MEETING OF THE BOARD
4 April 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 – Board Secretary

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

8.00 – 9.30am BOARD ONLY SESSION

9.40am 1. AGENDA ORDER AND TIMINGS

2. BOARD MINUTES

9.40am 2.1 Confirmation of Minutes of the Meeting of the Board – 28 February 2017
9.45am 2.2 Actions arising from previous minutes
9.50am 2.3 Minutes Community and Public Health Advisory Committee – 21 February 2017 (Colleen Brown)
9.55am 2.4 Minutes Hospital Advisory Committee – 31 January/14 March 2018 (Lyn Murphy)

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3. EXECUTIVE REPORTS

10.00am 3.1 Chief Executive Officer’s Report (including Patient Story) (Gloria Johnson)
10.10am 3.2 Health and Safety Performance Report/Flu Campaign 2018 (Elizabeth Jeffs)
10.20am 3.3 Corporate Affairs and Communications Report (Donna Baker)

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4. PERFORMANCE REPORTS

10.30am 4.1 Finance and Corporate Business Report (Margaret White)

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10.40am 5. RESOLUTION TO EXCLUDE THE PUBLIC

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## 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>
<th>Nov</th>
<th>12 Dec</th>
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<tbody>
<tr>
<td>Rabin Rabindran (Chair)</td>
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<td>Dr Lyn Murphy</td>
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<td>Dianne Glenn</td>
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<td>Reece Autagavaia</td>
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<td>George Ngatai</td>
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<td>Catherine Abel-Pattinson</td>
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<td>Katrina Bungard</td>
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<td>Mark Darrow</td>
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<td>Dr Ashraf Choudhary</td>
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</tbody>
</table>

* Attended part meeting only
## BOARD MEMBERS’ DISCLOSURE OF INTERESTS
4 April 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  
• **Chair, Rawiri Residents Association** |
<table>
<thead>
<tr>
<th>Name</th>
<th>Roles and Affiliations</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  
• Trustee, Epiphany Pacific Trust  
• Trustee, The Good The Bad Trust  
• Member, Otara-Papatoetoe Local Board  
• Member, District Licensing Committee of Auckland Council  
• **Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation**
| 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  
<p>| | • Justice of the Peace |</p>
<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, 28 February 2018

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

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT
   Rabin Rabindran (Board Chair)
   Ashraf Choudhary
   Colleen Brown
   Catherine Abel-Pattinson
   Dianne Glenn
   Lyn Murphy
   George Ngatai
   Katrina Bungard
   Apulu Reece Autagavaia

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

PUBLIC AND MEDIA REPRESENTATIVES
   Dr Colin Thompson, CM Health

APOLOGIES
   Mark Darrow

WELCOME
   The Chair welcomed all those present.

DISCLOSURE OF INTERESTS/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.

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 – 6 December 2017

Resolution (Moved: Rabin Rabindran/Seconded: Colleen Brown)

That the Minutes of the Board Meeting held on the 6 December 2017 be approved.

Carried

2.2 Actions Arising from Previous Meeting

There were no actions arising from the previous meeting.

2.3 Draft Minutes of Community Public Health & Advisory Committee (29 November 2017)

The minutes were taken as read.

2.4 Draft Minutes of Disability Support Advisory Committee (22 November 2017)

The minutes were taken as read.

Ms Brown noted that there had been no action in progressing the stock-take of disability provider services within the health sector and the accessibility audit of the MMH campus facilities and these two important items will need to be followed up.

Ms Brown also drew the Board’s attention to the health indicators for New Zealander’s with an intellectual disability noted on page 31 noting they are very disturbing statistics.

2.5 Draft Minutes Hospital Advisory Committee (15 November 2017)

The minutes were taken as read.

3 EXECUTIVE REPORTS

3.1 Chief Executive’s Report (Dr Gloria Johnson)

The report was taken as read. Dr Johnson summarised the following key areas:

Clinical services have remained extremely busy this summer, with January having the highest number of ED presentations ever. It appears that there are no particular issues or group of patients driving this apart from purely population numbers.

Northern hemisphere flu season has been very busy and severe resulting in a high rate of mortality and hospitalisations, particularly children and the elderly, and has exceeded the rates experienced during the Swine Flu epidemic. This is a concern for the DHB as it may indicate the type of flu season we will get in New Zealand. If that happens, the hospital will not only have a very busy winter, we will also have very, very sick patients in the hospital which will put pressure on the entire system including the intensive care services.
Flu vaccinations commence in March. We need to have a particularly proactive and strong campaign around our staff but also out in the community to get more coverage.

The Board agreed that they must lead by example and asked that a vaccinator be available at the 4 April Board meeting to vaccinate Board members. Comms to attend to take photos for use on social media site and in the local community.

Jenny Parr read Sarah’s story from August 2017.

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

That the Board:

Received the Chief Executive’s Report.

Endorsed the Chief Executive’s request to circulate the report to CM Health staff after each Board meeting.

Carried

3.2 Health and Safety Report (Elizabeth Jeffs)

The report was taken as read.

There were no notifiable events for December 2017.

Regional Internal Audit has completed a review of the Health & Safety Board Report and the report will be refreshed over the next few months to align with their recommendations.

Staff Flu Vaccination Update - it was noted that the target for 2018 will increase from 70% to 74% in line with the national target. Whilst the Board acknowledged the rise in the target, they expressed a strong and firm desire to aim for a 100% flu vaccination rate of staff in Paediatrics, Maternity and Health of the Elderly as these are the most vulnerable groups of people in the hospital.

The Board requested a report back (4 April) which will explain how the organisation will conduct the flu campaign this year, how it will be different from other years and how the organisation will implement the Board’s desire to have a 100% vaccination rate in the three services noted above.

Aggression and Violence – there is an upward trend of aggression and violence incidents year on year which in part is due to the acuity of some of the patients. All incidents in December were directed at staff. Under the Health & Safety at Work Act, the Board has an obligation to ensure that staff are safe, and that is the very least it should do. Whilst the Board accepts that in some areas patients are not aware of what they are doing, at the same time it cannot accept violence against staff, it is totally unacceptable.

Dr Johnson advised that from an operational perspective, one programme of work that may be helpful is the work currently being led by the Quality & Safety Commission in attempting to eliminate
the use of seclusion in all Mental Health services throughout the country. As part of this programme there will be a lot of work undertaken on how to better anticipate and de-escalate all forms of aggression in mental health services where people end up seclusion.

The Board asked that Mental Health Services provide a report on this programme once the work is underway.

The Chair confirmed that from a governance perspective, the Board has to be able to show what it is doing to minimise risk for the staff - whilst staff are undergoing training on best practice, what else should the Board be doing. The Board requested a deep dive into aggression and violence to enable them to get a sense of the overall problem (the training programmes available, the work occurring in Mental Health and ED together with the recent OIA data that was put together).

**Resolution** (Moved: Colleen Brown/Seconded: Ashraf Choudhary)

That the Board:

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

Expectation is a 100% flu vaccination uptake by staff who work in the following three particular Services - Paediatrics, Maternity and Health of Older People.

Carried

3.3 Corporate Affairs and Communications Report (Donna Baker)

The report was taken as read. Donna Baker summarised the report noting:

*Census* - a lot of work has gone into the upcoming Census; there are eight videos out on social media in the community which are getting good coverage, everywhere you look in the hospital you are reminded about the upcoming Census by way of posters, screensavers and there has also been coverage in the media and on television. The significant message throughout has been that if you do not fill in the census, it will impact on the hospital’s future funding.

*Flu Vaccination* – it will be important to communicate the Board’s expectation that there is a 100% flu vaccination uptake by the staff who work in three particular services noted above.

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

That the Board:

Received the Corporate Affairs and Communication Report for the period 14 January to 14 February 2018.

Carried
PERFORMANCE REPORTS

4.1 Finance and Corporate Business Report (Margaret White)

The paper was taken as read.

Whilst the full finance report is not available for December 2017, it was pleasing to note that the DHB achieved a result close to budget ($10k unfavourable).

The ongoing pressure that the hospital is under extends itself to the community teams and community providers and the good work being done, whilst operating in what is a very tight budget, was acknowledged.

Attention is now focusing on forecasting for the balance of year through to 30 June 2018 with budgeting for 18/19 well under way.

Indications from the Ministry around the funding signal suggest that this will be delayed again this year.

RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: George Ngatai/Seconded: Lyn Murphy)

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

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

<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>Risk Workshop</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>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>
</tr>
<tr>
<td>Public Excluded Minutes of 6 December 2017/Actions</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<tr>
<td>Section Title</td>
<td>Resolution</td>
<td>Reference</td>
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<tr>
<td>Public Excluded Minutes of the Community and Public Health Advisory Committee, Hospital Advisory Committee and the Audit Risk &amp; Finance Committee</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
</tr>
<tr>
<td>Confirmation of Minutes</td>
<td>As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<td>Turnaround Plan</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
</tr>
<tr>
<td>Commercial Activities</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
<td>Official Information Act 1982 S9(2)(i)</td>
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<tr>
<td>NZHP Combined SOI/SPE and Annual Plan</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
</tr>
<tr>
<td>Commercial Activities</td>
<td>Information contained in this report is related to commercial activities and the DHB would be prejudiced or disadvantaged if that information was made public.</td>
<td>Official Information Act 1982 S9(2)(i)</td>
</tr>
<tr>
<td>Integrating Governance for Disability Issues</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>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
</tr>
</tbody>
</table>
| 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)]
<table>
<thead>
<tr>
<th>Specialised Rehabilitation Centre Investment</th>
<th>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.</th>
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</thead>
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<tr>
<td>Commercial Activities</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
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</table>

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

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<thead>
<tr>
<th>Northern Region Procurement Policy</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect Confidentiality of Advice Tendered by Officials</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>
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</table>

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

<table>
<thead>
<tr>
<th>Delegated Financial Authority Policy</th>
<th>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.</th>
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<td>Protect Confidentiality of Advice Tendered by Officials</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>

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

<table>
<thead>
<tr>
<th>Final NRLTIP</th>
<th>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.</th>
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<tr>
<td>Protect Confidentiality of Advice Tendered by Officials</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</td>
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</table>

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

**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)(f)(iv); S9(2)(g)(i); S9(2)(j)]

### 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.**

**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**

**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)]
<table>
<thead>
<tr>
<th>Section</th>
<th>Information Made Public</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance &amp; Corporate Business Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities/Negotiations/Commercial Position</td>
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<tr>
<td>APAC Forum 2017 Cancellation</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>Protect Confidentiality of Advice Tendered by Officials/Commercial Activities/Commercial Position</td>
</tr>
<tr>
<td>Social Investment Board Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Communication with the Sovereign</td>
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<tr>
<td>County Manukau District Health Board</td>
<td>Information was made public.</td>
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<tr>
<td>County Manukau District Health Board</td>
<td>[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(iii)]</td>
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<td>County Manukau District Health Board</td>
<td>[Official Information Act 1982 S9(2)(i); S9(2)(j) and S9(2)(b)(iii)]</td>
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</table>

The public meeting closed at 10.50am.
SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 28 FEBRUARY 2018.

BOARD CHAIR

DATE
### Counties Manukau District Health Board
#### Action Items Register (Public)

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 February 2018</td>
<td>Health and Safety Report</td>
<td>The Board requested a report back (4 April) which will explain how the organisation will conduct the flu campaign this year, how it will be different from other years and how the organisation will implement the Board’s desire to have a 100% vaccination rate in the three services noted above. The Board requested a deep dive into aggression and violence to enable them to get a sense of the overall problem (the training programmes available, the work occurring in Mental Health and ED together with the recent OIA data that was put together). The Board asked that Mental Health Services provide a report on this programme to eliminate the use of seclusion in all MH services throughout the country once the work is underway.</td>
<td>4 April</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 3.2 on today’s agenda.</td>
<td>✔️</td>
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<td></td>
<td></td>
<td></td>
<td>Date TBC</td>
<td>Elizabeth Jeffs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Date TBC</td>
<td>Tess Ahern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 February 2018</td>
<td>Chief Executive’s Report</td>
<td>The Board agreed that they must lead by example and asked that a vaccinator be available at the 4 April Board meeting to vaccinate Board members. Comms to attend to take photos for use on social media site and in the local community.</td>
<td>4 April</td>
<td>Vanessa Thornton</td>
<td>Deferred to 16 May as vaccine not yet available.</td>
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<tr>
<td>6 December</td>
<td>Health and Safety Report</td>
<td><em>Way Finding</em> – 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>
<td></td>
<td></td>
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<tr>
<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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<tr>
<td>25 October</td>
<td>Demonstration – E-Vitals</td>
<td>The Chair noted that the Board would schedule a ward visit in the New Year to enable them to see how e-Vitals is working at the bedside.</td>
<td>Date TBC</td>
<td>Board Secretary</td>
<td>Work in progress.</td>
<td></td>
</tr>
<tr>
<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>Deferred to 16/5/18</td>
<td>Margaret White</td>
<td>Work in progress.</td>
<td></td>
</tr>
<tr>
<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>4 April</td>
<td>Carmel Ellis</td>
<td>Refer Item 5.3 on today's Public Excluded agenda</td>
<td></td>
</tr>
<tr>
<td>2 August</td>
<td>Health and Safety Report</td>
<td>Executive Health &amp; Safety Committee Minutes to be submitted to the Board six weekly for the Board’s information.</td>
<td>16 May</td>
<td>Elizabeth Jeffs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee
Held on Wednesday, 21 February 2018 at 9.00am – 10.45pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Ashraf Choudary
Dianne Glenn
Katrina Bungard
George Ngatai
John Wong
Reece Autagavaia

ALSO PRESENT

Margie Apa (Director, Population Health & Strategy)
Benedict Hefford (Director Primary, Community and Integrated Care)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Vicky Tafau (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

Pauline Brown of the Auckland Women’s Health Council was present.

APOLOGIES

Apologies were received and accepted from Rabin Rabindran, Gloria Johnson and Margie Apa and Katrina Bungard for lateness.

WELCOME

The Chair welcomed all those present to the meeting. Ms Brown advised the forum that she had met with Mr Hefford in regard to organising a meeting with Maori Providers in order for the DHB to work more closely with them to enable a change in the health statistics for the community. This will be a workshop style meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted.
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 29 November 2018.**

**Resolution** (Moved: Colleen Brown/Seconded: John Wong)

That the minutes of the Community and Public Health Advisory Committee meeting held on 29 November 2017 be approved.

**Carried**

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

Noted.

Ms Brown and Mr Hefford to have an offline conversation in regard to what is to be kept on for 11 April agenda or deferred to 23 May agenda.

3. **BRIEFING PAPERS**

3.1 **Green Prescriptions (GRx) in Counties Manukau (Pippa van Paauwe)**

The initiative consists of two components: GRx (for adults) and the GRx Active Families programme which aims to increase physical activity for children, young people and their families, and was introduced in 2004.

GRx began in 1998. The initiative was transferred from Sport and Recreation New Zealand (SPARC) in 2009 to the Ministry of Health with the expectation in future that funding would be more closely aligned with other services helping manage long term conditions.

In 2013 there was an additional $7.2 million allocated, over the next four years, to the GRx budget to increase adult referrals, particularly for patients with pre-diabetes or diabetes.

Research published in the New Zealand Medical Journal indicates that a Green Prescription is an inexpensive way of increasing physical activity.

Research published in the British Medical Journal found that a Green Prescription can improve a patient’s quality of life over 12 months, with no evidence of adverse effects.

Research published in the British Medical Journal on the cost-effectiveness of physical activity in primary care stated that ‘community walking, exercise and nutrition, and brief advice with exercise on prescription (Green Prescription) were the most cost-effective with respect to cost-utility.’

Usually the programme is delivered through a Regional Sports Trust. CM Health maintains a contract with Sports Auckland to deliver its Adult programmes.
CM Health has a separate provider – Otara Health Charitable Trust - delivering the Active Futures and Families programme. For Active Futures, we are one of 10 DHBs that have this kind of programme.

Most referrals for GRx are to support prevention and management in patients with chronic disease and long term conditions such as cardiovascular disease and diabetes. In particular, GRx encourages patients to manage their own conditions by increasing physical activity and improving nutrition.

The majority of referrals are from General Practice Teams and the majority of people are referred due to diabetes and weight issues.

Ms van Paauwe advised the forum of relevant statistics pertaining to the CM Health community:

- Around 21% of children and young people (5-18) in CM are overweight and 19% are obese. For children under 5 it is 19%
- Higher rates for Maaori (23.6%) and Pacific 28.9%
- Obese children are more likely to be obese in adult hood, have abnormal blood pressure and have an increased risk of developing diabetes and heart disease as adults
- High body mass index (BMI) has now overtaken tobacco as the leading risk to health in New Zealand

The Childhood Obesity Plan consists of a package of initiatives that aim to prevent and manage obesity in children and young people up to 18 years of age by focusing on:

- targeted interventions for those who are obese;
- increased support for those at risk of becoming obese; and
- broad approaches to make healthier choices easier for all New Zealanders.

Long term goals of the programme are to:

- be involved in regular physical activity – at least 60 minutes on most days of the week;
- eat a wide range of healthy food options; and
- be healthier overall.

Referral is usually from a GP or health professional, however, people can also self-refer but this requires (like GRx) sign off from a GP. Priority is given to 5-12 year olds.

The emphasis of the programme is on food, behaviour change, the environment and being active at each life stage, starting during pregnancy and early childhood. Comprehensive lifestyle action involves the child’s whaanau and combines healthy eating, increased physical activity, less sedentary activity and behavioural support. Referrals also obtained from GP or other Health Professional.

As of the most recent Quarter, GRx families are now transitioned through to the Ponga stage and Active Futures are transitioned to the silver stage. BMI maintenance and reduction is now being monitored.

- 100% felt the staff is fully trained and capable
- 78% felt their life is now better and healthier since working with Otara Health
- 89% overall, were satisfied with the AF programme 20% of Active Futures participants were satisfied with their overall health and wellbeing in their baseline assessment. This increased to 60% by their final assessment
- 70% of Active Futures participants said they had a good understanding of the benefits of physical activity/exercise/movement by their final assessment
CM Health is looking to share their reporting template with ADHB and WDHB in order to look at collecting data together.

CM Health is also engaging with local marae and churches to connect families with activities within their communities.

The Committee thanked Ms van Paauwe for the very informative presentation.

**Action**

The CPHAC committee would like Ms van Paauwe to return in the latter half of year to provide an update on progress.

4. **BRIEFING PAPERS**

4.1 **New Government’s Health Policies & Priorities**

The Minister has stated that the government intends to implement Labour’s health policy and coalition agreements in full. Key commitments include:

**Primary Care:** From 1 July 2018, lowering the cost of GP visits by $10 through:
- lowering the Very Low Cost Access (VLCA) fee cap by $10 to $8 for adults and $2 for teens (under 13s are already free), with a funding increase to VLCA practices to cover this
- increasing government funding for all practices that lower their fees by $10, lowering the average non-VLCA fee from $42 to $32 and the maximum fee from $69 to $59
- annual free health checks for seniors with the SuperGold card
- free doctors' visits for all under 14s
- increasing funding for GP training places, taking the intake to 300 per year
- carrying out a review of primary care funding to further reduce barriers to primary care and ensure the financial sustainability of practices
- increasing the age for free breast screening to 74.

**Mental Health:**
- increasing resources for frontline health workers and co-locating mental health and primary care teams
- re-establish the Mental Health Commission
- extend School Based Health Services to all public secondary schools so all schools have a comprehensive youth (mental) health service.
- Free counselling for under 25s, and ensure everyone has timely access to quality mental health services
- boost funding for alcohol and drug addiction services
- initiating a review of mental health and addiction services to identify gaps in services (the Terms of Reference for this review are attached).

In many of these areas, such as integrated mental health services, CM Health is already at the forefront of implementing new locality based models of care and the learning from our experience can potentially feed into national policy developments and pilots. In other areas, such as lower primary care part charges for low income earners, the additional funding could have a disproportionately positive impact for our high needs population in South Auckland. Although it is still early days, various CM Health clinicians and managers are engaged with
national policy activity to ensure we lend influence and expertise where appropriate. We will update the Committee as the policy details emerge.

CPHAC queried where the trained personnel will come from and Mr Hefford advised that this is on the radar, and clarified that concerns don’t just lie with budget issues.

In response to a funding query re VLCA practices, Mr Hefford advised that the capitation amount will increase for those services that have $0 fees.

**Decision**
The Community & Public Health Advisory Committee:

**Noted** that the new Coalition Government is in the relatively early stages of planning implementation of key health policies agreed by Cabinet, therefore operational details about how those policies will be funded and rolled out is still being determined.

**Noted** that the Minister of Health has confirmed the Government’s commitment to key coalition policy initiatives, including lowering the cost of GP visits; re-establishing the Mental Health Commission; annual free health checks for seniors; free doctors’ visits for all under 14s; increasing the age for free breast screening to 74; free counselling for under 25s, and ensuring everyone has timely access to quality mental health and alcohol and drug addiction services.

**Noted** that key clinical and managerial leaders from Counties Manukau Health are engaging with the Ministry and national groups and programmes to lend expertise and influence to the operationalisation of these policies over the next three years.
5. RESOLUTION TO EXCLUDE THE PUBLIC

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

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
</table>
| 2.1 Confirmation of the Public Excluded Minutes of 29 November 2017 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |
| 3.1 Social Investment Board | 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. |

**Carried**

The open session of the meeting concluded at 10.20am.


______________________________
Colleen Brown  
Committee Chair
 Minutes of Counties Manukau District Health Board  
Hospital Advisory Committee  
Held on Wednesday, 31 January 2018 at 1.00pm  
Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland  

PART I – Items considered in Public Meeting  

BOARD MEMBERS PRESENT  
Catherine Abel-Pattinson (Deputy Chair)  
Dr Ashraf Choudary  
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)  
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 for the public section of this meeting.  

APOLOGIES  
An apology was received and accepted from Dr Lyn Murphy.  

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 15 November 2017

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

That the minutes of the Hospital Advisory Committee meeting held on 15 November 2017 be approved.

Carried

2.2 Action Item Register

Noted.

3. PROVIDER ARM PERFORMANCE REPORT

Phillip Balmer introduced the report highlighting:

*Executive Summary* – Summer review was held yesterday which revealed the reduction in volumes over summer was for a very short period of time only and our acute growth continues and the pressures associated with that.

December/January also saw a significant increase in both spinal and burns patients concurrently which tested both regional and national ICH/HDU capacity and capability to provide a quality of care for these patients. More accidental injuries occur in general over the summer.

*System Level Measures* – will report back with an update around the work programme to 14 March HAC meeting.

*Health Targets* – Dianne Glenn advised that the Prime Minister had just announced that the State Services targets would no longer need to be met and queried whether our national health targets come under that umbrella. Dr Johnson advised that we are awaiting official confirmation from the Ministry which is expected before the next reporting period. An update will be provided to the next HAC meeting (14 March) to confirm whether those targets will be what is required going forward or whether there may be new ones.

*Finance Report* – a question was raised in relation to the significant reduction in donation revenue of $574k. Margaret White confirmed that the DHB had budgeted $2m for Middlemore Foundation funded projects which are always subject to variability and timing. The revenue is also not recognised until the cash is actually received. In this case, this year they have had some quite large projects that they have been looking at but which haven’t managed to progress through (ie) the Kidz First re-development. Moving forward for 18/19, the expectation has been cut down to a more realistic figure. The Committee asked Mr Balmer to invite the Middlemore Foundation to attend the 16 May Board meeting to provide an overview of how the Foundation supports the hospital and to discuss their new strategy and structure. A copy of the MMF constitution to be provided to the Board at this time.
Non-Resident Bad Debt – undertake a peer review of our process compared to the WDHB process to see what the outcomes are and report back to 14 March HAC meeting. Provide a deep dive to the 14 March HAC meeting into how our funding works including an overview of what fits within the revenue categories.

Emergency Department, Medicine and Integrated Care (Brad Healey)

ED Volumes - volumes have continued at very high levels. What used to be winter is now becoming summer and winter is becoming a whole new territory.

Bowel Screening Programme – the Ministry do not have sufficient funding for what they want us to do and we are therefore proceeding on the basis that the Ministry accept that we have to cut our cloth to fit - the rate of people going into the programme will be lower than what the national standard will be. Planning continues for a start date in July. Invitations will be issued late-June to all eligible people in the Counties Manukau area between the age of 50-69yrs. The expectation is that 950 people will go through the programme in Year 1 with 70 additional surgeries occurring at an earlier stage.

Breastscreening – it was noted that Breastscreening volumes for Māori women remains below target. Ask the Population Health team if there is any Public Health initiatives/activity around teaching women to undertake self-breast examinations.

Surgery, Anaesthesia & Perioperative Services (Mary Burr)

Acute outputs increased during November which enabled the Service to provide a buffer for busier times. High acutes over the Christmas period did impact on electives in December but because of the buffer, YTD volumes were able to be maintained.

Ophthalmology – continue to make good progress with the high level of delayed follow-ups. All long waiting patients are being sent personalised letters to inform of delays and offer advice on self-care. The Suite on Level 3 Galbraith is working well and has potential to keep growing in relation to the number of patients that are seen there. The region is now sharing images through a shared database. A See and Treat Cataract model has commenced.

Central Clinical Services (Ian Dodson)

Laboratory – the Patient Blood Management project which targets improved appropriate usage of red blood cells in the management of iron deficiency anaemia, started in December. This should deliver both savings in red blood cell usage (circa $400k pa) and better surgical outcomes.

Radiologists – the Service has had a number of key risks for well over a year now in relation to staffing and service capacity - 15FTE down at the worse time. With students coming out and a refreshed push for staffing, vacancy rate is now down to 4 but this has caused significant wait lists in MRI and plain film. Outsourcing has been increased where possible to try and mitigate some of the risk however, private MRI capacity is close to maximum as well. A new MRI machine has been approved and should be in situ in October this year.

Histology Lab – IANZ have been kept informed of the progress to date and are aware that to progress a move into a new space, we are waiting the outcome of the seismic review of the Galbraith building. The recent lab reconfiguration has provided the best possible workflow in the meantime given the space constraints. Histology growth rate of testing is still double
digit and whilst this reconfiguration will work for the time being, it will only buy us another 6-12 months. IANZ are due to undertake another accreditation visit in April.

**Food Service** – the Food Service Agreement includes a KPI for patient satisfaction survey responses with a monthly survey carried out aiming for 150 responses per month. In November, Compass distributed 165 surveys with 114 patients responding. Three areas scored less than 95% satisfaction – appearance of meals, taste of meals and temperature of the hot food. Compass will be asked to add this to their Improvement Plan and to target action on these areas.

**Kidz First & Women’s Health** (Nettie Knetsch)

*Neonatal Capacity* – occupancy for November increased to 94% (32 resourced cots) and continues to be high in December. From the regional work it is clear that we have to increase the resourced occupancy in the unit (don’t have enough resourced beds). This has been signed off and recruitment commences although recruiting for neo-natal nurses is not easy as it takes 3-4 years to be trained to the highest level.

If we continue to grow and need to bring back some of the Counties-domiciled babies that currently stay too long at ADHB, we will need to increase the physical capacity of the unit as well. Planning is underway to understand how we would do that and what space would be available.

Work is underway regionally looking at the lower level neonates to get regional consistency with the L1 babies – are they better to be with mum on the post-natal floor, what is the impact of that and how many more beds would be needed. We also need more regional flexibility and being more proactive about moving babies around that are rather fragile.

There is discussion going on nationally that neonatal care may be provided one week earlier if resuscitating 23 week old babies is nationally signed off. CM Health does not currently resuscitate 23 week old babies, ADHB do at times. This is something that needs to be agreed nationally so everyone understands the immediate consequences for the neonatal units but also the ongoing long term care that these babies will need.

**Midwifery Workforce** – we need more midwives but also need to look at the ratio of midwives to mother and baby because of the acuity of the women. Work is underway regionally on this.

**Security Arrangements for Babies** – a verbal update was provided.

**Middlemore Central** (Dot McKeen)

*Care Capacity Demand Management* – limitations have been identified with the available reporting tools within the AWM tool (McKesson) which are needed to guide Charge Nurse Managers in effective decision-making for rosters and staff allocations. 15 DHBs currently use Trendcare and that tool is recognised by both the SSHW and NZNO for the safe management of staffing levels. There is a MECA expectation that we are CCDM compliant by June 2021. A paper is being prepared to update the Executive Leadership Team and inform further discussions.
Adult Rehabilitation & Health of Older People

The report was taken as read.

Mental Health & Addictions

The report was taken as read.

Facilities

Fleet Replacement Plan – the hA RFP for the northern regions lease vehicles has concluded with a panel of suppliers identified. Agreement of the master –lease documents between the suppliers and hA has been frustrated and is holding up the first batch of CM Health vehicles being placed with lease vehicles. Further delays may jeopardise the replacement plan and ultimately affect savings targets. Mark Darrow asked that an update on this be tabled at the next Audit Risk & Finance meeting (14 March) and that the $ value of the contract is confirmed in order to determine whether this requires Board approval or can be delegated to the CEO/CFO for sign-off.

(Gloria Johnson, Rabin Rabindran & Margaret White departed the meeting at the afternoon tea break).

4. CORPORATE REPORTS

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

Leadership Changes – Denise Kivell, Director of Nursing has announced she will be leaving the DHB in February. She has been the DoN for 10 years and a valued and well-connected clinical leader at CM Health for over 26 years. She has championed the role of nursing in health care, supported development of innovative models of care and contributed nationally via roles including 4 years as Chair of Nurse Executives NZ.

Dr Wilbur Farmilo also retired at the end of December 2017 after almost 40 years at CM Health. Dr Farmilo began work as a general surgeon and in later years took up clinical leadership roles, leading first General Surgery followed by the Clinical Director of Surgical Services, and finally the deputy CMO of CM Health. During that time he achieved many successes and made great a contribution to improving the health and outcomes for people living in Counties.

Wendy McKinstry has been appointed as the acting Director of Allied Health for six-months while permanent arrangements are finalised.

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

The Hospital Advisory Committee sends a letter to Dr Wilbur Farmilo and Denise Kivell recognising their contribution to the HAC Committee and their service to CM Health.

Carried

Manukau Super Clinic Shuttle Service – it was noted that a reduced northern shuttle service route for patients resumed on 10 July 2017 however, it is challenging maintaining this service using only volunteers who are not always available. There is no immediate plan to re-establish the southern shuttle service route. The Committee asked for the Northern and
Southern routes to be clarified and included in this report at the next HAC meeting (14 March).

4.2 HR Report

The report was taken as read.

5. INFORMATION PAPERS

5.1 Q1 2017-18 Non-Financial Summary 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:

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Carried

The open session of the meeting concluded at 3.48pm.


_____________________________
Catherine Abel-Pattinson (Deputy Chair)
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Wednesday, 14 March 2018 at 1.00pm
Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

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)
Vicky Tafau (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 for the public section of this meeting.

APOLOGIES

Apologies were received from Mr Rabindran and Dr Johnson who will be departing the meeting at 2.30pm.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

There were no specific interests to note regarding 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 31 January 2018.**

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

   That the minutes of the Hospital Advisory Committee meeting held on 15 November 2017 be approved.

   **Carried**

2.2 **Action Item Register**

   It was noted that all actions are either on task or have been rescheduled.

   The Hospital Advisory Committee (HAC) would like the Middlemore Foundation to present to this forum at a later date, to be determined.

3. **PROVIDER ARM PERFORMANCE REPORT**

   Phillip Balmer introduced the report highlighting:

   **Executive Summary** – There is a level of concern with the demand experienced in December 2017 continuing into January 2018. Work is being undertaken around capacity and Middlemore will need to accommodate for an increased acute demand.

   The committee was asked to refer to graph Total Burns Surface Area on page 18. The numbers for November/December 2017 are sitting at 250. We haven’t seen this number since 2012.

   There was a period of time where we had to shut theatres due to a significant risk of infection. It was necessary to get other centres to manage their burns locally as part of a Burns Service escalation plan. Counties Manukau Health (CM Health) needs to grow the system of care. Work that we’re doing will see us focussing on system level measures.

   30% of our beds are linked to four chronic conditions. We know that the system of care needs work.

   Mr Balmer was asked if we know the cause of the increases in number of burns patients. Mr Balmer advised that a detailed breakdown is being worked on. This may well be of interest to the Accident Compensation Commission.

   The Tahitian burns contract was raised by the Hospital Advisory Committee and they were advised that patients had been rerouted to Australia whilst infection was prevalent. CM Health are currently working with the Ministry of Health to think through what additional funding needs to be asked for. Three theatres per day were in use for burns during summer. Another strain on the system is the isolation rooms. Some Intensive Care Unit rooms are to be converted to accommodate the peak demand.
The Tahitian contract (District Health Board) has been a useful source of revenue to date and a good source of training and keeping surgeon’s skills current, however, we may need to revisit this due to the volume of in-country burns.

**Action**
A paper will be bought back to the Hospital Advisory Committee on 23 April 2018 re acute admissions.

An investigation into resources and volume of care regarding burns patients will also be bought back to HAC along with an Elective Catch-Up Plan that is also being worked on.

**Finance Report** – Provider Arm
The report was taken as read.
The Committee was advised that CM Health have under delivered on our electives. Despite this there has been a large overspend on additional Emergency Department nurses.

Mr Balmer advised the forum that if Middlemore doesn’t have sufficient capacity, it will become inefficient. Surgery patient length of stay has increased, and this has increased the need to be mindful of the fact that we need to keep focus on performance/benchmarking and remaining efficient. Middlemore working in conjunction with the community teams to assist patients to be able to return home earlier, is on the radar.

Virtual wards will mean that patients could go home a full day or two earlier.

Mr Balmer was asked about support for families when patients return home early and he advised that Senior Medical Officer’s teams linked to specific geographical areas can work more closely with General Practitioners. We are currently working through electronic options for that. The intent is to ensure the success of virtual wards.

Community Central currently works with the referrals. They analyse the need for each visit and look at risks, in particular with Service Level Measures (SLM). There is a stream of work being undertaken and Community Central is already working in this space.

There is requirement for a well-coordinated team to ensure the right patients are referred to the right out-patient service. Phone calls are made to homes the day after release to ensure medications are being taken. Other support is also on offer. We need to ensure all services are linked back to the General Practitioner (GP).

The Hospital Advisory Committee queried who it is that holds responsibility to improve health literacy for care givers in the home. The Population Health team is undertaking a large body of work in this area. This is an ongoing iterative process whereby each message needs to be consistent.

Ms Glenn raised a question around bad debt and was directed to the paper appended to the Bad Debt paper. It appears the paper as dropped off Diligent. Ms Tafau will ensure it is reloaded.

**Action**
Bad Debt summary to be bought to HAC quarterly by Finance.
Emergency Department, Medicine and Integrated Care (Brad Healey)

The report was taken as read.

General Medicine has a project team working around the development of the Model of Care.

Medical Staffing Roster
With additional bed capacity we need to implement the roster. A consultation process is about to be undertaken.

CM Health has a contract with Diaverum NZ Limited (Diaverum) for the provision of a managed renal haemodialysis service. The service operates at a facility leased and operated by Diaverum, located at 10 Waddon Place, Mangere. The term of the agreement is 10 years and commenced in February 2016. A significant change in circumstances for Diaverum has led to them deciding to sell their business interests in Australia and New Zealand. Diaverum are seeking CM Health consent to the sale of the NZ business pursuant to clause 33-1 of the agreement as part of a sale of the Australasian operations of Diaverum.

We are currently undertaking a due diligence on the proposed sale and will be formally reporting on this to ELT and the Audit Risk & Finance Committee.

Highlighted: Non-Achievement of the CM Health Gastroscopy P2
The CM Health P2 Gastroscopy target continues to be in breach, and the waiting list is now growing again. This is due to the reduced capacity over the holiday, and sustained increases in demand since December. Gastroscopies have a comparatively shorter completion time, but the recovery time is the same, and requires Post Anaesthetic Care Unit (PACU) capacity. Further outsourcing for colonoscopies will be revisited to create more capacity on lists for gastroscopies.
A paper will be going to the Executive Leadership Team (ELT) regarding this issue.

The challenge is that there is no target for gastroscopy and volumes are going up, as they are for colonoscopies. The clinical concern is around P1 performance for gastroscopy. Performance is well below target sitting at 38%, should be 72%. There is a need to ensure we are not disadvantaging patients in our endeavour to hit targets.

Currently there are approximately 1000 patients on the waiting list. How do we get the list down in order to have a sustainable group moving forward in order to achieve target? Is there sufficient resource in the community to do this? The answer is yes, but it is also dependent on what other DHBs are doing.

Surgery, Anaesthesia & Perioperative Services (Mary Burr)
The report was taken as read.

High level of acuity and services are coping well. However, it is impacting on electives. Strategies are in place to deal with the impacts such as looking at using MSC in a different way. Since the beginning of February 2018, 20 surgical cases have taken longer than nine hours. This will utilise two anaesthetists and means a surgeon can’t work the following day. Increases are, in part, due to co-morbidities. More electives are being undertaken at Middlemore, in particular for patients with co-morbidities.

In regard to the anaesthetic shortage, there has been good success in recruiting four fixed term positions and three permanent positions. Further interviews are currently going on.
The burns influx has been worked through. An external review of the service is being undertaken to ensure we are prepared if there is a serious influx again. There is a need to rewrite the escalation plan.

The Central Sterile Services Department refurbishment has been completed.

Ophthalmology: RANSGO are very much behind CM Health in this. Four mega clinics have been held, including weekend clinics. There will also be joint clinics with Auckland. These should clear 2000 patients. There is a need for an ongoing plan and additional investment will be required long term. The right model of care will also work towards solving this issue. CM Health is easily the worst in the country in terms of overdue patients. In 2009 we had 18,000 overdue patients, in 2018 that number has increased to 50,000 patients. This is due, largely to an aging population.

In terms of funding it was mentioned that the Board members sitting at the table are concerned with the undercount in Census. CM Health is working closely with Statistics NZ to work through this.

**Central Clinical Services** (Ian Dodson)

The report was taken as read.

The current staffing shortage is improving with staff agreeing to work extra hours/weekends. Currently the longest wait is nine weeks. Target is to have 95% wait time within six weeks. Additional clinics have been added with MRI and CT, however, MRI is still a long way off from achieving targets.

Osteoarthritis patients appear to have the longest waiting period, due in part to the fact that the x-ray is not critical to the treatment path and they are a lower risk group. We are currently prioritising acute chest imaging and cancer patients.

Maternity/primary scanning is also under pressure. There are workforce issues across the board. There has been a need to manage primary maternity patients that are being advised to attend hospital, complaining of stomach pains. Central Clinical Services are picking this up and managing it.

Electronic ordering of orderlies in Emergency Care (EC) has seen an uptake of 95%. Previously there was up to a 70-minute wait per patient and this has been reduced to 25 minutes per patient. The positive impact has been felt by the whole process. The reduction in wait time has eliminated a full eight hours of a nurse’s work in EC. This will in turn reduce overcrowding and will assist with the hospital being better able to cope with the EC demand.

**Kidz First & Women’s Health** (Nettie Knetsch)

The report was taken as read.

There has been an increase into presentations of children into KidzFirst. We are currently drilling down on who these patients are, particularly after hours. The volume increase is a change as is the time of presentation. 70% of the presentations are after 3pm in the afternoon. 50% have been seen in Primary Care first. The admission rate for children however, is only 12%.
Consideration has been given to a different model of care, possibly an in-house GP. School nurses play an important role, particularly during the day.

Regional neonatal capacity planning continues, with meetings to progress the regional management of cots and transfer of baby’s processes. The work plan for 2018 is to review models of care across all 4 DHBs (including Northland), in particular in regard of the management of level 1 babies (low acuity neonates). A multidisciplinary meeting (including Neonatologist, Obstetricians and Planning and Funding) is scheduled for 12 March 2018.

The Caesarean rate for January 2017 was 27%, YTD the rate is 28% (2% up on last year). The increase is all in acute Caesarean Sections (CS). The CS rate and processes are reviewed routinely with the clinical team.

The region continues with data analysis and clinical discussion to understand what is driving the significant spike across the region over the past 7 months. Midwifery (both Lead Maternity Carer and self-employed) and junior medical staff shortages may well be a factor in this increase, as well as the impact of new practice guidelines.

The increasing acuity and complexity in maternity (Caesarean Section rate up by 2% and Induction of Labour rate up by 2%) combined with the additional neonatal workload resulted in more midwifery workforce required than budgeted. Fortunately, availability of bureau staff has been good over the December and January period, but there were significant overtime hours as well. In anticipation for the 2018/19 budget, we have reviewed the midwifery ratios required for our current workload and complexity. This amounts to 12 FTE additional midwives, as well as 4 Health Care Assistants for Middlemore and the community birthing units.

Only 45% of patients with Gestational diabetes are followed up with another blood test. The forum was advised that Auckland District Health Board is also seeing increases as they have an older population of women having babies.

The region as a total is seeing pressure. Hospitals must keep one acute theatre free at all times. As a result, CM Health are planning one more acute theatre at Middlemore, increasing the number from 14 to 15.

CM Health will look to send more electives to Manukau Surgery Centre (MSC), this includes resources for Saturdays, Sundays and long weekends.

We are still awaiting the full detailed Midwifery data from Health Workforce NZ, but initial data shows a significant difference of number of birth per midwife FTE for our DHB – i.e. 11 births more per FTE than the national average.

The regional General Managers, Clinical Directors, and Directors of Midwifery meet monthly to provide updates on the current regional midwifery shortages. The local pressure area is the Birthing and Assessment Unit, where shortages and skill mix issues exist due to experienced midwives that have retired or are on parental leave. Birthing and Assessment have started their workflow and process project with Ko Awatea and follows the principles of the Maternity Ward project (Living our Values). The local Midwifery Strategic Staffing group continue, with representation from both the Midwifery Employee Representation and Advisory Service (MERAS) and New Zealand Nursing Organisation (NZNO), to discuss local short-term strategies, and act on feedback and ideas from the midwifery workforce.
The Clinical Maternity Co-ordinator roles have commenced. This senior midwifery role will be pivotal across the Women’s Health service, with a consistent single point of contact for 24/7 bed management and patient flow across Birthing and Assessment, Maternity Ward and the 3 Units.

Recruitment for new graduate midwives (with an expected starting date in May 2018) is underway with interviews taking place late February and early March.

There are 20 new midwives in the hospital and 10 to 12 Lead Maternity Carers (LMCs). This is a good step in the right direction. Midwives have made a pay equity claim. NZNO and MERAS awaiting the outcome of this claim.

Mr Rabindran and Dr Johnson left at 2.40pm.

Adult Rehabilitation & Health of Older People

The report was taken as read.
Mr Balmer talked to the report as Ms Ralph-Smith was unavailable to attend the Health Advisory Committee.

The Stroke Unit’s thrombolysis rates are pleasing. Good indicators and low readmission rates. The average length of stay is eight to nine days. Benchmarking has been undertaken and our results were good.

**Action**
A summary of a National Health Service (NHS) report mentioned by Mr Balmer is to be bought to the Health Advisory Committee on 23 April 2018.

Mental Health & Addictions

The report was taken as read.

The Mental Health Inquiry has contacted Ms Ahern and she has identified a day at which we will be able to highlight some of the areas of good gains that are different from other areas.

Specialist Community Mental Health

Direction is good, but staff wants to know more detail. This is a challenging time for workforce as it is looking to change the way people work.

Primary Care is going well, and we are building some stories. Community Alcohol and Drug (AOD) is a Regional Service and is challenging to work with and this has been highlighted to ELT. While we pay for the service, it is proving difficult to get them on-board with the service integration model.

Community Alcohol and Drug Services (CADS) Regional Service is being invited to attend ELT where these issues can be worked through.

**Action**
Update on CADs process at the next Hospital Advisory Committee meeting on 23 April 2018.

Facilities

The report was taken as read.
**Middlemore Central** (Dot McKeen)

The report was taken as read.

Medical volumes up for most of January, Surgery on target which enabled medical to be moved around a bit.

Following the previous winter, we planned to close 2230 bed days. We, in fact, closed at just over this amount which was 300 lower than last year. This period covers Christmas Eve 2017 through to 5 January 2018.

Dot Days mean that absolute everywhere is full (resourced beds).

Ms McKeen advised the forum that a Quad Flu Vaccine will be made available this year. This is a positive for the coming winter season. The vaccine may be free in pharmacies, and only a small charge at the GP. Regional and local flu planning meetings are underway.

School based vaccinations were raised by the Hospital Advisory Committee, as it has been previously at Community and Public Health Advisory Committee (CPHAC). There is a need to work harder this winter to increase the amount of people vaccinated.

**Care Capacity Demand Management (CCDM)**

In February, we are hosting Lisa Skeet, Director - Safe Staffing Healthy Workplace. She will give the CCDM Steering Group advice on the application to work with the unit on development of the CCDM suite of tools. A business plan for Trendcare has been prepared for ELT to consider.

Winter planning: data has been collated and will be presented to the Middlemore Central Governance meeting.

**4. CORPORATE REPORTS**

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

The paper was taken as read.

A number of events and celebrations were held for Denise Kivell, Director of Nursing prior to her leaving CM Health in mid-February 2018. Karyn Sangster has been appointed as the acting Deputy Director of Patient Care – Nursing, starting on Monday 26 February until the end of June 2018. This role will provide nursing leadership following Denise’s departure. This is an interim role for the next few months, while the directorate determines the permanent senior professional leadership requirements.

Ms Parr will look to close out acting roles by end of June and will spend the next four weeks in consultation to see what future roles will look like. The Head of Feedback role is currently being recruited.

**Action**

Northern Shuttle Route. Ms Parr to send to Ms Tafau for dissemination to the group.

The forum was advised that the second route is not currently operating.

It was suggested that there could be a philanthropic organisation that may like to fund this? Ms Parr advised that the cessation of MTA vouchers for the volunteers saw a reduction in
volunteers. Ms Parr reiterated that it is very challenging to run this service. 10% of people in Mangere/Otara don’t have cars and affordability is a barrier.
The question was raised around how we might work more closely with Auckland Transport to improve routes? Might Mr Rabindran have some contacts?
Ms Parr asked for this conversation to be continued in the Public Excluded section of this meeting.

The Nursing Staff target is 12% and we are currently standing at 5%.
Work in schools: there is a lot of work being undertaken in this area. Ms Parr will be visiting Auckland University to talk to Y3 students.
The Maaori and Pacific doctor quota has been filled for this year. A Maaori Doctors support group has been implemented in conjunction with Maaori Health Development.

Community Nurses in Mangere and Otara: staff retention is an issue. Due in part to flea bites.

**Action**
Cellulitis update is to be provided at an upcoming CPHAC meeting. Information is to be provided in terms of staff losses and the increase in presentations at ED and with GPs. It was noted that the Social Investment Board does a lot of work in this area too. Ms Tafau to contact Margie Apa, Karyn Sangster and Wendy Walker to coordinate a presentation.

4.2 HR Report

The report was taken as read.
Mr Balmer advised the forum that the organisation is heading in a better direction in terms of turnover than in the past.

Dr Johnson returned to the meeting.

5. INFORMATION PAPERS

5.1 Q1 2017-18 Non-Financial Summary Report

The report was taken as read.

The Hospital Advisory Committee asked if we have a way of tracking the target for obese children who are referred and confirming if they did in fact attend the appointment?

**Action**
The requested information is to be sourced and bought back to the following Hospital Advisory Committee meeting on 23 April 2018.

**Action**
In terms of Maaori Men and Women Health Targets, the Hospital Advisory Committee should make decisions regarding what targets we should focus on, where can we make the most gains. Mana Whenua i Tamakai Makaurau’s Board have already signalled their willingness to work in conjunction with CM Health around these targets. Dr Murphy advised that CPHAC could also follow up on these targets.
6. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution** (Moved: Mark Darrow/Seconded: Ashraf Choudhary)

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:

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**Carried**

The open session of the meeting concluded at 3.48pm.


Dr Lyn Murphy
Chair
Counties Manukau District Health Board
Chief Executive’s Report

Recommendation

It is recommended that the Board:

Receive the Chief Executive’s Report.

Prepared and submitted by: Gloria Johnson, Acting Chief Executive.

News and Events Summary

Middlemore Hospital welcomes Minister of Health

On 13 March CM Health was delighted to welcome the Minister of Health, the Honourable David Clark, to Middlemore Hospital. The Minister briefly visited to look at some of our facilities and talk to staff about some of the challenges CM Health is experiencing. He was provided with a dossier of information on some key issues. He was very appreciative of everyone’s hard work and held our DHB in high regard “CM Health is one of the biggest, busiest and brightest DHBs in the country” he said. “The services and care you provide sit at the core of this community.”
New MRI Suite in Harley Gray

In December 2017, the CM Health Board gave final approval to install two new MRI scanners in the Ground Floor of the Harley Gray Building. This will signal the beginning of a long-term plan to relocate the main Radiology department to the Ground Floor of Harley Gray.

The Board will recall that the Middlemore Hospital site currently has only one MRI scanner, which causes significant constraints on being able to cope with the variable demand of acute scanning. It is expected that the addition of a second scanner will provide immediate improvements in the turnaround time for hospital referred MRIs. The 3T and 1.5T scanner will be co-located and this will enable the Radiology service to provide a wider range of imaging capability on site. This will also provide faster and automated processing and better service continuity.

The new technology in the scanners, including a wider bore hole and faster patient positioning, will significantly improve the patient experience and provide higher quality images. The Radiology Service is currently outsourcing approximately 2,000 MRI scans per year to meet current demand so the additional machine, with a capacity of approximately 2900 scans, will enable nearly all of this imaging to be performed within CM Health.

Construction of the new MRI Suite is now underway and the new scanners are anticipated to be fully operational by the end of 2018.

The news and this photo of the construction site received a lot of positive attention (128 thumbs up and hearts!) when it was placed on our Facebook page.
Future Focus

Expansion of services to meet immediate demand

Further to previous discussions and in line with our commitment to adequately resource for immediate clinical demand and winter, our Executive Leadership Team (ELT) has assessed proposals for additional capacity to address critical pressure areas. At the time of writing the ELT has approved 205 FTE and associated non-staff costs amounting to $30m (annualised). This resource has been prioritised for immediate recruitment to increase capacity and improve flow in the following areas:

- 79 additional adult beds and 4 neonatal cots – the adult beds include re-opening beds in Galbraith and also staffing unused beds at Manukau.
- 542 additional theatre sessions via extended hours/lists at both MMH and MSC to provide additional capacity to meet growth in acute demand and reduce the cancellation rate for elective lists. Additional Anaesthetic FTEs have also been approved to reduce theatre session cancellations more generally.

Acknowledging the immediate need to expedite assessment and resolution of asset remediation works, funding (largely one off/non recurring) has also been approved to support:

- Facilities Management Programme (FMP) delivery.
- Clinical Engineering reduction of non-compliant Warrants of Fitness for clinical equipment.
- Implementation of an Asbestos Management Plan, completion of seismic and criticality assessments and engineering costing assessments to support remediation business cases and procurement.

Further investment requirements will be assessed over the coming weeks and more formally once the 2018/19 funding signal is received (now expected May 2018).

Executive Leadership Team, Ko Awatea and Healthy Together 2020 Directorate Review

The consultation process regarding roles and structures in relation to Ko Awatea and the Healthy Together 2020 Directorate has concluded and the Decision Document was issued in the week commencing 12 March.

The changes that were proposed were intended to:

- clarify Ko Awatea’s role as the centre for system improvement, innovation and change.
- establish a single team dedicated to managing our information systems and producing high quality health intelligence.
- integrate workforce and organisational development functions into other relevant directorates.

Key high level outcomes were that:

1. The Ko Awatea team will manage and support strategic change projects, continuous quality improvement initiatives and develop improvement and change leadership capability. It will include an Improvement and Change team, a Strategic Project Management Office (SPMO), a Business Support team, Research & Evaluation Office and the Library and Knowledge Management team, configured as three portfolios: Improvement and Change, Strategic Programme Management Office (SPMO) and a Knowledge Hub. Portfolio Manager roles will be introduced to lead specific programmes of improvement and change. These new roles will partner with senior leaders across the system to identify, advise and support improvement and change activity. There will continue to be a 0.5 FTE Director, Ko Awatea on the ELT.

Ko Awatea will support system change and improvement across CM Health as a priority. It will continue to collaborate regionally with the metro Auckland regional innovation network, whilst also maintaining strong relationships with the Health Quality & Safety Commission (HQSC) and other New Zealand health boards. Support for other sectors may be undertaken as directed by the ELT.
The name, Ko Awatea, will continue to be used to describe the team, the centre and as a CM Health brand for appropriate services, products and expertise.

2. A new directorate of Health Intelligence and Information Systems will be formed to build on the existing Health Intelligence & Informatics and Healthy Together Technology programme teams. This directorate, under the leadership of a newly created inter-DHB CIO role, will be responsible for developing and delivering on CM Health’s Information Strategy to ensure CM Health benefits from ongoing advances in big data, analytics, intelligence and technology. The CIO role, positioned in the ELT, will be shared with Waitemata DHB, each DHB contributing 0.5 FTE. Once that role is in place a further consultation process regarding the set up of the Health Intelligence and Information Systems directorate, its operational leadership and its components, will be undertaken. This consultation will include discussion with additional teams for potential inclusion. In the interim period, the Director Hospital Services will provide executive leadership for the teams in the new directorate. Changes to roles or reporting lines for most members of the current Healthy Together 2020 group will be paused until the further consultation process has occurred. There are some exceptions to this, including the disestablishment of the Director Healthy Together 2020 role and movement of some roles to relevant teams in Ko Awatea to support integration of benefits analysis and change management into all programmes and projects.

3. Elements of the Building Capability team will be repositioned with some roles under the Director of Patient Care and some under the Director Human Resource. This will ensure this capability remains a vital part of the organisation and is more closely linked with similar functions.

There are some reporting line and role changes and a very small number of disestablished positions as a result of the review. The changes are effective 31 March and recruitment will commence immediately for the new leadership roles.

Complaints Review Update
The review of CM Health’s feedback and complaint process is now concluded. It has resulted in the development of Feedback Central, a centralised team comprised of redistributed existing organisational resources from Surgery, Anaesthesia and Perioperative Care Services and the Directorate of Patient Care. This team will be able to work flexibly across the organisation to address coordination, timeliness and expertise gaps that exist with Complaint and Adverse Event management.

Feedback Central will be a direct report to the Chief Medical Officer and is now in the implementation phase as the Head of Feedback and Adverse Events role is being recruited.

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>Emergency Departments</td>
<td><strong>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</strong>&lt;br&gt;&lt;br&gt;December 2017 (Q2 final result): 90% (target 95%)&lt;br&gt;January 2018 (individual month result): 88%&lt;br&gt;&lt;br&gt;Note: Patient volume and bed demand pressures mean that the hospital has been unable to reach the six-hour target; achieving 88% for January against a target of 95%. This is due to a variety of factors, high consistent surge presentation rates and consistently high hospital occupancy.</td>
<td>AT RISK</td>
</tr>
<tr>
<td>Elective Surgery*</td>
<td>Elective surgery will increase by an average of 4,000 discharges per year.</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>December 2017 (Q2 result): 97.9% (target 100%)</td>
<td>AT RISK</td>
<td></td>
</tr>
<tr>
<td>ESP12: 24 FSA breaches (0.2%) for December (target 0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESP15: 33 treatment breaches (0.9%) for December (target 0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January 2018 (Indicative individual month result) 97% (target 100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Due to sustained high acute volumes and anaesthetists shortage, there is continued pressure on both ESP12 (FSAs) and ESP15 (Treatment) in a number of services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Faster Cancer Treatment</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017 (Q2 result): 94% (target 90%)</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>January 2018 (Indicative individual month result) 97% (target 90%)</td>
<td></td>
</tr>
<tr>
<td>8 breaches in January:</td>
<td></td>
</tr>
<tr>
<td>1 was due to capacity – patient took 25 days to reach FSA due to SMO leave and high patient volumes.</td>
<td></td>
</tr>
<tr>
<td>7 were due to clinical considerations.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> A review of all patients that have required access to services across the Christmas and summer period is underway to identify areas of slow down or breach in the pathway. This will be used to inform future service planning across this timeframe. Focus remains on completion of action plans by all tumour streams, aiming to achieve sustainability in processes and pathways. Feedback on activity is provided via the FCT operations group weekly meeting and will inform the FCT governance meeting.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>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).</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017 (Q2 result): 93% for total population (Maaori coverage: 86%, Pacific coverage: 94%)(target 95%)</td>
<td>AT RISK</td>
</tr>
<tr>
<td>February 2018 (individual month result) 93% total population (Maaori coverage: 86%, Pacific coverage: 94%)(target 95%)</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Maaori immunisation rates have risen from 84% In January to 86% in February.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Raising Healthy Kids**</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017 (Q2 result): 100% total population (Maaori: 100%, Pacific: 100%)(target 95%)</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>February 2018 (individual month result): 100% total population (Maaori: 100%, Pacific: 100%)(target 95%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco Primary</th>
<th>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017 (Q2 result): 89% total population (Maaori: 88%, Pacific: 89%)(target 90%)</td>
<td>ON COURSE</td>
</tr>
<tr>
<td>February 2018 (individual month result): 87% total population (Maaori 86%, Pacific 86%) (target 90%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2017 (Q2 result): 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.

NOTE: At the time of authoring, Q3 results were not available due to the timing of results being reported to the Ministry of Health.
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 28 February 2018.

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

Notifiable Incidents

There was one notifiable event in January 2018 involving an incident in which a contract Security Guard (First Security) was assaulted while attempting to restrain a consumer resulting in the Security Guard injuring his recently repaired retina. The incident was notified to WorkSafe who advised it would not investigate the matter further. An internal investigation has taken place and liaison with First Security to support the recovery of the Guard.

Leading and Lagging Measures

There was some movement in the key leading and lagging results with an increase from the December period in reporting of staff incidents and a reduction in attendance at H&S induction. In addition, the completion rate of pre-employment screening did not meet target due to the number of people required to return for vaccinations. The injury claims also reduced during this period and some of this result was due to decrease in slips, trips and falls.

Other Leading and Lagging measures are either on target or slightly below target (substantially achieved).

Board Report Improvements

Recommendations from the Regional Internal Audit continue to be incorporated in this Board report with particular emphasis on improved reporting on the following areas in this report: Executive Summary, KPI’s and data tracking; critical risks and controls; worker participation; contractor management; monitoring and assurance and inclusion of actions from previous Board meeting. The Board Report will be progressively updated over the next few months to align with the recommendations in the report with the target of including regulatory updates; improved KPI’s and data tracking. 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.
Key H&S Projects

The key projects under development of contractor management and Violence and Aggression (Board requested deep dive following December Board Report presented at the February 2018 meeting), have been started.

In addition, the Safe Moving and Handling project, Flu Vaccine Campaign, Wellness portal and Lone Community Worker projects have progressed during the Jan/Feb period.

Regional co-operation with ADHB and WDHB have provided insights and recommendations following similar project work streams and key learning’s on key projects of Moving and Handling, Lone Community Worker and Violence and Aggression.
Trend highlights at a glance (rolling 13 months)

Staff incidents (IRS)
Number of staff reported incidents has increased from last reporting period but decreased year on year.

Pre-employment Screening (PEHS)

Attendance at H&S Orientation
Inductions in Jan/Feb reduced in comparison to last year, with expectation that March should increase.

Number of injury claims
Jan slightly higher than Dec and Feb reduction with year on year figures lower than previous year.

Key
Increased performance
Steady performance
Decreased performance

In summary, for February 2018

↑ There was a slight increase in staff reported incident for Jan and then a reduction in Feb, although within marginal change in the number of incidents being reported year on year.

↑ There was a slight increase in the Jan lost time incidents, injury frequency and injury severity rates and then a reduction in Feb. The aim is to have less than 5 LTI’s. We are below the set target.

↓ There has been a decrease in the figures for Oct-Feb period as a result of a change in reporting methodology. Prior to Oct the completed transfer and secondment PEHS were included in the reported total whereas now Pre-employment screening (PEHS) is completed only for new hired candidates.

↓ The aim is to have 190 fully trained Health and Safety Reps by Mar 2018. Currently we are tracking behind of the annual target by 30 Reps, due to extremely low uptake in Jan and Feb. Promotion of the Health and Safety Reps Training has continued and we are now starting to get increased response. Manager training is commencing in March, with participants confirmed.

↓ The staff hand hygiene target is set at 80%. Increased levels of staff hand hygiene from 86% in Jan to 88% in Feb.
## Health and Safety Scorecard
### February 2018

### Leading Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at H&amp;S Orientation</td>
<td>91%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>H&amp;S Representative training completed</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Pre-employment health screening completed</td>
<td>84%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Staff flu vaccination uptake</td>
<td>67%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Staff hand hygiene</td>
<td>88%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

### Number of Reported Incidents

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>107</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Visitor</td>
<td>4</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

### Number of Injury Claims

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>18</td>
<td>&lt;35</td>
<td></td>
</tr>
<tr>
<td>Lost time incidents</td>
<td>1</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Lost time injury frequency rate</td>
<td>1.24</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Cost of Injury claims</td>
<td>52,000</td>
<td>&lt;50</td>
<td></td>
</tr>
<tr>
<td>Lost time injury severity rate</td>
<td>49.52</td>
<td>&lt;60</td>
<td></td>
</tr>
</tbody>
</table>

### Number of Notifiable Events

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Visitor</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

### Predominant Incident Profile

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBFE</td>
<td>23</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>12</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Aggression and Violence</td>
<td>24</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Slips/ Trips/ Falls</td>
<td>11</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

### Comment on Variations

#### Indicators in Blue

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff flu vaccination update</td>
<td>The National Target set by the Ministry of Health for 2018 is 85% and CM Health Board has an aspirational target of 100% across key services associated with children/older people. Planning is underway for the 2018 Flu Vaccine Campaign with a Steering Group in place, advertisements of flu vaccinators, the vaccine delivered and a communications plan under development.</td>
</tr>
</tbody>
</table>

#### Indicators in Red

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&amp;S Representative Training</td>
<td>Annual target at 84% of 100% target. Jan/Feb annual leave and low numbers required cancellation of courses. The team will target areas with no H&amp;S Representation to ensure organisational coverage.</td>
</tr>
<tr>
<td>Pre-employment health screening completed prior to commencement</td>
<td>February data of 84% tracked less than 100% target and this was due to large number of call backs during the January period so people did not complete vaccinations before starting work.</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/issues related to that risk and remedial actions have been taken:

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Aggression and Violence Steering Group, chaired by the CMO, this action will be carried forward to Jan/Feb 2018 to follow up on initial meeting to agree on work plan.</td>
<td>Aggression and Violence Steering Group to meet following ‘deep dive’ governance audit completion and recommendations prepared on policy/guideline and programme.</td>
</tr>
<tr>
<td>CM Health in conjunction with Health Alliance, has undertaken a pilot trial of a Personal Duress Alarm Following review of trial, findings collated and recommendation to be produced on efficacy.</td>
<td>Health Alliance have decided to trial another Application which they advise is more cost effective. This will start in April.</td>
</tr>
<tr>
<td>Community Worker Personal Duress Alarms: Trial commenced as scheduled. 50% complete</td>
<td>Following review of draft programme and comparison with WDHB policy/process further work required to modify CMH programme expected to have draft completed end of March for further review.</td>
</tr>
<tr>
<td>Draft Lone Worker programme produced and under consultation with services with expected final version for consultation with Stakeholders late-Feb 2018.</td>
<td>Current Riskpro programme undergoing upgrade by Quality Team and will review the reporting capability. Also reviewing the WDHB H&amp;S Software functionality to assess if will deliver the audit standard.</td>
</tr>
<tr>
<td>Lone Worker Policy: Draft being reviewed. 50% complete</td>
<td>ED Steering group meeting recommended review of WDHB programme and onsite inspection of WDHB processes. Security guard stationed located at ED as additional control. 65% complete</td>
</tr>
<tr>
<td>Review of reporting through Riskpro or other software options that will enable standardisation of categories to provide more robust reporting. 0% complete</td>
<td></td>
</tr>
<tr>
<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. 60% complete</td>
<td></td>
</tr>
</tbody>
</table>

**Residual Risk:** The residual risk remains the same at present, although additional security allocated to key risk area to manage residual risk.

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Home visiting training completed with catch-up sessions scheduled for Jan/Feb.</td>
<td>Safe Home visit training completed as scheduled with a few as catch up sessions with staff unable to attend.</td>
</tr>
<tr>
<td>Follow up briefings on finalised Lone Worker programme to be scheduled end Feb/March.</td>
<td>Review of Lone Worker programme and alignment with work completed by Regional DHB’s to look at improving and alignment of processes to be completed by April.</td>
</tr>
</tbody>
</table>
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.

Follow up on rollout of Personal Duress Alarm controls with approval for expenditure and ongoing costs.

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

<table>
<thead>
<tr>
<th><strong>Residual Risk:</strong></th>
<th><strong>Residual Risk:</strong></th>
</tr>
</thead>
</table>

**Risk: Blood and Body Fluid Exposure (BBFE)**

<table>
<thead>
<tr>
<th><strong>Previous Report Action</strong></th>
<th><strong>Current Action</strong></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>On-going review with no update since last reporting period. Reduction in BBFE incidents following continued briefing of clinical and cleaning staff of risks of incorrect disposal of needles.</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.

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

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

<table>
<thead>
<tr>
<th><strong>Current Status / Issues</strong></th>
<th><strong>Action</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit report action points discussed with Facilities/Maintenance and need to follow up on close out plan for action points. 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>
<td>No further update since last reporting period.</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th><strong>Previous Action Point</strong></th>
<th><strong>Current Action</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>TROPHI tool data analysis to be reviewed by Moving and Handling Steering Committee to assess efficacy</td>
<td>TROPHI project debrief to Steering group with update on key trends. Next stage of the TROPHI</td>
</tr>
</tbody>
</table>
in the CM Health environment.

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

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.

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

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.

Project 30% complete

**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. 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. | Continue to be compliant with regular meetings/updates on site construction contractors. Facilities need to update on compliance for contractors on site with process that is consistent and includes all elements required under HSAW legislation. Facilities team undertaking development of a contractor management process and will liaise with OHSS once draft complete for review. External contractor briefed on taking over the contractor management project as initial contractor failed to deliver programme. Scope, costing and timeframe of project to be finalised in March. |

**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**
The training programme will be updated following the HSWP development and current training will continue to complete baseline training as follows.

Training planned for 2018 to include:
- Health & safety representative training and Manager training in risk management, incident investigation and the online inspection tool.
- Monthly tutorial for health & safety representatives completing the unit standard AS/NZS 29315.
- Manager training in H&S will commence in 2018.
- H & S training dates for all of the above for 2018 have been confirmed and will be communicated across the organisation throughout the year.

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.

H&S 2018 training plan covering all CMH staff:
- **H & S Competency Training** - two levels of:
  1. **H & S Champions**: 1 day training and then become champions for work area.
     Conduct bi-monthly workplace inspections. Point of contact on hazards/investigations.
  2. **H&S Representatives**: Formal recognition as H&S Representatives (HSAW 2015) 2 day training. Lead the management of hazards through assessing risks and recommending control methods based on discussion with management/team.
- **Monthly Tutorials**: Monthly tutorial sessions for H&S representatives completing the unit standard AS/NZS 29315.
- **Manager Training**: Manager Training in H&S commenced in Jan 2018 and covering the Accident / Incident training. Delivering targeted information to Managers in a shorter time frame.
- **Health & Safety Risk Management**: Workshop providing guidance on H&S risk management, covering hazard identification and risk mitigation, hazard monitoring and review as required by the HSWA 2015. Target Managers and H&S Representatives.

H & S training dates communicated across the organisation throughout the year. In addition, Training to support the rollout of the new Online Site Inspection Tool commenced in February 2018. Target is to have implemented by June 2018.

In addition, offering training to NGO Rescare Home Trust (Clendon) H&S Reps (10-11 staff) to ensure compliance and to support CMH our community based NGO’s to become safer environments to commence in March.

**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**

**Residual 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>No lost time injuries in December attributed to slip, trip, fall incidents.</td>
<td>One lost time injury in February attributed to slip, trip, fall incidents.</td>
</tr>
<tr>
<td>Proactively encourage incident reporting and near miss reporting to ensure hazards are identified,</td>
<td>Slips, trips, falls tracking lower than previous months, partly due to drier seasonal months –</td>
</tr>
</tbody>
</table>

---
reported to Facilities and eliminated, isolated or minimised.
and increased communication and housekeeping practices.
H&S commencing regular meetings with Cleaning teams to highlight hazards, control awareness and possible consequences/impact.
Additional initiatives into improving organisational communication prior to winter season to highlight slip, trip, fall hazards to be undertaken.

**Residual Risk:** The residual risk has decreased following operational interventions by Facilities and the Cleaning teams.

**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>
| Wellness group from Capstone project has reduced in numbers. | Remaining Wellness group member met with OHSS and action points agreed to implement Wellness portal within Paanui.  
Meeting scheduled with PMO to develop project management tracking on Daptiv and align project with OHSS workplan reporting.  
Project target to implement in 3 month period to align with support of Flu Vaccination campaign and winter wellness initiatives.  
Briefing paper for ELT will be presented in April on project plan for Wellness Portal.  
EAP programme to support OHSS/HR team developed and roll out in March/April.  
Other projects that will feed into the Wellbeing strategy:  
• National GM HR website for wellness  
• National GM HR support for Mental Health Awareness Week  
• “Speak Up” Campaign planning and development underway with project plan to be developed for ELT in May (Elizabeth).  
• Flu vaccination campaign underway with steering group and resource plan underway. |
| Project briefing to be completed in March to Manager, OHSS and then incorporated into Wellbeing strategy to include elements already planned e.g. vaccination campaign, flu vaccination, EAP etc. |  
Briefing to be produced for ELT to review following closeout of Capstone programme and finalised strategy from OHSS team.  
Other projects that will feed into the Wellbeing strategy:  
• “Speak Up” Campaign incorporating: Violence and Aggression; bullying and harassment; fatigue; unusual behaviour.  
• Flu vaccination campaign  
• Workforce Planning ‘safe and healthy rostering’ to be investigated.  
25% complete |

<table>
<thead>
<tr>
<th>Original Risk</th>
<th>Residual Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>The residual risk remains the same as previous report.</td>
<td>The residual risk remains the same although reduction in incidents.</td>
</tr>
</tbody>
</table>
### 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.</td>
<td>Jan/Feb very hot period with impact on staff with mitigations put in place such as moving to air conditioned areas.</td>
</tr>
<tr>
<td>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.</td>
<td>H&amp;S followed up with facilities and dust has been reduced following cleaning of air conditioning unit and monitoring continuing on ‘dust’ with investigation into whether dust is contaminated with any substance that could need managing.</td>
</tr>
<tr>
<td>Investigation into air quality as a result of ‘dust’ being emitted from air conditioning unit.</td>
<td></td>
</tr>
<tr>
<td>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>No follow up action within the facility but understand the roof has been repaired.</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.

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

### Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Current Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<td>Lead for the National GM HR forum has requested a meeting with the President of the CTU to discuss one national DHB agreed Worker Participation Agreement. There is slow progress.</td>
</tr>
<tr>
<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>
<td>Worker Participation plan to be developed. JCC presentation on H&amp;S plans and request for Union involvement in relation to Worker Participation.</td>
</tr>
<tr>
<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>
<td>Training programme being developed to update existing H&amp;S reps to comply with HSWA and refresh – to be rolled out in Apr/May.</td>
</tr>
<tr>
<td>Annual Health and Safety Recognition Awards Ceremony highlighted the importance of H&amp;S Representatives and Champions to CM Health. H&amp;S Representatives’ dedication and exceptional efforts were celebrated and three winners, who went above and beyond their daily activities announced.</td>
<td>Targeted information going out to H&amp;S Reps to update on incidents and keep motivated/ informed. Online training tool currently being rolled out to improve reporting for H&amp;S Reps.</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.

**Original Risk**
Reported Incidents

Rolling year-on-year monthly average comparison:
Previous 13 months – 105.5
Current 13 months – 114.5

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:
113 incidents were reported in February 2018.

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>1 notifiable event in Jan 2018</td>
<td>Aggression</td>
<td>Eye injury to Security Contractor with existing eye injury</td>
<td>31/01/2018</td>
<td>Incident investigation completed into MH open wards relating to control of intoxicated clients. Additional training for staff and review minimum staffing onwards.</td>
</tr>
<tr>
<td>Nil to report for February 2018</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 February 2018 including all employee, visitor and contractor incidents:

- Aggression and Violence: 26
- BBFE: 23
- Moving and Handling: 17
- Slip, Trip and Falls: 8

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

Body Blood Fluid Exposures has remained fairly constant, while Slip, Trip and Falls and Moving and Handling have 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 have been followed up with the manager of the work area to investigate and to close off.
Aggression and Violence

Rolling year-on-year monthly average comparison:

Previous 13 months – 21
Current 13 months – 26.2

The number of aggression and violence incidents appears to be increasing. We cannot tell whether there has been an increase in level of reporting rather than an increase in incidents. There is greater awareness through safety induction, H&S rep training and Leadership for Safety Walk Around about the need to report incidents. There is a separate project to look at the level of risk and how this is being managed.

Current Period:

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

Assault – Physical: 14
Behaviour – Inappropriate: 4
Behaviour – Aggressive: 3
Assault – Sexual: 2
Hit/bitten/scratched by person: 2
Assault – Verbal/gesture: 1

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

Rolling year-on-year monthly average comparison:
Previous 13 months – 23
Current 13 months – 23.2

BBFE incidents reported for the rolling year have tracked similar to same period in 2017.

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 February.

Causation profile:
Inattention/Distraction: 5
Unnecessary Haste: 4
Incorrect Work Techniques: 3
Other: 3
Patient Condition: 3
PPE not used: 2
Acts of others: 1
Fatigue/Tiredness: 1
Job factor: 1
Moving and Handling

Rolling year-on-year monthly average comparison:
Previous 13 months – 20.5
Current 13 months – 21

The trend for Moving and Handling incidents fluctuated over the rolling year, with a slight increase in January and significant decrease in February. 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 is underway with pilot programme of TROPHI tool being rolled out to more services.

Causation profile:
Awkward posture/ equipment malfunction/ job factors/ action/ behaviour of employee or patient/ affiliate, human factors: 10
Slips, Trips, Falls

Rolling year-on-year monthly average comparison:
Previous 13 months – 13.2
Current 13 months – 13.3
Slips/Trips/Falls incidents have remained on average relatively consistent for the rolling year although in comparison to February last year there was a sharp decrease this is consistent with the proactive work and a dryer summer period.

Current period:
1 Lost time injury due to a slip, trip and fall incident was reported in February.

Causation profile:
Human factors: 3
Slipped/tripped/stumbled: 3
Surface - slippery/wet: 2
Reported Incidents Summarised by Workforce and Division

Reported Incidents Summarised by Category & Workforce for February 2018

- Aggression & Violence: 16 ( Administration & Management: 2, Allied Health & Technical: 3, Medical: 3, Non-Clinical Support: 2, Nursing/Midwifery/HCA: 2 )
- BBFE: 9 ( Administration & Management: 2, Allied Health & Technical: 2, Medical: 3, Non-Clinical Support: 2, Nursing/Midwifery/HCA: 2 )
- Moving & Handling: 13 ( Administration & Management: 2, Allied Health & Technical: 2, Medical: 3, Non-Clinical Support: 2, Nursing/Midwifery/HCA: 2 )
- Slip/Trip/Fall: 4 ( Administration & Management: 2, Allied Health & Technical: 2, Medical: 3, Non-Clinical Support: 2, Nursing/Midwifery/HCA: 2 )

Reported Incidents Summarised by Division & Category for February 2018

- ARHOP: 2 ( Aggression & Violence: 2, BBFE: 6, Moving & Handling: 2, Slip/Trip/Fall: 1 )
- CCS: 1 ( Aggression & Violence: 1, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- EMC: 1 ( Aggression & Violence: 2, BBFE: 5, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- Franklin Locality: 2 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- HR: 1 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- Kidz First: 1 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- Mangere Otara Locality: 2 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- Mental Health: 12 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 2, Slip/Trip/Fall: 1 )
- MMC: 2 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- PHCS: 2 ( Aggression & Violence: 2, BBFE: 2, Moving & Handling: 1, Slip/Trip/Fall: 1 )
- SAP: 14 ( Aggression & Violence: 1, BBFE: 3, Moving & Handling: 1, Slip/Trip/Fall: 3 )
- Women's Health: 3 ( Aggression & Violence: 2, BBFE: 3, Moving & Handling: 1, Slip/Trip/Fall: 1 )
Workplace Inspections Conducted

For the Jan/Feb 2018 inspection cycle, OHSS received 98% (117) of the total (120) expected submissions showing an improved response rate across the organisation.

The purpose of the Workplace Inspections is to monitor existing hazards; identify new or temporary hazards within the workplace, assess the risk and review existing and new controls to element or mitigate the residual risk to a reasonably practicable level.

Consistent feedback as a result of the inspections indicates that a large number of the existing and new hazards relate to lack of facilities, building and equipment maintenance.

Following the successful rollout of the online inspection tool, on-going reporting of the workplace inspection process will change and this will be communicated in the next Board report.

Key indicators of the new workplace inspection process:

- The online inspection tool will replace the paper based process and provide better reporting capability.
- The reporting process will enable better reporting to services, the Executive Leadership Team and Board.
- The new online tool is in final stages of refinement with training having commenced in February 2018. The target date to use the new online submissions will be the June inspection round.

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

Community Health and Lone Workers

The lone worker safety project has involved the OHSS team through on-going incident investigations and working with Community Services and Mental Health. Working with the Regional partners on reviewing their practices and comparing to our draft lone worker policy and the Community Health Orientation Handbook which will be complete in April and is intended to meet the needs and manage the risks associated with Community and Mental Health teams who are required to work in our community.

The project has a number of other elements including review of the proof of concept for a lone worker security and distress application. The 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.

Occupational Health Service

Occupational Health Team

The team consists of two senior medical officers (Total FTE .8) and three nursing staff (2.7 FTE), one ACC Co-ordinator and one administrator. 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, vaccinations and workstation assessments. The work of the team ensures that we remain a tertiary ACC provider and have significantly reduced ACC costs as well as payments for lost time injuries. The team are one of the largest purchasers of vaccines in the Health Board.

Following WellNZ half yearly review, CM Health are the best performing Healthcare provider within the self-managed ACC programme they manage, with consistently better results in return to work outcomes, reduced costs associated with injury and lost % of declined claims. Further information will be reported within the April Board report.

Injury Claim Data

<table>
<thead>
<tr>
<th>INJURY CLAIM DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total: Injury Claim Report for February 2018</td>
</tr>
<tr>
<td>Lost days</td>
</tr>
<tr>
<td>Number of lost days for month</td>
</tr>
<tr>
<td>120.28</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>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lost time incidents</strong></td>
<td>Any injury claim resulting in lost time.</td>
</tr>
<tr>
<td><strong>Lost time injury Frequency Rate</strong></td>
<td>No of lost time Injuries per million hours worked. <strong>LTIFR (Lost Time Injury Frequency Rate)</strong> = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td><strong>Injury Severity Rate</strong></td>
<td>Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked. <strong>LTISR (Lost Time Injury Severity Rate)</strong> = (Number of Lost Hours / Hours Worked) x 1,000,000.</td>
</tr>
</tbody>
</table>
| **Notifiable Injury/illness**             | (a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations.  
(b) any admission to hospital for immediate treatment  
(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance  
(d) any serious infection (including occupational 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.e.g 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
Flu Campaign 2018

Recommendation

It is recommended that the Board:

Endorse the plan as outlined below.

Prepared and submitted by: Marie Townsley on behalf of Elizabeth Jeffs, Director HR

Purpose

To outline the planned approach to set the aspiration that 100% of Counties Manukau Health staff working with children and the elderly will get the flu vaccine.

Executive Summary

Management and senior nursing in the areas working with Children and the Elderly welcome the Board’s request that an aspirational target be set that 100% of staff will have the flu vaccine and are developing a plan to deliver on this. The staff will be advised that the Board, in their role as the voice of the community, are asking staff in the areas working with children and the elderly to have the vaccine because the community want to be protected from the flu.

Flu Campaign

The Flu Campaign is expected rollout to the organization in early to mid-April, following receipt of the vaccinations in early March.

The Flu Campaign will target all areas through a combination of peer vaccinators and independent vaccinator. The peer vaccinators will provide a ward/service offering with availability during all shifts while the independent vaccinators will provide a service to all other employee, volunteer and student groups in common areas during Monday-Friday, 8 hour shifts.

This combination has been successful in the past and will follow a similar pattern while noting the feedback from 2017 that greater coverage of sites and accessibility will improve staff access (ie make it really easy to get a vaccination).

The commencement of vaccinations will align with providing employees, volunteers, students and selected contractors optimum levels of vaccination efficacy (which is up to 4 weeks following vaccination) to coincide with the expected highest level of winter patient acuity.

Objectives of the Campaign

1. All staff informed and provided with opportunity to receive flu vaccination.
2. Achievement of National Flu Immunization target of 85% vaccinated.
3. Achievement of 100% vaccination across vulnerable service groups of Kidz First, Women’s Health and Adults Services for Older People which will include general medicine, emergency medicine and surgical services.
4. Communication is clear, inspiring and reaches the audiences.
**Governance of the Campaign**

A steering group has been formed to start the Campaign and this is jointly chaired by the Health and Safety Manager and the General Manager, Middlemore Central.

A second work group will be formed once the communication plan is approved. The work group will comprise the Clinical Nurse Directors, and key stakeholders in all areas.

**Communication Plan**

The communications plan will target the widest number of staff groups via Daily Dose, in service champions, direct email information via work email and posters/ banners/ videos and visible flu vaccinations stations. In addition, there is an opportunity for high profile CM Health advocates to talk to groups to ensure informed decisions are made by staff to ensure they keep themselves, their families and our clients safe.

The Communications Plan will note the Board’s message that it speaks on behalf of the Community in Counties Manukau who want protection from the flu this year and that the best manner for CM Health to deliver on the requests of our Community is to get vaccinated.

The Plan will target workforces where there has been lower rates of engagement in previous years.

**Resourcing**

1. 1 FTE fixed term (Apr-Sep) Admin resource to complete collating, checking, loading of information into spreadsheet and return of immunization data to MOH & GP’s.

2. Casual Independent Vaccinators (x 6) to cover all service areas on part-time basis to accommodate maximum coverage of staff timetables/site access to provide:
   a. Information;
   b. Administering vaccination; and
   c. Completing consent paperwork/answering FAQ’s etc.

3. OHN Flu Campaign Co-ordinator to ensure project is complete on-time; vaccinators trained and compliant with processes; vaccination is correctly ordered/stored and returned if not used. Compliance with CMH/MOH and GP reporting standards.
### Appendix 1 - Project Timeframe

The proposal is for the project timeline/action/completion as outlined below

<table>
<thead>
<tr>
<th>Action</th>
<th>Owner</th>
<th>2018 Timeframe</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Data complied</td>
<td>HR</td>
<td>Mar</td>
<td>Complete</td>
</tr>
<tr>
<td>Communication Plan</td>
<td>H&amp;S/ Comms</td>
<td>Mid-Mar</td>
<td>Underway</td>
</tr>
<tr>
<td>Manager Information</td>
<td>H&amp;S/ Comms</td>
<td>Mid-End Mar</td>
<td></td>
</tr>
<tr>
<td>Project Plan:</td>
<td>H&amp;S</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-planning/vaccination ordered/training/MOH</td>
<td></td>
<td>Jan/Feb</td>
<td>Complete</td>
</tr>
<tr>
<td>• Kick of meeting with Stakeholders</td>
<td></td>
<td>Ear-Mar</td>
<td>Complete</td>
</tr>
<tr>
<td>• Meeting with Steering Group (weekly)</td>
<td></td>
<td>Mid-Mar</td>
<td>Complete</td>
</tr>
<tr>
<td>• Meet with Comms to discuss programme</td>
<td></td>
<td>Ear-Mar</td>
<td>Complete</td>
</tr>
<tr>
<td>• Brief KA on development of Flu Immunization Project Plan to improve future programme and planning.</td>
<td></td>
<td>Mid-Mar</td>
<td>Commenced</td>
</tr>
<tr>
<td>• H&amp;S Flu campaign resourcing approval</td>
<td></td>
<td>Ear-Mar</td>
<td>To complete</td>
</tr>
<tr>
<td>• Commence recruitment (internal/external)</td>
<td></td>
<td>Ear-Mar</td>
<td>To complete</td>
</tr>
<tr>
<td>• Standing Order signed off</td>
<td></td>
<td>Ear-Mar</td>
<td>To complete</td>
</tr>
<tr>
<td>• Training and recruitment of Peer Vaccinators</td>
<td></td>
<td>Ear-Apr</td>
<td>To complete</td>
</tr>
<tr>
<td>• Vaccination received</td>
<td></td>
<td>Ear-Apr</td>
<td>To complete</td>
</tr>
<tr>
<td>• Rollout of Vaccination programme</td>
<td></td>
<td>onwards</td>
<td>To complete</td>
</tr>
<tr>
<td>• Updates on progress to organizations and Key Stakeholders.</td>
<td></td>
<td>onwards</td>
<td>To complete</td>
</tr>
<tr>
<td>Other considerations:</td>
<td>H&amp;S</td>
<td>Apr onwards</td>
<td>To complete</td>
</tr>
<tr>
<td>• Board updates on progress</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Tasks</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&amp;S Administrator</td>
<td>Capture all information; track progress and inform.</td>
<td>09 April – Sep 2018</td>
</tr>
<tr>
<td>Independent Vaccinators</td>
<td>Approx 6 FTE (part-time casual resource)</td>
<td>09 April onwards</td>
</tr>
<tr>
<td>Peer Vaccinators</td>
<td>100 inclusive of new trainees and existing</td>
<td>09 April onwards</td>
</tr>
<tr>
<td>OCN co-ordinator of Flu vaccination programme</td>
<td>Internal cost mid-Mar to end Sep</td>
<td>05 March onwards</td>
</tr>
</tbody>
</table>
Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 14 February to 22 March 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 February to 14 March 2018.

Major Issues or Events

Fungal growth in hospital buildings

Following the release of an OIA into the safety and weather-tightness of several CM Health buildings, a significant number of media inquiries were made. The story was covered by all major media outlets, with the Minister releasing a statement about extra funding approved for Middlemore building work. CM Health repeatedly emphasised that the fungal growth presents no risk to patients, visitors or staff and plans were being developed for remediation, as appropriate. CM Health fronted questions about what planning had been done to address remediation.

Flu preparedness

Vanessa Thornton was interviewed about how well the hospital is prepared for the upcoming flu season. Her messages emphasised getting immunised, hand washing, and the importance of choosing the right care, be that Accident and Emergency clinics, GPs, Healthline, or the Emergency Department. The communications team is working on two external campaigns (one encouraging influenza immunisation and the other, formerly known as the Winter campaign, which encourages our population to get the right care at the right place). Both campaigns will utilise multiple pieces of collateral through multiple channels.

Emergency Department

The communications team managed several inquiries regarding the continuing high numbers of people presenting at ED. In January, we had 10 per cent higher patient numbers than the same time last year, this meant that on each day, ED saw 30 patients more than expected.

Media and Email Enquiries

The Corporate Affairs and Communications Group manage a generic communications email box responding to all emails and connecting people to departments. For this period 225 emails were received. 80 were not related to communications issues and, where appropriate, were referred to other departments and services at the CM Health.
Routine Sector Communications

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

Campaigns in Development

*Flu Campaign – staff vaccinations*

This year’s staff flu campaign kicks off from 9 April with the national target for staff vaccination set at 85%. The Board have also given us an aspirational target of 100% with a specific focus on staff working in the following services: Aged, young and Women’s Health. A revised communication plan has been developed to support this year’s campaign goals with an emphasis on strong leadership, targeting of groups who have low vaccination rates, myth busting and a consistent message that as caregivers it’s our responsibility to protect ourselves, our families and our vulnerable patients from harm. This year’s collateral will once again draw on the Flu Fighter tag line, which will be used for a number of internal and external channels. Our jab-o-metre will measure the progress we are making and will be a visual marker and motivator for staff.

*Winter Wards*

A communication plan is currently being developed to support the refurbishment and opening of a medical ward on Level 5 Galbraith and a medical ward at the Manukau Surgery Centre. This involves the re-housing of people so refurbishment work can begin, keeping people informed during the building works and the commissioning and opening of the two wards. The aim of the communication plan is to inform people of what’s happening, why it’s happening, any impacts and what people are required to do.

*Other Internal communication campaigns and activities*

*Turn Around Plan*

To ensure we engage with as many people as possible, the Turn Around Plan team have been visiting sites across the organisation, including localities to engage with staff, discuss some of the themes that were emerging and test some scenarios. Some of the discussions have proved really valuable and people have appreciated the effort made to come out and see them. To encourage transparency, comments and feedback can be found on the Turn Around Plan web page. Regular engagement is also been taking place with the Consumer Council.

A media plan has been developed. The plan is centred on our main messages, which focus on growing demand, how we are working together with our clinicians, health care providers, Manawhenua and consumers to address our challenges and that our community has an important voice in the decisions we make. A proactive press release outlining plans to turn around the DHB’s financial position was sent out 27 February. This was picked up by various media outlets who were particularly interested in the possible example of virtual appointments. We will continue to monitor and grab any proactive opportunities to engage with the media to tell our story.

Following approval by the Board, communication plans (internal and external) are being developed with GMs and Clinical Leads for Turn Around Plan proposals that have a high to medium stakeholder and reputational risk. Our aim is to be proactive and front foot any impacts, issues or concerns.
Transition from four digit extensions to five digit extensions

On 22 March Spark and healthAlliance completed the final migration (of 5 migrations) of 4-digit extension conversion to 5-digit numbers at Middlemore hospital and MSC. The entire migration of all of our sites took four weeks to complete and was supported by a range of communication material.

Other internal activities

- **Team Counties blogs**
  - Nutrition readiness for natural disasters
  - Profile of the Kaumaatua service.

- The March issue of Connect+ is now available online and hard copy

External communication key activities

CMH Census 2018 Communication Activities

The primary focus for the external communications team during this reporting period was promoting staff and public participation in the 2018 Census. A comprehensive range of communications activities took place including the following:

**RESOURCES & DISTRIBUTION**

A special Census page was created on Paanui where all information and resources were made available in one area. This page was given a profile on the home page of Paanui so it was high visibility and is easy to find.

- Printed Census resources (A5 leaflets and posters) in English, Samoan, Tongan, Maaori, Cook Island Maaori, Simplified Chinese, Korean and Hindi were distributed to CMH locations, Charge Nurses and community-facing staff.
- Electronic versions of this leaflet were emailed to Primary Care, PHOs and service providers throughout Counties Manukau.
- Comms developed a talking points document to support staff and volunteers when talking to patients/clients and their whaanau about the Census.
- Staff from Whaanau Ora, Fanau Ola, Home Health Care, Public Health nursing staff and our LMC’s distributed the Census leaflets to their patients and clients in the community.
- A Census visual display was created in the display cabinet at the main MMH reception area.
- Census posters were displayed extensively in MMH, MSC and the seven other CMH sites.
- Comms crafted and sent out an email from Gloria advising staff that they could fill out the Census at work, and also encouraged staff to promote the Census to patients/clients and their whaanau.
- New Census skins were installed on the two MMH billboards.
- Electronic Census files were created for Facebook banners and computer screensavers.
• Two Census reminders were put on the Auckland Health Pathways website.

• Easter weekend/Joseph Parker fight – comms worked with Matua Moari and ED doctor Inia Tomash on a video for our social media channels to promote safety on our roads over the long weekend, as well as drinking responsibly. This will be live on Good Friday.

• Bowel screening programme – the programme is set to start around June. Comms is 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 screening information.

• Maternity Services resources – comms is working with the Maternity team to promote the First Contact Pregnancy Packs for pregnant women and their whaanau. This includes a video with a member on the Maternity Consumer Group promoting the pack and this will go onto our Healthy Together Facebook page in early April.

• Work has started on mapping out the content for the Women’s Health and Newborn 2017/2018 annual report.

Digital Channels

Website (www.countiesmanukau.health.nz)
The site shows an increase in traffic this period as is consistent with the end of summer. Mobile traffic begins to rise again this period.
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>7,461</td>
<td>0.84%</td>
<td>28</td>
<td>92,728</td>
<td>3,312</td>
<td>1,672</td>
<td>59.7</td>
<td>48</td>
</tr>
<tr>
<td>Healthy Together Facebook</td>
<td>8,626</td>
<td>0.49%</td>
<td>19</td>
<td>64,518</td>
<td>3,396</td>
<td>1,390</td>
<td>73.2</td>
<td>107</td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,537</td>
<td>0.87%</td>
<td>82</td>
<td>14,457</td>
<td>176</td>
<td>62</td>
<td>0.02</td>
<td>9</td>
</tr>
<tr>
<td>CM Health Linkedin</td>
<td>5,223</td>
<td>2.90%</td>
<td>6</td>
<td>30,480</td>
<td>5,080</td>
<td>306</td>
<td>51.0</td>
<td>230</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>23,847</td>
<td>+1.2%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>120</td>
<td>+0.7%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>25</td>
<td>+0.9%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>147</td>
<td>+2.5%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>292</td>
<td>+1.2%</td>
</tr>
</tbody>
</table>

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

CM Health Facebook

Our focus on this channel was increased slightly in this reporting period. We included staff-focused census messaging from Dr Gloria Johnson and Dr Campbell Brebner as well as updates on new facilities that are under construction. We saw a 33% increase in reach for this period.
### 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>County Manukau Health</td>
<td>Today is International Women’s Day! A day to celebrate women across the globe. Did you know 78% of our staff are women? #GirlPower #Excellent #Diversity</td>
<td>262</td>
<td>20</td>
<td>18.0%</td>
</tr>
<tr>
<td>County Manukau Health</td>
<td>Did you know? Construction is now well underway at Middlemore hospital for the new MR Suite. The department will house a brand new MRI machine along with our current MRI machine. This means shorter turnaround times for hospital referred MRI’s. #Excellent #DidYouKnow #HealthyTogether</td>
<td>131</td>
<td>19</td>
<td>13.4%</td>
</tr>
<tr>
<td>County Manukau Health</td>
<td>With the help of our Recycling Ninjas, on average, we are recycling 10 TONNES MORE per month! This is the same as 250 more wheelie bins! #teamwork #excellent #sustainable</td>
<td>122</td>
<td>6</td>
<td>7.9%</td>
</tr>
<tr>
<td>County Manukau Health</td>
<td>John from our Recruitment Team and EBi who is the Undergraduate and Entry to Practice Co-ordinator for Physiotherapy had the opportunity to talk to a Lecture theatre of over 80 excited and motivated 4th Year AUT Physiotherapy students. It is always exciting seeing students coming through university and looking for their first role in health! To all the health students out there – we wish you all the best and look forward to seeing you in the Health industry in the very near future! #TagANewGrad #DoYouKnowSomeoneAwesome #StudyHealth #HealthCareers</td>
<td>117</td>
<td>12</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

*(Post) March 08, 2018 5:00 pm
(Post) March 15, 2018 11:00 am
(Post) February 22, 2018 10:00 pm
(Post) March 10, 2018 11:00 am*
**Healthy Together Facebook**

We saw a drop in reach and engagement on this channel during this reporting period. This gives us some insight into the type of content our audience likes to consume - our audience reacts strongly to videos of staff members talking directly to the community in more than just English.

**Top 4 Posts by Reactions:**

<table>
<thead>
<tr>
<th>Post</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>396</td>
<td>60</td>
<td>11.8%</td>
<td>12,729</td>
</tr>
<tr>
<td>(Post) February 28, 2018 10:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>134</td>
<td>8</td>
<td>7.8%</td>
<td>3,745</td>
</tr>
<tr>
<td>(Post) March 12, 2018 1:45 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>113</td>
<td>24</td>
<td>11.6%</td>
<td>2,788</td>
</tr>
<tr>
<td>(Post) February 22, 2018 1:15 pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Together - Counties Manukau</td>
<td>110</td>
<td>12</td>
<td>9.4%</td>
<td>2,202</td>
</tr>
<tr>
<td>(Post) February 20, 2018 11:00 am</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

This was a steady reporting period for Twitter with only a slight decrease in posts, and impression metrics. Our recruiting content continues to be the most popular.

Top 3 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 - Feb 19</td>
<td></td>
<td>344</td>
<td>4</td>
<td>1.2%</td>
</tr>
<tr>
<td>CM Health @cmdhb - Mar 9</td>
<td></td>
<td>314</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>CM Health @cmdhb - Mar 12</td>
<td></td>
<td>278</td>
<td>2</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Figure 10 Top 6 Tweets by impressions

CM Health LinkedIn

This was a steady reporting period for LinkedIn with an increase in per-post impressions and higher than usual click engagements. Talent acquisition content continues to lead the way in popularity with our top post amassing over 6000 impressions and 113 clickthroughs.

Top 3 Posts by Engagement:
Figure 11 LinkedIn Top 3 Posts by engagement
Recommendation

It is recommended that the Board:

Receive and note the Finance and Corporate Business Report.

Note that this paper presents an overview of the finance update presented to the Audit Risk and Finance Committee at their meeting of 14 March 2018.

Prepared and Submitted by: Margaret White, Chief Financial Officer

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>AMH</td>
<td>Adult Mental Health</td>
</tr>
<tr>
<td>AMHU</td>
<td>Adult Mental Health Unit</td>
</tr>
<tr>
<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
</tr>
<tr>
<td>ATR</td>
<td>Authority to Recruit</td>
</tr>
<tr>
<td>BNZ</td>
<td>Bank of New Zealand</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>GST</td>
<td>Goods and Services Tax</td>
</tr>
<tr>
<td>HT2020</td>
<td>Healthy Together</td>
</tr>
<tr>
<td>IDF</td>
<td>Inter District Flows</td>
</tr>
<tr>
<td>KA</td>
<td>Ko Awatea</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NOS</td>
<td>National Oracle Solution</td>
</tr>
<tr>
<td>NZHPL</td>
<td>New Zealand Health Partnerships</td>
</tr>
<tr>
<td>PAYE</td>
<td>Pay As You Earn</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
<tr>
<td>WIP</td>
<td>Work in Progress</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>

1.0 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 14 March 2018.
2.0 Financial Report for the period ended 31 January 2018

YTD 31 January 2018 the consolidated result is $0.609m favourable to budget. Performance by operating arm is presented below.

Table 1: Statement of Performance by Operating Arm for the period ended 31 January 2018
(Refer also Table 2)

<table>
<thead>
<tr>
<th>Net Result</th>
<th>Month</th>
<th>Year to Date January 2018</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>2,983</td>
<td>3497</td>
<td>(514)</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(3,418)</td>
<td>(3,729)</td>
<td>311</td>
</tr>
<tr>
<td>Ko Awatea</td>
<td>(1,016)</td>
<td>(1,364)</td>
<td>348</td>
</tr>
<tr>
<td>Provider</td>
<td>(1,451)</td>
<td>(1,596)</td>
<td>145</td>
</tr>
<tr>
<td>Funder</td>
<td>183</td>
<td>411</td>
<td>(228)</td>
</tr>
<tr>
<td>Governance</td>
<td>(63)</td>
<td>(46)</td>
<td>(17)</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(1,331)</td>
<td>(1,231)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

2.1 Commentary on by Division:

Provider

YTD Provider Arm is $1.502m favourable to budget. Low elective performance $2.6m adverse YTD has been mitigated by the one off contribution from the ACC arrears programme which YTD is $5.98m favourable to budget. Favourable creditors and vacancies have been partially offset by outsourced personnel and an un-favourable 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. Favourable results within Integrated Care (vacancies and timing of leave) and Ko Awatea (structural vacancies) have contributed to the favourable result.

Funder

YTD the Funder Arm is $0.222m adverse to budget, attributable to continued provisioning for anticipated IDF wash-up exposure in Community Pharmaceuticals, Community Laboratory (Rheumatic Fever tests) and Auckland Regional Dental Service (ARDS). This has been mitigated to some extent by the delay to implement a new procurement model and the delay to complete the AMHU.

Funder for the month was particularly impacted by an increase in the YTD IDF wash up provision accrual of $0.9m.

Governance

YTD Governance Arm is $0.671m adverse to budget, reflecting $0.089m contracted resource covering vacancies and one off facilities projects, $0.232m write down of previously capitalised (WIP) costs. Full year forecast reflects a $3.0m settlement.
Sustained acute demand, compounded by anesthetist and theatre space shortages continue to impact Elective surgery volumes. YTD Elective WIES were 7.4% adverse to contract and 8.0% less than the same period last year. Outsourced surgical volumes account for 8% of the YTD elective volumes. Completion of the elective programme has been forecast balance of year, with planning to be finalised this month.

2.2 Commentary on Major Variances:

Crown Revenue
YTD was $16.325m favourable to budget, reflecting the following:
- favourable unbudgeted MoH funding for Disability Support Services Pay Equity (offset in Funder Provider Payments) $6.076m
- favourable accrual for System Level Measures funding paid to PHO’s during the month (offset in Funder Provider Payments) $0.923m
- favourable unbudgeted revenue for After Hours Service provided on behalf of other DHB’s and PHO’s (offset in Funder Payments) $1.060m
- favourable Social Investment Board Funding from State Services Commission $1.060m
- favourable IDF wash up adjustment on inflows $1.503m
- on-going ACC arrears initiative $5.98m
- unfavourable $2.6m 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 $0.970m unfavourable to budget attributable to:
- favourable $0.133m cost reimbursement Hauora Maori training funding
- favourable private patients $1.3m
- favourable non-residents offset by bad debt expense $0.495m
- favourable doubtful debt recovery $0.289m
- favourable research grants $0.441m
- unfavourable $1.0m Pharmacy revenue (offset in infrastructure)
- unfavourable Pacific Regional funding less than budget (offset in Funder Provider Payments) $0.508m
- Reduction in donation revenue $0.907m with the likelihood of further reductions in future months.

Personnel and Outsourced Personnel

YTD net personnel costs for January are $1.405m unfavourable. This, combined with $0.721m favourable outsourced services, reflects pressure on our underlying result (refer Table 3 on overleaf). Total FTEs are 6,254 (budget 6,345).

Funder Provider Payments

YTD was $10.623m unfavourable to budget, reflecting the following:
- unfavourable $6.076m accrual for Disability Support Services Pay Equity (offset in Crown Revenue)
- unfavourable $0.923m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue)
- unfavourable $1.080m payments for After Hour costs (offset in Other Revenue)
- unfavourable $3.854m accrual for the current estimate of IDF shortfall for the 17/18 year
- $0.918m Mental Health underspend greater than budget.

Clinical Supplies

YTD was $2.2m unfavourable to budget, reflecting high clinical demand and significant increase in treatment disposables, instruments, equipment and pharmaceuticals, offset by favourable movement in creditors.

Depreciation, Interest and Capital Charge

Depreciation and Capital Charge YTD is $1.3m unfavourable to budget reflecting timing in capitalisation of projects, and a revision in the capital charge.

2.3 Forecast Year End Position as at 31 January 2018

The full year forecast reflects the position as at 31 January 2018. The current forecast suggests that the overall 17/18 budget is still achievable, however dependant on savings initiatives and offsets.

2.4 Performance against Savings Programme

As at 31 January 2018, performance against the organisation wide savings programme was $4.191m unfavourable. YTD and forecast variances in many of these initiatives require additional remediation for the balance of year.
2.5 Analysis of underlying operating Variance

Consistent with previous months, the January result has been buoyed by a number of favourable one off adjustments. These one off transactions are predominantly a combination of additional ACC arrears, closeout of Balance Sheet provisions and Mental Health underspend. These adjustments mask the operating result (deficit), as outlined in Table 3 below. The underlying operating deficit is $18.554m YTD. This is $3.325m at variance to the YTD budgeted deficit of $15.229m.

Table 3: Analysis of Underlying Operating Result YTD 31 January 2018

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th>Year to Date</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>Reported Operating Surplus (Deficit)</td>
<td>(1,331)</td>
<td>(1,231)</td>
</tr>
<tr>
<td>MH Underspend</td>
<td>(993)</td>
<td>(723)</td>
</tr>
<tr>
<td>Net Favourable One Offs</td>
<td>(1,099)</td>
<td>0</td>
</tr>
<tr>
<td>Underlying Operating Deficit net of AMH and One Off</td>
<td>(3,423)</td>
<td>(1,954)</td>
</tr>
</tbody>
</table>

Note that the 2017/18 Mental health underspend will erode in 2018/19 as the AMHU and community programmes come online.
## Statement of Financial Position as at 31 January 2018

<table>
<thead>
<tr>
<th></th>
<th>Act 2017</th>
<th>Bud 2018</th>
<th>Var June 2017</th>
<th>Movement 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></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>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank</td>
<td>25,879</td>
<td>49,779</td>
<td>(23,900)</td>
<td>20,894</td>
</tr>
<tr>
<td></td>
<td>885</td>
<td>890</td>
<td>(5)</td>
<td>883</td>
</tr>
<tr>
<td>Prepayments</td>
<td>1,974</td>
<td>2,307</td>
<td>(333)</td>
<td>2,307</td>
</tr>
<tr>
<td>Debtors</td>
<td>55,301</td>
<td>51,108</td>
<td>4,193</td>
<td>46,990</td>
</tr>
<tr>
<td></td>
<td>8,380</td>
<td>7,484</td>
<td>896</td>
<td>7,484</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>5,320</td>
<td>5,320</td>
<td></td>
<td>33,743</td>
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<tr>
<td><strong>Total current Assets</strong></td>
<td>97,747</td>
<td>116,896</td>
<td>(19,149)</td>
<td>112,309</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></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>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>616,649</td>
<td>624,644</td>
<td>(7,995)</td>
<td>600,455</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,626</td>
<td>1,627</td>
<td>(1)</td>
<td>1,627</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,087</td>
<td>12,640</td>
<td>(8,553)</td>
<td>4,259</td>
</tr>
<tr>
<td>Information Software</td>
<td>561</td>
<td>561</td>
<td></td>
<td>561</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>4,416</td>
<td>4,466</td>
<td>(50)</td>
<td>4,416</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>839,759</td>
<td>856,358</td>
<td>(16,599)</td>
<td>823,738</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(166,978)</td>
<td>(170,333)</td>
<td>3,355</td>
<td>(151,706)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>672,781</td>
<td>686,025</td>
<td>(13,244)</td>
<td>672,032</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>56,688</td>
<td>54,190</td>
<td>2,498</td>
<td>50,551</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>729,469</td>
<td>740,215</td>
<td>(10,746)</td>
<td>722,583</td>
</tr>
<tr>
<td>Investments in Associates</td>
<td>45,429</td>
<td>48,645</td>
<td>(3,216)</td>
<td>41,834</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>872,645</td>
<td>905,756</td>
<td>(33,111)</td>
<td>876,726</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>90,123</td>
<td>97,789</td>
<td>(7,666)</td>
<td>92,119</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>9,995</td>
<td>10,364</td>
<td>(369)</td>
<td>6,164</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>14,458</td>
<td>17,278</td>
<td>(2,820)</td>
<td>13,324</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>30,868</td>
<td>27,290</td>
<td>3,578</td>
<td>26,370</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>88,048</td>
<td>89,978</td>
<td>(1,930)</td>
<td>86,083</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>233,492</td>
<td>242,699</td>
<td>(9,207)</td>
<td>224,060</td>
</tr>
<tr>
<td>Working Capital</td>
<td>(135,745)</td>
<td>(125,803)</td>
<td>(9,942)</td>
<td>(111,751)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>639,153</td>
<td>663,057</td>
<td>(23,904)</td>
<td>652,666</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></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>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>885</td>
<td>898</td>
<td>(13)</td>
<td>898</td>
</tr>
<tr>
<td>Insurance Liability - non current</td>
<td>931</td>
<td>931</td>
<td></td>
<td>931</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>20,533</td>
<td>20,546</td>
<td>(13)</td>
<td>24,487</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></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>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>283,553</td>
<td>283,552</td>
<td>1</td>
<td>283,553</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(64,722)</td>
<td>(65,329)</td>
<td>607</td>
<td>(55,163)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>618,620</td>
<td>642,511</td>
<td>(23,891)</td>
<td>628,179</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>639,153</td>
<td>663,057</td>
<td>(23,904)</td>
<td>652,666</td>
</tr>
</tbody>
</table>
2.6 Commentary on Major Variances:

- Bank was $23.9m adverse to budget, largely attributable to timing with the budgeted $24.5m funding from the Ministry of Health for the AMHU now to be received in tranches, part offset by a $3.0m settlement received during the month of August. AMHU Funding tranches are forecast to begin in April 2018 with $7.8m and the balance during the 2018/19 financial year.

- Debtors were $4.2m higher than budget attributable to timing differences of debtor billings and accruals.

- Total Fixed Assets were $10.7m lower than budget reflecting timing major capital projects spend.

- Creditors were $7.666m unfavourable to budget reflecting the following:
  - Capital spend being $3.2m lower than planned for January 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 $5.9m accrual for 2017/18 IDF shortfall.

- GST and PAYE were $2.8m lower than budget attributable to lower than expected creditors balance, and timing of payroll.

- Payroll Accrual & Clearing were $3.6m higher than budget reflecting timing of Salaries and Wages.

- Employee Provisions were $1.930m less than budget, attributed to entitlements paid out as opposed to the flat line budget.

- Working Capital $9.9m unfavourable to budget mostly attributable to the timing variance for the $24.5m AMHU funding from the Ministry of Health, offset by delayed capital expenditure spend, and assumptions inherent in the budget creditor’s balance.
## Statement of Cash flow for the period ended 31 January 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>YTD</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
</tbody>
</table>

### Cash flows from Operating activities
Cash was provided from:

- **Crown Revenue**: 119,608 133,372 (13,764) 938,101 930,887 7,214
- **Other**: 6,142 2,877 3,265 24,060 20,304 3,756
- **Interest rec.**: 167 217 (50) 1,342 1,519 (177)

Cash was applied to:

- **Suppliers**: (87,295) (75,256) (12,039) (585,499) (556,346) (29,153)
- **Employees**: (54,062) (51,923) (2,139) (353,795) (359,295) 5,500

### Net cash from Operations

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(15,439)</td>
<td>9,287</td>
<td>(24,726)</td>
<td>5,545</td>
<td>19,105</td>
<td>(13,560)</td>
</tr>
</tbody>
</table>

### Cash flows from Investing activities
Cash was applied to:

- **Fixed assets**: (3,308) (6,503) 3,195 (26,105) (36,338) 10,233
- **Sale of Asset**: - - - - - -
- **Investments**: 7 (2,587) 2,594 (2,879) (6,811) 3,932
- **Restricted & Trust Funds**: - - - 1 - 1

### Net cash from Investing

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(3,301)</td>
<td>(9,090)</td>
<td>5,789</td>
<td>(28,983)</td>
<td>(43,149)</td>
<td>14,166</td>
</tr>
</tbody>
</table>

### Cash flows from Financing activities
Cash was provided from:

- **Sale of Asset**: - - - - - -
- **Debt**: - - - - - -
- **Other Non-Current Liability**: - 1 (1) - 24,506 (24,506)

### Net cash from Financing

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>- 1 1</td>
<td>(1)</td>
<td>28,423</td>
<td>52,929</td>
<td>(24,506)</td>
<td></td>
</tr>
</tbody>
</table>

### Net increase / (decrease)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash</td>
<td>44,627</td>
<td>49,589</td>
<td>(4,962)</td>
<td>20,902</td>
<td>20,902</td>
<td>0</td>
</tr>
<tr>
<td>Closing cash</td>
<td>25,887</td>
<td>49,787</td>
<td>(23,900)</td>
<td>25,887</td>
<td>49,787</td>
<td>(23,900)</td>
</tr>
</tbody>
</table>

### Reconciliation Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(1,331)</td>
<td>(1,231)</td>
<td>(100)</td>
<td>(9,559)</td>
<td>(10,168)</td>
<td>609</td>
</tr>
</tbody>
</table>

### Add/(Less) non-cash items

- **Impairment of Intangibles**: - - - - - -
- **Depn**: 2,648 2,661 (13) 18,489 18,627 (138)

### Add/(Less) items Classified as Investing or Financing activities

- **Gain on Disposal**: - - - - - -

### Add/(Less) Movements in Financial Position items

- **Debtor and Other Receivables**: (12,684) 26 (12,710) (7,978) (4,118) (3,860)
- **Inventories**: 176 - 176 - (896) - (896)
- **Creditors**: (1,883) 7,438 (9,321) 2,967 13,890 (10,923)
- **Employee Entitlements**: (2,365) 393 (2,758) 2,522 874 1,648

### Net Cash flow from Operations

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Cash</td>
<td>44,627</td>
<td>49,589</td>
<td>(4,962)</td>
<td>20,902</td>
<td>20,902</td>
</tr>
<tr>
<td>Closing Cash</td>
<td>25,887</td>
<td>49,787</td>
<td>(23,900)</td>
<td>25,887</td>
<td>49,787</td>
</tr>
</tbody>
</table>

### Net Increase / (Decrease)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Cash</td>
<td>44,627</td>
<td>49,589</td>
<td>(4,962)</td>
<td>20,902</td>
<td>20,902</td>
<td>0</td>
</tr>
<tr>
<td>Closing Cash</td>
<td>25,887</td>
<td>49,787</td>
<td>(23,900)</td>
<td>25,887</td>
<td>49,787</td>
<td>(23,900)</td>
</tr>
</tbody>
</table>
2.7 Commentary on Major Variances:

- YTD cash-flow from Crown Revenue is $7.214m favourable to budget, representing:
  - favourable $5.9m from the on-going ACC arrears initiative
  - favourable $6.0m Ministry of Health funding for Disability Support Services (offset in payments to suppliers)
  - Offset by the increase in debtors $4.1m.

- YTD payments to suppliers were $29.153m higher than budget, reflecting:
  - October payment of $11.8m for 2016/17 IDF wash-up
  - unfavourable $6.5m outsourced personnel, unfavourable $2.2m for clinical supplies together with the increased Funder Provider Payments
    - unfavourable $0.9m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue)
    - unfavourable $1.1m payments for After hour cost (offset in Crown Revenue)
    - unfavourable $6.0m Disability Support service Pay Equity (offset in Crown Revenue).

- Employee Payments were $5.5m favourable to budget representing the vacancies across the service together with the higher balance in Payroll Accrual & Clearing predominantly due to timing of the payroll.

- Fixed Assets $10.233m favourable to budget representing the timing of capital spend for major capital projects (KA II, AMHU and HT2020).

- Investments were $3.93m 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 financial year.

2.8 Treasury Report – 31 January 2018

<table>
<thead>
<tr>
<th></th>
<th>$NZ 000’s</th>
<th>Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base operating cash</td>
<td>$25,840</td>
<td>2.87%</td>
</tr>
<tr>
<td>Hypothecated Capital</td>
<td>$37,448</td>
<td>2.87%</td>
</tr>
<tr>
<td>Overdraft</td>
<td>($11,608)</td>
<td>3.37%</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 31 January 2018, 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.
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>
| Public Excluded Minutes of 28 February 2018/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. |
| MRI Lease Funding | 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. |
| University of Otago | 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. |
| Move of Infrastructure as a Service | 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. |
<table>
<thead>
<tr>
<th>Subject</th>
<th>Under Section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</th>
<th>Made Public.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negotiations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[Official Information Act 1982 S9(2)(j)]</td>
</tr>
<tr>
<td>Eligibility of Publicly Funded Health &amp; Disability Services/Renal Patients Not Eligible for Publicly Funded Care</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Free and Frank Expressions of Opinion</td>
</tr>
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<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>The disclosure of information would not be in the public interest because of the need to 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 or officers and employees of any department or organisation in the course of their duty; and maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials.</td>
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<td>One Link Agreement</td>
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<td>Section/Case Study</td>
<td>Reasons for Information Withholding</td>
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<td>17/18 Capital Plan</td>
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<td>Fleet Vehicle Procurement &amp; Replacement Programme</td>
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<td>Scott Building Reclad Business Case</td>
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<td>L5 Galbraith Ward Capital Fit Out</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.</td>
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<td>[Official Information Act 1982 S9(2)(i); S9(2)(j) and 9(2)(b)(iii)]</td>
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<td>Topic</td>
<td>Reason</td>
<td>Exemption under the Act</td>
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<td>ACC Contract Options for Specialised Spinal Rehabilitation</td>
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<td>Finance &amp; Corporate Business Report</td>
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<td>Turn Around Plan</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>Access to Ante-natal Care in CM Health</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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**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.

- 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.

- 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.

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