frank Expression of Opinion/Negotiations  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials; maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation of officers and employees of any department or organisation in the course of their duty; information contained in this report is related to commercial negotiations and the DHB would be prejudiced or disadvantaged if that information was made public. |

[Official Information Act 1982 S9(2)(j)]  
[Official Information Act 1982 S9(2)(a)]  
[Official Information Act 1982 S9(2)(f)(iv); S9(2)(g)(i); S9(2)(j)]
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<tr>
<td>12. Finance &amp; Corporate Business Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities/ Negotiations/Commercial Position Information contained in this report is related to commercial activities and negotiations and the DHB would be prejudiced or disadvantaged if that information was made public. [Official Information Act 1982 S9(2)(j); S9(2)(j) and S9(2)(b)(ii)]</td>
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<td>13. Risk Management</td>
<td>That the public conduct of the whole or the relevant part of the proceeding 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>Confidentiality of Advice Tendered by Officials The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. [Official Information Act 1982 S9(2)(f)(iv)]</td>
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<td>14. Social Investment Board Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Communication with the Sovereign The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)(ii)]</td>
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SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 6 DECEMBER 2017.
<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
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<tr>
<td>6 December</td>
<td>Health and Safety Report</td>
<td>Annual Leave - it was noted that 70% of people had not taken a 2-week continuous holiday in the last 12-months. Elizabeth to investigate this further and report back in the New Year.</td>
<td>28/2/18</td>
<td>Elizabeth Jeffs</td>
<td>Verbal update to be at 28 February Board meeting.</td>
<td>✓</td>
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<td>DHB Vehicles – the Chair advised that there should be zero tolerance of speeding fines and asked that the relevant DHB policies are made available at the next meeting.</td>
<td>28/2/18</td>
<td>Elizabeth Jeffs</td>
<td>Verbal update to be given at 28 February Board meeting.</td>
<td>✓</td>
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<td>Way Finding – the Board asked that a review of the Middlemore campus is undertaken by a traffic/transport management expert.</td>
<td>Date TBC</td>
<td>Elizabeth Jeffs</td>
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<td>6 December</td>
<td>CE Report</td>
<td>The Board asked for regular updates to show the reduction of harm as a result of the Alcohol Position Statement.</td>
<td>Date TBC</td>
<td>Doone Winnard</td>
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<td>6 December</td>
<td>Establishment of Executive Committee of the Board</td>
<td>All decisions made by the Executive Committee will be reported back to the Board at its meeting on 21 February.</td>
<td>28/2/18</td>
<td>Board Chair</td>
<td>The Executive Committee was not called upon between 6/12/17 – 28/2/18 to take care of any business that required Board-level approval.</td>
<td>✓</td>
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<td>25 October</td>
<td>Demonstration – E-Vitals</td>
<td>The Chair noted that the Board would schedule a ward visit in the New Year to enable them to see how e-Vitals is working at the bedside.</td>
<td>28/2/18</td>
<td>Board Secretary</td>
<td>Work in progress.</td>
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<td>25 October</td>
<td>Decision Item – CM Health Hospices</td>
<td>The Chair requested a reconciliation of all of the increases and all of the uptake of demographic uplift so that every time the Board considers something, it can understand fully what is really being given away.</td>
<td>28/2/18</td>
<td>Margaret White</td>
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<tr>
<td>Date</td>
<td>Report Type</td>
<td>Description</td>
<td>Action Notes</td>
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<td>25 October</td>
<td>CE Report</td>
<td>The Board requested a deep dive on ante-natal care to cover the DHBs approach for different population groups, progress made/not made and what evidence there is, or isn’t, to links to better outcomes.</td>
<td>21/2/18 Deferred to 4/4/18 Carmel Ellis</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. Executive Health &amp; Safety Committee Minutes to be submitted to the Board six weekly for the Board’s information.</td>
<td>28/2/18 Deferred to 4/4/18 Kerry Bakkerus Refer Item 2 on today’s Public Excluded agenda.</td>
<td>✔</td>
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<td>2 August</td>
<td>Financial Performance</td>
<td>The Chair advised that the metro-Auckland DHBs need to consider an alternative mechanism for IDF’s to better manage risk for all parties with a process that is less transactional. He requested that a paper on this matter be submitted to the metro-Auckland Boards in February 2018 for their consideration.</td>
<td>Date TBC Margaret White 28/2/18 - ADHB are conducting an independent review in IDF costs. This work will inform next steps, together with evidence from MoH regarding national pricing mechanisms via National Technical Advisory Group. Ms White will provide progress updates as they become available.</td>
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<td>Date</td>
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<td>2 August</td>
<td><strong>2017/18 Maaori, Pacific and Asian Health Plans</strong></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. <em>It was agreed to invite Professor Spoonley to present his insights on Auckland’s growing ethnical diversity to the Board.</em></td>
<td>28/2/18</td>
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<td>Margie Apa</td>
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<td>21.2.18 – An invitation was issued to Professor Spoonley however, he was unable to attend a Board meeting until September 2018. The previous Board Chair was informed and decided that was too far away to proceed.</td>
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Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 29 November 2017 at 10.15am – 12.00pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART II – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dianne Glenn
Katrina Bungard
Rabin Rabindran
Ashraf Choudhary
John Wong

ALSO PRESENT

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

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media present at this meeting.

APOLOGIES

Apologies were received and accepted from George Ngatai and Apulu Reece Autagavaia and from Katrina Bungard for leaving early (10.30am).

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS

Mr Rabindran is no longer a member of the Auckland Transport Board.

There were no Specific Interests to note with regard 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

2.1 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 18 October 2017.

Resolution (Moved: Dianne Glenn/Seconded: Rabin Rabindran)

That the minutes of the Community and Public Health Advisory Committee meeting held on 18 October 2017 be approved.

Carried

2.2 Action Item Register

Noted.

It was suggested that Dr Peter Gow could be contacted in relation to the suggested link between Gout and Family Violence. The CPHAC Secretary is to contact Dr Gow.

3. PRESENTATION

3.1 Every $ Counts (Sarah Sharp)

Applying a health equity lens to procurement in Planning & Funding.

This project aims to examine the CM Health Planning & Funding procurement system and processes with an equity lens in order to:

a) Determine the current status of the system from an equity perspective; and
b) Improve the system and processes so that we are transparently and systematically applying an equity approach

Learning’s to date:
- We have demonstrated that Planning & Funding teams are not transparently and systematically applying an equity approach to community health service procurement processes.
- There are opportunities for improving procurement processes and systems and ensuring that every contracted dollar counts towards achieving equity.
- The first priority for action is improving the quality of Service Specifications as there are flow-on effects further on in the procurement process.

Stages 2 and 3 of this work continue. Subsequently this work could be scaled up to other parts of organisation if appropriate.

The Chair requested that the project team return to present an update in the latter part of 2018.

3.2 Eastern Locality Update (Penny Magud)

Penny Magud took the Committee through her updated presentation on developments to date in the Eastern Locality highlighting the following:
4. BRIEFING PAPERS

4.1 System Level Measure Quarterly Report (Benedict Hefford)

Overarching activities for Q1:

- Final submission and approval of the 2017/18 Improvement Plan to the Ministry.
- Q4 reporting for 2016/17 approved with payment processed on 15 September to all Primary Health Organisations without impediment.
- Stocktake of existing, new, planned and boosted activity under SLMs, which has been developed into a Regional Action Plan (Implementation Plan), with a plan to present to the Alliance Leadership Teams after Q2.
- Consideration of the business-as-usual stage for SLMs, with a plan for operation agreed and preparation in progress.
- First steps to business-as-usual, development of a consolidated governance structure: data panel, Primary Health Organisation implementation group and acute hospital bed days working group reporting to steering group, with a view to the permanent home of the other SLM working groups in negotiation.
- Formation of quarterly static and on-going dynamic reporting and a formal workshop to launch these reports, explain the process for data requests and discuss the attributes and limitations of SLM related data.
- SLMs have become core business for the metro-Auckland Data Sharing Data Stewards during embedding of the data release and governance processes, also presented at Regional Privacy Advisory Group (RPAG).
- Some data has been delivered for almost all milestone and contributory measure data sets. Those that have not been received have been formally requested. There is some lag from Ministry data sets and where there is lag, wait times range from 3 to 6 months.
- Several improvement activities requiring data have also had the Metro-Auckland Data Sharing Framework (MADSF) user request completed and have either received data or is in the approval process. Some further improvement activity-related data sets are currently being defined with a view to analysis shortly.

Oral Health - CM Health has the lowest rate of enrolment for preschool children, 1st quarterly report was released yesterday. The knowledge from CM Health could be used to assist the Oral Health Service to increase the uptake of their services.

Household Smoking Cessation - collection of data is poor and quite a few of these measures have begun with a low baseline. This is hoped to improve as we move forward.

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

The Community & Public Health Advisory Committee received the System Level Measures Quarterly Update Report.

Carried
4.2 Q1 2017/18 Population Health Plans (Margie Apa/Filipo Katavake-McGrath)

Activities in Q1 have included defining data and sourcing and stocktaking activities in DHBs to identify gaps and engagement with key stakeholders. This work will contribute to a PHO implementation meeting in early Q2 which will promote development of primary care and hospital-discharge related activities.

Population enrolled in a PHO - for Pacific this shows as 116% which means, potentially, that ineligible patients are enrolled or, people are enrolling from outside our domicile.

99.3% of Pacific Children Identified as Obese in their B4School Check have been Referred for Assessment/Support Services - the Committee is interested to determine if these referrals are, in fact, being acted upon and requested an update be provided at the next meeting (21 February) on follow through and information on the child obesity pathway that gives guidance to the practitioners.

Resolution (Moved: Dianne Glenn/Seconded: Ashraf Choudhary)

The Community & Public Health Advisory Committee received the 2017/18 Q1 Performance and Outcomes Report for Population Health Plans.

Carried

4.3 Community Nurse Prescribing Update (Karyn Sangster)

Thirty three nurses have just completed the first Registered Nurse prescribing in Community Health: Trial and Evaluation. CM Health and Family Planning New Zealand are the only sites for the trial and evaluation for this new scope of prescribing. The initial group includes nurses working in the following clinical areas: Secondary schools, Primary Care, Mana Kidz and Public Health Nursing.

The nurses are now able to prescribe from a limited list of medicines using Auckland Regional Health Pathways for clinical decision support for common skin, ear, and sore throat conditions as well as over the counter medicines. Nurses who have completed the Family Planning Certificate as well in Sexual Health and Contraception are also able to prescribe a limited range of medicines in this area as well. The education programme has a significant focus on pharmacology, health literacy and antimicrobial stewardship.

The benefits of nurse prescribing in community nursing allow greater access to medicines at the point of care. The nurses have stated they have greater assessment skills and critical thinking, and improved team relationships with their prescribing mentors. This will provide a more comprehensive approach to health service delivery from nurses working in the community.

This trial and evaluation was run with a ‘no frills’ approach. GPs provided their time free of charge and participants had access to Ko Awatea.

Rigour within the assessment and the training has been demonstrated. Registered nurses who undertake this course have the support of their employer/umbrella organisation with access to a Supervisor within the workplace. A learning contract was completed and signed by both the registered nurse and Supervisor. The Supervisor met fortnightly with the RN to discuss progress and identify any learning needs. The registered nurse maintained a logbook that was taken to each meeting with their Supervisor. These were viewed as part of the assessment process.
The Nursing Council has contracted Ko Awatea to undertake the evaluation. This is to be completed by March 2018. The evaluation of the programme will determine the quality, safety and cost benefits to the health system and consumers. It will also determine the training and support needed by the RN to prescribe medicines safely and appropriately. The findings of the evaluation will inform the national roll out of the course.

The Chair asked Ms Sangster to pass on the Committee’s congratulations to the participants.

Resolution (Moved: Dianne Glenn/Seconded: Ashraf Choudhary)

The Community & Public Health Advisory Committee received the Registered Nurse Community Prescribing Trial & Evaluation paper

Carried

The meeting concluded at 12.00pm.


Colleen Brown, Committee Chair
Minutes of Counties Manukau District Health Board
Disability Support Advisory Committee

Held on Wednesday, 22 November 2017 at 1.00pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dianne Glenn
Katrina Bungard
Dr Lyn Murphy

ALSO PRESENT

Jenny Parr (Director Patient Care, Chief Nurse & Allied Health Professions Officer)
Dana Ralph-Smith (General Manager, Adult Rehabilitation & Health of Older People)
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, Catherine Abel-Pattinson and Apulu Reece Autagavaia.

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

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

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

2. **COMMITTEE MINUTES**

   An amendment to the minutes was noted on page 2 – should read ‘400 NGO organisations’ not ‘40 different MSD funded organisations’.

2.1 **Confirmation of the Minutes of the Disability Support Advisory Committee meeting held on 16 August 2017.**

   **Resolution** (Moved: Dianne Glenn /Seconded: Katrina Bungard)

   That the minutes of the Disability Support Advisory Committee meeting held on 16 August 2017 be approved.

   **Carried**

2.2 **Action Items Register**

   *Aligned Regional DiSAC ToR* – Colleen Brown confirmed that she had created a merged ToR document which she sent to Jo Agnew who has advised that the Board Chair has given this to the CEs to work through. Colleen will investigate further through the Board Chair.

   *Disability Provider Stocktake* – Lyn Murphy to look into whether AUT could undertake the stocktake of who provides disability services generally within the health sector, starting with what DSS provide (list and scope).

   *Disability Friendly Hospital Maps* – Colleen Brown advised that she has spoken to Phillip Balmer who has agreed to undertake an accessibility audit of the MMH campus facilities. Jenny Parr to follow up with Phillip Balmer and Chester Buller in relation to see where to from here and come up with a brief for the audit.

   *HQSC/Mid Central* – Colleen Brown advised that she had been in contact with HQSC in relation to what they did in conjunction with Mid Central to make their campus accessible for disabled people. HQSC advised that they just in fact reported on it and had nothing to do with funding it.


3. **FOR DISCUSSION**

3.1 **NZ Disability Strategy Implementation Update** (Annelize de Wet)

   At their meeting on 16 August 2017, the DiSAC Committee endorsed the recommendation to work with Waitemata and Auckland District Health Boards to contribute CM Health community engagement and perspectives into a metro-Auckland approach to implementation of the New Zealand Disability Strategy. Following that decision a small working team was formed to undertake the work plan. The Counties approach is to undertake two community engagements in 2017:

   Event 1: Thursday 23 November, Te Roopu Waiora, Manukau
   Event 2: Thursday 7 December, MIT Pasifika Community Centre, Otara
An additional opportunity to attend a collaboration workshop facilitated by Disability Connect has been offered for 16 November.

In addition to the two engagement events, an electronic survey has been circulated through the disability network to allow for those who are unable to attend the events. This has been adapted from the Waitemata and Auckland DHB survey that was carried out earlier this year.

Next Steps - the results of the two engagement events and the electronic survey results will be provided to the DiSAC committee at its next meeting after 20 December 2017 and to WDHB and ADHB for contribution to the metro Auckland strategy in early 2018. In the interim, Counties Manukau Health continues to liaise with Waitemata and Auckland DHB.

Resolution (Moved: Colleen Brown/Seconded: Lyn Murphy)

The Disability Support Advisory Group:

Endorsed the current work plan of community engagement around the NZ Disability Strategy Implementation.

Support Counties Manukau Health to work with Waitemata and Auckland District Health Boards to produce a Regional implementation plan by circulating the survey and invitations to the two events to their networks and attending these where possible.

Agreed that at the first DiSAC meeting in 2018 the Committee receive written feedback on the two meetings and what this is going to mean for CMDHB for endorsement and circulation to the participants.

Carried

3.2 Overview of Long Term Support Chronic Health Conditions Services at CM Health (Dana Ralph-Smith)

Long term support chronic health conditions (LTS-CHC) services are provided through CM Health funded contracts to support people who have chronic conditions such as, but not limited to, renal failure, respiratory disease, diabetes and obesity. To be eligible for LTS-CHC services at CM Health the person should be:

- Aged under 65 on first presenting to NASC.
- Not eligible for Ministry funded Disability Support Services (DSS) or other DHB funded long-term support services (may be joint funded if has disability plus chronic health condition).
- Have one or more chronic health condition(s) that is/are expected to continue for six months or more.
- Have high need for long-term support services, defined as requiring assistance with activities of daily living at least once a day for five days a week to remain safely in their own home or needing residential care. Some or most of it may be provided by family, Whanau or friends.
- The person’s wellbeing and functional status is deteriorating, their needs are increasing and safety issues are becoming apparent.
- Does not have an informal/or natural support system (family/Whanau) or the caregiver is under considerable pressure and their ability to support the person is compromised.

Natural (unfunded) support is provided by family/whanau/friends to enable the person to remain as independent as possible.
Funded supports includes DHB clinical programmes and DHB funded/contracted services. DHB clinical support can come in the form of clinical services such as home health care, reablement, specialist assessment and treatment. Funded contracted service support can come in the form of home based support, day care, respite and carer support services. While these services are needs assessed they are not asset tested/restricted.

3.3 Deaths of Intellectually Disabled People (Dr David Hughes)

At a previous meeting, the Committee discussed a Radio New Zealand article from 6 March 2017 that 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.

The Committee asked that a small investigation be undertaken to see what that turns up. Dr David Hughes undertook such investigation and reported:

- Across the whole of New Zealand, during 2014 (latest stats available), according to MoH statistics, there were 45 primary cases of death related to a disability:
  - 25 attributable to Cerebral Palsy
  - 15 attributable to Down syndrome
  - 4 attributable to unspecified mental retardation
  - 1 attributable to chromosomal abnormalities

- These categories come from and are recognised in the ICD-10 coding system.
- We should be identifying the primary cause of death, followed by the antecedent cause of death and then thirdly, the underlying cause of death.
- Doctors do not get a lot of training around completing death certificates.
- The Coroner’s Office was not particularly interested.

Next Steps
- Dr Hughes, on behalf of the DiSAC Chair and the Committee, to provide some feedback to the MoH:
  1. To update their Guideline and Training Package and encourage them to provide some correct examples regarding disability.
  2. That this issue has been shared regionally with the Auckland/Waitemata DHB DiSAC Chair and Committee.
  3. That this does not give people with disabilities much dignity in death and this is something that the DHBs will be advocating for (ie) that they have accurate diagnosis and explanation in death.
- Dr Hughes to ask MoH when they will be publishing more up to date data, most recent data is from 2014.
- Dr Hughes to provide feedback to the Committee in the New Year.

3.4 Experience of People with a Disability Accessing Mental Health & Addiction Services (Tess Ahern, Peter Watson and Marlene Verhoeven))

It was confirmed that there has been no funding reduction for Whirinaki.

Health indicators for New Zealander’s with an intellectual disability:

- 3560 people in the Counties Manukau district.
- Males have an average life expectancy of 59.7 years, which is more than 18 years below the life expectancy for all New Zealand males (78.4 years).
• Females have an average life expectancy of 59.5 years, which is almost 23 years below the life expectancy for all New Zealand females (82.4 years).
• Adjusted for age, people with an intellectual disability were approximately 1.5 times more likely to receive treatment for a chronic health condition than people without intellectual disability (ie) 31.5% of all people with ID.
• Māori had the highest age-adjusted rates of treatment for chronic health conditions, followed by Pacific, Asian and Other/European people.
• Compared to people without ID, people with ID were:
  o Over 3 times more likely to receive care or treatment for any type of mental disorder
  o Twice as likely to receive care or treatment for a mood disorder
  o 17 times more likely to receive care or treatment for a psychotic mental disorder
  o 10 times more likely to receive care or treatment for dementia
• The average cost per person with an ID of both primary health care and total health care was almost 3 times higher than the average annual cost per person for people without ID.

The Chair thanked the presenters for attending and providing a lot of great information to the Committee.

The Chair asked that a special letter of thanks be sent to Tess Ahern for attending the meeting today when she was on annual leave.

4. GENERAL BUSINESS

There was no general business.

The meeting concluded at 3.25pm.


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

Held on Wednesday, 15 November 2017 at 1.30pm
Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

ALSO PRESENT

Gloria Johnson (acting Chief Executive)
Margaret White (Chief Financial Officer)
Avinesh Anand (Deputy CFO, Provider)
Phillip Balmer (Director Hospital Services)
Vanessa Thornton (acting Chief Medical Officer)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions 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

Emily Ford, Manukau Courier attended the public section of this meeting.

APOLOGIES

An apology was received and accepted from Dr Ashraf Choudary.

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 4 October 2017

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

That the minutes of the Hospital Advisory Committee meeting held on 4 October 2017 be approved.

Carried

2.2 Action Item Register

Noted.

3. INFORMATION PAPERS

3.1 Hospital Technology Update

Stuart Barnard and Sarah Thirlwall took the Committee through a presentation which provided an overview and update on hospital technology.

3.2 NZREX Briefing Paper (Dr David Hughes)

NZREX is a shorthand term for a doctor who has graduated from a recognised medical school in a country that is *not considered* to be comparable to the New Zealand health system. These doctors have had to pass the NZREX exam within the last 5 years. There are 21 countries considered to have *a comparable* health system to New Zealand - doctors from these countries do not have to sit the NZREX exam and have far fewer requirements in order to practise medicine in New Zealand.

For a country to be recognised as having a comparable health system to New Zealand it must fit within the Medical Council of NZ criteria.

MCNZ organises 3 sittings of the NZREX exam each year and numbers are limited to 28 per sitting. The next three exams are fully booked. The next available exam is in November 2018.

In the metro-Auckland region, there have been 22 expressions of interest from successful candidates in the past 12 months. Six of these have been employed in the region.

Doctors who pass the NZREX have to undertake prevocational training in an identical manner to newly graduated New Zealand medical students. This is independent of whether the doctor has 1 year or 20 years of medical experience.

In the immediate future, the Resident Doctors Association MECA has led to the development of new rosters that attempt to limit the impact of fatigue on junior doctors. This has resulted in the need for extra house officers and registrars to be recruited. However, as it currently
stands, these additional roles are not suitable for NZREX doctors. Further development and discussion would be required to allow NZREXs to take advantage of this increase in roles.

By 2020, MCNZ has mandated that all prevocational trainees spend at least three months in a community based attachment. The shift of workers into the community will impact on the availability of staff in the hospital and again this may be an opportunity for NZREXs. However, NZREXs themselves will be required to undertake a community based attachment also and these will be limited.

There are a number of SMOs who have shown great commitment to the plight of the NZREXs and have organised clinical observerships in each of the hospitals and have developed roles for NZREXs. However, these observerships are short in duration and any roles developed are ad hoc. Access to these opportunities is not based on merit or a transparent application process.

A workshop was held in late October with key opinion leaders in post graduate medical education. The purpose of the workshop is to develop more consistent processes for application for observerships and more robust methods of assessment of readiness for work whilst acknowledging the funding constraints that the DHBs and HWNZ operate under and the Ministry's priority for graduates of New Zealand medical schools.

3.3 Inpatient Experience Survey

The Nine Fundamentals of Care - Fundamental care involves actions on the part of the healthcare team that respect and focus on a person’s essential physical, psychological and relational needs to ensure their physical and psychological wellbeing. The delivery of this care often goes unnoticed in part because it is primarily concerned with meeting everyday basic human needs we take for granted.

It was noted that the current survey is very long, some 60-odd questions and needs to be narrowed down.

4. PROVIDER ARM PERFORMANCE REPORT

Phillip Balmer introduced the report highlighting:

Project Initiatives - across the hospital Services, 108% of the target benefit for the first three months of the financial year has been delivered (end of Q1). Benefits are exceeding target for ACC and ARHOP savings which have contributed to delivering a favourable variance to target for Q1. Mitigations are in place to ensure that benefits are delivered as per the plan and where that is not possible, alternative benefit avenues are considered.

Finance Report - the Committee asked for a report for the next meeting (31 January) on what the last three years of non-resident bad debts has looked like.

Emergency Department, Medicine and Integrated Care

Bowel Screening Programme – Meeting with MoH next week to discuss funding of the programme. Implementation may have to be deferred for a year whilst funding is secured. It is important to get this right.

Eligibility Policies – Currently awaiting feedback from the MoH on what their position is on the draft policies. Once received, these will be presented to HAC for feedback.
Mental Health and Addictions

Cultural Toolkit – the Cultural Toolkit for integrated Mental Health and Addiction Service was launched in September. The website and associated resource booklets are designed to enhance the cultural competency and capability of all staff working with Māori tangata whaiora and whānau and to encourage Whanaungatanga across services.

Adult Rehabilitation and Health of Older People

Acute Stroke Ward – the ward has mostly been open at 16 beds however, with fluctuating stroke numbers, this has been increased to 20 beds. Discussions are underway with regard to the model of care and nursing staff levels required for 20 beds.

Mr Balmer advised that a report would be submitted to the next HAC meeting (31 January 2018) on some of the initiatives that are working in the community to reduce fractures in older people.

5. CORPORATE REPORTS

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

Certification – comprehensive work is underway targeting reporting, training and clarity about responsibilities for the overdue controlled documents (policies, procedures and guidelines). The Committee asked for a report to the next HAC meeting (31 January 2018) in relation to controlled documents (learning from the internal audit) and the action plan to resolve the outstanding issues.

Allied Health Awards - the Committee asked that letters of congratulation be sent to the finalists.

5.2 HR Report
The report was taken as read.

6. RESOLUTION TO EXCLUDE THE PUBLIC

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

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>
<tbody>
<tr>
<td>2.1 Public Excluded Minutes of 4 October 2017</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
</tbody>
</table>
### 3.1 Patient Experience and Safety Report

<table>
<thead>
<tr>
<th>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</th>
<th>Privacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</td>
<td>The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons.</td>
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</tbody>
</table>

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

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**Carried**

The open session of the meeting concluded at 4.48pm.

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Dr Lyn Murphy, Committee Chair
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

Our clinical services remained unusually busy over the summer and presentations to the emergency department were exceptionally high in January, reaching a peak which would normally occur only in winter. This is very concerning and we have already started our winter planning, expecting that the sustained, marked increase in demand evident over the past year will be further exacerbated if we experience the severe influenza season currently overwhelming health services in the northern hemisphere.

Visit by Associate Minister of Health

Associate Health Minister the Hon Julie Anne Genter recently visited Middlemore Hospital to look at the ways we have reduced our carbon footprint. So far, CM Health has reduced its carbon emissions by more than 20 per cent – a goal set in 2012. Ms Genter was shown several of the steps we are taking towards achieving our new goal of being carbon neutral by 2050.

During her visit, Ms Genter visited critical care and the theatre department where anaesthetist Rob Burrell talked about his efforts in promoting a way to manage anaesthetic gases that has less impact on the environment, one of the projects being led by clinicians. Other activities which have reduced CM Health’s carbon emissions include programming computers to go sleep mode after a period of not being used and waste reduction activities.
Certification Surveillance Audit

On 7 – 9 February the DAA Auditor Group reviewed our progress to resolve the corrective actions from the previous Certification audit in February 2016. We entered this audit with 19 open Corrective Actions, of which 9 were closed. Two new corrective actions were identified, one of which attracted a moderate risk rating (the documentation of informed consent). With a total of 12 Corrective Actions we have continued with our positive downward trend of reducing the number of corrective actions over time.

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
<td>Type</td>
<td>Surveillance</td>
<td>Certification</td>
<td>Surveillance</td>
<td>Certification</td>
<td>Surveillance</td>
</tr>
<tr>
<td>No. of CI* rating</td>
<td>0 CI rating</td>
<td>0 CI rating</td>
<td>0 CI rating</td>
<td>1 CI rating</td>
<td>0 CI rating</td>
</tr>
<tr>
<td>No. of corrective actions</td>
<td>31 corrective actions</td>
<td>24 corrective actions</td>
<td>22 corrective actions</td>
<td>19 Corrective actions</td>
<td>12 Corrective actions</td>
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<tr>
<td></td>
<td></td>
<td>13 moderate risks</td>
<td>10 moderate risks</td>
<td>9 moderate risks</td>
<td>4 moderate risks</td>
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<td></td>
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<td>1 moderate risk</td>
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</table>

* CI refers to Continuous Improvement - whereby the performance exceeds the set standard. In 2016 Tamaki Oranga was awarded a CI rating for its eradication of the use of seclusion.

Summary of the Corrective Actions

The auditors made a number of positive observations about our performance, progress with resolving Corrective Actions and improvement culture during what have been challenging times. Several corrective actions were noted to be very close to resolution such as the revised risk management process, the re-engineered complaint and adverse event process, the roll out of the Plan of Care, bedrail e-learning package and development of a Corrective Action Database. Pleasingly the Corrective Actions relating to nutrition, Tiaho Mai and access to theatre (Maternity) were closed. Those remaining open not covered above primarily relate to documentation (particularly medication prescribing) and the need for improved capture / visibility of data (mandatory training for example).

The 2 new Corrective Actions relate to the documentation of informed consent for mental health services and bed rail use within inpatient services. This was rated as a moderate risk. Franklin Hospital was identified as needing to undertake regular satisfaction surveys to satisfy the requirements of its ARC contract (rated as low risk).

Next steps

- The Auditors develop a draft report with corrective action plan which is peer reviewed before being sent to the Ministry for its review. This process takes several weeks.
- A formal draft report is sent to us for a factual check. This provides us with the opportunity to ensure there no errors of fact or inconsistencies and the opportunity to challenge the findings where appropriate.
- The final Report is issued and a summary of the findings is published on the Ministry’s website. Reporting on progress resolving the corrective actions commences which will be managed via the Corrective Action Monitoring Group.
Achievement Milestones

The Pu Ora Matatini Midwifery Scholarship awards were held on 7 December 2017. The Tindall Foundation has supported this under the “Grow Our Own Workforce” for the past 7 years at Counties Manukau Health. As a result, there are now 24 Māori midwives in South Auckland and 58 future midwives studying through AUT.

Hand hygiene audits have grown impressively. In January 2017 the DHB had four departments auditing hand hygiene and collected 374 moments. In December 2017, 35 wards were actively auditing, with 23 of those capturing over 100 moments per month. This has been achieved through a planned approach led by Rachael Hart, Hand Hygiene Co-ordinator/Clinical Nurse Specialist.

Clinical Leadership Changes

Chief Nurse Jane O’Malley resigned from her MOH role in late December 2017 after 7 years in the role. She is to taking up the Chief Nurse National Plunket role. Jane spent a day in Counties Manukau prior to Christmas. A requested key area to visit and discuss was the Mental Health Integration & Community Transformation programme of work. Jane was impressed with Community Central and her Patient Safety Leadership Round in Critical Care. Jane spent time with the Clinical Leaders in the Director of Patient Care Directorate.

Denise Kivell, Director of Nursing, left CM Health in February 2018. She had been DON at CM Health for 10 years, and a valued and well-connected clinical leader at Counties Manukau for over 26 years. Denise championed the role of nursing in health care, supported development of innovative models of care and contributed nationally via various roles, including 4 years as Chair of Nurse Executives NZ.

Denise was the first Charge Nurse Manager of Kids Medical, and worked across a number of areas prior to her most recent role. Her Counties Manukau career was characterised by her genuine care for staff and patients and a strong belief in the importance of service and staff development, which strengthened our ability to provide the best care for our population. There were several opportunities to celebrate Denise’s contribution, including a formal farewell, before her last working day on Friday 16 February 2018.

Wilbur Farmilo, Deputy Chief Medical Officer, retired at the end of December 2017, after an exceptionally long and distinguished career in Counties Manukau Health services, which began during his years as a medical student in the 1970s. This was followed by his completion of surgical training and subsequent employment as a consultant surgeon. He was held in such high regard by his medical colleagues that the department of medicine allowed one of their positions to be used to ensure that a job was available for him at Middlemore when he returned from further training overseas. His career spanned major changes in his specialty and he was one of the pioneers of
laparoscopic surgery here. Whilst he developed areas of special expertise such as vascular surgery and, in more recent years, breast surgery, he was described at his farewell as one of the last true “generalists”, able to turn his hand to a full gamut of surgical procedures in all parts of the body. He moved into leadership roles as Clinical Director for Surgical Services and Deputy Chief Medical Officer, where he continued to shine. His skill for collaboration was recognised at a regional level and he will continue to oversee a regional project on cancer services over coming months.

The Acting Director of Allied Health role has changed hands. Annelize de Wet stepped down from the Acting DAH role as of the end of 2017, having led these staff groups for the previous 12 months. Wendy McKinstry has been appointed as the Acting Director of Allied Health for six months while permanent arrangements for leadership of the Allied Health Scientific and Technical workforces are finalised. Wendy first started at CM Health as a graduate physiotherapist in 1998, and has held various clinical and leadership roles within the organisation over this time.

The Big Ward

Following on from the very popular first series, series two of The Big Ward begins on TV2 on Thursday, 15 February at 8pm.

The series, filmed at Middlemore hospital, follows the emotional and inspiring journeys of six morbidly obese South Aucklanders on the road to healthier lives. The producers of the show have worked with Radio NZ’s Nine to Noon show to arrange a support interview with one of CMDHB’s bariatric nurse specialists on Tuesday 20 February.

The Counties Manukau Healthy Together Facebook page, which now has a following of over 8,500 people, will leverage interest in this series to promote free and low-cost exercise classes and healthy eating programmes in the Counties Manukau area.

2. Future Focus

Turnaround Plan

The working group set up to develop the Turnaround Plan worked throughout December and January, while many other staff and activities were having a break, to get this work underway. Substantial progress has been made and this will be the subject of ongoing presentations to the Audit Risk and Finance Committee and the Board, including the current Board meeting.

The Chief Financial Officer and I travelled to Wellington to meet with Ministry of Health officials on December 8 and have provided additional briefings to them regarding our financial position and related challenges. This engagement has been positive to date and we look forward to receiving more specific indications from them over coming weeks about any financial and other assistance which might be available to us.

Executive Leadership Team, Ko Awatea and Healthy Together 2010 Directorate Consultation

A document outlining proposed changes to roles and structures pertaining to these teams was distributed widely to staff and regional partners, seeking feedback, from January 22 to February 16. This followed an earlier period of extensive consultation regarding the role of Ko Awatea in particular after changes in its leadership and the emergence of various organisational challenges during 2017.

Once the feedback has been considered a final proposal for change will be developed.
### 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Departments</strong></td>
<td>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</td>
<td>AT RISK</td>
</tr>
<tr>
<td>December 2017 (Q2 final result):</td>
<td>90% (target 95%)</td>
<td></td>
</tr>
<tr>
<td>January 2017 (single month result):</td>
<td>88%</td>
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<tr>
<td><strong>Note:</strong> The ED health target was not met in Q2 (October – December 2017) and performance was at 88% for January 2018. During January, presentations totalled 10,133 which is a 10.3% increase over last year’s volumes for the same month. Year-to-date (YTD) presentations represent a 3.9% increase from YTD last year. Consistent surge presentation rates and consistently high hospital occupancy have impeded patient flow throughout the hospital meaning our ED has been unable to process patients within the target timeframe. A range of initiatives are underway to address underlying system challenges and manage demand.</td>
<td></td>
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<tr>
<td><strong>Elective Surgery</strong>*</td>
<td>Elective surgery will increase by an average of 4,000 discharges per year</td>
<td>AT RISK</td>
</tr>
<tr>
<td>December 2017 (Q2 result):</td>
<td>97.9% (target 100%)</td>
<td></td>
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<tr>
<td>ESPI2:</td>
<td>24 FSA breaches (0.2%) for December (target 0%)</td>
<td></td>
</tr>
<tr>
<td>ESPI5:</td>
<td>33 treatment breaches (0.9%) for December (target 0%)</td>
<td></td>
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<tr>
<td><strong>Note:</strong> The electives health target was not met in Q2 with a final shortfall of 212 discharges (10,032 discharges delivered against a target of 10,244). The shortfall is a result of ongoing high acute volumes causing cancellation of elective theatre lists (and clinics) in order to create acute capacity, as well as a shortage of anaesthetists. Under delivery of volumes is likely to continue into Q3 due to the impact of the summer holiday period and the closure and refurbishment of two theatres for five weeks at Manukau Super Clinic.</td>
<td></td>
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<tr>
<td><strong>Faster Cancer Treatment</strong></td>
<td>90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>December 2017 (Q2 result):</td>
<td>94% (target 90%)</td>
<td></td>
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<tr>
<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. Under the new target definition, only those relating to capacity constraints are counted as breaches.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td>95% of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Maaori and Pacific population groups).</td>
<td>AT RISK</td>
</tr>
<tr>
<td>December 2017 (Q2 result):</td>
<td>93% for total population (Maaori coverage: 86%, Pacific coverage: 94%) (target 95%)</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Maaori immunisation rates have dropped from 89% in Q1 to 86% in Q2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>Current Results</td>
<td>Status by 30 June 2018</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Raising Healthy Kids</strong></td>
<td><em>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</em> <strong>December 2017 (Q2 result):</strong> 100% total population (Maaori: 100%, Pacific: 100%) (target 95%)</td>
<td>ON COURSE</td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td><strong>Primary</strong> <em>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</em>* <strong>December 2017 (Q2 result):</strong> 89% total population (Maaori: 88%, Pacific: 89%) (target 90%)</td>
<td>ON COURSE</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td><strong>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</strong> <strong>December 2017 (Q2 result):</strong> 91% (Maaori 91%, Pacific: not reported) (target 90%)</td>
<td>ACHIEVED</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.
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 December 2017.

Prepared by: Marie Townsley, Acting Manager Occupational Health and Safety Service and endorsed by Elizabeth Jeffs, Director Human Resources.

Purpose

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

Executive Summary

There were no notifiable events for December 2017. All key leading and lagging results decreased for the December period because of the impact of annual leave and statutory leave over Christmas/New year. The end of calendar year position delivered achievement of all key leading and lagging target measures, with achievement at either on target or slightly below target (substantially achieved).

Regional Internal Audit completed a review of the Health and Safety Board Reporting for CM Health. A report has been provided and will be submitted to Audit Risk and Finance. The Board Report will be progressively updated over the next few months to align with the recommendations in the report. In addition the Health, Safety and Wellness Plan (HSWP) will be refreshed and presented to the Board following consultation with the ELT expected in April 2018. The HSWP will include proposed

Staffing levels within the OHSS team remain steady with no turnover. The Manager, Occupational Health and Safety Team vacancy has been filled with an interim resource with the permanent resource to be recruited in February 2018.
Trend highlights at a glance (rolling 12 months)

**Staff incidents (IRS)**
Number of staff reported incidents has decreased.

**Pre-employment Screening (PEHS)**
Change in report methods from October plus decrease over Xmas

**Attendance at H&S Orientation**
24 employees attended the Welcome Day inductions in December due to Xmas.

**Number of injury claims**
Steady decline continues in December following a slight increase in Nov.

**Key**
- Increased performance
- Steady performance
- Decreased performance

**In summary, for December 2017**
- Decrease in number of staff reported incidents.
- Decrease in lost time incidents, injury frequency rates and injury severity rates.
- There has been a decrease in the figures for Oct-Dec period as a result of a change in reporting methodology which now accounts for actual Pre-employment screening (PEHS) completed for new hired candidates, with addition decrease attributed to the shutdown period.
- The aim is to have 190 fully trained Health and Safety Reps by March 2018. Currently we are ahead of the annual target. 8 Managers have also been trained during December.
- Increase in levels of hand hygiene.
Performance Scorecard

Health and Safety Scorecard

December 2017

Comment on Variations

<table>
<thead>
<tr>
<th>Indicators in Blue</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff flu vaccination update</td>
<td>Annual target completed at 67% below target of 70%. Target for 2018 will increase to 74% aligned with National target.</td>
</tr>
<tr>
<td>Pre-employment health screening completed prior to commencement</td>
<td>December data of 97% tracked less than 100% target and this was due to large number of call backs which were addressed during Christmas/New Year period.</td>
</tr>
</tbody>
</table>
Key Health and Safety Risks

The table below outlines key health and safety risks together with commentary on the current status/issus related to that risk and remedial actions have been taken:

<table>
<thead>
<tr>
<th>Risk: Occupational Health and Safety - Aggression and Violence</th>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Aggression and Violence Steering Group, chaired by the Chief Medical Officer, is due to meet for next steps in the coming month.</td>
<td>This action will be carried forward to Jan/Feb 2018 to follow up on initial meeting to agree on work plan.</td>
<td></td>
</tr>
<tr>
<td>CM Health in conjunction with healthAlliance, has undertaken a pilot trial of a Personal Duress Alarm application with 15 – 20 Community Health Team workers which includes mobile application and a duress alarm.</td>
<td>Following review of trial, findings collated and recommendation to be produced on efficacy.</td>
<td></td>
</tr>
<tr>
<td>Community Worker Personal Duress Alarms: Trial commenced as scheduled. 50% complete</td>
<td>Draft Lone Worker programme produced and under consultation with services with expected final version for consultation with Stakeholders late-Feb 2018.</td>
<td></td>
</tr>
<tr>
<td>Lone Worker Policy: Draft being reviewed. 50% complete</td>
<td>Review of reporting through Riskpro or other software options that will enable standardisation of categories to provide more robust reporting.</td>
<td></td>
</tr>
<tr>
<td>Incident Reporting: Review of current reporting categories and follow up to better track frequency and trends. 0% complete</td>
<td>Incident Investigation action to improve process for managing aggression in ED and MSC. Recommend process to enable staff to respond and alert Security to ensure safety of patient(s) and staff.</td>
<td></td>
</tr>
<tr>
<td>OHSS working with ED and MSC on incident management. 60% complete</td>
<td></td>
<td></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>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community teams to engage in review of the safe home visit process, with focus on: • awareness of clinical risk assessment • environmental checks • option of home visiting with a colleague • use of mobile phones • staff whereabouts procedure • vehicle use</td>
<td>Safe Home visiting training completed with catch-up sessions scheduled for Jan/Feb.</td>
<td></td>
</tr>
<tr>
<td>Safe Home Visiting training is continuing for all staff who visits service users in a community setting. Twenty full day courses are being completed by end of December with the capacity for 390 staff to attend by the end of this year.</td>
<td>Follow up briefings on finalised Lone Worker programme to be scheduled end Feb/March.</td>
<td></td>
</tr>
</tbody>
</table>
**Lone worker Personal Duress Alarm application trial completed.**

Feedback from trial with recommendation for future use of the Personal Duress Alarm as part of the controls for reducing risk to Community workers to be included in report.

**Residual Risk:** The risk remains a constant with the DHB having completed Safe Home Visiting training to enable better management of volatile work areas.

**Risk: Blood and Body Fluid Incidents (BBFA)**

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing alternatives to current needle system e.g. Needleless Systems and self-retracting systems. Controls in place to reduce incidents e.g. separate bin storage, monitored within wards, theatres and clinics.</td>
<td></td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk is medium, as CM Health has processes in place to enable safe disposal/usage procedures for health and safety at work.

**Risk: Hazardous Substances and new Organisms (HSNO)**

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>HASNO audit identified key areas to improve in storage, data sheet collation and hazard registers.</td>
<td>Audit report action points discussed with Facilities/Maintenance and follow up on close out plan for action points to be provided. WorkSafe HASNO guidelines are available and review against guidelines to be completed. Data sheets on all chemicals need to be collated and a register completed as per Audit action points. Hazard Registers on site to be updated following above actions and regular reviews to ensure continued compliance.</td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk is high as audit report indicated multiple actions required to become compliant with regulations.

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The “TROPHI” tool implementation has commenced following the training of data collectors with the baseline data being submitted for analysis from the areas within the Middlemore site where the most</td>
<td>TROPHI tool data analysis to be reviewed by Moving and Handling Steering Committee to assess efficacy in the CM Health environment.</td>
</tr>
</tbody>
</table>
Injuries occurred. Data collection groups include Occupational Therapists, Physiotherapists and Nursing staff.

Training requirements for Moving and Handling to include the CM Health Workforce Capability Team.

WDHB training programme at the Waitakere Hospital site will be observed and discussed by members of the steering committee in January 2018.

Improvement advisor resourcing and the project approach have been discussed with Ko Awatea to support the Moving and Handling initiative.

Discussion with CM Health Workforce Capability Team on training requirements following observation of WDHB programme and feedback from TROPHI trial to enable recommendation to be developed in Q1 2018.

Project 30% complete

Follow up on Improvement Advisor resourcing needed and the project approach to proposed with Ko Awatea to support the Moving and Handling initiative.

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

| **Risk: Compliance - Contractor Management and Procurement Management** |
| **Previous Action Point** | **Current Action** |
| The Capital Works projects are fully compliant. They have active assurance regimes, are monitored, measured and validated by third party H&S auditors. Facilities are assured of compliance. The Hospital and Facilities Contractor management process remains immature and will require resourcing, under the Facilities (and possibly other) functions to provide organisational assurance for H&S as required under the legislation. | Continue to monitor and engage with Capital Works contractor to maintain compliance. An external audit of H&S Management systems and evaluation and recommendations to be provided in Q1 2018, delays have been due to the complexity and diversity of the scope. |

**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.

| **Original Risk** | The residual risk remains the same at present. | **Residual Risk** |
## Risk: Compliance - Health & Safety Training Framework

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current programme is designed to cover:</td>
<td>The training programme will be updated following the HSWP development and current training will continue to complete baseline training as follows.</td>
</tr>
<tr>
<td>- Health &amp; Safety Representative and Champion Training programme to improve Worker Participation and compliance is on target. With the remaining 190 Representatives to be trained by 31 March 2018.</td>
<td>Training planned for 2018 to include:</td>
</tr>
<tr>
<td>- 72 employees are working through the unit standard AS/NZS 29315 to formally qualify as a health &amp; safety representative.</td>
<td>- Health &amp; safety representative training and Manager training in risk management, incident investigation and the online inspection tool.</td>
</tr>
<tr>
<td>- H&amp;S Inductions on target both for month of December and YTD.</td>
<td>- Monthly tutorial for health &amp; safety representatives completing the unit standard AS/NZS 29315.</td>
</tr>
<tr>
<td></td>
<td>- Manager training in H&amp;S will commence in 2018.</td>
</tr>
<tr>
<td></td>
<td>- H &amp; S training dates for all of the above for 2018 have been confirmed and will be communicated across the organisation throughout the year.</td>
</tr>
<tr>
<td></td>
<td>- Training on the new Online Site Inspection Tool will recommence in February 2018. Reaction from trial users has been very positive. The target is to have all personnel responsible for the bi-monthly site inspection trained and using the new monthly online inspection tool by end of 2018.</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.

### Original Risk

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidents of slips, trips, falls continue to be significant causations of injury at CM Health. Continue to focus on reporting of trends and proactive communication with Facilities when repairs are required.</td>
<td>No lost time injuries in December attributed to slip, trip, fall incidents.</td>
</tr>
<tr>
<td>Communication with Cleaning Service continues to ensure that wet floors are managed quickly, to reduce the risk to staff.</td>
<td>Continue to focus on proactive communication to facilities, cleaning and services on reminding staff to consciously reduce risk of slips, trips and falls.</td>
</tr>
<tr>
<td>Slips, trips, falls continue to be a focus of discussion in health &amp; safety training, with reporting of near misses also encouraged.</td>
<td>Proactively encourage incident reporting and near miss reporting to ensure hazards are identified, reported to Facilities and eliminated, isolated or minimised.</td>
</tr>
</tbody>
</table>

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

### Original Risk

### Residual Risk

The residual risk remains the same although reduction in incidents.
## Risk: Wellness – Employee Health and Wellbeing Programme (stress, fatigue, depression)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| Following the Capstone Project Presentation in November, an initial scoping meeting was held to determine the next steps for the Wellness Programme. | Draft action plan following Capstone survey will be incorporated in the overall Wellness plan which will be reviewed by the ELT prior to being presented to the Board. Q1 delivery. Key areas to be included:  
- ‘Speak Up’ campaign  
- Mental Health initiatives  
- Women’s Health escalation programme  
- Manager training to identify: fatigue, stress, mental health within teams.  
- Mobile App for Junior Doctors  
- SMO wellbeing initiatives  
- RMO Mental health initiatives  
- National ‘Wellbeing 4 Health’ due Q1 2018  
- Encourage staff to utilise sick leave if unwell  
- Better utilisation of immunisation (flu, whooping cough, mumps). Workforce Planning ‘safe and healthy rostering’ to be investigated. Continue with the Wellness Programme group is to meet in February to discuss the draft plan and the Terms of Reference for the group. |

20% complete

### Original Risk
The residual risk remains the same as previous report.

### Residual Risk

## Risk: Physical environment (ventilation, lighting, noise, equipment)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring incident reports which report high temperatures, dust quality and water leaking through roof. Facilities/Engineering following up with reports on dust and repair to roof. Additional fans placed in offices and other controls in place e.g. alternative work during heat of the day, ensuring staff take breaks and keep hydrated. Investigation into air quality as a result of ‘dust’ being emitted from air conditioning unit. Facilities/Engineering investigating cause of emissions and test to be taken on dust. Report of water leaking through roof and damaging walls, ceiling tiles and carpet. Following investigation by plumber, roof under repair. Concerns raised as asbestos present in ceiling tiles.</td>
<td></td>
</tr>
</tbody>
</table>

### Residual Risk
The residual risk is low, as CM Health has processes is 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 - Worker Participation**

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current H&amp;S Rep training programme:</td>
<td>Worker Participation plan to be developed as part of the HSWP to ensure compliance with legislation and support H&amp;S communication throughout CM Health.</td>
</tr>
<tr>
<td>• 347 employees trained as H&amp;S Representatives in 2018.</td>
<td>Update programme for existing H&amp;S Representatives who were trained pre- Health &amp; Safety at Work Act 2015 designed and will be delivered in 2018.</td>
</tr>
<tr>
<td>• Communication programme for current H&amp;S Representatives increased as follow up to training.</td>
<td>Utilisation of communication to leverage improvements in H&amp;S and update H&amp;S Representatives has increased to ensure that worker engagement and participation is maintained.</td>
</tr>
<tr>
<td>NB: This includes training on both the old and new curriculum.</td>
<td></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.
Reported Incidents

Rolling year-on-year monthly average comparison:

Previous 12 months – 104
Current 12 months – 114

The year-on-year average reported incidents have increased by 9% compared to the previous period.

Environmental factors with no acute injury impact but have been notified are included in the ‘Other’ category and include hazards and risks:

- excessive noise
- glare
- cleanliness
- temperature
- damaged property,
- blocked/obscured entrances
- trespass

These incidents are followed up by the relevant manager of the work area.

Current Period:

89 incidents were reported in December 2017.
Notifiable Events

<table>
<thead>
<tr>
<th>Date Reported to WSNZ</th>
<th>Type of Incident</th>
<th>Injury Sustained</th>
<th>Date of Incident</th>
<th>Outcome Recommendations Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil to report for December 2017</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Predominant Incident Profile

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

- Aggression and Violence: 24
- BBFE: 23
- Moving and Handling: 12
- Slip, Trip and Falls: 11

The number of reported incidents for the current reporting period (December) has decreased from the previous reporting period (October).

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

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

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

Rolling year-on-year monthly average comparison:

Previous 12 months – 21.3
Current 12 months – 24.5

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

Current Period:

All of the Aggression and Violence incidents were directed at staff.

Assault – Physical: 10
Behaviour – Aggressive: 6
Behaviour – Inappropriate: 3
Assault – Verbal/gesture: 3
Hit/bitten/scratched by person: 2

Incidents remain high in Mental Health and EMIC.
BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly average comparison:

Previous 12 months – 23
Current 12 months – 23.3

BBFE incidents reported for the rolling 12 months has remained relatively constant.

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

Current Period:
23 BBFE incidents were reported in December.

Causation profile:
Other: 6
Acts of others: 5
Patient Condition: 3
Defective Tools/Equipment: 2
Fatigue/Tiredness: 2
Incorrect Work Techniques: 2
By-pasing Safety Devices: 2
Inattention/Distraction: 1
Moving and Handling

Rolling year-on-year monthly average comparison:
Previous 12 months – 21.4
Current 12 months – 20.3

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

A steering group to address the reduction in the organisation risks associated with incidents relating to moving and handling.

Current period:
1 Lost time injury due to a moving and handling incident was reported in December.

Causation profile:
Awkward posture/ equipment malfunction/ job factors/ action/ behaviour of employee or patient/ affiliate, human factors: 7
Lifting /carrying/load size: 4
Repetitive handling/movement: 1
Slips, Trips, Falls

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

Previous 12 months – 13.1
Current 12 months – 14.0

Slips/Trips/Falls incidents have remained relatively consistent for the rolling year, with a sharp increase in September.

**Causation profile:**

- Slipped/tripped/stumbled: 5
- Surface - slippery/wet: 2
- Equipment malfunction/faulty: 1
- Unbalanced when tried to step backwards: 1
- Action/behaviour of employee/affiliate: 1
- Human factors: 1
Reported Incidents Summarised by Workforce and Division

Reported Incidents Summarised by Category & Workforce for December 2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Administration &amp; Management</th>
<th>Allied Health &amp; Technical</th>
<th>Medical</th>
<th>Non-Clinical Support</th>
<th>Nursing/Midwifery/HCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression &amp; Violence</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>BBFE</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving &amp; Handling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slip/Trip/Fall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reported Incidents Summarised by Division & Category for December 2017

<table>
<thead>
<tr>
<th>Division</th>
<th>Aggression &amp; Violence</th>
<th>BBFE</th>
<th>Moving &amp; Handling</th>
<th>Slip/Trip/Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARHOP</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CCS</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Eastern Locality</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>EMIC</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Kidz First</td>
<td>1</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mangere Otara Locality</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td></td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>MMC</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SAP</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Women's Health</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Workplace Inspections Conducted

For the November/December 2017 inspection cycle, OHSS received 97% (117) of the total (121) expected submissions showing an improved response rate across the organisation.

Workplace Inspection locations have been amended to match with the new divisional update that occurred in September 2017. Historical data for the Workplace Inspections is available, however this only matches the new data set for two inspection cycles across the October to December 2017 period as shown in the graph below.

The purpose of the Workplace Inspections is for the manager and staff safety representative to identify hazards within the workplace, assess the risk and initiate plans to manage and mitigate the risk.

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

The next inspections are due to be completed in February 2018.
Health, Safety and Wellbeing Activity

Driver Safety

Following a fatal incident involving a staff member driving to deliver patient medications, the OHSS queried the driving processes at CM Health. As reported in the last Board Report, action points from external Risk Consultants and CM health the following:

- All employees who use a CM Health vehicle, have a completed license check to confirm that the NZTA has approved them to drive on the New Zealand roads. License details retained within “AutoCentral” – the vehicle booking system in use within CM Health.
- Each employee who books out a CM Health vehicle, will have a valid driver’s license and will not permit bookings to a person who has not registered or who has an expired license.
- CM Health does not currently undertake any driver training as a standard. The organisation does offer professional driver training courses for those that frequently use CM Health vehicles, on a case-by-case basis. These can be booked through the relevant Service Managers.

The CM Health Car Parking Working Group involves ACC, Secure Parking Ltd, OHSS and CM Health Facilities. This is headed by the CM Health Facilities Manager. Driver behaviour is currently being reviewed and practical options being considered to support improvement in driver behaviour.

Community Health and Lone Workers

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

In addition, OHSS has also been involved with review of the proof of concept for a lone worker security and distress application. A trial of a Personal Duress Alarm application involving 15 – 20 workers across the various Community Health teams has just concluded. Results are currently under review.

Health and Safety Workforce

Staffing levels within the OHSS team remain steady with no turnover. The Manager, Occupational Health and Safety Team vacancy has been filled with an interim resource with the permanent resource to be recruited in February 2018.

Capacity Planning to enable delivery of the workplan for the Health and Safety and Occupational Health teams will commence in February with recommendations for OSSH workforce on short and long term needs to align with capability and capacity planning programme.
Occupational Health Service

OCC Health Team

The team consists of two senior medical officers and three nursing staff (2.7 FTE) and three administrators. The team provide a service to staff, candidates and students through clinic appointment for work related injuries, managing ACC claims and work place safety checks. The work of the team ensures that we remain a tertiary ACC provider and have significantly reduced ACC payments. The team are one of the largest purchasers of vaccines in the Health Board.

Injury Claim Data

<table>
<thead>
<tr>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total $ cost for month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lost days for month</td>
<td>$ total for month</td>
<td>$ total for month</td>
<td>$ total cover cost for month</td>
<td>Total $ cost for month</td>
</tr>
<tr>
<td>108.60</td>
<td>15,540.73</td>
<td>21,544.53</td>
<td>0</td>
<td>37,085.26</td>
</tr>
</tbody>
</table>

Influenza Program – 2018

The planning for the influenza vaccinations for 2018 has commenced and is due to start in April/May.
**Case and Claims Management:**
Current Claims refer to Low-and High-risk claims that are currently being managed by OHSS.

Pending Claims takes into account the New Claims which require Initial Assessments and further investigation before a cover decision is made.

Theoretically a new complex claim may be pending for 21 days before all evidence is gathered and the employee is booked to see an OHP for review and recommendation to either Accept/Decline.

**Vaccinations:**
Vaccination programmes for pre-employment have increased with whooping cough (Boostrix) and mumps (MMR).

**Clinic Appointments:**
Increase in clinic bookings with Nursing aligning with new graduate intake in January. Work continued over the Christmas period with pre-employment checks completed to enable commencement of employment.
### Glossary for Monthly Performance Scorecard and Report

<table>
<thead>
<tr>
<th><strong>Lost time incidents</strong></th>
<th>Any injury claim resulting in lost time.</th>
</tr>
</thead>
</table>
| **Lost time injury Frequency Rate** | No of lost time Injuries per million hours worked.  

\[
\text{LTIFR (Lost Time Injury Frequency Rate)} = \frac{(\text{Number of Lost Time Injuries})}{\text{(Hours Worked) x 1,000,000}}.
\]

| **Injury Severity Rate** | Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked.  

\[
\text{LTISR (Lost Time Injury Severity Rate)} = \frac{(\text{Number of Lost Hours})}{\text{(Hours Worked) x 1,000,000}}.
\]

| **Notifiable Injury/illness** | (a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations.  
(b) any admission to hospital for immediate treatment  
(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance  
(d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals.  
(e) any other injury/illness declared by regulations to be notifiable. |

| **Notifiable Incident** | An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person’s health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident. |

| **Notifiable Event** | Death of a person, notifiable injury or illness or a notifiable incident. |
| **Pre-Employment** | Health screening for new employees. |
| **Worker** | An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer. |

| **Reasonably Practicable** | Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters. eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk. |
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
</tr>
<tr>
<td>ARF</td>
<td>Audit, Risk and Finance</td>
</tr>
<tr>
<td>BBFE</td>
<td>Blood and/or Body Fluid Exposure</td>
</tr>
<tr>
<td>CCS</td>
<td>Central Clinical Services</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Programme (Counselling)</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>EMIC</td>
<td>Emergency Medicine &amp; Integrated Care</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSNO</td>
<td>Hazardous Substance New Organisms Act</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
</tr>
<tr>
<td>IRS</td>
<td>Incident Reporting System</td>
</tr>
<tr>
<td>JCC</td>
<td>Joint Consultative Committee</td>
</tr>
<tr>
<td>LTI</td>
<td>Lost Time Injury</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MMC</td>
<td>Middlemore Central</td>
</tr>
<tr>
<td>OHSS</td>
<td>Occupational Health and Safety Service</td>
</tr>
<tr>
<td>PHCS</td>
<td>Primary Health &amp; Community Services</td>
</tr>
<tr>
<td>PEHS</td>
<td>Pre-Employment Health Screening</td>
</tr>
<tr>
<td>SAP</td>
<td>Surgical, Anaesthesia &amp; Perioperative</td>
</tr>
<tr>
<td>SPEC</td>
<td>Safe Practice and Effective Communication</td>
</tr>
<tr>
<td>WellNZ</td>
<td>Injury Management Third Party Administrator</td>
</tr>
</tbody>
</table>
**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 January to 14 February 2018.  
**Prepared and submitted** by Donna Baker, General Manager Communications and Engagement 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 January to 14 February 2018.

**Major Issues or Events**

- **Carbapenem-resistant organisms:** The communications team responded swiftly to the discovery of the transmission of CRO among three patients being treated by the National Burn service. A media release advised admissions to the National Burns service were to be limited. Subsequent communications stressed the hospital followed standard procedures to ensure that patient safety remained paramount, and emphasised the support being provided to patients and their families, including a 75% burn patient who remains in the care of Waikato DHB.  

- **Associate Minister of Health’s visit:** Associate Minister of Health Julie Anne Genter visited Middlemore Hospital to celebrate its success in reaching sustainability targets. Over the last five years the organisation has reduced its carbon footprint by more than 20 per cent and is now committed to becoming carbon neutral by 2050. Both the Minister’s Office and CM Health Communications team put out media releases which were picked up by at least two websites.

**Media and Email Enquiries**

Approximately 177 media enquiries (email and calls) received. Significant media issues addressed during the period are included in the section titled ‘major issues or events’.

The Corporate Affairs and Communications Group manage a generic communications email box responding to all emails and connecting people to departments. For this period 132 emails were received. 38 were not related to communications issues and, where appropriate, were referred to other departments and services at the CM Health.

**Routine Sector Communications**

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

**Campaigns in Development**

- **Census** – Promotion of the Census to our Counties Manukau population is well underway with the intensity increasing from 24 February when StatsNZ saturation marketing begins nationwide. Promotional electronic collateral includes screensavers, Facebook banners, and slider for CM Health
Census skins on both Middlemore Hospital billboards and a promotional flyer for community-based staff to share with patients are underway.

Social media videos are underway for the Healthy Together Facebook page. George Ngatai (Board Member), Hineroa Hakiaha (Senior Nurse and Cultural Advisor), and members of the Mental Health team have agreed to be filmed to promote the Census. We are also sourcing a Pacific doctor. These videos will be boosted to gain maximum exposure.

There is already media interest in how the Census impacts on CM Health with Margie Apa interviewed by stuff.co.nz and a proactive piece picked up in the Manukau Courier. More media activity is planned including pitches to ethnic media. The relationship between the number of Census returns and funding is being stressed.

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

- **Transition from four digit extensions to five digit extensions**: To meet telecommunication needs as CM Health grows in services and facilities, phone extensions will change from four digits in length to five from 22 February. A communication action plan is currently being rolled out to support this work.

**Internal communication**

**Key focus: Turn Around Plan**

A communication strategy and action plan has been developed to support the Turn Around Plan. It aims to raise visibility of the plan, encourage participation and manage people’s expectations and concerns. A range of internal and external channels will be utilised and content will be targeted depending on the audience.

To ensure we engage with as many people across the organisation as possible, an engagement schedule has been developed, which outlines existing forums/meetings for the TAP team to attend as well as a series of drop in sessions across the organisation. Work is also being done with the Consumer Council on the best way to engage with patients.

A media plan is being developed which includes key messages, a holding statement and proactive opportunities to engage with the public. This will ensure we minimise any negative reactions and press. It also means we can tell a consistent story.
Other key internal communication activities

- Support provided for certification week. Collateral included posters, screensaver, content on Paanui, Team Counties blog and Daily Dose content.
- **Patient safety leadership walk-around** attended. Key content/messages shared via internal channels and FB.
- Assistance and promotion of Paatuka Place survey. Over 200 staff participated. Awaiting feedback from patients and visitors.
- **Team Counties blogs**: The Team Counties blogs recommenced in February 2018. Certification gets underway was published 7 February.
- Planning for the March issue of Connect+ is underway

External communication key activities

- Communications met with Jo Rankine to plan promotional activity to showcase CM Health’s achievements as reflected in the Quality Accounts 2016/2017. As a first action, Jo will consult with the Consumer Council about the areas they would like to see highlighted and a communications strategy will developed from there.
- Communications has engaged with the Child, Youth and Maternity to begin planning for the Women’s Health and Newborn Annual Report 2018/2019. Planning has also begun on this year’s report launch with previous attendees being surveyed as to what format would add the most value to their work streams.
- In January, CM Health communications participated in a discussion with the four regional DHBs and the Northern Regional Alliance about a collaborative approach to raising awareness of HepC including testing and treatment options. Discussion is ongoing on a collective approach.
- Communications support continues on the Mental Health and Addictions programme of work to develop an integrated Model of Care (MOC) which aligns with CM Health’s Localities approach. There are four work streams requiring communications support:
  - Integrated Locality Care (establishment and spread of the iLoC approach)
  - CADS/Addictions (developing an integrated response to addiction needs)
  - Reconfiguration of Community Mental Health Services (to support the integrated MoC & align with localities approach)
  - Procurement of community NGO services (to support the integrated MoC & align with localities approach).
- We are working with the Fanau Ola team on resources to communicate with our Pacific community on how the Emergency Department works. Emergency consultant, Dr Josh Tutone and Fanau Ola nurse Leilani Jackson were filmed for social media posts in November/December. Due to popular demand and social media requests, we’ve filmed Leilani’s video in Samoan which is doing well on social media. We’re currently in the process of filming Dr Tutone’s video in Tongan.
- Waitangi Day – we worked with the Maaori Workforce to promote the importance of Waitangi Day on social media, as well as a staff quiz.
- Bowel screening programme – the programme is set to start around June. We’re currently working with the communication leads from the National Screening Unit, Ministry of Health, and other involved DHBs on raising awareness in our areas and rolling out information.
• Mum’s Kitchen Rules (MKR) – we promoted MKR on social media for the February and March workshops. Both of these workshops filled to their capacity.

• Maternity Services resources – we’re working with the Maternity team to update some of their resources for pregnant women and their whaanau. We held a photo-shoot at Turuki Health Care with women and whaanau in their parenting classes.

• Our Monthly Maternity e-update and the Primary Care e-update – both newsletters were published in early February.

Digital Channels

Website (www.countiesmanukau.health.nz)
The site shows a slight drop in traffic this period as is consistent with the onset of summer. To our surprise there has been a 3% drop in mobile traffic as users are favouring desktop this period.

Figure 1 Web Site Data Metrics from Google Analytics
Social Media

This was a strong period of growth for all of our social channels, however slightly slower than last period. This can be attributed to fewer posts being released. We continue to see high impression numbers due to increased use of video.

<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>7,384</td>
<td>0.79%</td>
<td>23</td>
<td>69,758</td>
<td>3,033</td>
<td>1,413</td>
<td>61.4</td>
<td>68</td>
</tr>
<tr>
<td>Healthy Together Facebook</td>
<td>8,583</td>
<td>1.13%</td>
<td>9</td>
<td>82,213</td>
<td>9,135</td>
<td>2,060</td>
<td>228.9</td>
<td>168</td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,512</td>
<td>1.05%</td>
<td>94</td>
<td>19,831</td>
<td>211</td>
<td>81</td>
<td>0.9</td>
<td>13</td>
</tr>
<tr>
<td>CM Health LinkedIn</td>
<td>5,076</td>
<td>3.32%</td>
<td>11</td>
<td>48,835</td>
<td>4,441</td>
<td>918</td>
<td>83.5</td>
<td>295</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>23,558</td>
<td>+3.1%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>152</td>
<td>+1.0%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>32</td>
<td>+1.2%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>166</td>
<td>+3.4%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>700</td>
<td>+3.8%</td>
</tr>
</tbody>
</table>

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

CM Health Facebook

The focus on this channel has reduced slightly since the last reporting period. We had a 53% reduction in posts due to annual leave which naturally resulted in a decrease in metrics. We still managed follower growth over this period with positive content such as a visit from our Associate Health Minister.
Top 4 Posts by Reactions:

<table>
<thead>
<tr>
<th>Date Sent</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 23, 2018 3:08 pm</td>
<td>156</td>
<td>30</td>
<td>19%</td>
</tr>
</tbody>
</table>

Counts Manukau Health
Big day for our Mental Health Graduates as they started their career with us yesterday. Congratulations and all the best everyone. #Gradlife #MentalHealthJobs #Welcome #CMHealthCareers

<table>
<thead>
<tr>
<th>Date Sent</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 02, 2018 3:38 pm</td>
<td>71</td>
<td>11</td>
<td>9%</td>
</tr>
</tbody>
</table>

Counts Manukau Health
Midwives bring life into our community and play an important role in our organisation. If you want to be a part of our dynamic team then join our Midwifery New Graduate Programme (April 2018 intake). Applications are open until 18th February 2018. Submit your application today at http://ow.ly/uMXxO9hwz

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

This month was a very strong reporting period for Healthy Together due to an increased focus on video content. We noticed a 96% increase in engagement and a 134% increase in impressions despite halving the number of posts. A video from one of our nurses in full Samoan and our wahakura competition were two heavy-hitting pieces of content.

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&lt;br&gt;“O le avagaga o le vaega po’i le pula mo fa’aeelevate ma pesega ce (ma’s) ove Na’asua’i o Na’amua’i lava e o tamalao la sofitua po’i le oia. E pai a na’a namatasi la e laa fasia lutua la i lea leau.”&lt;br&gt;nurse Lalani Jackson. We had many comments on a video we posted a month ago from one of our nurses! Lalani Jackson on how patients are looked after at Middlemore Hospital’s RD. Thank you to everyone for those comments. Some of you requested this video to be translated into Samoan, which we’ve done below. We hope this is helpful for you and your Samoan whanau. Keep an eye out for Dr Tutone’s video translated in Tongan - coming soon!</td>
<td>715</td>
<td>69</td>
<td>10.0%</td>
<td>11,971</td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau&lt;br&gt;“We’re pleased to announce that South Auckland new Mum, Jordan Rogers, is the winner of our wahakura competition promoting safe sleep for babies. Jordan’s daughter Reign is pictured snug as a bug in her new bed. During the competition, we had a few enquiries about where to buy wahakuras. You can buy them directly on TradeMe. Search wahakuras on the TradeMe site to find them. In Counties Manukau, wahakuras are available for free to families who qualify. Ask your midwife for more information.”</td>
<td>482</td>
<td>30</td>
<td>17.8%</td>
<td>5,980</td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau&lt;br&gt;Went to learn how to cook healthy, delicious food on a budget? Register for Mum’s Kitchen Rules March workshop! It’s FREE. Childcare is available, and at the end each workshop you have an amazing meal for you and your whānau. The next workshop starts 7 March! Check out the poster below to register! #COUNTIESMKB</td>
<td>281</td>
<td>119</td>
<td>4.2%</td>
<td>15,613</td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau&lt;br&gt;“We want to promote having a healthy lifestyle as a family and be able to create memories together and this is something that will help that.” Love this! Treat to see this Māngere whānau getting involved! Best of luck to the Māngere whānau on the lead up to Auckland Round the Bays. #motivation #healthywhanau</td>
<td>69</td>
<td>9</td>
<td>7.6%</td>
<td>1,953</td>
</tr>
</tbody>
</table>
CM Health Twitter

This was a steady reporting period for Twitter, with only a slight decrease in posts and impression metrics. The arrival of our graduate nurses and mental health graduates were great for engagement metrics and provided a strong boost.

Top 6 Posts by impressions:

<table>
<thead>
<tr>
<th>Tweets</th>
<th>Promoted</th>
<th>Impressions</th>
<th>Engagements</th>
<th>Engagement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health @cmdhb · Jan 30  Consultant Psychiatrist- If you want to make a positive contribution to your community then please contact Radhika Dodderi on 092760D44 or <a href="mailto:radhika.dodderi@middlemore.co.nz">radhika.dodderi@middlemore.co.nz</a>. Photo: Siale- Consultant Psychiatrist at our CAMH Services. #MentalHealthJobs #Psychiatrist #CMHealth pic.twitter.com/ZqojWIOOY9</td>
<td>458</td>
<td>2</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>CM Health @cmdhb · Jan 22  Today is a special day as we welcome 73 Graduate Nurses to Team Counties. Big Congratulations to everyone and we look forward to working with you all. #HaereMai. #TeamCounties #NETP #NewYearNewGrads</td>
<td>404</td>
<td>17</td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>CM Health @cmdhb · Jan 23  Big day for our Mental Health Graduates as they started their career with us yesterday. Congratulations and all the best everyone. #Gradlife #MentalHealthJobs #Welcome #CMHealthCareers pic.twitter.com/8pqF8mTZBb</td>
<td>363</td>
<td>1</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>CM Health @cmdhb · Jan 15  Community Clinical Nurse Specialist- A new child-centered initiative is being established by the South Auckland Social Investment Board in partnership with Counties Manukau Health, Plunket &amp; Turuki Health Care Family Start. Click here to apply- ow.ly/OI2O30hlZD1 #NurseJobs pic.twitter.com/zwjETvByBY</td>
<td>318</td>
<td>5</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>CM Health @cmdhb · Jan 18  Are you an experienced HR Advisor with a strong ER background looking for the next step in your career? We currently have an opportunity for a HR Advisor at Counties Manukau Health! Click on the link information- ow.ly/GSSX09hQuzX #HRJobs #HumanResource #Healthcareers pic.twitter.com/Z7qohAMEFz</td>
<td>299</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>CM Health @cmdhb · Jan 28  Midwifery New Graduate Programme- Counties Manukau Health Applications closing on 18th February 2018 Submit your application today at- ow.ly/aKKG30dA24 You can also directly contact our Recruitment Consultant Amy Varcoe at <a href="mailto:amy.varcoe@middlemore.co.nz">amy.varcoe@middlemore.co.nz</a> pic.twitter.com/P6M9TW5md8</td>
<td>282</td>
<td>1</td>
<td>0.4%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 10 Top 6 Tweets by impressions
LinkedIn managed higher per-post engagement and impressions this month despite a 38% drop in messages sent. Our workforce-focused posts proved quite popular with the top post amassing over 7000 impressions, more than three times last period’s most popular post.

Top 3 Posts by Engagement:

<table>
<thead>
<tr>
<th>Date Sent</th>
<th>Impressions</th>
<th>Clicks</th>
<th>Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.6k</td>
<td>101</td>
<td>1.87%</td>
<td></td>
</tr>
</tbody>
</table>

Counts Manukau Health
Are you an experienced HR Advisor with a strong ER background looking for the next step in your career? We currently have an opportunity for a HR Advisor at Counties Manukau Health! Click on the link for more information - https://ow.ly/GSSX30hQuzX

Counts Manukau Health
Today is a special day as we welcome 73 Graduate Nurses to Team Counties. Big congratulations to everyone and we look forward to working with you all.
#HaereMaio #TeamCounties #NETP #NewYearNewGrads

Counts Manukau Health
Big day for our Mental Health Graduates as they started their career with us yesterday. Congratulations and all the best everyone. #Gradlife #MentalHealthJobs #Welcome #CMHealthCareers

Figure 11 LinkedIn Top 3 Posts by engagement
INFORMATION PAPER
 Counties Manukau District Health Board
 Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Receive and note this Finance and Corporate Business Report.

Note that this paper presents an overview of the update presented to the Audit Risk and Finance Committee at their meeting of 31 January 2017.

Prepared and submitted by: Margaret White, Chief Financial Officer

Purpose

The purpose of this paper is to provide the Board with an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 31 January 2018.

1.0 Financial Result – December 2017:

While the full finance report is not available for December 2017, is it pleasing to report that the DHB achieved a result close to budget ($10K unfavorable). Refer Table 1 below for summary highlights.

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>136,731</td>
<td>132,845</td>
</tr>
<tr>
<td>Other</td>
<td>2,539</td>
<td>3,062</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>139,270</td>
<td>135,907</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>50,405</td>
<td>49,891</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,436</td>
<td>922</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>5,471</td>
<td>5,524</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>59,522</td>
<td>57,516</td>
</tr>
<tr>
<td>Clinical Sup.</td>
<td>9,869</td>
<td>9,281</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>5,642</td>
<td>6,225</td>
</tr>
<tr>
<td>Operating Exp</td>
<td>132,345</td>
<td>129,359</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>6,925</td>
<td>6,548</td>
</tr>
<tr>
<td>Depn.</td>
<td>2,643</td>
<td>2,661</td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital Chg.</td>
<td>3,399</td>
<td>2,994</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>883</td>
<td>893</td>
</tr>
</tbody>
</table>
Brief commentary on Major Variances

1. Revenue: favourable variances primarily reflect Pay Equity funding for Rest Home workers, additional ACC revenue from the arrears program, offset by a $2m adjustment reflecting YTD under delivery of electives (to be delivered by 30 June).
2. Personnel: year to date variances reflect long term vacancies (offset by outsourcing) and delay in approving new roles. Total FTEs are 6,314 (budget 6,350). The negative variance for the month reflects high bureau costs (highest so far this year) and Schedule 10 costs for House Officers.
3. Outsourced Personnel: reflects locum and bureau cover for staff vacancies along with management personnel associated with strategic projects.
4. Outsourced Services: reflects hospital capacity constraints, but overall, largely close to budget for the month. Main outsourcing areas for the month are Orthopaedics, Ophthalmology and MRI services.
5. Funder Provider payments: variance primarily reflects the Pay Equity settlement for Rest Home workers and continuing provision for net IDF flows.
6. Clinical Supplies: reflects increased costs for treatment disposables, instruments and equipment (especially in Surgery), Pharmaceuticals (PCTs) and delay for delivery of procurement savings.
7. Infrastructure Expenses: costs unfavourable to budget offset in the month by expense capitalisations with respect to HT2020 and sundry accrual reversals.
8. Capital Charge: represents a recalculation with respect to the half year liability.

Consistent with previous months, the December result has been buoyed by a number of favourable one off adjustments amounting to $2.3m ($4.585m YTD). These one off transactions are predominantly a combination of additional ACC arrears, release of Balance Sheet provisions and Mental Health underspend over and above the level budgeted. When added to the budgeted underspend in Mental Health, these adjustments mask the operating result (deficit), as outlined below.

Table 2: Analysis of Underlying Operating Result

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Reported Operating Surplus (Deficit)</td>
<td>883</td>
</tr>
<tr>
<td>MH Underspend</td>
<td>1,088</td>
</tr>
<tr>
<td>Net Favourable One Offs</td>
<td>1,935</td>
</tr>
<tr>
<td>Underlying Operating result (deficit)</td>
<td>(2,140)</td>
</tr>
</tbody>
</table>

The underlying operating deficit is $17.113m YTD. This is $3.87m at variance to the YTD budgeted deficit of $13.237m. Mitigation strategies to manage to budget include the continued identification of “immediate opportunities” (Turnaround Plan) and tightening of processes and criteria for approval of Authorities to Recruit (ATRs). A full review of balance sheet accounts is also underway to confirm actions required to release term provisions.

The full Financial Report for the period ended 30 November 2017 is presented in section 2.0 below.
2.0 Financial Report for the period ended 30 November 2017

Year to date to 30 November 2017 the consolidated result is $0.27m favourable to budget. Performance by division is presented in the table below.

Table 1: Statement of Performance by Operating Arm for the period ended 30 November 2017
(Refer also Table 2)

<table>
<thead>
<tr>
<th>Net Result</th>
<th>Month November 2017</th>
<th>YTD November 2017</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act $000</td>
<td>Bud $000</td>
<td>Var $000</td>
</tr>
<tr>
<td>Hospital Provider</td>
<td>2,402</td>
<td>2,224</td>
<td>178</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(3,677)</td>
<td>(3,725)</td>
<td>48</td>
</tr>
<tr>
<td>Ko Awatea</td>
<td>(1,241)</td>
<td>(1,301)</td>
<td>60</td>
</tr>
<tr>
<td>Provider</td>
<td>(2,516)</td>
<td>(2,802)</td>
<td>286</td>
</tr>
<tr>
<td>Funder</td>
<td>417</td>
<td>411</td>
<td>6</td>
</tr>
<tr>
<td>Governance</td>
<td>(311)</td>
<td>(46)</td>
<td>(265)</td>
</tr>
<tr>
<td><strong>Surplus (deficit)</strong></td>
<td>**(2,410)</td>
<td>**(2,437)</td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>

Provider
YTD Provider Arm is $1.391m favorable to budget. Low elective performance $2.3m adverse YTD has been mitigated by the one off contribution from the ACC arrears programme which YTD is $3.9m favorable to budget. Favorable creditors and vacancies have been partially offset by outsourced personnel and an unfavorable YTD revision in the Capital Charge. Full year forecast reflects our commitment to increase clinical capacity to respond to immediate demand pressures and prepare for 2018 winter.

Funder
YTD the Funder Arm is $0.103m adverse to budget, attributable to a continued provisioning for anticipated for IDF wash-up exposure in Community Pharmaceuticals, Community Laboratory (Rheumatic Fever tests) and Auckland Regional Dental Service (ARDS). This has been mitigated to some extent by the recognition of lower PHO enrolments relative to budget growth assumptions and Mental Health surplus.

Governance
YTD Governance Arm is $0.569m adverse to budget, reflecting $0.089 contracted resource covering vacancies and one off projects, $0.232m write down of previously capitalised (WIP) costs, offset by continued vacancies in Maori Health, Planning and Funding and Mental Health. Full year forecast reflects the $3.0m Scott cladding settlement.

Volume Summary
Sustained acute demand over and above the increases already budgeted, compounded by anesthetist shortages continue to impact Elective surgery volumes. YTD Elective WIES were 6.3% adverse to contract and 6.9% less than the same period last year. Outsourced surgical volumes account for 8% of the YTD elective volumes. $2.3m has been put aside (provisioned) to fund additional capacity required to deliver to the MOH Elective discharge target by 30 June 2018.
Table 2: Statement of Revenue and Expenditure for the period ended 30 November 2017

<table>
<thead>
<tr>
<th></th>
<th>Act $000</th>
<th>Bud $000</th>
<th>Var $000</th>
<th>Act $000</th>
<th>Bud $000</th>
<th>Var $000</th>
<th>Bud $000</th>
<th>Forecast $000</th>
<th>Var $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>135,028</td>
<td>132,706</td>
<td>2,322</td>
<td>673,783</td>
<td>665,217</td>
<td>8,566</td>
<td>1,594,070</td>
<td>1,616,504</td>
<td>22,434</td>
</tr>
<tr>
<td>Other</td>
<td>3,787</td>
<td>3,089</td>
<td>698</td>
<td>16,547</td>
<td>15,664</td>
<td>883</td>
<td>37,478</td>
<td>45,308</td>
<td>7,830</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>138,815</td>
<td>135,795</td>
<td>3,020</td>
<td>690,330</td>
<td>680,881</td>
<td>9,449</td>
<td>1,631,548</td>
<td>1,661,812</td>
<td>30,264</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>51,228</td>
<td>51,971</td>
<td>743</td>
<td>254,221</td>
<td>259,178</td>
<td>4,957</td>
<td>621,256</td>
<td>617,946</td>
<td>3,310</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,929</td>
<td>957 (972)</td>
<td>9,940</td>
<td>4,773</td>
<td>(5,167)</td>
<td>11,339</td>
<td>16,562</td>
<td>17,935</td>
<td>(5,223)</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>5,554</td>
<td>5,816</td>
<td>262</td>
<td>28,746</td>
<td>29,001</td>
<td>255</td>
<td>68,368</td>
<td>69,030</td>
<td>(662)</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>58,579</td>
<td>57,516 (1,063)</td>
<td>294,450</td>
<td>287,580 (6,870)</td>
<td>690,191</td>
<td>708,126</td>
<td>(17,935)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Sup.</td>
<td>11,089</td>
<td>10,107 (982)</td>
<td>51,075</td>
<td>50,171</td>
<td>(904)</td>
<td>125,492</td>
<td>130,733</td>
<td>5,241</td>
<td>(5,241)</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>6,810</td>
<td>6,210 (600)</td>
<td>32,194</td>
<td>31,733</td>
<td>(461)</td>
<td>67,055</td>
<td>68,425</td>
<td>(1,370)</td>
<td></td>
</tr>
<tr>
<td>Operating Exp</td>
<td>135,189</td>
<td>132,577 (2,612)</td>
<td>670,626</td>
<td>662,436 (8,190)</td>
<td>1,583,701</td>
<td>1,610,822</td>
<td>(27,121)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating surplus</td>
<td>3,625</td>
<td>3,218</td>
<td>408</td>
<td>19,704</td>
<td>18,445</td>
<td>1,259</td>
<td>47,847</td>
<td>50,990</td>
<td>3,143</td>
</tr>
<tr>
<td>Depn.</td>
<td>2,637</td>
<td>2,661</td>
<td>24</td>
<td>13,198</td>
<td>13,305</td>
<td>107</td>
<td>31,932</td>
<td>32,325</td>
<td>(393)</td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>322</td>
<td>(322)</td>
</tr>
<tr>
<td>Capital Chg.</td>
<td>3,399</td>
<td>2,994 (405)</td>
<td>15,617</td>
<td>14,970</td>
<td>(647)</td>
<td>35,928</td>
<td>38,385</td>
<td>(2,457)</td>
<td></td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(2,410)</td>
<td>(2,437)</td>
<td>27 (9,111)</td>
<td>(9,830)</td>
<td>719 (20,013)</td>
<td>(20,042)</td>
<td>(29)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Commentary on Major Variances:

**Crown Revenue**

YTD was $8.566m favourable to budget, reflecting the following:

- favourable unbudgeted MoH funding for Disability Support Services Pay Equity (offset in Funder Provider Payments) $4.3m
- favourable accrual for System Level Measures funding paid to PHO’s during the month (offset in Funder Provider Payments) $1.0m
- favourable unbudgeted revenue for After Hours Service provided on behalf of other DHB’s and PHO’s (offset in Funder Payments) $0.619m
- favourable Social Investment Board Funding from State Services Commission $0.776m
- on-going ACC arrears initiative $3.9m
- unfavourable $2.3m due to under delivery of elective programme (funding has been provisioned in balance sheet for release in line with delivery against the MoH contract for the balance of year)

**Other Revenue**

YTD was $0.883m favourable to budget attributable to:

- favourable $0.133m cost reimbursement Hauora Maori training funding
- favourable private patients $0.467m
- favourable patients co-payments $0.295m
- favourable doubtful debt recovery $0.227m
- favourable research grants $0.324m
- unfavourable $0.889 Pharmacy revenue (offset in infrastructure)
Personnel and Outsourced Personnel
YTD net personnel costs for November are $0.210m unfavourable. This combined with $210K unfavourable outsourced services reflects pressure on our underlying result (refer Tables 4 and 5 overleaf).

Funder Provider Payments
YTD was $6.870m unfavourable to budget, reflecting the following:
- unfavourable $4.3m accrual for Disability Support Services Pay Equity (offset in Crown Revenue)
- unfavourable $1.1m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue)
- unfavourable $1.3m payments for After Hour costs (offset in Other Revenue)
- unfavourable $0.788m accrual for the current estimate of IDF shortfall for the 17/18 year

Clinical Supplies
YTD was $0.904m unfavourable to budget, reflecting high clinical demand and significant increase in treatment disposables, offset by favourable movement in creditors.

Infrastructure
YTD $0.461m unfavourable to budget, mostly reflecting Retail Pharmacy Cost of Goods Sold (offset in Other Revenue), offset by additional hotel services due to winter patient volumes and facilities maintenance overspends.

Depreciation, Interest and Capital Charge
Depreciation and Capital Charge YTD is $0.540m unfavourable to budget reflecting timing in capitalisation of projects, and a revision in the capital charge.

Forecast Year End Position as at 30 November
The full year forecast reflects the position as at 30 November 2017. The current forecast suggests that the overall 17/18 budget is still achievable, however dependant on savings initiatives and offsets.

Performance against Savings Programme
As at 30 November 2017, performance against the organisation wide savings programme was $3.033m unfavourable. YTD under delivery on savings programmes have been offset by a number of transactions, a number of these are one off in nature (those which are not expected to repeat or be sustained in future FY).

Analysis of underlying operating result
To understand the underlying operating result, the consolidated result is adjusted for “net one off” transactions together with the underspend from the Mental Health ring-fence. This reveals an underlying operating deficit of $35.976m. Refer Chart 1 below.
Chart 1: Underlying Operating Result:

Note that the 2017/18 Mental health underspend will erode in 2018/19 as the AMHU and community programmes come online.
Table 4: Statement of Financial Position as at 30 November 2017

<table>
<thead>
<tr>
<th></th>
<th>Act</th>
<th>Bud</th>
<th>Var</th>
<th>June 2017</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Bank</td>
<td>45,821</td>
<td>68,801</td>
<td>(22,980)</td>
<td>20,894</td>
<td>24,927</td>
</tr>
<tr>
<td>Trust</td>
<td>886</td>
<td>888</td>
<td>(2)</td>
<td>883</td>
<td>3</td>
</tr>
<tr>
<td>Prepayments</td>
<td>2,756</td>
<td>2,307</td>
<td>449</td>
<td>2,307</td>
<td>449</td>
</tr>
<tr>
<td>Debtors</td>
<td>46,146</td>
<td>51,091</td>
<td>(4,945)</td>
<td>46,990</td>
<td>(844)</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,388</td>
<td>7,484</td>
<td>(96)</td>
<td>7,484</td>
<td>(96)</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>5,320</td>
<td>5,320</td>
<td>-</td>
<td>33,743</td>
<td>(28,423)</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td>108,325</td>
<td>135,899</td>
<td>(27,574)</td>
<td>112,309</td>
<td>(3,984)</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>602,700</td>
<td>621,146</td>
<td>(18,446)</td>
<td>600,455</td>
<td>2,245</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,627</td>
<td>1,627</td>
<td>-</td>
<td>1,627</td>
<td>-</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,097</td>
<td>10,385</td>
<td>(6,288)</td>
<td>4,259</td>
<td>(162)</td>
</tr>
<tr>
<td>Information Software</td>
<td>561</td>
<td>561</td>
<td>-</td>
<td>561</td>
<td>-</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>4,416</td>
<td>4,466</td>
<td>(50)</td>
<td>4,416</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>825,821</td>
<td>850,605</td>
<td>(24,784)</td>
<td>823,738</td>
<td>2,083</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(162,289)</td>
<td>(165,011)</td>
<td>2,722</td>
<td>(151,706)</td>
<td>(10,583)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>663,532</td>
<td>685,594</td>
<td>(22,062)</td>
<td>672,032</td>
<td>(8,500)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>64,149</td>
<td>47,354</td>
<td>16,795</td>
<td>50,551</td>
<td>13,598</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>727,681</td>
<td>732,948</td>
<td>(5,267)</td>
<td>722,583</td>
<td>5,098</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>45,201</td>
<td>45,538</td>
<td>(337)</td>
<td>41,834</td>
<td>3,367</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>881,207</td>
<td>914,385</td>
<td>(33,178)</td>
<td>876,726</td>
<td>4,481</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>100,881</td>
<td>108,982</td>
<td>(8,101)</td>
<td>92,119</td>
<td>8,762</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>7,462</td>
<td>9,164</td>
<td>(1,702)</td>
<td>6,164</td>
<td>1,298</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>12,663</td>
<td>16,362</td>
<td>(3,699)</td>
<td>13,324</td>
<td>(661)</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>29,398</td>
<td>26,838</td>
<td>2,560</td>
<td>26,370</td>
<td>3,028</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>91,209</td>
<td>89,644</td>
<td>1,565</td>
<td>86,083</td>
<td>5,126</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>241,613</td>
<td>250,990</td>
<td>(9,377)</td>
<td>224,060</td>
<td>17,553</td>
</tr>
<tr>
<td>Working Capital</td>
<td>(133,288)</td>
<td>(115,091)</td>
<td>(18,197)</td>
<td>(111,751)</td>
<td>(21,537)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>639,594</td>
<td>663,395</td>
<td>(23,801)</td>
<td>652,666</td>
<td>(13,072)</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Provisions (non-current)</td>
<td>18,717</td>
<td>18,717</td>
<td>-</td>
<td>22,658</td>
<td>(3,941)</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>878</td>
<td>898</td>
<td>(20)</td>
<td>898</td>
<td>(20)</td>
</tr>
<tr>
<td>Insurance Liability - non current</td>
<td>931</td>
<td>931</td>
<td>-</td>
<td>931</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>20,526</td>
<td>20,546</td>
<td>(20)</td>
<td>24,487</td>
<td>(3,961)</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>399,789</td>
<td>424,288</td>
<td>(24,499)</td>
<td>399,789</td>
<td>-</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>283,553</td>
<td>283,552</td>
<td>1</td>
<td>283,553</td>
<td>-</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(64,274)</td>
<td>(64,991)</td>
<td>717</td>
<td>(55,163)</td>
<td>(9,111)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>619,068</td>
<td>642,849</td>
<td>(23,781)</td>
<td>628,179</td>
<td>(9,111)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>639,594</td>
<td>663,395</td>
<td>(23,801)</td>
<td>652,666</td>
<td>(13,072)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

• Bank was $22.98m adverse to budget, largely attributable to timing with the budgeted $24.5m funding from the Ministry of Health for the AMHU now expected to be received in tranches, offset by a $3.0m contract settlement during the month of August. AMHU Funding tranches forecast to begin in April 2018 with $7.8m and the balance during the 2018/19 financial year.

• Debtors were $4.945m lower than budget attributable to undelivered Electives $2.6m.

• Total Fixed Assets were $5.267m lower than budget reflecting timing of capitalisation for major capital projects (KA II, AMHU and HT2020).

• Creditors were $8.1m unfavourable to budget reflecting the following:
  ▪ Capital spend being $2.2m lower than planned for November not therefore being carried in Creditors balance.
  ▪ Budget assumed holding opening balance sheet, which includes $11m for 2016/17 IDF wash-up, which was paid out in October, offset by the above budget, $2.7m accrual for 2017/18 IDF shortfall, and the accrual $1.9m for healthAlliance in relation to HT2020.

• Income in Advance was $1.7m lower than budget, with budget assuming a month on month increase of $0.6m to allow for under delivery of service, where YTS average has been $0.260k.

• GST and PAYE were $3.7m lower than budget mostly attributable to timing of for PAYE.

• Payroll Accrual & Clearing were $2.56m higher than budget reflecting timing of Salaries and Wages.

• Employee Provisions were $1.56m higher than budget. The current leave provision was $0.892m higher than budget, together with long service leave $0.332m higher than budget.

• Working Capital $18.197m unfavourable to budget mostly attributable to the timing variance for the $24.5m AMHU funding from the Ministry of Health.
Table 5: Statement of Cash flow for the period ended 30 November 2017

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td><strong>Cash flows from Operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>129,602</td>
<td>133,402</td>
</tr>
<tr>
<td>Other</td>
<td>4,198</td>
<td>2,872</td>
</tr>
<tr>
<td>Interest rec.</td>
<td>164</td>
<td>217</td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(83,464)</td>
<td>(77,488)</td>
</tr>
<tr>
<td>Employees</td>
<td>(56,917)</td>
<td>(51,579)</td>
</tr>
<tr>
<td>Interest paid</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital charge</td>
<td>(1)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Operations</strong></td>
<td>(6,600)</td>
<td>7,424</td>
</tr>
<tr>
<td><strong>Cash flows from Investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(3,829)</td>
<td>(5,940)</td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>(1,067)</td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(3,829)</td>
<td>(7,007)</td>
</tr>
<tr>
<td><strong>Cash flows from Financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>28,423</td>
<td>28,423</td>
</tr>
<tr>
<td>Equity Injection</td>
<td>-</td>
<td>24,500</td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td>28,423</td>
<td>52,923</td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>17,994</td>
<td>53,340</td>
</tr>
<tr>
<td>Opening cash</td>
<td>27,835</td>
<td>15,469</td>
</tr>
<tr>
<td><strong>Closing cash</strong></td>
<td>45,829</td>
<td>68,809</td>
</tr>
<tr>
<td><strong>Reconciliation Summary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(2,410)</td>
<td>(2,437)</td>
</tr>
<tr>
<td>Add/(Less) non-cash items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairment of Intangibles</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depn</td>
<td>2,637</td>
<td>2,661</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>227</td>
<td>224</td>
</tr>
<tr>
<td>Add/(Less) items Classified as Investing or Financing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on Disposal</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Add/(Less) Movements in Financial Position items</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtor and Other Receivables</td>
<td>(1,415)</td>
<td>96</td>
</tr>
<tr>
<td>Inventories</td>
<td>282</td>
<td>-</td>
</tr>
<tr>
<td>Creditors</td>
<td>(2)</td>
<td>6,712</td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>(5,692)</td>
<td>392</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(6,827)</td>
<td>7,200</td>
</tr>
<tr>
<td><strong>Net Cash flow from Operations</strong></td>
<td>(6,600)</td>
<td>7,424</td>
</tr>
<tr>
<td><strong>Net Cash from Investing</strong></td>
<td>(3,829)</td>
<td>(7,007)</td>
</tr>
<tr>
<td><strong>Net Cash from Financing</strong></td>
<td>28,423</td>
<td>52,923</td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>17,994</td>
<td>53,340</td>
</tr>
<tr>
<td>Opening Cash</td>
<td>27,835</td>
<td>15,469</td>
</tr>
<tr>
<td><strong>Closing Cash</strong></td>
<td>45,829</td>
<td>68,809</td>
</tr>
<tr>
<td>- Base operating cash</td>
<td>45,829</td>
<td>68,809</td>
</tr>
<tr>
<td>- Hypothecated capital</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- YTD cash-flow from Crown Revenue is $9.4m favourable to budget, representing:
  - favourable $3.0m from the on-going ACC arrears initiative; and
  - favourable $4.3 Ministry of Health funding for Disability Support Services (offset in payments to suppliers).

- YTD payments to suppliers were $24.8m higher than budget, reflecting:
  - October payment of $11.8m for 2016/17 IDF wash-up,
  - unfavourable $3.7m outsourced personnel, unfavourable $1.1m for clinical supplies together with the increased Funder Provider Payments:
    - unfavourable $1.1m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue);
    - unfavourable $1.3m payments for After hour cost (offset in Crown Revenue);
    - unfavourable $4.3m Disability Support service Pay Equity (offset in Crown Revenue).

- Employee Payments were $7.871m favourable to budget representing the vacancies across the service together with the $2.56m higher balance in Payroll Accrual & Clearing predominantly due to timing of the payroll.

- Fixed Assets $4.7m favourable to budget representing the timing of capitalisation for major capital projects (KA II, AMHU and HT2020).

- Investments were $1.04m favourable to budget representing the NZHPL spend for NOS, not incurred in accordance with budget.

- Other Non-Current Liability $24.5m adverse to budget, attributable to the capital injection from the Ministry of Health for the AMHU now expected to be received in tranches rather than the budgeted payment in advance. First tranche is forecast for April 2018 for $7.8m, balance in the 2018/19 and 2019/20 financial year.

Treasury

Table 6: Treasury Report NZHPL sweep

<table>
<thead>
<tr>
<th></th>
<th>$NZ 000's 30 Nov 17</th>
<th>Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated funds - NZHPL sweep</td>
<td>$45,783</td>
<td>2.68%</td>
</tr>
<tr>
<td>Hypothecated funds (included in sweep)</td>
<td>$0</td>
<td>2.68%</td>
</tr>
<tr>
<td>Base cash</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Overdraft</td>
<td>$0</td>
<td>3.18%</td>
</tr>
</tbody>
</table>

The interest rate is the rate on the last day of the month as advised by NZHPL, who manage the sector cash sweep for cash funds on hand and the BNZ rate applying to drawn debt. As at 30 November 2017, the BNZ facility limit was $75m for CM Health. This facility is reviewed annually based on the final year end results reported to the MoH.

Following the 6 December 2017 Board meeting, the following funds were hypothecated to a subsidiary account comprising:

<table>
<thead>
<tr>
<th></th>
<th>$NZ 000's - 7 Dec 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMHU</td>
<td>$9,987</td>
</tr>
<tr>
<td>Net proceeds from sale of land</td>
<td>$28,400</td>
</tr>
<tr>
<td>Re-clad settlement</td>
<td>$3,000</td>
</tr>
<tr>
<td>Total</td>
<td>$41,387</td>
</tr>
</tbody>
</table>
**Counties Manukau Health Board Meeting**

**Resolution to Exclude the Public**

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| Risk Workshop                                                                 | 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. | Confidentiality of Advice Tendered by Officials  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. |
| Public Excluded Minutes of 6 December 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. |
| Public Excluded Minutes of the Community and Public Health Advisory Committee, Hospital Advisory Committee and the 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. |
| Turnaround 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. |
| NZHP Combined SOI/SPE and 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 | Commercial Activities  
Information contained in this report is related to commercial activities and the DHB would be prejudiced or |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Reason for Withholding</th>
<th>Information</th>
<th>Act or Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating Governance for Disability Issues</td>
<td>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>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td></td>
</tr>
<tr>
<td>Specialised Rehabilitation Centre Investment</td>
<td>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>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td></td>
</tr>
<tr>
<td>Northern Region Procurement Policy</td>
<td>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>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td></td>
</tr>
</tbody>
</table>

Disadvantaged if that information was made public.

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

**Protect Confidentiality of Advice Tendered by Officials/Free and Frank Expression of Opinion/Negotiations**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials; maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation of officers and employees of any department or organisation in the course of their duty; information contained in this report is related to commercial negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.

[Official Information Act 1982 S9(2)(f)(iv); S9(2)(g)(i); S9(2)(j)]

**Commercial Activities**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.

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

**Negotiations**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.

[Official Information Act 1982 S9(2)(j)]
<table>
<thead>
<tr>
<th>Delegated Financial Authority Policy</th>
<th>Protect Confidentiality of Advice Tendered by Officials</th>
</tr>
</thead>
<tbody>
<tr>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final NRLTIP</th>
<th>Protect Confidentiality of Advice Tendered by Officials/Free and Frank Expression of Opinion/Negotiations</th>
</tr>
</thead>
<tbody>
<tr>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials; maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation of officers and employees of any department or organisation in the course of their duty; information contained in this report is related to commercial negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RISSP</th>
<th>Protect Confidentiality of Advice Tendered by Officials/Free and Frank Expression of Opinion/Negotiations</th>
</tr>
</thead>
<tbody>
<tr>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials; maintain the effective conduct of public affairs through the free and frank expression of opinions by or between or to Ministers of the Crown or members of an organisation of officers and employees of any department or organisation in the course of their duty; information contained in this report is related to commercial negotiations and the DHB would be prejudiced or disadvantaged if...</td>
</tr>
</tbody>
</table>
Metro Auckland Urgent Care & Overnight Services Procurement

That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S32(a)]

Commercial Activities/ Negotiations/Commercial Position

Information contained in this report is related to commercial activities and negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.

[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(ii)]

Temporary Accommodation for East Care

That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S32(a)]

Commercial Activities/ Negotiations/Commercial Position

Information contained in this report is related to commercial activities and negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.

[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(ii)]

Finance & Corporate Business Report

That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S32(a)]

Commercial Activities/ Negotiations/Commercial Position

Information contained in this report is related to commercial activities and negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.

[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(ii)]

APAC Forum 2017 Cancellation

That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S32(a)]

Protect Confidentiality of Advice Tendered by Officials/Commercial Activities/Commercial Position

The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials.

Information contained in this report is related to commercial activities and negotiations and the DHB would be prejudiced or disadvantaged if that information was made public.

[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(ii)]

Social Investment Board Update

That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S32(a)]

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
<table>
<thead>
<tr>
<th>Section</th>
<th>Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>9(3)(g)(ii) of the Official Information Act 1982.</td>
<td>Confidentiality of communications by or with the Sovereign or her representative.</td>
</tr>
</tbody>
</table>