MEETING OF THE BOARD
8 August 2018

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

CMDHB BOARD MEMBERS
Mark Gosche – 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 Bungar – CMDHB Board Member

CMDHB MANAGEMENT
Gloria Johnson – acting Chief Executive
Margaret White – Chief Financial Officer
Vanessa Thornton – acting Chief Medical Officer
Jenny Parr – Chief Nurse/Director of Patient & Whaanau Experience
Dinah Nicholas – Board Secretary

PART 1 – Items to be considered in public meeting

AGENDA
BOARD ONLY SESSION (8.00 – 9.00am)

1. GOVERNANCE
9.10 – 9.15am
1.1 Apologies
1.2 Disclosures of Interest
1.3 Specific Interests

2. BOARD MINUTES
9.15 – 9.20am
2.1 Confirmation of Minutes of the Meeting of the Board – 27 June 2018
9.20 – 9.25am
2.2 Action Items Register
9.25 – 9.27am
2.3 Minutes Community & Public Health Advisory Committee – 23 May 2018 (Colleen Brown)
9.27 – 9.30am
2.4 Minutes Hospital Advisory Committee – 6 June (Lyn Murphy)

3. PRESENTATIONS
9.30 – 10.00am
3.1 Climate Change and Health Presentation (Dr David Galler)
10.00 – 10.45am
3.2 Health Equity Campaign Summary Report and Presentation (Gloria Johnson)

Morning Tea Break (10.45 – 11.00am)

4. EXECUTIVE REPORTS
11.00 – 11.15am
4.1 Chief Executive Officer’s Report (including Patient Story) (Gloria Johnson)
11.15 – 11.25am
4.2 Health and Safety Performance Report (Elizabeth Jeffs)
11.25 – 11.35am
4.3 Corporate Affairs and Communications Report (Donna Baker)

5. PERFORMANCE REPORTS
11.35 – 11.45am
5.1 Finance and Corporate Business Report (Margaret White)
11.45 – 12.00pm
5.2 Turn Around Plan Stage 1 Close-Out Report (Kathryn deLuc)

6. DECISION PAPERS
12.00 – 12.10pm
6.1 CMH/UoA Agreement (Vanessa Thornton)
12.10 – 12.15pm
6.2 Joint Statement of Representation (Margaret White)

7. RESOLUTION TO EXCLUDE THE PUBLIC

Lunch Break (12.15 – 12.40pm)

 Counties Manukau District Health Board

001
# Board Member Attendance Schedule 2018

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<tr>
<th>Name</th>
<th>Jan</th>
<th>28 Feb</th>
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** Appointed effective 3.5.2018

* No longer on the Board effective 2.5.2018
# BOARD MEMBERS’ DISCLOSURE OF INTERESTS

8 August 2018

**New items in red italics**

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
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| Mark Gosche, Chair | • Trustee, Mt Wellington Licensing Trust  
• Director, Mt Wellington Trust Hotels Ltd.  
• Director, Keri Corporation Ltd  
• Trustee, Mt Wellington Charitable Trust  
• Chief Executive, Vaka Tautua  
• Trustee, Pacific Information Advocacy & Support Services Trust  
• Life Member, Labour Party  
• Life Member, ETU Union  
• Deputy Chair & Board Member, Housing NZ |
| 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>
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<tr>
<th>Name</th>
<th>Positions/Institutions</th>
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</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  
• Life Member of Business and Professional Women NZ |
| 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  
• Member, NZ Maori Council |
| 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 Inter professional 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 |
| Ken Whelan, Crown Monitor | • Board Member, Royal District Nursing Service NZ  
• Contracts with Francis Health & GE Healthcare (mainly Australia & Asia) |
# BOARD MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 8 August 2018

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Gosche</td>
<td>Funder Contract Price Increase Recommendations for 2018/19</td>
<td>Vaka Tautua is covered by these price increases.</td>
<td>27 June 2018</td>
<td>That Mark Gosche’s specific interest be noted and that he will depart the room when this particular item is discussed.</td>
</tr>
<tr>
<td></td>
<td>Social Investment Board Quarterly Report</td>
<td>Vaka Tautua is mentioned in this report.</td>
<td>27 June 2018</td>
<td>That Mark Gosche’s specific interest be noted and that may remain in the room and participate in any discussion but be excluded from any voting, if applicable.</td>
</tr>
<tr>
<td>Katrina Bungard</td>
<td>Turn Around Plan</td>
<td>Chair of MECOSS</td>
<td>16 May 2018</td>
<td>That Katrina Bungard’s specific interest be noted and that the Board agree that she will depart the room when this particular item is discussed.</td>
</tr>
<tr>
<td>Catherine Abel-Pattinson</td>
<td>Whaanau Accommodation Options at MMH</td>
<td>Catherine’s husband owns a business that has hotel/motels in the Counties Manukau catchment area that are from time to time used for CM Health or WINZ clients.</td>
<td>4 April 2018</td>
<td>That Catherine Abel-Pattinson’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
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Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 27 June 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
Mark Gosche (Board Chair)
Ashraf Choudhary
Colleen Brown
Catherine Abel-Pattinson
Dianne Glenn
George Ngatai
Lyn Murphy
Katrina Bungard

ALSO PRESENT
Gloria Johnson (acting Chief Executive)
Margaret White (Chief Financial Officer)
Vanessa Thornton (acting Chief Medical Officer)
John Hanson (Chief Legal Advisor)
Donna Baker (General Manager Communications & Engagement)
Mere Martin (External Communications)
Dinah Nicholas (Board Secretary)
Mark Whelan (Crown Monitor)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
Emily Ford (Manukau Courier)

APOLOGIES
Apologies were received and accepted from Apulu Reece Autagavaia and Jenny Parr.

WELCOME
George Ngatai opened the meeting with a karakia.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
The Disclosures of Interest were noted with no amendments.

Mark Gosche noted a specific interest in relation to Items 3.4 and 6.2 on today’s agendas.
Ken Whelan noted a specific interest in relation to Item 5.7 on today’s agenda.

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 – 16 May 2018

Matters arising:
Item 3.2 – Bullying complaints
Item 3.3 – Flu vaccinations
Both these items will be discussed in Item 3.2 below.

Resolution (Moved: Ashraf Choudhary/Seconded: Dianne Glenn)
That the Minutes of the Board Meeting held on the 16 May 2018 be approved.
Carried

2.2 Action Item Register
Noted.

2.3 Draft Minutes Community & Public Health Advisory Committee (11 April 2018)
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:

Improved Equity in Access to Timely Cancer Treatment – an audit of patients entering the Faster Cancer Treatment 62-day pathway over the period 1 February 2015 – 31 January 2016 found that Māori and Pacific patients along with those living in the highest areas of socio-economic deprivation, were significantly less likely to meet the 62-day target than their counterparts. Due to a series of interventions that were developed, a more recent audit covering the period 1 November 2016 – 31 October 2017 has found ethnicity and level of deprivation are no longer associated with passing this target. The findings from this recent audit have demonstrated that the efforts to achieve equity through developing standardised pathways for patients and improving care coordination for these vulnerable patient groups is working. This outcome is significant and indicates a sustained focus on reducing disparities in health for more vulnerable groups referred with a high suspicion of cancer has made a tangible difference.

Health Targets – the Executive Leadership Team is developing a new dashboard of key targets that will be monitored and reviewed for 18/19. Suggestions from the Board included DNA rates, falls, pressure areas and some targets from the Māori Health Plan. A draft of the new dashboard will be included in the next CEs Report to the Board.

Cutting Emissions in Healthcare – the Board asked that their congratulations be passed onto the Sustainability Energy team at the DHB for achieving a reduction of 21.2% in the carbon footprint of CMDHB in just five-years.
Resolution (Moved: Catherine Abel-Pattinson/Seconded: George Ngatai)

That the Board received the Chief Executive’s Report.

Carried

3.2 Health and Safety Performance Report (Elizabeth Jeffs)
The report was taken as read. Elizabeth Jeffs summarised the following key areas:

*Flu Vaccinations* for the Board Priority areas, as at 25 June Women’s Health is at 60% (5% declined); Kidz First 81% and ARHOP 80%. The Vulnerable Children’s Act compliance and the NZNO strike have taken precedence in recent weeks but a further push will be made on flu vaccinations in the coming weeks but more questions will be asked to drive these numbers up. The Board asked that the Priority areas be reported back within the Health & Safety Performance Report going forward.

Ms Jeffs to report back (8 August) with some ideas about providing stickers to those staff in areas that look after our vulnerable patients to reflect they are vaccinated.

*Bullying & Harrassment* - Elyse Oh, Registered Nurse ED and Debbie Hailstone, Quality Improvement Facilitator ED presented their Violence in the Emergency Department Research Week poster.

As the number of presentations in the Emergency Department have increased, so too have the number of incidents of aggression. This is not limited to just patients, but also visitors. Understanding the reasons behind the increase is multi-factorial including increased violence in the community, changes to police processes and management of patients with mental health. Many instances of verbal abuse to staff go unreported due to the complexities of reporting formally and care of emergency patients taking precedence over paperwork.

Elizabeth Jeffs confirmed that the DHB has a number of pieces of work underway to address bullying and harassment which includes:

- Pastoral Care groups in every Service to resolve any issues.
- A good complaint process.
- The Bullying & Harrassment policy has been recently refreshed.
- Speak Up programme.
- MyHR – employee information on how to speak up.
- MyPeople – manager information to assist dealing with a complaint.
- Team charters are in development.

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

That the Board:

Received the Health and Safety Report for the period ending 31 May 2018.

Carried
3.3 **Corporate Affairs and Communications Report** (Donna Baker)

The report was taken as read.

The Communications Team is working with Recruitment to create compelling content to market CM Health vacancies to people living outside New Zealand. Current staff that came to New Zealand to work have been surveyed and the information gathered will inform the recruitment and marketing materials for this audience. The survey has revealed areas such as work/live balance, the diversity of the population and the people, free education and free health are some of the drivers making people come to work here. A full report will be provided to the Board in the next report.

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

*That the Board:*

*Received the Corporate Affairs and Communication Report for the period to 31 May 2018.*

*Carried*

4 **PERFORMANCE REPORTS**

4.1 **Finance and Corporate Business Report** (Margaret White)

The paper was taken as read. Margaret White summarised the following areas:

This year the Finance team is working very hard to ensure we deliver to the budget that has been agreed by the Board and the Minister.

The only area likely to change as we head into 30 June is the Elective profile. We have suffered this year due to an overload in elective pressures on the hospital, some ongoing challenges with the Anaesthetist team and workforce which has had a significant impact on our elective delivery. We are trying to bring this up as fast as we can in the lead to 30 June with the hope that by year end, our claw back liability will be less than currently forecast. The Executive Leadership Team has commissioned a report back, after year end, to look at what happened this year and what could have been done about the various factors that contributed to the situation in order to ensure the same does not occur next year.

The nursing MECA is yet to be ratified and all DHBs are taking a consistent approach into year end.

**Resolution** (Moved: Katrina Bungard/Seconded: Ashraf Choudhary)

*That the Board:*

*Received the Finance and Corporate Business Report for the period ending 30 April 2018.*

*Carried*
5 DECISION PAPERS
5.1 2018-19 Capital Plan (Margaret White)
The paper was taken as read.

The DHB capital requirement for 2018/19 is $69m funded as follows:
• $27.2m from 2018/19 depreciation free cash flow budget.
• $11.3m of the clinical equipment capital requirements have been identified as candidates for leasing finance, of which $1.5m cash will be required to fund the leases in 2018/19.
• $9.975m of the 2018/19 capital spend will be funded from the net land sale proceeds of $28.4m.
• $3m from Scott settlement proceed.
• $17.4m of capital spend will be funded from equity injections received in 2018/19 for the AMHU and Scott Re-clad projects.

These capital requirements exclude any business cases still scheduled to go to the Capital Investment Committee whereby additional equity injection funding will be sought.

The current capital plan excludes $3.4m of planned Facilities Master Planning and Business Case development costs that will be capitalised to major strategic projects. Discussions are underway with the MoH regarding regional seed funding for these projects.

The plan is also predicated on our ability to achieve a $10m deficit position for the 2018/19 budget. In the event that the final agreed deficit position is greater than $10m, there would need to be further prioritisation of the capital requirements for 2018/19, or we would need to obtain confirmation regarding deficit support from the MoH to fund the cash shortfall.

Any additional capital requirements not in the 2018/19 Board approved capital plan will need to be funded by either reprioritisation, donation revenue or equity funding from the Ministry of Health. Invest to save cases will be considered on a case by case basis.

Resolution (Moved: Colleen Brown/Seconded: Katrina Bungard)

That the Board:

Approve:
• the proposed 2018/19 Capital Plan, subject to confirmation of MOH support for the 2018/19 operating and cash position; and
• proceeding with the Quarter 1 cases as planned.

Carried

5.2 Proposal to Establish a Major Capital Works Oversight Sub-Committee (Margie Apa)
The paper was taken as read.

There are significant capital investments proposed to begin in the 2018 year including the Scott Building re-cladding and business cases in progress for major capital works.

The establishment of a Sub-Committee of the Board called ‘Major Capital Works Oversight’ sub-committee will provide governance assurance of the progress of major capital investments including
their execution and the management of risk. This would not sidestep CEO delegated authorities or accountability but would aim to ensure the Board has its own independent expertise and that Management have a way of assuring governance on an area of major risk to the organisation.

The Board supported the membership of the Committee including the Board Chair, the Chair of HAC and the Chair of Audit Risk and Finance.

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

**That the Board:**

**Agree the establishment of a sub-committee of the Board named ‘Major Capital Works Oversight Sub-Committee’**.

**Agree the draft Terms of Reference which is an amended version of the original Facilities and Management and Planning sub-committee noting that the membership of the Sub-Committee will be finalised once the two vacant positions on the Board are filled.**

**Carried**

5.3 **Alice Nelson Charitable Trust** (Karli Menary, Legal Advisor and Philippa Wilkie, Chapman Tripp by telephone).

The paper was taken as read.

CMDHB proposes to establish a charitable trust in the name of Alice Nelson, the late Edward Nelson’s mother, for charitable purposes that include providing financial assistance to nurses, midwives and their families in Auckland in financial need.

Once the Alice Nelson Charitable Trust is established, CMDHB plans to transfer approximately $1,950,000, representing the proceeds of sale of 18 The Parade, Bucklands Beach, Auckland which was bequeathed to one of its predecessor organisations under the will of Edward Nelson dated 1973, less agreed costs to the Trust. Once the Trust has been established and the funds have been transferred to the Trust, the trustees of the Trust will become responsible for the management and distribution of the funds in accordance with the terms of the deed establishing the Trust, as drafted by Chapman Tripp.

CMDHB has approval from the Attorney-General to establish the Trust as per the Trust Deed. Once approvals from CMDHB and WDHB are provided with respect to establishing the Trust and the appointment of specific trustees, final approval from the Minister of Health will be sought. On 23 May 2018, the Board of ADHB approved the appointment of its Chief Nursing Officer as a Trustee of the Trust. WDHB’s response is pending.

At its 23 April meeting, the Audit Risk & Finance Committee directed Management to investigate options for increasing the capital and inflation protection mechanisms for the Trust prior to submitting the proposal to Board for consideration. The proposed approach for increasing such protection is reflected in the Opening Trustee Resolutions presented today.
Resolution (Moved: Ashraf Choudhary/Seconded: Catherine Abel-Pattinson)

That the Board:

Approve the establishment of the Alice Nelson Charitable Trust on the terms of the trust deed and with the assets described in the background section of this paper.

Approve the appointment of Jenny Parr, Director of Patient Care, Chief Nurse & Allied Health Professions Officer as a trustee of the Alice Nelson Charitable Trust.

Note that the two approvals above are subject to final approval by the Minister of Health.

Carried

5.4 Metro Auckland Urgent Care After Hours Procurement (Benedict Hefford, Director Primary Community and Integrated Care).

The paper was taken as read.

On 28 February 2018 the Board endorsed establishing subsidised access for high needs groups to urgent care services across the district, including after hours (until 8pm) at up to eight clinics and extended hours (8pm until 11pm) at up to four clinics. Negotiations with the preferred providers have now been concluded and 120,000 patient visits per annum will now be subsidised for low income patients at clinics spread across the localities, with a maximum co-payment of $39 for adults in the target group, and free access for all under 13’s until 11pm.

Mr Hefford confirmed that East Care, with support from Easthealth PHO, will continue their overnight service utilising clinicians delivering Hospital in the Home services in the Eastern locality. Hospital in the Home allows treatment to be delivered within a patient’s own home or community based locations and supports the transition of care from hospital. An Advanced Paramedic will be based at the Botany Superclinic to provide overnight clinical cover for both Hospital in the Home and urgent care patients. The initiative will also support the development of an innovative new workforce and model of care in collaboration with St John’s Ambulance Trust. There will still be a cost for after 11pm and East Care are still working through the parameters of what that will be. The Board asked that the finalised co-pays for East Care be reported back to the Board.

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

That the Board:

Agree that the public and other interested parties be informed via a media release and other communications of the new arrangements, which represent a doubling of access to subsidised urgent after hours care in Counties Manukau.

Carried
5.5 Proposed Internal Audit Plan 2019-2021
The paper was taken as read.

At the start of the internal audit planning process, Regional Internal Audit submits the draft Internal Audit Plan for the new financial year and indicative plans for a further two years. These plans are designed to address the unique set of risks CMDHB is facing and are determined after consulting with Audit NZ, CMDHB management and Regional Internal Audit management.

The audit plan is risk-based and flexible. As new risks emerge, fraud incidences arise or the risk appetite of the Board changes, the internal audit plan will be adjusted to maintain its relevance.

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

That the Board:

Approve the proposed FY2019 Internal Audit Plan.

Carried

5.6 Regional Internal Audit Budget for 12 Months Ending 30 June 2019

Regional Internal Audit is proposing the same level of funding as last year, or $489,744. This represents 0.03% of the FY2017 revenue which aligns well with other similar size DHBs.

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

That the Board:

Approve Regional Internal Audit’s request to be allocated the same budget as prior year of $489,744 to deliver its Internal Audit Plan.

Carried

5.7 General Medicine Bed Capacity (Brad Healey, Phillip Balmer & Carl Eagleton)
The paper was taken as read.

Over the past two years inpatient bed capacity, particularly during the winter period, has been a major challenge for Middlemore Hospital and particularly the General Medicine Service. During the winter of 2017, despite best efforts to plan an appropriate level of bed capacity, the hospital struggled to cope with the increased winter demand further compounded by increasing patient complexity, an aging demographic and high levels of socioeconomic deprivation. Medicine bed occupancy ran above 100% for six months of the year. This resulted in delays to patient care, patients being cared for in less than optimal environments (eg) gastroenterology procedure room, increased clinical risk and the inherent inefficiencies created because of the need to spread patients across multiple locations outside of the General Medicine ward environment.

These pressures have impacted patient flow in General Medicine over the past two years and
resulted in an increase in Average Length of Stay (ALOS) from 3 days up to 3.4 days. This equates to a significant increase in the number of acute bed days used, hence the pressure on patient flow and increased bed occupancy (up to 130%). The main increase has been amongst those patients staying greater than 11 days. This group now account for 7.2% of admissions but 1/3 of General Medicine bed days.

CM Health has 20% of the national quintile 5 population and 22% acute bed days. We believe that this high level of deprivation has a flow-on impact into the nature and complexity of presentations which has a disproportionate impact on ALOS for CM Health, particularly General Medicine.

As part of the winter planning process, we have identified a need to increase General Medicine bed capacity to cope with the expected increase in presentations during the winter period. For the past two years, General Medicine has been working on a significant change programme which is intended to improve patient flow through improved management of long stay patients, implementation of Home Based Wards, new medical staffing roster and structured interdisciplinary based Rounds together with rigorous monitoring of performance against patient flow metrics. However, these initiatives will not of themselves solve the bed capacity issues for winter 2018.

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

That the Board:

Approve the establishment of 30 beds on Ward 21 for use by General Medicine in winter.

Note the cost of the additional 30 beds for winter is estimated to be $2.3 million. We expect this cost will be partially offset by savings of $1.4 million generated through the General Medicine Change Programme and the closure of beds across General Medicine during the remainder of the year. These savings are in addition to those identified in the Turn Around Plan.

Note the net incremental cost of establishing Ward 21 for use in winter is $0.9 million.

Agree that the official announcement of the opening of Ward 21 is deferred to Monday 2 July 2018.

Carried

5.8 Turn Around Plan
The paper was taken as read.

Stage 1 of the Turn Around Plan (defined as December 2017 – June 2018) is nearing completion and the project team is currently working to validate the final benefits position with the business and the ELT.

The Turn Around Plan team’s approach/methodology for identifying saving opportunities - to bridge the financial gap - was endorsed by the Board in February 2018 and emphasised the need to develop a plan with sufficient rigour and transparency to meet the expectations of the NZ Public Health and Disability Act 2000 and standards of good practice in the management of public sector organisations.
The Turn Around Plan project team is validating annual benefits in the range of $12M (low) to $16M (high). The project’s final proposals, benefit numbers and ‘next steps’ recommendations are currently being reviewed with the business and the ELT and will be presented to the Board in August 2018.

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

That the Board:

Receive the Turn Around Plan Update for June 2018.

Carried

5.9 Integrating Governance, Leadership and Planning Arrangements for Maori Health Alliance

The paper was taken as read.

Because of changes in Board leadership, there have been delays in implementing decisions taken by the Boards of the Auckland, CM Health and Waitemata DHBs at their meetings on 1 November 2017, 6 December 2017 and 8 November 2017 respectively in respect of the governance, leadership and planning arrangements for Maori health across the metro Auckland DHBs.

The interim Chairs of Auckland and Waitemata DHBs, together with the Chief Executives of the metro Auckland DHBs, recently met to discuss best ways forward in the light of this and agreed that:

a) As soon as all three new Board Chairs are in place (by 10 June), the Chairs will be asked to appoint members of the new MHAC, in accordance with decisions 2-3 of the Waitemata DHB Board Resolution 08 November 2017. A first meeting of MHAC will then be able to be scheduled.

b) The extension of the role of the Chief Advisor Tikanga for both Auckland and Waitemata DHBs to include CM Health should be placed on hold for the time being until CM Health and Manawhenua signal they are ready for this extension.

c) Dr Bramley, as lead Chief Executive Officer for Maori Health across the metro Auckland DHBs, will consult with the Maori Health Advisory Committee (MHAC) once established, on a suitable process for the recruitment and appointment of a Director, Maori Health Services. Assuming MHAC favours a single Director of Maori Health Services across the metro Auckland DHBs, Dr Bramley will lead the appointment panel for the position and invite the other metro Auckland Chief Executives to join the panel, should they wish to do so.

d) As an interim measure, and recognising that the process contemplated in (c) above may take a number of months, CM Health should immediately move to fill its vacant position of General Manager Maori Health on a fixed term basis of 12-18 months.

e) A further update should be provided to all three metro Auckland DHB Boards once tangible progress has been made with steps 1-4 outlined in the ‘comment’ section of the report.
Resolution (Moved: George Ngatai/Seconded: Dianne Glenn)

That the Board:

Note that, as provided by the New Zealand Public Health and Disability Act 2000, appointments to staff positions, as contemplated in (b) above, are the preserve of a Chief Executive not a Board or Board Committee.

Note that Gwen Tepania-Palmer and George Ngatai are co-Lead Chairs for Maori Health for the metro-Auckland DHBs.

Endorse the actions set out in (a), (b), (d) and (e) above, subject to the Minister of Health first being advised of the intention to create a combined MHAC and the Boards of the metro-Auckland DHBs considering any feedback that he may have.

Endorse Dr Bramley consult with MHAC on a suitable process for the recruitment and appointment of a Director, Maori Health Services noting that the Board would want MHAC to consider that Board members make up the initial recruitment panel for the Director Maori Health Services position and that Chief Executives only join a second recruitment panel.

Carried

6. INFORMATION PAPERS
6.1 Safety for All – Goal of Zero Seclusion 2020

The paper was taken as read.

It was noted that there was a large variation in seclusion rates depicted in the graph on page 2 of the report however, the graph was hard to read as it had no numbers or context around it.

The Board felt that more work needs to be done in this area to give them greater comfort and assurance and requested that a more detailed presentation on how this is progressing is provided to the Hospital Advisory Committee (15 August) prior to the 19 September Board meeting.

6.2 Social Investment Board Quarterly Report

The report was taken as read.
7. **RESOLUTION TO EXCLUDE THE PUBLIC**

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

That the Crown Monitor, Mr Ken Whelan, be permitted to remain in the Public Excluded section of this meeting.

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>Public Excluded Minutes of 16 May 2018/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>
</tr>
<tr>
<td>Construction Project Update - verbal</td>
<td>The public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. Commercial Position The disclosure of information would not be in the public interest because of the greater need to protect the commercial position of a third party. [Official Information Act 1982 S9(2)(b)(ii)]</td>
</tr>
<tr>
<td>NZNO Strike Contingency Planning</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>Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.</td>
</tr>
<tr>
<td>Topic</td>
<td>Reason</td>
<td>Negotiation Details</td>
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<td>----------------------------------------------------------------------</td>
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</tbody>
</table>
| Rheumatic Fever Prevention Programme Revenue Agreement                | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | **Negotiation**  
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. |
| Funder Contract Price Increase Recommendations 2018/18               | 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. | **Negotiation**  
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. |
| Master Procurement Agreement                                         | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | **Commercial Position**  
The disclosure of information would not be in the public interest because of the greater need to protect the commercial position of a third party. |
| Lease of CMDHB Fleet Vehicles                                        | 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. | **Negotiation**  
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. |
| Statement of Performance Expectations 18/19 | 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. | Public Interest  
The disclosure of information would damage the public interest. |
| Vector Power Contract for Middlemore Site | 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. |
| First Draft Annual Plan and Statement of Expectations 2018/19 | 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. | Public Interest  
The disclosure of information would damage the public interest. |
| Risk Management Report | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | 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. |

**Carried**
The public meeting closed at 12.50pm.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 27 JUNE 2018.

__________________________  8 August 2018
BOARD CHAIR
<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>27 June 2018</td>
<td>Information Paper – Safety for All Goal of Zero Seclusion 2020</td>
<td>The Board felt that more work needed to be done in this area to give them greater comfort and assurance and requested a more detailed presentation on how this is progressing.</td>
<td>19 Sept</td>
<td>Tess Ahern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 June 2018</td>
<td>Metro Auckland Urgent Care After Hours Procurement</td>
<td>The Board asked that the finalised co-pays for East Care be reported back to the Board.</td>
<td>8 August</td>
<td>Benedict Hefford</td>
<td>Refer Item 2.2 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>27 June 2018</td>
<td>Health and Safety Report</td>
<td>Vaccination Priority Areas to be reported back as part of the H&amp;S Report each month. Report back with some ideas around providing stickers to those staff in areas that look after our vulnerable patients to show they have been vaccinated.</td>
<td>8 August</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 4.2 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>16 May 2018</td>
<td>Health and Safety Report</td>
<td>One of the key components in the Health Equity Campaign is equity in the workforce and diversity. It would be timely to have a presentation to the Board on the campaign as it is winding up shortly.</td>
<td>8 August</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 4.2 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>28 February 2018</td>
<td>Health and Safety Report</td>
<td>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).</td>
<td>8 August</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 4.2 on today's agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>31 January 2018 (transferred from HAC)</td>
<td>Provider Arm Performance Report</td>
<td>The HAC 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 Deferred to 19 September as the new MMF Director has just commence.</td>
<td>8 August/19 Sept</td>
<td>Phillip Balmer</td>
<td></td>
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<tr>
<td>DATE</td>
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<td>discuss their new strategy and structure. A copy of the MMF Constitution to be provided at this time.</td>
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<tr>
<td>6 December</td>
<td>Health and Safety Report</td>
<td><strong>Way Finding</strong> – the Board asked that a review of the Middlemore campus is undertaken by a traffic/transport management expert.</td>
<td>8 August/19 Sept</td>
<td>Margie Apa</td>
<td>Work in progress. An update will be provided at the 19 September Board meeting.</td>
<td></td>
</tr>
<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>12 Dec</td>
<td>Doone Winnard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 October</td>
<td>Demonstration – E-Vitals</td>
<td>The Chair noted that the Board would schedule a ward visit to enable them to see how e-Vitals is working at the bedside.</td>
<td>19 Sept</td>
<td>Phillip Balmer</td>
<td></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>8 August/19 Sept</td>
<td>Margaret White</td>
<td>Work in progress and will be reported back in full at the 19 September Board meeting.</td>
<td></td>
</tr>
</tbody>
</table>
Response to Action Item

An action previously assigned by the Board is reported back on in this section.

Board Meeting 27.6.2017 – Metro Auckland Urgent Care After Hours Procurement

“The Board asked that the finalised co-pays for East Care be reported back to the Board”.

<table>
<thead>
<tr>
<th>FEES APPLICABLE FROM 1st JULY 2018</th>
</tr>
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<tbody>
<tr>
<td><strong>MEDICAL</strong></td>
</tr>
<tr>
<td>Mon - Fri Mon - Fri 8am - 5pm 11pm</td>
</tr>
<tr>
<td>Child 0-5 25 25</td>
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<tr>
<td>Child 6-12 years card holder 55</td>
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<tr>
<td>Child 6-12 years non card holder 60</td>
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<tr>
<td>13-17 years card holder 55</td>
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<tr>
<td>13-17 years non card holder 60</td>
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<tr>
<td>Adults 18-64 card holder 64</td>
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<tr>
<td>Adults 18-64 non card holder 80</td>
</tr>
<tr>
<td>Adults 65+ 80 39 45</td>
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<tr>
<td><strong>ACC</strong></td>
</tr>
<tr>
<td>Mon - Fri Fri 8am - 5pm 11pm 11pm</td>
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<tr>
<td>Child 0-12 free free free</td>
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<tr>
<td>13-17 years card holder 43 39 69</td>
</tr>
<tr>
<td>13-17 years non card holder 43</td>
</tr>
<tr>
<td>Adults 18-64 card holder 43 39 80</td>
</tr>
<tr>
<td>Adults 18-64 non card holder 43</td>
</tr>
<tr>
<td>Adults 65+ 43 39 45</td>
</tr>
</tbody>
</table>

A $15 surcharge will apply on a public holiday unless covered by After-hours funding.
Non residents: Medical $390; ACC $150.
Additional charges apply for materials, equipment hire and pregnancy tests.
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 23 May 2018 at 9.00am – 12.00pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART II – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dr Ashraf Choudary
Dianne Glenn
George Ngatai
John Wong

ALSO PRESENT

Dr Gloria Johnson (acting Chief Executive)
Benedict Hefford (Director Primary, Community and Integrated Care)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Margie Apa (Director, Population Health & Strategy and Acting GM, Maaori Health)
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 at this meeting.

APOLOGIES

Apologies were received and accepted from Katrina Bungard and Apulu Reece Autagavaia,
George Ngatai for lateness and Jenny Parr for an early departure.

NOTE

This meeting commenced with a Tour of Community Central and then moved directly into
Public Excluded at 9.30am. Please see Public Excluded minutes.
RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Colleen Brownn/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:

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

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<tr>
<td>3.1 Mental Health &amp; Addictions Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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</tr>
</tbody>
</table>

Carried

RESOLUTION TO INCLUDE THE PUBLIC

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

Carried

WELCOME

The Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted. Ms Tafau to amend items for Ms Glenn.

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 11 April 2018.

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

That the minutes of the Community and Public Health Advisory Committee meeting held on 11 April 2018 be approved.

Carried
2.2 Action Items Register/Response to Action Items

Noted.
Mr Hefford to send Pat Tuhoy letter to Ms Tafau for dissemination to CPHAC
CPHAC would like a further B4 School Update (regional concern) Ministry of Health so we can
have a discussion around concerns. Mr Hefford is to ask for a more substantive response
from the Ministry of Health.

3. BRIEFING PAPERS

3.1 Auckland Regional Public Health Service Briefing (William Rainger/Jane McEntee)

The report was taken as read:

Points to note included:

- Mumps – ARPHS has been managing a mumps outbreak in the Auckland region since
  January 2017. The community spread of mumps is established both in the Auckland region
  and other parts of New Zealand. As at 27 April 2018, 1253 confirmed and probable
  mumps cases have been notified to ARPHS. However, volumes are decreasing
- From 1 August 2017 to 27 April 2018, 206 confirmed and probable dengue cases have
  been notified to ARPHS. The majority of cases (91%) reported recent travel to the Pacific
  Islands, particularly Samoa (124), Tonga (40), Fiji (21) and French Polynesia (2). 146 cases
  (71%) have been hospitalised, mostly for severe dengue (fever or bleeding disorders), and
  the ethnic groups commonly affected identified as Samoan (n=121) and Tongan (n=36).
- ARPHS opposed a new application for an off-licence (bottle shop) in Takanini on the
  grounds of outlet density. Approval of the application would have meant there were four
  off-licences within a 1km radius. Takanini, which has high socioeconomic deprivation and
  Māori population, already experiences high levels of alcohol-related harm compared to
  other areas. The new store would have exacerbated this further. After communicating its
  concerns to the District Licencing Committee, ARPHS was commended by the community,
  particularly the Māori Wardens, for being the first agency (to their knowledge) to give the
  Māori community a direct voice. ARPHS’s opposition to this application was in line with its
  newly developed regulatory protocol, which provides an evidence based framework of
  public health concern priorities.
- WAI Auckland: The three Auckland DHBs have committed funding of $150,000 per annum
  over three years to a tap water project, titled “Wai Auckland”. The DHBs have requested
  ARPHS to redevelop the Wai Auckland business case to reflect the reduced level of funding
  ($250,000 p.a. from each DHB had been requested).
- ARPHS has been informed an aerial 1080 operation will be undertaken by Auckland
  Council in the Hunua Ranges this winter. ARPHS recently met with Council about this
  year's operation, which follows the first aerial 1080 operation in the Hunua Ranges in
  winter 2015. The 2015 operation was the first aerial 1080 operation in Auckland in a
decade, and Council correctly anticipated that pest numbers (rats, possums, stoats) would
  need to be addressed on a 3-5 yearly basis with repeating operations.
- Undercover operations in Mangere were disappointing with three retail outlets selling to
  underage people.
- Provisional Local Alcohol Policy appeals: ARPHS will be required to review submissions
  from the various parties, prepare evidence and/or legal submissions and attend hearings
  in order to continue to support Auckland Council to arrive at a reasonable and effective
  LAP that contributes to reduced alcohol related harm within the Auckland region.
- Flu vaccination: watching flu trends but the usual spike hasn’t yet appeared, warmer
  weather is helping with that.

Mr George Ngatai arrived at 10.55am

Counts Manukau District Health Board 8 August 2018 026
• Auckland being a major entry into the country sees more unlikely diseases than around the rest of the country. ARPHS works with mult-agencies with airport and marine ports. CM Health are involved with Auckland Airport in particular.

• In relation to dengue, these are introduced cases, but we don’t want the vector to take hold. This is a downside of the unseasonably warm weather. Disease vectors (mosquitos) won’t flourish in our current temps, but with climate temps increasing generally, an eye is kept on this. Resourcing in this area is key.

Resolution
The Community & Public Health Advisory Committee:

Received this update from Auckland Regional Public Health Service on key pieces of work that are underway and/or completed since our last update and asked ARPHS to return in 6 months time.

Moved: Dr Ashraf Choudhary /Seconded: Dianne Glenn
Passed: Unanimously

3.2 System Level Measures Framework (Kate Dowson)

The report was taken as read.

Key areas of note are:
• Although CMH has not yet achieved our ASH 0-4 milestone, our rates have improved over time. This is of note given that ASH is a very challenging measure to influence as it is closely related to socio-economic deprivation. Related to this, the number of hospitalisations for skin infections has dropped and this is most noticeable in Pacific children.

• We have made significant progress towards achieving the Maaori Acute Hospital Bed Days milestone and are 8 ‘bed days’ per 1000 off our target.

• The Patient Experience of Care milestone for Primary Health Care Patient Experience Survey has been met.

• We are very close to achieving the in-patient experience survey target (achieving a score of 8.4 where the goal is 8.5) for this quarter and likely will achieve it by the end of the year.

• Counties Manukau Health has already achieved the Amenable Mortality target for this year. As part of this measure, we have the highest Cardiovascular Risk Assessment rate in metro Auckland.

• We are still working with the Ministry of Health to get accurate data for the Youth and Babies in Smokefree Households SLMs. We anticipate this will provided by the end of quarter four, which will enable us to move forward with planning for the next year.

As we near the end of the 2017/18 year, we have begun planning for next year’s plan. This has included a number of consultation meetings with consumers (e.g. CMH Consumer Council) including mana whenua and Pacific peoples. Next year’s plan is likely to include a smaller number of activities which are focussed on improving equity (in line with CM Health’s strategic goals) and making meaningful change across the region.

Resolution
The Community & Public Health Advisory Committee:

Noted the quarterly reporting on the 2017/18 Metro Auckland System Level Measures Improvement Plan.
**Moved:** Dr Ashraf Choudhary  
**Seconded:** Dianne Glenn  
**Passed:** Unanimously

4. **PRESENTATION**

4.1 **Kootuitui ki Papakura Overview (Julia Burgess Shaw)**

Ms Burgess Shaw introduced Mr Lee Orten and other attendees from the Kootuitui strands.

Kootuitui ki Papakura supports the wellbeing and positive lifelong outcomes of children and young people in Papakura. The Trust delivers an integrated programme of activities focused on health, homes and education. This includes the delivery of:

- The Manaiakalani Outreach Programme based on 1:1 digital immersion in schools;
- Comprehensive school-based health services; and
- Work with volunteer whaanau to support whaanau-led programmes such as warm, dry homes, money skills and chromebook literacy.

The overall aim of the programme is to support the wellbeing of children in Papakura and their ability to reach their potential. Five primary schools and one high school are participating in the programme; Edmund Hillary School, Red Hill Primary, Kereru Park Campus, Park Estate School, Papakura Central School and Papakura High School.

The Papakura Kootuitui Trust was established in 2015 to support the community of Papakura and to oversee delivery of the three strands of the programme. “Kootuitui” means interweaving and connecting together.

The Trust is associated with the following key delivery partners:

- Middlemore Foundation for Health Innovation;
- Counties Manukau Health;
- Manaiakalani Education Trust;
- National Hauora Coalition;
- Papakura Marae;

The Trust is in service to the kaupapa of the schools and is guided by Te Tiriti o Waitangi and the principles of participation, partnership and protection.

**Education Strand Outcomes**

- Learners in Kootuitui start school at 5 years old well below the national norm, but by 6 years old they have caught up to the norm for Letter Identification and Concepts about Print and are very close to the norm for Word Reading but below the norm for Writing Vocabulary.
- While still achieving below the national norm, Kootuitui learners on average have made accelerated progress in Writing.

**Health Strand Outcomes**

- The most significant improvement in health outcomes has been improved access to sexual health services (particularly contraception) and a subsequent reduction in teenage pregnancies (from 23 in 2012 to 2 in 2017).
- An increase of ~ 42% in the number of young people and whanau accessing the nursing service;
- An increase of ~ 54% in the number of young people and whanau accessing the GP service;
- Delivery of educational sessions around sexual health, healthy lifestyles, hygiene, oral health and how to access health services when young people leave school;
Within the primary school programme, here's an example of the outputs achieved:

- 100% of children who had a GAS positive throat swab received antibiotic treatment. 80% of children who received treatment reported good adherence on completion.
- In Term 1 2018, a total of 245 skin assessments were completed. The three most prevalent skin conditions children presented with were injury, impetigo and eczema.

**Homes Strand Outcomes**

- A co-design methodology is being used to implement a whaanau-led approach and the Warm, Dry Healthy Homes prototype was developed.
- Whaanau engagement and participation, eg engagement with 12 whaanau represented 51 school-age children, with 32 of these in 1:1 digital classes.
- Whaanau facilitating workshops for other whaanau in use of chromebooks, accessing children’s learning, Money Skills courses and Warm, Dry, Healthy Homes.

**Future direction of the programme**

Going forward, the Kootuitui ki Papakura seeks ongoing, sustainable funding. The Trust intends to focus on:

- Further design and implementation of the Homes strand;
- Continuing to build local networks;
- Increasing the number of schools participating in the programme;
- Broadening the scope of the programme, e.g., moving into employment and sport and recreation opportunities.

**Implications for Counties Manukau Health**

Counties Manukau Health currently funds a portion of the health services in the primary schools and the high school. Without further additional funding, these services will not be able to continue in their current form from 1 July 2018.

CPHAC thanked Mr Orten and the other attendees from the various Kootuitui strands for their continued efforts in the Papakura Community advising that this programme is transformational and inspirational. CPHAC wished Kootuitui ki Papakura well for their current funding applications.

**Resolution**

The Community & Public Health Advisory Committee:

- **Noted** that the Kootuitui ki Papakura programme comprises three strands; education, health and housing.
- **Noted** that Kootuitui ki Papakura is in the final stages of the pilot, in conjunction with the Middlemore Foundation for Health Innovation, and is developing its own funding streams to continue into 2019 and beyond.

**Moved:** Dr Ashraf Choudhary  
**Seconded:** Dianne Glenn  
**Passed:** Unanimously
The meeting concluded at midday.


______________________________
Colleen Brown
Committee Chair
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Wednesday, 6 June 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)
Ms Catherine Abel-Pattinson (Deputy Chair)
Dr Ashraf Choudhary
Ms Dianne Glenn

ALSO PRESENT

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

No apologies were received.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted.

There were no specific interests to note regarding the agenda for this meeting.

1. AGENDA ORDER AND TIMING

The meeting commenced with a tour of the Adult Mental Health Unit.
Items were then taken in the same order as listed on the agenda.
2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee meeting held on 23 April 2018.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: Dr Ashraf Choudhary)

That the minutes of the Hospital Advisory Committee meeting held on 23 April 2018 be approved.

Carried

2.2 Action Item Register

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

3. PROVIDER ARM PERFORMANCE REPORT

Executive Summary

Phillip Balmer introduced the report highlighting:

Delivery of our 2017/18 initiatives work plan is continuing; across Hospital Services divisions and related programmes, there are now 102 total projects being monitored, which range from localised service improvements through to major transformational activities. There are 14 projects in initiation, which largely relate to new project commencing in line with the organisational Turnaround Plan. In total, 50 projects are now in execution phase, with 5 in Benefits Realisation. Further detail is provided in the ‘Initiatives Programme’ section of this month’s report.

Projects are on track to deliver improved patient outcomes and reduced costs with savings YTD forecast to be $15M. Some of these savings will be ongoing for subsequent years. We are working on closing out the 17/18 projects.

We have also been working on our improvement program for 18/19 to achieve the triple aim of improving value and closing the equity gap by developing plans to deliver results in each of the turnaround focus areas. Our preliminary benefits for the provider arm equal $6.5M. We are working on project implementation plans to commence delivery of these improvements as soon as possible and will be providing regular reports back to ELT, ARF and HAC.

Work has been undertaken around the better management of chronic conditions including linking with Primary Care. One of the aims is to provide better support for End Of Life (EOL) care. Considerable thought and engagement has been invested into putting patients first and considering their wishes, providing advice, etc. Support is provided to the whaanau depending on requirements, when patients return home for the EOL journey. EOL and Chronic conditions are well supported by Community Central ensuring they have continued support at home.

A regular report in terms of metrics of how that will look will be provided.

Balanced Scorecard – Provider Arm

The report was taken as read.
The Scorecard shows significant improvements in many areas. Maaori BreastScreening was of particular note.

Action
Mr Balmer will ask Mr Brad Healy to provide an update for HAC highlighting what is being done differently in order to produce significant improvements for Maaori Breastscreening.

Finance Report – Provider Arm

The report was taken as read.

- Non-resident revenue: Mr Avinesh advised that CM Health don’t write off bad debt. It is sent to Debt Collection agencies. A full report will be included in the Financial Year report – 18 July 2018.
- The last funding envelope saw CM Health’s MoH contribution to non-resident revenue increased.
- Overspending in facilities is to be expected.

NZNO negotiations: to be discussed later in the meeting.

Emergency Department, Medicine and Integrated Care (Brad Healey)

The report was taken as read.

In regard to Breastfeeding, Mr Healy advised the results were reflective of the effort and focus of the leadership of the service. Mr Healy is confident that CM Health is doing well comparatively.

As at 31 February total coverage for women aged 50-69 years was 71.1%. Maaori coverage was 65.3%, and Pacific 83.3%. The national target of 70% has been achieved for the total population and Pacific. There has been a slight increase in Maaori coverage this month as the service has exceeded the Maaori screening volume target over the last 2 months.

- Readiness assessment: went well.
- Histopathology: case before board, endorsed. Submitted IANZ, successfully.
- Colonoscopy wait times: MOH is concerned due to the fact that CM Health is falling behind with wait times. Outsourcing is working well, however from Christmas 2017 to May, there has been a 30% increase in volume of those waiting. As such CM Health has fallen behind the P2 target. A recovery plan has been requested. Outsourcing is forming part of the recovery plan. Preliminary discussions are going live from end of June 2018.
- Bowel screening requires regular follow up.
- Winter Bed Capacity: effort is being put into what the needs of General Medicine are. Francis Group will undertake some diagnostics of the Patient Journey. This will challenge our thinking in a number of areas. Will give the process credibility. Many factors will feed into this study of the average length of stay. Average length of stay for 40% is currently 13 hours.
- Local delivery of oncology: Plan for next 12 to 24 months – Auckland looking to push some volume out our way. Longer term picture, post two years, will we continue to use level 5 of Galbraith. If not there Manukau Health Park seems to be the logical choice. Will require some thinking around this. Call centre, clerical tasks, these could potentially be done from home.

Surgery, Anaesthesia & Perioperative Services (Mary Burr)

The report was taken as read.
Highlights included:
- Acute WIES is 5.12% lower than contract for the month over contract by 2.22% YTD.
- We treated 70 Hip and Knee patients (YTD 709/685) against target of 65. For cataracts we treated 241 against a target of 103 patients (YTD 1473/1082).
- Theatre utilisation at MSC has increased to 78.8% for April 2018. Theatre Performance - Acute outputs returned to high volumes in April 2018 after a slight reprise in March 2018.
- 100% for discharges, YTD. Outputs are well over-phasing. Another positive.

Challenges include:
- Elective throughput.
- Workforce planning group: keeping an eye on anaesthesia.
- Population (worldwide) is aging and therefore an increase in aged related care in particular ophthalmology. Technology, recruitment (international shortage) and ‘mega-clinics’ will continue to assist CM Health in catching up by the end of the calendar year.

Action
Determine how many cataracts patients are being outsourced to ADHB and report back to the next HAC meeting.

Central Clinical Services (Phillip Balmer)

The report was taken as read.

Highlights included:
- The Laboratory has completed its surveillance audit (conducted by IANZ) during April. There were two CARs received. One was a continuation of the Histopathology accommodation CAR and requires progress to be made towards the reconstruction of the department. The second was related to the documentation currency in the department and requires us to make significant steps toward ensuring that our documents are reviewed in a timely manner. There was also a list of recommendations made by IANZ. The feedback from IANZ was generally very positive and stated that the lab continues to demonstrate high levels of performance.
- The updated Histopathology business case was approved again at ELT and is scheduled to go to the Board on the 16th of May.
- We have ceased routine laboratory testing at the Manukau Super Clinic retaining Point of Care urgent testing and Blood Bank Services. We have reduced the staffing at MSC from two to one and deployed the released resource to support the routine testing being performed at the Middlemore laboratory.
- The Patient Blood Management project is progressing well with good savings achieved in April although less than those in March. The new PBM nurse starts in May.
- Electronic Prescribing and Administration (Medchart) was rolled out successfully to two ARHOP wards in April. The uptake of MedChart in these wards has been excellent and there have been no significant clinical issues or risks identified. There have been some integration related issues highlighted and these have a plan for resolution. The planned roll out to the 5 Adult Rehabilitation and Health of Older Persons wards is expected to be completed on schedule in early June.
- MRT’s and sonographer staffing much improved. Current vacant FTE – MRT – 4.00FTE and Sonography is .54FTE. Overseas advertising has resulted in a good response for MRT staff, however recruiting MRI trained staff remains challenging as the requirements of the MRTB are restrictive.
- The conversion rate to Radiology electronic orders is now close to 80% with excellent uptake across inpatient services. Some workflow issues with the new process are impacting the uptake in outpatient services.
**Kidz First & Women’s Health** (Nettie Knetsch)

The report was taken as read.

Highlights included:
- Neonates continues to be a concern and CM Health are waiting on a sit down with the MoH.
- The Neonatal Unit has 4 fewer discharges YTD; WIES however are up by 119. In addition, the discharges under WH for Secondary Neonates (i.e. Neonates transferred from Neonatal Unit to maternity) is up by 161 discharges (61 WIES) YTD. Occupancy and acuity in April in the Neonatal Unit remain high.
- With the Unit reaching capacity frequently we have seen an increase in babies moving to the postnatal floor and being discharged from there. In addition, since March 2018 we have commenced using Kidz First Medical C-Pod for lower acuity level 2 Neonates. On average 4 babies and their mothers have been accommodated. Resource nurses on Kidz First Medical have developed a Resource Board on C Pod to provide education to the staff on caring for these neonates and provide support to the nurses when required.
- A public Health Registrar is to look at what is driving the need for increased neonatal care.
- The increasing acuity and complexity in maternity (YTD Caesarean Section rate up by 2% and Induction of Labour rate up by 1%) combined with the additional neonatal workload is resulting in more midwifery workforce being required than budgeted. Fortunately, the availability of bureau staff has been good over the past 3 months as well as the commencement of the new graduate midwives (20) and the very end of April but we still needed to allocate significant overtime hours as well to support the new graduate midwives during their orientation. Staff sickness in Women’s Health continues to be higher than previous year reflecting the pressure on the workforce due to vacancies and increasing acuity particularly in the Birthing and Assessment area.
- Ineligibility, in Womens’ health it is different from other departments. If baby’s father is eligible, then the baby is and so is the mother until the baby is born.
- IDF: will be increased once the eligibility issues are resolved.
- Research: mostly ventilation and CPAP clinical trials, implementations. CM Health are leading experts in the country for CPAP.
- Gestational Diabetes: understanding the impact of comorbidities is an ongoing focus.

**Adult Rehabilitation & Health of Older People** (Dana Ralph-Smith)

The report was taken as read.

Highlights included:
- The Indicative Business Case for the Specialised Rehabilitation Investment went to the Capital Investment Committee this month; a month earlier than previously expected in our previous report. We have subsequently commenced planning the next steps for the Detailed Business Case Development.
- E-prescribing began its rollout in April and has gone live in Wards 23 and 24. Throughout May the rollout will continue to go live in Wards 4, 5 and 31. Additionally, e-vitals has gone live in Ward 23 with implementation of e-vitals expected to occur early May for Ward 31 and the Spinal Rehabilitation Unit.
- Pyxis has been implemented at the Spinal Unit and training will commence early May.

Challenges included:
- The ARHOP services are working hard to plan for the increased service demand throughout the winter months.
- We are continuing in our efforts to encourage staff and patients to get their flu vaccinations that are available at Middlemore Hospital and in the community.
• The services are all developing contingency plans should a nursing strike occur in July.

Ms Ralph-Smith asked HAC to note the additional information paper re fractures.

**Mental Health & Addictions** (Tess Ahern)

The report was taken as read.
HAC had a tour of the new Adult Mental Health Unit at the start of the meeting.
Mental Health enquiry highlight: Mason Durie was impressed with the model of care that CM Health are working towards.
Reconfiguration of specialist services: underway, appointed most of the major roles. Maaori and Pacific roles being recruited for next week.
The overarching structure of Integrated Care North, Integrated Care South and District-wide services is confirmed (with Acute & Hospital Services being out of scope).
• Three Service Managers will oversee the Integrated Care North, Integrated Care South and District-wide services.
• IC North and IC South will each have a CAMHS Clinical Head and an Adult Clinical Head.
• There will be five locality Adult Community MH teams: two (Eastern and Otara-Mangere) in the IC North service and three (Manukau North, Papakura-Manurewa, Franklin) in the IC South service.
• There will be two CAMHS services: Whirinaki North in the IC North and Whirinaki South in the IC South
• Establishment of a new Franklin Adult Community Mental Health team based at Pukekohe hospital
• Realignment of administration FTE to support these services and teams following consideration of work done by the administration working group

**Middlemore Central** (Dot McKeen)

The report was taken as read.
Contingency planning for potential industrial action is well underway working with Service Managers and Clinical Nurse Directors should the industrial action by the NZNO go ahead.

An independent panel requested by the Prime Minister has been meeting with both parties, DHBs and NZNO, to find common ground in reaching an agreed outcome. The NZNO has advised that failing to reach an agreement could result in a total withdrawal of labour for 24 hours starting at 0700 hours on Thursday 5th July and finishing at 0700 hours on Friday 6th July. We are advised that similar action could take place again the following week on Thursday 12th July.

Draft plans have been prepared and sent to Anne Aitcheson, the National Contingency Planner, for review. Discussion will then take place around what constitutes Life Preserving Services.

Work has been undertaken over the last three months to prepare and agree on a Metro Winter Plan for the three Auckland region District Health Boards – Auckland, Waitemata and Counties Manukau Health.

The plans will cover daily regional reporting, Influenza preparation and agreed indicators of when escalation to Director of Hospital level may be required taking a regional operational stance.
4. CORPORATE REPORTS

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

The paper was taken as read.

- Ms Parr advised that the Nursing Midwifery Awards were very much appreciated by staff.
- Certification: waiting for final confirmation of action plan from MoH. Gone from 19 corrective actions down to 12. Developing actions plans currently.
- Note: pictures of tables/graphs become difficult to read on Diligent.
- Parking: Esme Green machine doesn’t produce a receipt. Philip to follow up with Parking Services. Intensive work is currently being undertaken around understanding car parking issues.
- ACC: compassionate parking and senior staff parking has been allocated. Looking at night staff parking at the hospital to alleviate any safety fears.
- Hoping to reinstate the payment machine in the main carpark.

4.2 Patient Experience & Safety Report (David Hughes)

Report taken as read.

- There has been a bounce back in the feedback on food. More positive results are being seen.
- There has been a significant increase on in-patient surveys completed in Women’s Health due to tablets being used. The response rate has gone up bringing us closer to the national average.
- Open book: continuation of excellent work being undertaken in falls prevention.
- Falls preventions most recent focus has been away from the hospital.

4.3 Patient & Whaanau Feedback on Parking (Jenny Parr)

The report was taken as read.

Resolution

The Hospital Advisory Committee:

Received the patient, family and Whaanau feedback on parking issues at the Middlemore Hospital site and recommendations for improvement.

Noted the recommendations which were considered by the Executive Leadership Team in conjunction with the Car Parking Improvement Options paper submitted by Phillip Balmer

Carried

Action

Mr Balmer to report further on car parking at the next meeting on 18 July 2018 and is to provide his Car Parking Improvement Options paper for HAC’s information.

4.2 HR Report (Phillip Balmer)

The report was taken as read.

- A question was raised around whether or not bullying was an issues at CM Health and CM Health representatives at the table were asked if a survey been conducted? HAC were
advised that this issue is being looked at as a Health & Safety issue and a full report will be coming to the next Board meeting on 27 June 2018.

- CM Health is looking at better support for those teams under the most pressure, eg Neonatal.
- Voluntary turnover is currently remarkably low which is a pleasing result.

5. INFORMATION PAPER

The 2017/18 Non-Financial Summary Quarter 3 Report was taken as read.

6. RESOLUTION TO EXCLUDE THE PUBLIC

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

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Public Excluded Minutes of 14 March 2018</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes For the reasons given in the previous meeting.</td>
</tr>
<tr>
<td>3.1 Patient Experience and Safety Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons.</td>
</tr>
</tbody>
</table>

Carried

The open session of the meeting concluded at 3.45pm.


Dr Lyn Murphy
Chair
Mana Taurite: Equity in Health

A Health Equity campaign for Counties Manukau Health
2016-2018

A SUMMARY REPORT FOR THE CEO AND CM HEALTH BOARD
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Report Purpose

This report provides a summary of the Mana Taurite: Equity in Health campaign for the period Oct 2016 to June 2018. It includes a summary of what went well, the challenges and the learnings.

Executive Summary

Mana Taurite: Equity in Health, the Health Equity campaign was initiated in response to a request from the Counties Manukau Health (CMH) Executive Leadership Team (ELT) in 2015/16 to support the Healthy Together strategic goal of achieving health equity for Maaori, Pacific, and high needs communities of Counties Manukau by 2020.

Data analyses show that Maaori and Pacific communities fare worse on key health equity indicators including childhood obesity and workforce representation than other population groupings and these disparities are unfair and unjust (Whitehead 1992, Mariot and Sim 2014).

The CMH Leadership team commissioned Ko Awatea to support a campaign using an adapted Breakthrough series methodology or COIIN (IHI, 2003, Ghandour et al 2017) focusing on improvements in childhood obesity and workforce. The project work began in October 2016 with the receipt of project expressions of interest (EOIs). The projects accepted into the campaign were organised into three work streams and began working to understand the problem they were trying to solve. Change ideas were tested and where appropriate, implemented in the relevant services areas. Scale up and spread has not occurred due to the changed timeframe of the campaign, however information about what works and resources developed will be distributed across CMH where appropriate.

Achievements to equity have included highlighting the value of equity in CMH, and providing an opportunity for people with a passion to work together to innovate and identify what works in Counties Manukau to reduce health disparities linked to workforce capability, representation and child obesity.

Project results included the development of new processes to support child obesity screening, screening for alcohol harm, identifying and keeping children well from bronchiectasis, effective patient management for people with Gout, developing and maintaining a network of Maaori Doctors and working with whaanau affected by suicide. Resources were co-designed to support healthy nutrition and weight gain for tamariki, women with diabetes and pregnant women, to support contraception choice in women, to attract and retain Pasifika nurses at CMH and to embed equity in the procurement process.

The campaign offered an opportunity for staff with a passion for health equity to work, learn and achieve together. The campaign has also highlighted the value of equity for CMH and delivered project learning that can be distributed across the organisation. The passion and determination of staff working in the projects and the campaign team supporting them should particularly be acknowledged.
Introduction

Mana Taurite: Equity in Health, the Health Equity campaign was commissioned by CMH Executive Leadership Team (ELT) in 2015/16. The campaign was intended to contribute to delivery of the strategic goal of improving health equity for Māori, Pacific, and high needs communities of Counties Manukau by 2020, by:

- Fostering healthy communities, healthy people and whaanau/ families by accelerating the spread of effective interventions to address childhood obesity disparities
- Supporting healthy services by building the capability of our workforce to apply a health equity approach in their work and increasing the representation of Māori and Pacific staff across our workforce to better reflect the community.

Why equity?

“We care about achieving health equity for our community. Together the Counties Manukau health system will work with others to achieve equity in key health indicators for Māori, pacific and communities with health disparities by 2020…. This means that people will live longer healthier lives in the community” (Healthy Together Strategic Plan 2015-2020).

Health inequities are systematic differences in the health status of different population groups (WHO 2011) which are considered unnecessary, unfair and unjust (Whitehead 1992, Marmot, Bell, Houweling and Taylor 2008). Health equity is important because health is a fundamental human right and has impacts on the physical, mental and social wellbeing of individuals and groups (MOH 2002). Health inequities are known to have significant social and economic costs both to individuals and societies (WHO 2011).

Health inequities are often linked to the social determinants of health; social factors that influence health such as income, housing conditions, social networks and others. However evidence has shown that many disparities are not solely caused by the determinants of health, but are compounded by inequitable health care itself (HQSC NZ 2017).

There are many factors that influence health that can be modified by the health sector; such as how easy it is to access and pay for health services, staffing, available technology and medicines, the amount and outcomes of care provided and whether services are socially and culturally responsive to their populations (HQSC NZ 2017). Focusing quality improvement work on the needs of populations experiencing worse health outcomes, and using data to identify disparities helps target specific high-leverage opportunities for improvement (Wyatt et al, 2016).

In order for all people in our community to live longer healthier lives, the significant inequities that currently exist among our Māori and Pacific communities need to be addressed (Healthy Together Strategic Plan 2015-2020).
Strategic Background

CMH through its Healthy Together strategy placed a focus on health inequities and made a commitment to support change towards more equitable outcomes with a particular focus on Maaori and Pacific people and high needs communities (CMH 2015).

Data analyses show that overall Maaori and Pacific communities fare worse on key health equity indicators than other population groupings. National data identifies inequities in many areas including morbidity, surgery complications, and poor patient experience (HQSC 2017, Marriot and Sim 2014). The leading conditions in relation to absolute inequality include CVD, diabetes, lung cancer, and COPD for Maaori (MOH 2013).

Statistics indicate that obesity rates are higher in those of Pacific (30% children and 67% adults) and Maaori (15% children and 47% adults) ethnicity, compared to non-Pacific and non-Maaori (MOH 2015). Data from the Before School Check for Counties Manukau Health (CMH) in 2015, showed higher rates of obesity in our Pacific (33%) and Maaori (18%) four year old children compared to New Zealand European (11%) children (Winnard, 2016).

Literature indicates that a varied and diverse work force that reflects the population it serves can contribute to health equity (Wyatt et al 2016). While 16% of the CM population are Maaori, this is reflected in only 6% of the CMH workforce, with 21% of the population being Pacific Island and 11% of the workforce (Ministry of Health 2015, NRA Workforce Ethnicity Report, June 2016).

Following a review by the Population Health team (2015) of the burden of ill-health across CMH communities, existing health system indicators, life course considerations and short to long term impacts, the following areas were recommended to track and impact on equity efforts; Smoking prevalence, CVD/Diabetes management, Hazardous use of alcohol, Childhood obesity or oral health, and Health literate systems and people and Workforce development. ELT considered that the campaign was best placed to target obesity and workforce. During the campaign development workforce was later further broken down into healthy services work stream (supporting staff and services to be equity responsive and apply an equity lens to the disparities in their services), and healthy systems work stream (to increase the representation of Maaori and Pacific staff in CMH).

The work stream purposes were agreed as follows:

- to innovate and identify what works to reduce disparities for childhood obesity for children from Maaori and Pacific communities in Otara – Counties Manukau (Healthy Kids)
- to innovate and identify what works to reduce disparities for identified health outcomes for Maaori and Pacific patients and whaanau in participating services in Counties Manukau (Healthy Services)
- to innovate and identify what works to increase the number of Maaori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community (Healthy Systems).
At a Campaign level

What we did

- **An engagement strategy** was enacted that involved key CMH and community leaders, teams and services identified as being critical to the focus areas of the campaign, as well as a strategic top-down engagement plan.
- **A governance structure** was set up for the campaign including; a Campaign Leadership Board, Campaign team, Campaign clinical leads group, Campaign measurement group, and projects (Further information at appendix 1).
- In October 2016 an **open Expression of Interest (EOI)** was circulated across all CMH and community services. Teams were notified of their success and a first learning session was held on the 30th November 2016.
- The campaign used an adapted **Break Through Series (BTS)/ COIN methodology** as the model of achieving change, supported by the Model for Improvement (PDSA testing) (Further information at appendix 2).
- **A phased approach to project management** is also included in this method.

Successes

- In the preparation of EOIs, **information sessions** were held to support interested individuals to explore and refine their project ideas, to join up with others with similar interests and aims and to support completion of the EOI forms.
- Setting the **location of the obesity work in Otara** as a defined area of high disparity in which to start engaging and testing with that community via the Otara Network Action Committee (ONAC).
- Developing a **Leadership Board (Steering Committee)** of key and senior CMH and community members.
- Having the **Chief Executive Officer (CEO) as the campaign sponsor** who remained a strong advocate through the duration of the campaign.
- **Engaging members of ONAC** to join our campaign team and Leadership Board.
- Developing a **diverse and multi-skilled Improvement campaign team**.
- **Using the methodology** (adapted Breakthrough Series/COIN) to understand the problem, test ideas and implement solutions supported by master classes and learning sessions.
Challenges

- Although the initial campaign was initiated and sponsored by the CEO and ELT, there was limited opportunity to fully consult on and gather support for the campaign at a senior level prior to its setting up which created challenges as the campaign progressed, particularly in a changing environment.
- Regular attendance at the Health Equity Leadership board was variable, making it difficult to realise the full opportunities this structure could have offered.
- Change in the Leadership of both CMH and Ko Awatea impacted significantly on the campaign as key sponsors and thought leaders left the organisation.
- Communication was challenging across the campaign hampering open discussion about risks and issues and emerging constraints.
- The team was skilled in improvement however the complexity of the topic of health equity made the work more challenging. Whittington, Botwinick and Wyatt (2018:2) write “There is an emotional component to the work of improving health equity that is much more intense than other work such as quality and safety”.
- There were difficulties setting work stream and campaign aims and measures to demonstrate the impact of the work, particularly within the timeframe of the campaign.

Lessons learned

- Ensure there is sufficient opportunity for debate and solid support for any programme/campaign at the Leadership level before progressing and a shared understanding and agreement on the model and deliverables.
- Enact a stage gate model re: project phases prior to moving on with the campaign/work.
- Be more flexible in setting measures where robust population measures are not available or within the timeframe including the use of qualitative and quantitative measures.
- Cultural competency is important to equity – the cultural competency of staff and services impact on the drivers of inequity such as acceptability and accessibility and support diagnosis and identification of opportunities for improvement.
At a Project level

What we did

- The project work began in October 2016 with the receipt of project EOIs.
- The projects accepted into the campaign were organised into three work streams.
- Campaign staff were matched to projects.
- Projects entered a set up phase and began working to understand the problem they were trying to solve by reviewing data and evidence where it existed, setting their project aim, and developing their theory of change.
- They defined measures and developed and tested change ideas using PDSA cycles of learning to contribute towards their project aim.
- Change ideas that were evidenced by testing have been developed into a change package and implemented back into business as usual in the relevant service areas. Teams have been encouraged to identify business owners for their work and products.
- Scale up and spread has not occurred due to the changed timeframe of the campaign, however some projects are continuing and may be able to spread in the future.
- Four learning sessions, a number of master classes and a campaign celebration have been held.
- A visual diagram of project activities is attached at appendix 3 and a graph of staffing against projects is attached at appendix 4.

What went well

- Grouping projects into work streams assisted the campaign team to link projects with similar aims.
- Projects invested considerable time understanding the problem they felt strongly about and this sometimes shifted the focus of the project to one that was more likely to have impact.
- Teams that had sufficient members, where membership matched the scope of the project, who met regularly and had a strong sponsor made better progress.
- Providing protected FTE to support the projects 1 or 2 days a week made a significant difference to the ability of teams to test change ideas and progress the work.
- Central dissemination of campaign information worked well ensuring consistency and reinforcing that teams were part of a bigger whole.
- We had a genuine desire to engage with and work with community and were excited at the number of community teams in the campaign.
- Co-design was applied well within the campaign with many teams using focus groups within their ‘understand and diagnose’ phase and then co-designing resources and aspects of their service models with patients and whaanau.
- A mixture of project approach/methodology was used depending on the project aim and type.
• There have been many **articles featuring aspects of the campaign**; the engagement activities, the learning sessions and showcasing some of the projects, which have been featured in Daily Dose, Connect and Stuff.

• **Learning sessions** were an opportunity for teams to meet together, to learn about the methodology, to share their learning and to plan their next steps as a project team. Four were held during the campaign.

### Challenges

- **Testing early** which is seen as a sign that teams are more likely to succeed, was **challenging for some teams** due to their type of projects (process design vs. process improvement) and the Plan Do Study Act (PDSA) cycle was not well used or valued by some teams.

- **Some project leads with more than one project struggled** with the time commitment and (where there were different campaign staff) with the variation in style of staff supporting their projects.

- Despite successful early engagement, we **struggled to retain community groups** in the campaign.

- As the CMH environment changed and pressure came onto the campaign to deliver results and demonstrate benefits, this **pressure was passed onto projects** rather than finding a way to hold this tension or to discuss it transparently and find a way forward together.

- CMH went through a period of change which resulted in several budget reviews, the consequence of which was many campaign **projects entering a “pause phase”** that was difficult to climb out of.

### Lessons Learned

- Ensure **EOIs focus on the problem** rather than asking for solutions given the emphasis in the campaign on the ‘Understand and Diagnose’ project phase. More focus on the sponsor and their role and team membership would have also supported teams better.

- **Give more attention to the type of project** (e.g. process improvement, process design/redesign) as this can impact significantly on the time required to set up and make progress, making it difficult for teams to keep up with other projects and the campaign timeline.

- **Use tools** such as the Health Equity Assessment tool (HEAT) (Signal, Martin, Cram and Robson, 2008) or other models such as the Equity of Health care for Māori: A framework (MOH 2014) to support Health equity work.

- Work and communicate **transparently** with all project teams and across the campaign in times of challenge or crisis.

- Maintain **budget control at a central level** as this saved considerable funds as the estimated resources were not required once the ideas had been tested.
• Ensure there is a **clear process developed and followed to prematurely close projects** including the involvement of sponsors.

• **Increase stability** in campaign leaders and staff where possible by implementing succession planning and providing a backup or replacement for staff (leave/ training etc.) when required.

• Ensure **communications about work** such as the Campaign **engages the hearts** as well as minds of readers.

• **Celebrate the work early.** A celebration session was held in May as it was feared that some teams may disengage early without funding to keep them in the campaign and the opportunity to celebrate their work would be lost. The effect of this has been to validate teams which has motivated them in the final stretch of the campaign to complete their final project actions and reports to represent their projects well.

• Hold a **12 month review** with teams to assess project efforts.

### Achievements

**Campaign Achievements**

- Teams were formed and brought together to **work on equity** within and on behalf of CMH.
- Teams were introduced to **improvement methodology and equity tools** that will be of value to them beyond the campaign.
- **13 projects have finished the campaign;** 4 Healthy Kids projects, 3 Healthy Systems projects and 6 Healthy Services projects from the original 29 projects that began. The drop in projects is due to an initial failure of some projects to progress and then an increasing focus on a reduced number of projects that were believed would achieve the greatest gains for the campaign.
- **Work streams focused on the key problems of childhood obesity, workforce representation and health outcome disparity** and have **innovated and identified service improvements** to impact their project areas. Ideas that have been tested that impact the work stream drivers can be seen in the appendices.
- Many of the projects have gained **significant learning and achieved successes** that should not be undervalued.
- The **passion and persistence of project and campaign staff** working in the projects demonstrates their commitment and **determination to make a difference** even with the challenges of changing timeframes and constrained budgets. This **commitment should be strongly acknowledged and celebrated.**
Project Achievements

We now have a process to:

- Screen and provide brief intervention to patients in ED for alcohol harm (over 95% of patients screened)
- Screen and provide brief intervention to children who are overweight or obese in Kidz First ED (more than 1070 patients screened since January 2017)
- Assess the risk of bronchiectasis and support children on a wellness pathway (all children admitted with respiratory illness in Kidz First ED are now screened)
- Support local job candidates to jobs at CMH (over 20 local job seekers employed in positions at CMH)
- Support Primary care to engage patients with Gout and support care management proactively and efficiently
- Change the interview process to better suit Pasifika nurses (the percentage of NEt-P nurses employed has been greater than 20% for the last 3 intakes)
- Develop and maintain a network of Maaori Doctors (approximately 60 Maaori Drs engaged in the network)
- Engage with local whaanau developing leadership, resilience and wellbeing in families affected by suicide (5 families of 16 people engaged in suicide resilience activities in Papakura).

We now have resources to assist patients and whaanau and health professionals:

- 5 healthy nutrition messages co-designed using a Te Ao Maaori approach (video currently in development)
- Pre-pregnancy card and key messaging for women with diabetes
- New ‘weight change in pregnancy’ card
- Keeping your child well pamphlet (Bronchiectasis)
- Inspirational videos to attract Pasifika nurses and staff to CMH
- Patient infographic re: healthy weight gain in pregnancy
- Patient infographic re: contraception awareness and advice
- Patient/whaanau video about project members experience of suicide and suicide resilience
- Digital toolbox for procurement re: equity focus.

We now have knowledge and tools to assist health professionals with:

- Embedding equity into the procurement process
- Identifying children at high risk of bronchiectasis and care planning to wellness
- Talking with children and their parents and pregnant women about weight
- Understanding the barriers to long acting contraception for women
- Attracting more Maaori and Pasifika staff to CMH
- Care management for patients with Gout.
Contribution to Equity

- As a campaign, we highlighted the value of equity and we provided an opportunity for people with a passion in particular areas to learn and to focus on that work in a supported environment.
- Small gains to equity were made in individual areas.
- There is significant benefit to be had if the value of working on equity, as demonstrated by the efforts and commitment of the project staff, can be spread across CMH.
- We have embedded an equity approach in the Improvement and Change team which can be spread across CMH one project at a time.
- Further opportunities exist as the campaign closes, to promote the issue of equity and the work of the individual projects as examples that all services in CMH are capable of.
- Efforts discussed at the Health Equity Leadership Board to create Equity awards in conjunction with other Nursing, Allied Health and Patient week awards and other like ideas will further contribute to raising the profile.

Conclusion

The campaign offered an opportunity for staff with a passion for health equity to work, learn and achieve together in their project areas. The campaign has also highlighted the value of equity for CMH and delivered project and work stream learning that can be distributed across the organisation. This must be acknowledged and celebrated. The challenge for CMH will be to continue to prioritise equity work amid other competing priorities. There is much work still to be done.

*Kia kotahi te hoe o te waka nei e, Ka oti ka oti nga mahi e.*
*Let us row our canoe in unison, So that our tasks can be completed*

Whaea Taui Thompson, Dec 2017.
Appendices

Appendix 1: Governance structure

Structures were set up to support the campaign including:

- Campaign Leadership Board
- Campaign team
- Campaign clinical leads
- Campaign measurement group
- Campaign work stream
- Projects.

The Leadership Board was developed from senior CMH leaders to support the development, oversight and governance of the campaign. Members of ONAC were also invited to take a place on the Leadership Board and campaign team to provide community input and representation and one member was voted as Board chair. The Chief Executive took the role of Executive sponsor for the work.
Appendix 2: Collaborative methodology

Previous campaigns have used the Breakthrough series (BTS) methodology to structure and support the work. This campaign is more accurately called a COIIN – a collaboration of innovation and improvement networks – this is because the work of the teams was a combination of testing and understanding if existing evidence fitted their service areas and innovating to understand what else might work (Ghandour et al, 2017).

In terms of the characteristics of the methodology, both involve pre-work; inviting teams to come together to work on shared goals, team coaching; learnings from both expert faculty and each other; monthly reporting and assessments; and on-going support during Action Periods, where the teams apply the learning and implement iterative tests of change. Teams also come together at learning sessions to share and learn together and all teams use the model for improvement (Ghandour et al 2017, IHI 2003).
Appendix 3: Project Guideline outlining project level activities

Health Equity project team guideline

HE Campaign
- Learning Session 6: 30 Nov 2016
- Learning Session 1: 17 Mar 2017
- Learning Session 2: 14 Jun 2017
- Learning Session 3: 20 Oct 2017

Action Period 1
- MC

Action Period 2
- MC

Project reviews

Action Period 3
- MC

Action Period 4
- Equity celebration

Cancelled: Learning Session 4: 16 March 2018

Project Phases
- Project Setup
- Understand & Diagnose
- Generate ideas & test
- Implement and Close

Team assessment score
- Time in months from start of project
- 1m
- 3m
- 4m
- 5m
- 6m
- 7m
- 8m
- 9m
- 10m
- 11m
- 12m

1 2.0 2.5 2.5 3.5 4.5 5 1m 3m 5-6m 7-8m 9m 10m 12m

Pre-work
- Identify Project
- Establish
- Project team
- Frame your Team
- Schedule team meetings
- Initiate Project Charter

Activities:
- Identify Target Population
- Collect Baseline Data
- Identify Gaps
- Develop Sets
- Develop Driver Diagram
- Develop Measures - Outcome & Process measures
- Complete Project Charter

Activities:
- Identify Areas for Improvement
- Create List of Change Ideas
- Test and evaluate each Change Ideas using through Multiple Cycles of PDOSA
- Document & file PDOSA’s (DiagPaper)
- Update Learnings from each PDOSA
- Update Driver Diagram and Project Charter based on improvement learnings
- Monitor Change in Process Level Measures
- Monthly Data submission
- Monthly Project Updates

Deliverables

Master classes
- L01: Storyboard
- L02: Storyboard
- Project Reviews
- L03: Storyboard

Activities:
- Develop change package
- Implement
- Re-evaluate BAU
- Close out

Celebration Storyboard
Appendix 4: Graph showing campaign projects and staffing over time/ project lists

Graph showing Campaign projects and staffing over time
<table>
<thead>
<tr>
<th>PROJECT</th>
<th>DESCRIPTION: COMPLETED PROJECTS</th>
<th>SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidz First ED Screening</td>
<td>To develop a brief screening programme in Kidz First ED/ inpatient to identify obese and overweight children</td>
<td>CM Health</td>
</tr>
<tr>
<td>Kura Kai Ora</td>
<td>To co-design key messages with Maaori children to promote healthy eating</td>
<td>NHC - Mana Kidz</td>
</tr>
<tr>
<td>Prepare Together</td>
<td>To deliver advice to women with diabetes about changing behaviours to reduce risk of perinatal complications.</td>
<td>CM Health</td>
</tr>
<tr>
<td>Weigh While We Wait</td>
<td>To support healthy weight gain in pregnancy through consistent messages from health professionals involved in a woman’s care, along with providing appropriate resources to increase health literacy (for both health professionals and women)</td>
<td>Dawson Road GP (ETHC) CM Health</td>
</tr>
<tr>
<td>Pacifica 2-7-4+</td>
<td>To scaffold Pacific RNs from the start of their undergraduate programme into yr. 2 of employment</td>
<td>CM Health / MIT Ward 34 East, CM Health / MIT</td>
</tr>
<tr>
<td>Whakamana Takuta Maaori</td>
<td>To mentor/professionally develop young Maaori medical students and doctors at CM Health to promote recruitment, retention and professional development.</td>
<td>CM Health</td>
</tr>
<tr>
<td>L.E.A.P</td>
<td>To support local Maaori and Pacific community members through mentoring, up skilling and clear pathways to employment within CMH</td>
<td>Accelerating Aotearoa</td>
</tr>
<tr>
<td>Every $ Counts</td>
<td>To examine the CM Health planning and funding procurement system and processes with an equity lens in order to determine current state and improve the system</td>
<td>CM Health Planning &amp; Funding</td>
</tr>
<tr>
<td>ED: Alcohol ABC approach</td>
<td>To test and implement a screening and brief intervention for hazardous alcohol use in ED</td>
<td>CM Health</td>
</tr>
<tr>
<td>5G Gout</td>
<td>To counter the misconception associated with Gout and of the Maaori and Pacific Island people who suffer with Gout and to work with practices to design and test new processes to engage with patients and support care management proactively and more effectively</td>
<td>CM Health</td>
</tr>
<tr>
<td>Lungs 4 Life</td>
<td>To develop and test a best practice approach to identifying children at high risk of developing bronchiectasis and placing them on a care pathway to maintain wellness</td>
<td>CM Health</td>
</tr>
<tr>
<td>Link4Life</td>
<td>A collaborative project with Hopewalk NZ, to enable Pacific and Maaori families affected by suicide to be champions and leaders in their community for suicide prevention.</td>
<td>CM Health / HopeWalks NZ</td>
</tr>
<tr>
<td>Planned Pregnancy:</td>
<td>To identify and remove barriers to reliable, effective contraception and increase the awareness and uptake of Long Acting Reversible Contraception (LARCs)</td>
<td>CM Health</td>
</tr>
</tbody>
</table>
Appendix 5: Campaign dashboard against progress

The majority of campaign projects are process design projects where there are no processes that exist and so new infrastructure and processes need to be created in order to achieve the desired outcomes, thereby taking longer.

All projects are in the implement and sustain phase which is as expected for this stage of the campaign. One project has completed implementation and a number have closed.

The number of teams meeting is currently varying. This is now starting to diminish as teams reduce their input to projects as they move to implement and sustain.

There have not been any learning sessions or masterclasses held since November. However, the majority of teams attended the celebration session in May.

Mana Taurite: Equity in Health Dashboard FINAL 2018

The number of PIUs has been increasing each consecutive month which is as expected for this stage of the campaign, however the size of the trends increases over time explaining the slowing of the curve on the graph.

Projects reported as at risk:

<table>
<thead>
<tr>
<th>Project</th>
<th>Reason for reporting at risk</th>
<th>Action plan in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>G 5 G 7</td>
<td>Multiple project issues</td>
<td>yes</td>
</tr>
</tbody>
</table>

Projects reported as off-track:

<table>
<thead>
<tr>
<th>Project</th>
<th>Reason for reporting off-track</th>
<th>Action plan in place</th>
</tr>
</thead>
</table>

One team remains at risk. A plan is in place to maximise the learning from this project.

The number of teams reporting data has been fairly stable however has diminished as we close the campaign.

This graph shows an alternative to the average reported progress score (above) and illustrates the different progress of projects in the campaign.
# Appendix 6: Healthy Kids Driver Diagram and Dashboard

## Health Equity Campaign: Healthy Kids

### Healthy Weight

**Primary Drivers**
- Physical Activity
  - Physical Activity included in curriculum
  - Social norms/values
  - Space to play
  - Risk management/Design
  - Prioritisation of physical activity

**Secondary Drivers**
- Screen time
- Safe place to play
- Homework
- Nutrition
  - Cost of healthy food
  - Prioritisation of healthy food
  - Family values/culture
  - Lack of time
  - Knowledge of health
  - Diet/Nutrition
  - Family health
  - Breastfeeding
  - Gestational diabetes
  - Emotional Wellbeing
  - Antenatal care
  - Knowledge/awareness of oral health

**Change ideas**
- Healthy goals fridge magnet
- Information pack on healthy living
- Using an atua/whakapapa approach to Kai influences healthy choices in tamariki
- Electronic discharge summary updated with request for GP to have healthy weight conversation
- Patients & families understand implications of not being healthy weight
- Patients categorised as healthy weight, obese or overweight
- Using a by-tamariki, for-tamariki approach to developing and promoting messages will improve uptake
- Co-design produces better results than designing in isolation
- Video is good medium for connecting with tamariki
- Key message card for patients
- Key message card guide for clinicians
- Brochure for women with diabetes of child baring age
- Pathway on Auckland Regional Health with guidance for Health Worker
- Health Navigator page and Health Point
- Resource Packs of information and props to support the four key weight gain messages
- Training Package for Practice Nurses: Incorporating Healthy Weight Gain in Pregnancy at the First Antenatal Visit
- Training Package for GPs: Reinforcing information given on Healthy Weight Gain in Pregnancy

---

*Kidz First Screening  ●  Kura Kai Ora  ●  Prepare Together  ●  W4*

The purpose of the Healthy Kids work stream is to innovate and identify what works to reduce disparities for childhood obesity/healthy weight for children from Māori and Pacific communities in Otara – Counties Manukau.

Version: 7.0
Updated: 18/07/2018
Healthy Kids Healthy Weight – work stream

**Final Dashboard**

The work stream purpose is “to innovate and identify what works to reduce disparities for childhood obesity/healthy weight for children from Māori and Pacific communities in Otara – Counties Manukau.”

**Kids First ED Screening:** Implementing an obesity screening intervention for children entering Kidz First emergency department.
- 71 patients screened in June 2018
- 16 different Kidz First clinicians screening and updating EDS
- >3089 patients screened to date since January 2017
- >302 patient EDS sent to GPs indicating patient being obese or overweight to date since January 2017

**Prepare Together:** Delivering advice to women with diabetes about changing behaviours to reduce risk of perinatal complications.

**Kura Kai Ora:** Application of a ‘whakapapa/tīpuna’ approach to develop and deliver nutrition messages that are engaging for children in all schools.

Testing is currently occurring with the storyboard designed by tamariki to showcase the Healthy Kai messages they previously developed. A developer has been engaged to develop this into a animated video with messages in both Te Reo and English.

He kai ora, he kai nō te whenua.
Grown foods are healthy foods

Me whakamahi i ngā kakano, me whakatipu i roto i te mara.
Ko ēnei ngā kai he whakaora i a koutou.
We should use seeds and grow them in our garden. These foods will nourish us.

Ki a kaha ki te kai ora
Try your best to eat healthy

He kakano i ruia mai ia Tānemahuta, he kai pai, he kai hauora
A seed that has grown from Tane Mahuta, it is a good food and a healthy food

Huawhenua – He kai ora, he pai mō tinana, he pai mō tipu, kia tipu pai mō te tangata
Vegetables – are a healthy food, good for your body, good for your growth, help people to grow strong

**Weigh While We Wait:** Enable Otara women to achieve a healthy weight gain during pregnancy.
- As at 30 June 2018, the team have received final weight information for 16 women.
- While 75% of these women had a weight gain that exceeded the IOM Guidelines, the median ‘average weekly weight gain’ of women with a booking BMI category of ‘obese’ was 0.34kg compared to the baseline of 0.42kg.
- Feedback from women was that they found the revised ‘Healthy Weight Gain in Pregnancy’ card very helpful and they’d want to use it again
- All participating midwives found the card helpful and all would like to continue to use them as standard practice.

**Number of Women by Weight Gain Category and BMI Category**
Appendix 8: Healthy Systems Driver Diagram and Dashboard

**Driver Diagram - Workforce Systems**

**Primary Drivers**
- Recruitment
- Retention
- Pipeline

**Secondary Drivers**
- Unconscious Bias
- Equitable Recruitment process
- Recruitment policies for Maori and Pacific Island staff
- Mentoring, Coaching, Training
- Leading a Diverse Workforce
- Organisational Performance
- Career Progression Opportunities
- Treaty of Waitangi Responsibilities
- Cultural Competence
- Engagement
- Career Progression Opportunities
- Development
- Making CMH the preferred workplace option

**Change Ideas**
- Organisational Interview Panel with Pacific/Maori representation
- Include Meditation test into “Role Play”
- Mandatory interviewing of Pacific/Maori
- Mentoring of Maori Junior Doctors
- PLUS clinical transition placements
- Cultural Network
- ACE and NEST data compared to NTA target
- NCT-Opportunities
- Culturally appropriate interview process
- Cultural Support with Pan-Pacific
- Inspirational Speaker series
- NEST-enrolment
- PLUS clinical transition placement
- Cultural Support with Pan-Pacific
- Permanent Contracts

**Project Teams:**
- Pasifika 2-7-4+
- LEAP
- Whakamana Takutuki
- Maori

**Purpose:**
“to innovate and identify what works to increase the number of Maori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community”

* (Aligned with Workforce Development Work Programme of CMH-2625)

Version: 3.0
Dated updated: 13th July, 2018
Healthy Systems- work stream
Final Dashboard
(MANA TAURITE CAMPAIGN)

The work stream purpose is “to innovate and identify what works to increase the number of Māori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community”

Pasifika 2-7-4+: A merged project to increase the number of Pasifika NET-P nurses through a Pasifika DEU and Inspirational speakers

Whakamana takuta Māori
To make Counties Manukau Health a preferred work environment for Māori Graduates (To make the proportion of Māori SMOs/RMOs equal to the proportion of Māori in our community)

The NET-P programme has maintained a Pacifica intake of 24% this year (above the goal of 18%)

NEt-P: This project is supporting local employment pathways for Māori and Pasifika into non-clinical and entry level roles with CMDHB and other local employers.

Total number of Māori & Pacific applicants employed through the LEAP programme into CM Health roles and non-CM health roles.

One of the most successful aspects of this project is the ability to ensure our local community feel welcome, safe and valued. Much of this has been achieved through the Tikanga Māori approach, specifically:

- Mihi Whakatau, the Māori tradition of acknowledging and greeting those present at a gathering has proved important to connecting with applicants.
- Karakia at the beginning of the session provides a safe place for applicants to explore their practice skills.
- Whakawhanaungatanga assisted in establishing relationships through the sharing of information about their family roots, stories and relationship with the world.

The P.L.U.S side of the Project was published in Kai Tiaki Nursing New Zealand Journal, June issue
Appendix 10 Healthy Services Driver Diagram and Dashboard

**Driver Diagram - Workforce Services**

**Primary Drivers**
- Equity Culture
  - Cultural Competency of Staff
  - Improving Health Literacy
  - Previous Patient Experience
  - Parental Education
  - Reducing Disparity with the Service

**Secondary Drivers**
- Strategic Direction of the Organisation
- Budgetary Support for Project
- Care Pathways
- Availability of Service
- Location of Service

**Change Ideas**
- Standardised Inpatient pathway adheres to culturally appropriate care
- Discharge planning checklist & Letter template
- Parental education around symptom recognition
- Follow up in 30 day post discharge with GP
- Pamphlet Design i.e. “Pengu”
- Family Leadership Days
- Identify Lungs 4 Life patients with screening tool
- Healthy Together 2020 Target
- Appropriate funding
- Project presentation(s) to stakeholders
- Parent / Patient resources & education
- Enabling community to deliver solutions to their people
- Primary Care Visits
- Using nurses to have conversations with patients
- Multi-disciplinary education sessions
- Provide coaching to nurses/ healthcare staff to use resources effectively
- Standardised Inpatient pathway adheres to culturally appropriate care
- Stage gate review process to ensure equity considerations
- Use of data systems to identify patients
- Decision making trees
- Reviewed retrospective data for inequality

**Project Teams:**
- Community Gout Champions
- ED: Alcohol ABC Approach
- Every 5 Counts
- Link 4 Life
- Lungs 4 Life

**Purpose:**
“To innovate and identify what works to increase the number of Maori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community”

* (Aligned with Workforce Development Work Programme of CMH-2025)

Source:
HEAT Tool
IHI Achieving Health Equity paper
Robert Wood Johnson Foundation

Version: 8.0
Dated updated: 13th July, 2018
**HE Services**

**Final Dashboard**

*(MANA TAURITE CAMPAIGN)*

"To innovate and identify what works to reduce disparities for identified health outcomes for Maaori and Pacific patients and whaanau in participating services in Counties Manukau by December 2020"

### Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
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<tr>
<td>1.0 SSs that define the inequity that the service is expected to reduce (i.e. all four indicators 1.1-1.4 are 'Yes')</td>
<td>3</td>
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<tr>
<td>1.1 Data used to define the inequity</td>
<td>5</td>
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<tr>
<td>1.2 Evidence or intervention logic (to reduce inequity)</td>
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<tr>
<td>1.3 Priority population defined</td>
<td>6</td>
<td>30%</td>
</tr>
<tr>
<td>1.4 Measure &amp; target for inequity</td>
<td>6</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Every 5 Counts: The data from the audit of service specifications demonstrates the need for this project. The team have developed a toolbox which includes templates and guides to assist planning and contracting staff to embed equity in all contracts.

### Planned Pregnancy: Participating GP Clinics tested change ideas to reduce the % of unplanned pregnancies and increase the uptake of LARCs. The most successful change was setting alerts on the records of women of childbearing age to prompt GPs to have opportunistic conversations about contraception.

### ED Alcohol ABC Approach: The graph shows the %age Maaori and Pacific Island patients where alcohol status is recorded. The team is working on a best practice bundle of care.

### Lungs 4 Life: To develop and test a best practice approach to identifying and managing children with bronchiectasis. Project team is screening and placing "high-risk" children on management pathway.

### Link 4 Life: The graph highlights the increasing numbers of family members engaging with the team over the course of the project. The project team continue to spread the support offered to families impacted by suicide.

### Process Measure - Numbers of patients recalled for medication treatment review.

### 5G Gout: Unfortunately the Practice Nurse resigned so no patients were recalled during May. Awaiting results from Rheumatology Registrar clinical audit. Team are working on a best practice bundle of care.
References


Health Quality and Safety Commission, 2017, A Window on the Quality of New Zealand’s Health Care, Wellington: HQSC.


Population Health Team, 2015, Key Indicators as Measures of Health Equity for the CM Health Population, Counties Manukau Health, Auckland.


Useful Resources for Equity work

Equity Models


Equity tools


Useful Reading


Health Quality and Safety Commission, 2017, A Window on the Quality of New Zealand’s Health Care, Wellington: HQSC.

Health equity clearinghouse

https://www.healthpoint.co.nz/public/other/counties-manukau-health-library-database/
Mana Taurite: Equity in Health
The Journey and the Achievements

Dr Gloria Johnson, Acting Chief Executive
Elizabeth Jeffs, Director Human Resources
John Coffey, Chair Leadership Board and Community Representative
Dr Margaret Aimer, Manager Improvement and Change team, Ko Awatea
Diana Dowdle, Previous Delivery Manager/ Campaign Manager, Ko Awatea
Tracey Popham, Programme Manager, Ko Awatea.
Health Equity

• Health inequities are systematic differences in the health status of different population groups (WHO 2011)
  • Unnecessary, unfair and unjust (Whitehead 1992, Marmot, Bell, Houweling and Taylor 2008)
  • Linked to social determinants of health however inequitable health care often compound disparities (HQ&SC, 2017)
  • Opportunities for improvement (Wyatt et al, 2016).
The faces of the campaign

**HEALTHY KIDS**
Dinithi was screened for obesity in Kidz First ED and spoke with staff about the risks and small changes that they make at home. Diniti’s mum: “The staff need to talk to the families as we don’t know how to make the changes... (but) every mum wants their kid to be healthy.”

**HEALTHY SERVICES**
Anita participated in the Link4Life project, taking a leading role in promoting suicide resilience with other families in Papakura. “I want to invest in people and offer them hope. I want to help them realise that they can actually gain from what they have been through. There is beauty in the darkness.”

**HEALTHY SYSTEMS**
After many years caring for her children, this job seeker got a position as an administrator for Community Central. “I feel privileged to work with such a friendly team of dedicated and benevolent clinical and administrative staff. They have welcomed me and share their knowledge. Thank you.”
“The Health Equity Campaign is our challenge to do more. Join us”.
Areas of Focus

- CVD/ Diabetes management
- Smoking prevalence
- Alcohol related harm
- Enablers: Health literate systems and workforces, Diverse & equity competent workforce
- Targeted areas to maximise impact
- Childhood obesity
What were we trying to do?

The purpose of the Health Equity Campaign is to innovate and identify what works to reduce health inequities for the community of Counties Manukau by December 2020 by:

- reducing the disparity for childhood obesity/healthy weight for children from Maori and Pacific communities in Otara – Counties Manukau (Healthy Kids workstream)

- reducing the disparity for identified health outcomes for Maori and Pacific patients and whaanau in participating services in Counties Manukau (Healthy Services workstream)

- increasing the number of Maori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community (Healthy Systems workstream).
Collaborative Methodology

Select Topic

Consult
Engage
Understand
Diagnose

Identify Change Concepts/Co-design

Pre work

LS0 -> LS1 -> LS2 -> LS3

Supports: emails/phone/one-on-one/site visits/regular meetings

Spread across Services, Sector, Community
What have we done?

Health Equity project team guideline

Project Phases:
- Project Setup
- Understand & Diagnose
- Generate ideas & test
- Implement and Close

Team assessment score:
- Time in months from start of project
  - 1 - 1m
  - 2.0 - 3m
  - 2.5 - 3.4m
  - 2.5 - 5-6m
  - 3 - 7-8m
  - 3.5 - 9m
  - 3.5 - 10m
  - 4 - 11m
  - 4 - 12m
  - 4.5 - ≥ 12m
  - 5 - ≥ 18m

Deliverables:
- Pre-work: Identify Project, Establish Project Team, Name your Team, Schedule team meetings, Initiate Project Charter
- Activities: Identify Areas for Improvement, Create List of Change ideas, Test and validate each Change ideas using through Multiple Cycles of PDSA’s, Develop & file PDSA’s (Digital/Paper)
- Activities: Update Learnings from each PDSA’s, Update Driver Diagram and Project Charter based on improvement learnings, Monitor Change in Process Level Measures, Monthly Data submission, Monthly Project Updates

Master classes:
- LB1: Storyboard
- LB2: Storyboard
- Project Reviews
- LB3: Storyboard

Activities:
- Develop change package
- Implement
- Sustain back into BAU
- Close out
Graph showing Campaign projects and staffing over time

- Projects accepted
- EOI received
- Projects closed due to failure to progress
- Project reviews indicating Dec closures
- Leadership Board project & budget reviews indicating Jan & Feb closures
- Project closures
- Campaign end
- 2 x budget review and projects closed due to budget restrictions
- Projects closed as a result of Sept reviews

<table>
<thead>
<tr>
<th></th>
<th>Number of projects</th>
<th>Campaign staffing (headcount)</th>
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<tbody>
<tr>
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<td>Jun-18</td>
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</table>
Completed projects

Healthy Kids
- Kura kai ora
- Prepare Together
- Kidz First ED screening
- Weigh while we wait

Healthy Systems
- LEAP
- Pasifika 274+
- Whakamana Takuta Maaori

Healthy Services
- Every $ Counts
- ED Alcohol ABC approach
  - 5G Gout
  - Lungs4Life
  - Link4Life
- Planned pregnancy
What worked well

• Focus on equity
• Strong engagement
• Using a methodology to understand the problems, test ideas and implement solutions
• Support from Senior Leadership including strong executive sponsor
• Community engagement and representation at all levels of the campaign
• Diverse and multi-skilled campaign and project teams
What didn’t work well

- Limited opportunity to consult on and gather support for the campaign prior to set-up
- Impact on the campaign of the changing DHB environment and senior CMH and KA leadership
- The impact on projects of repeated ‘pausing’ during budget reviews
- Challenges setting workstream and campaign aims and measures
- Communication was challenging across the campaign impacting on open discussion about risks and issues and emerging constraints
- Supporting community teams to remain in campaign
What we have learned

• Equity is hard and personal
• Cultural competency is important to equity
• Need a small and tight campaign team
• Communications is important for visibility
• Teams and project staff are resilient and passionate
• All achievements are worth celebrating
What has been the contribution to equity

- Brought more of a profile to equity
- Offered learning around equity and equity tools
- Contributed to learning at a project level
- Embedded an equity approach in the Improvement and Change team which can be spread across CMH one project at a time
- Made gains to equity in individualised areas
Project level gains to equity - Processes

We now have a process to/ or understanding about how to:

• Screen and provide brief intervention to patients in ED for alcohol harm
• Screen and provide brief intervention to children who are overweight or obese in Kidz First ED
• Assess the risk of bronchiectasis and support children on a wellness pathway
• Support local job candidates to jobs at CMH
• Support Primary care to engage patients with Gout and support care management proactively and efficiently
• Change the interview process to better suit Pasifika nurses
• Develop and maintain a network of Maori Doctors
• Engage with local whaanau developing leadership, resilience and wellbeing in families affected by suicide
Project level gains to equity – Resources

We now have resources to assist patients/whaanau and health professionals with:

• 5 healthy nutrition messages co-designed using a Te Ao Maaori approach (video currently in development)
• Pre-pregnancy card and key messaging for women with diabetes
• New ‘weight change in pregnancy’ card
• Keeping your child well pamphlet (Bronchiectasis)
• Inspirational videos to attract Pasifika nurses and staff to CMH
• Patient infographic re: healthy weight gain in pregnancy
• Patient infographic re: contraception awareness and advice
• Patient/whaanau video about project members experience of suicide and suicide resilience
• Digital toolbox for procurement re: equity focus
What’s next?

• Communications about the campaign
• Equity lens as a standard tool for use in Project diagnosis phase by Improvement and Change team
• Projects have implemented their changes and learning into BAU
• Resources for distribution
• 12 month post campaign project follow up.

Kia Kotahi te hoe o te waka nei e, Ka oti ka oti nga mahi e.
*Let us row our canoe in unison, so that the tasks shall be completed.*

*Whaea Taui Thompson 2017*
Campaign contacts

Margaret Aimer, Improvement and Change Manager
Margaret.aimer@middlemore.co.nz

Tracey Popham, Programme Manager
Tracey.popham@middlemore.co.nz
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.

As this will be my last Board meeting as Acting Chief Executive Officer, I would like to take this opportunity to thank the Board for the professional development and experience my tenure provided, for the great support I received from all Chairs and Board members past and present while I was in the role and for the confidence placed in me to oversee what turned out to be a prolonged transition period involving a number of changes and challenges. I look forward to handing over the reins to Margie Apa, who will I’m sure be a great Chief Executive, on September 3. I also look forward to continuing to serve CM Health as a member of Margie’s executive team and to providing ongoing input to Board meetings as Chief Medical Officer.

Since the last Board meeting a major programme of work to improve acute patient flows has commenced. It has a number of work streams:

- Emergency Department – to optimise the pathways and reduce stays for both admitted and non-admitted patients
- Zero Days – to decrease admissions and increase same day discharges
- Long-Stay Patients – the reduce length of stay for very long stay patients
- Models of Care – to develop a number of new models including, home wards, frail elderly pathways, Hospital in the Home and increased use of the Infusion Centre

Each work stream has a leadership group, including support from Ko Awatea and the Health Intelligence team, and a workshop is scheduled to clarify the elements of each work stream, develop agreed objectives and measures and ensure that there is a coordinated approach to deliver sustainable, significant overall improvement in patient flows and thus increased capacity.

The programme has been informed by an initial analysis undertaken for us by external consultants who have advised several other DHBs on this sort of programme and, thanks to our Crown Monitor Ken Whelan, we have also established contact with leaders from a health service in Brisbane where substantial improvements in patient flow were achieved – two of their clinical leaders visited us in July and we will maintain contact with them to keep sharing ideas.

The steering group for our programme is chaired by Dr Vanessa Thornton and will be reporting progress regularly to the Executive Leadership team.

News and Events Summary

Hand Hygiene

Recently, the Rito Unit celebrated achieving the highest Hand Hygiene compliance rate of 97% in CM Health for the period of November 2017 to March 2018.
In 2016, Rito Unit started with a low of 63% compliance. Through a multimodal approach of teaching sessions, workplace reminders, on the spot feedback and team work, the department improved their performance from 84% in December 2016 to consistently achieving over 90% in 2017 and 2018. Congratulations to Rito Unit for their continued improvement and commitment to reducing Hospital Acquired Infections at CM Health.

**Well Done Ward 6**
The team at Ward 6 have reached 100% uptake for the flu vaccination! Congratulations to the whole team of Flu Fighters for this amazing effort – especially their wonderful Peer Vaccinators; Jatinder Kaur and Sarita Kishun.

**Research Week 2018 showcases the latest health research at CM Health**

Research Week 2018, hosted by the Ko Awatea Research and Evaluation Office from Monday 18 to Thursday 21 June, was a celebration of the great variety of health research taking place at Counties Manukau Health – in the hospital as well as in the community.

In its third year, the event showcased eight research workshops, 41 research presentations and 42 general research posters as well as another six representing summer studentships. Presentation sessions covered a diverse range of clinical and health topics including mental health, health systems, medical and surgical issues and allied and women’s health.

Research Week closed with a prize giving ceremony. Congratulations to all prize winners (only presenters are listed however, others may also have contributed to the work).
Research Week Prize winners were:

- **Matire Harwood** - Best Research Presentation from Health Systems Session
  *Oranga Ki Tua Diabetes Self-Management Education 2017*

- **Nandoun Abeysekera** – Best Research Presentation from Medical and Surgical Session
  *Antimicrobial Resistance at Middlemore Hospital: Translational implications of CA-MRSA upper extremity infections 2011-2015*

- **Karaponi Okesene-Gafa** – Best Student/Emerging Researcher Presentation
  *Dietary interventions with or without probiotics in women with obesity during pregnancy in Counties Manukau Health (CM Health) – The Healthy Mums and Babies (HUMBA) randomised controlled demonstration trial*

- **Marie Young** – Mental Health Session award & People’s Choice Research Presentation
  *We do some great work! Faster cancer treatment at CM Health is reducing inequities in our community. Where to now?*

- **Heather Lewis** – Best Nurse Research Presentation
  *Estimated reduction in expenditure on hospital-acquired pressure injuries after an intervention for early identification and treatment*

- **Richard Matsas** – Best Doctor Research
  *Implementing the Bedside Paediatric Early Warning System (BedsidePEWS) at Middlemore Hospital*

- **Akshat Shah** - Best Research Presentation from Allied Health and Women’s Health Session
  *Training SLTs in cleft speech disorder*

- **Julie Collis** - Best Allied Health, Scientific and Technical Research Presentation
  *Outcomes following MCPJ arthroplasty treated postoperatively in a dynamic splint*

- **Stephen McBride** – Best Research Poster
  *Microbiological sampling for diagnosis of native joint septic arthritis*

- **Prishita Rajendra** – Summer Studentship Research Poster
  *Molecular classification and Mortality of Colorectal Cancer in Europeans vs. Non Europeans in New Zealand*

The following other research work was also Commended:

- **Deirdre Nielsen** – commended as Emerging Researcher
  *Evaluation of a nutrition training programme for Community Health Workers*

- **Sarah Cullum** – commended as Best Doctor Research
  *Do community-dwelling Māori and Pacific peoples present with dementia at a younger age and at a later stage compared to NZ Europeans?*

- **Melodie Barr** – commended for Mental Health Session
  *Cognitive dysfunction in service users of adult secondary mental health teams at CM Health*
Future Focus

Opening of Ward 21

Ward 21 opened on 9 July for a four month period and will provide 30 additional beds during our peak winter season.

The opening of the ward not only allows us to better meet our winter needs but to trial new approaches. For the next four months this ward will provide us with a place to try out different ways of working as a home ward for a multidisciplinary team focussed on ensuring that every day counts as adding as much value as possible to patient care. Lessons learnt will then be used to support similar changes in other wards.

Care Capacity Demand Management (CCDM) Agreement

Earlier in the month, CM Health in partnership with the NZ Nurses Organisation (NZNO), signed the CCDM Agreement. This Agreement provides a set of tools and processes that help DHBs better match the capacity to care with patient demand, with a goal of quality patient care, quality work environment and best use of health resources.
## Performance and Outcomes Priorities

### Health Target Summary – 2017/18 Q4

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Results</th>
<th>Expected status 2017/18</th>
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<tbody>
<tr>
<td><strong>Emergency Departments</strong>&lt;br&gt;95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours&lt;br&gt;May 2018 (individual month result): 92% (target 95%)&lt;br&gt;Note: Patent volume and bed demand mean the hospital has been unable to reach the six hour target, achieving 92% for May against the target of 95%. This is due to a variety of factors, including high consistent surge presentation rates and consistent high hospital occupancy. The April 2018 (single month) result was 91%. Steps we are taking to improve our performance included preparation of a business case to establish additional bed capacity in winter.</td>
<td>NOT ACHIEVED</td>
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<td><strong>Elective Surgery</strong>&lt;br&gt;Elective surgery will increase by an average of 4,000 discharges per year&lt;br&gt;May 2018 (individual month result): 100% (indicative) (target 100%)&lt;br&gt;ESPI results for May 2018 (individual month results):&lt;br&gt;ESPI2: 31 First Specialist Assessment (FSA) breaches (0.2%) (target &lt;0.2%)&lt;br&gt;ESPI5: 139 treatment breaches (3.9%) (target &lt;0.9%)&lt;br&gt;Note: Due to high acute volumes and anaesthetist shortages over this year, there is continued pressure on both ESPI 2 (FSAs) and ESPI 5 (Treatment) in a number of services. We have received RED ratings from the MOH in May 2018.&lt;br&gt;We have achieved 100% on our elective discharge target but despite our strong recovery plan, we have struggled to recover our elective WIES target which has financial implications for the organisation. We are continuing to work toward recovering this target, including through continuing to providing hips and knees and cataract outputs well in excess of targets, maximising coding opportunities for complexity and introducing outsourcing for some smaller cases. We are also working with the MOH to offset some of our good performance against this shortfall.</td>
<td>ACHIEVED</td>
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<td><strong>Faster Cancer Treatment</strong>&lt;br&gt;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.&lt;br&gt;June 2018 (preliminary six month result): 94% (target 90%)&lt;br&gt;Note: The Faster Cancer Treatment (FCT) data is reported by the MoH on a 6 month rolling basis. For the Q4 period 1.01.17 – 30.06.18 CMH has 94% performance with technical changes applied¹ for 62 day and 93% for 31 day patients. Clinical consideration remains a reason for the majority of breaches and this is examined to ensure breach reasons are accurately captured and recorded appropriately.</td>
<td>ACHIEVED</td>
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<td><strong>Immunisation</strong>&lt;br&gt;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).&lt;br&gt;June 2018 (preliminary 2017/18 result): 93% for total population (Maaori coverage: 84%, Pacific coverage: 94%) (target 95%)</td>
<td>NOT ACHIEVED</td>
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¹ Due to changes to the target definition in July 2017, only those breaches relating to capacity constraints are counted as breaches. Breaches due to patient choice and clinical consideration are excluded.
**Note:** 147 more babies needed to be immunised to meet the target. Maaori coverage has decreased by 2% from Q3, with 67 babies having missed the target age for immunisation (51 babies remain unimmunised as 16 babies were immunised late).

Quarter 4 has been a period of focused collaboration between the NIR team, Outreach Immunisation Services (OIS) and the general practice teams to reach the immunisation target of 95%. Achieving equity for Maaori at 8 months, 24 months and 5 years milestone ages is still a work in progress. A new outreach service was introduced in the last month of Quarter 4, with home visits on a Saturday to connect with families who we are not reaching through the current OIS service. Maaori and Pacific families are prioritised and this is working well for some families.

### Raising Healthy Kids**

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

**June 2018 (preliminary 2017/18 result):** 100% total population (Maaori: 100%, Pacific: 100%) (target 95%)

**Achieved**

### Tobacco Primary

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

**June 2018 (preliminary 2017/18 result):** 92.1% total population (Maaori: 91.3%, Pacific: 91.6%) (target 90%)

**Note:** We are pleased to note that the target has been met for our Maaori, Pacific and total patient populations. This is a significant achievement in support of our Healthy Together equity goal.

**Achieved**

### Maternity

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

**June 2018 (preliminary 2017/18 result):** 91% (Maaori 94%, Pacific: not reported) (target 90%)

**Note:** Preliminary results indicate that the target was achieved in 2017/18 for Maaori women and overall.

**Achieved**

**Achieved:** Final or preliminary results indicate the target was met in 2017/18.

**Not Achieved:** Target was not met in 2017/18 or where preliminary data only is available, is unlikely to have been met in 2017/18.

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

**Data provided from the MOH quarterly (for previous 6 months). Result reflects percentage of children identified as obese for whom a referral has been sent and that referral has been acknowledged.**
Counties Manukau District Health Board
Occupational Health and Safety Performance Report

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period ending 30 June 2018 and some activities in July.

Endorse the change the Lost Time Injury Frequency Rate (LTIFR) target from <5 to <10 based on a rolling 12 month average.

Endorse the change in reporting LTIFR from monthly to rolling 12 month average.

Prepared and submitted by: Marie Townsley, Acting Manager, Occupational Health and Safety on behalf of Elizabeth Jeffs, Director HR

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
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<tr>
<td>ARF</td>
<td>Audit, Risk and Finance</td>
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<td>ARHOP</td>
<td>Adult Rehabilitation and Health of Older People</td>
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<tr>
<td>BBFE</td>
<td>Blood and/or Body Fluid Exposure</td>
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<td>CD</td>
<td>Clinical Director</td>
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<td>CCS</td>
<td>Central Clinical Services</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<td>EAP</td>
<td>Employee Assistance Programme (Counselling)</td>
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<td>Executive Leadership Team</td>
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<td>EMIC</td>
<td>Emergency Medicine &amp; Integrated Care</td>
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<td>HSN0</td>
<td>Hazardous Substance New Organisms Act</td>
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<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
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<td>IRS</td>
<td>Incident Reporting System</td>
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<td>JCC</td>
<td>Joint Consultative Committee</td>
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<td>LTI</td>
<td>Lost Time Injury</td>
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<tr>
<td>LTIFR</td>
<td>Lost Time Injury Frequency Rate</td>
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<td>Mental Health</td>
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<td>Moving and Handling</td>
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<td>Middlemore Central</td>
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<td>Occupational Health and Safety Service</td>
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<td>Primary Health &amp; Community Services</td>
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<td>Pre-Employment Health Screening</td>
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<td>SAP</td>
<td>Surgical, Anaesthesia &amp; Perioperative</td>
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<td>Safe Practice and Effective Communication</td>
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<tr>
<td>WellNZ</td>
<td>Injury Management Third Party Administrator</td>
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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 event
One reported to WorkSafe resulting from patient fall in carpark in May 2018. Worksafe have advised that no investigation will take place.

Worker Participation Framework
The national Worker Participation Framework having been ratified by the National DHBs and Unions will be presented to CEO for approval. CM Health Worker Participation framework, aligned with the national agreement to be developed and presented to ELT/Board for adoption in the August reporting period.

2018 Flu Vaccine Campaign
Increase in completion rate to 69% as at 30 June 2018 (National target of 80%). A substantial increase in the total staff numbers vaccinated year on year.

Services with target of 100%:
ARHOP 81%
KidzFirst 82%
Women’s Health 60%

Activities to improve results:
- Email to all staff not vaccinated in July
- Daily dose communication weekly
- Discussion by GM/CDS to improve uptake.

Change in LTIFR Reporting
LTIFR reporting methodology changed from monthly to a ‘rolling 12 month average’ effective 01 June 2018, aligning with regional DHB and best practice reporting models.

Recommend the LTIFR target move from <5 to <10 (the Australian Healthcare target is <10) with current rolling 12 month average for CM Health at 14.6.

Injury claims June:
Reported injuries reduced in the June period compared to both the spike in May and compared to rolling year on year (104 compared to 115). Decrease due to a decrease in slips, trips and falls following work with the cleaning teams; stabilising of moving and handling injuries following the spike with the TROPHI tool pilot and higher than average rate of BBFE injuries.

Current Issues Update

Bullying, harassment and discrimination
Migrant Nurses racism Massey University study, follow up within CM Health environment to understand if client/staff issues are reported and investigate.

Continue promotion of ‘Speak up’ campaign to provide process and encourage staff to report on issues relating to bullying, harassment and discrimination.
Violence in ED topical issue in paper
CM Health ED pilot as reported to Board in May, follow up with ELT H&S Committee in August with initiative on issuing personal security alarms review following trial.

Dr Peter Watson, Clinical Director Mental Health is developing pathways for patients with behavioural issues.

Steering group on ED to violence and aggression recommendations being implemented to implement Zero Tolerance programme.

ACC AEP Audit preparation (November 2018)
Work plan to close out on self-audit gap analysis aligned with HSWA (2015) progressing with key projects being covered by external H&S Contractors:
  o Contractor Management
  o Worker Participation
  o Hazardous Goods.

Report to ELT/Board will be tabled in July with gap analysis against tertiary level with recommendations for projects, resourcing with expectations for audit results.
### Performance Scorecard

#### Health and Safety Scorecard

**June 2018**

### Comment on Variations

#### Indicators in Red

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTIFR</td>
<td>• Recommend change in reporting methodology to rolling 12 month average to align with regional DHB's and best practice.</td>
</tr>
<tr>
<td></td>
<td>• Recommended LTIFR target change from &lt;5 to &lt;10 for rolling 12 month average to align with both WDHB &lt;10 and Australian Healthcare target of &lt;10.</td>
</tr>
<tr>
<td>H&amp;S Representative Training</td>
<td>• Tracking behind target at 89.5% of 100% target.</td>
</tr>
<tr>
<td></td>
<td>• 138 H&amp;S Reps completed training in 12 month period.</td>
</tr>
<tr>
<td></td>
<td>• Training to recommence in August with external accredited provider.</td>
</tr>
<tr>
<td>Attendance at H&amp;S Orientation</td>
<td>• 63 of the potential 73 candidates attended orientation. The remaining 10 candidates were unable to attend.</td>
</tr>
<tr>
<td></td>
<td>• Winter campaign has impacted numbers of staff starting without prior attendance at Induction day.</td>
</tr>
<tr>
<td>Staff flu vaccination uptake</td>
<td>• 30 June at 69% (71% in July) staff vaccinated (national target 80%).</td>
</tr>
<tr>
<td></td>
<td>• On-going vaccination programme delivered through peer vaccinators (130), OHN and Middlemore Central.</td>
</tr>
<tr>
<td></td>
<td>• GMs/CNM target Women’s Health, KidzFirst and ARHOP.</td>
</tr>
</tbody>
</table>

#### Indicators in Blue

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-employment health screening completed</td>
<td>• Increased PEHS clearances due to winter recruitment, this is expected to normalise in Sep.</td>
</tr>
<tr>
<td></td>
<td>• 96 of 99 new employees had full clearance prior to starting with 3 outstanding starting with restrictions.</td>
</tr>
</tbody>
</table>

### Injury Claim Data

Counts Manukau District Health Board

8 August 2018

094
INJURY CLAIM DATA

Total: Injury Claim Report for June 2018

<table>
<thead>
<tr>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lost days for month</td>
<td>$ total for month</td>
<td>$ total for month</td>
<td>$ total cover cost for month</td>
<td>Total $ cost for month</td>
</tr>
<tr>
<td>214.50</td>
<td>45,717.78</td>
<td>28,901.11</td>
<td>13,934.07</td>
<td>88,552.96</td>
</tr>
</tbody>
</table>

LTIFR Reporting

Recommend the Board accept the change in the LTIFR reporting methodology from monthly total which is based on actual figures to a 12 month rolling figure as this will reflect more accurate data. The following table details the LTIFR figures for the previous 12 months with a 12 month rolling average figure of 14.6.

Recommend the the Board review and change the LTIFR target figure from <5 to <10 to align with the regional DHB target figures and the Australian Healthcare figure, recognising the more achievable target figure and in the context of the health industry best practice while providing a stretch target on current performance.

The August Board report will include a benchmarking graph to provide regional DHB benchmarking LTIFR figures to provide context on CMDHB LTIFR performance.

Review with WellNZ on LTI and LTIFR at quarterly meeting on 02 August 2018 with update on CM Health performance against Regional DHB performance provided in August Board report.
# Key Health and Safety Risks

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

<table>
<thead>
<tr>
<th>Risk</th>
<th>Status / Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk: Occupational Health &amp; Safety - Aggression and Violence</strong>&lt;br&gt;(Emergency Department, Mental Health, Community Mental Health)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Awaiting budget approval to initiate deep dive project for ED/Mental Health &amp; Community.</td>
<td>• Terms of Reference for an oversight group of Chief Medical Officer, Chief Nurse and HR Director to consider data, actions and activity.</td>
</tr>
<tr>
<td></td>
<td>• New pilot on personal duress in community showing stronger economic feasibility.</td>
<td>• Second lone worker duress alarm system pilot scheduled to commence with 13 community workers, in July.</td>
</tr>
<tr>
<td></td>
<td>• Review of WDHB policy and guidelines still on going.</td>
<td>• Monitoring to be undertaken by Fortlock.</td>
</tr>
<tr>
<td></td>
<td>• ED piloting separate personal duress system to capture incidents.</td>
<td>• Training resource/Standard Operating Procedure/communication is being refined to ensure it is simple and clear for community.</td>
</tr>
<tr>
<td></td>
<td>• Review of effectiveness of use of electronic calendars for Community Workers with Connectivity with personal alarm system software will enable better tracking.</td>
<td>• Following the pilot of the two systems in community and ED a recommendation on the preferred system based on functionality/cost will be assessed.</td>
</tr>
<tr>
<td></td>
<td>• Community Lone worker training continuing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trial of new personal protection unit/software continuing within the services.</td>
<td></td>
</tr>
<tr>
<td><strong>Risk: Blood and Body Fluid Exposure (BBFE)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No further update in May.</td>
<td>• Working with services on preventative measures and understanding root cause/trend analysis on rise in BBFE incidents.</td>
</tr>
<tr>
<td></td>
<td>• Increase in BBFE incidents reported due to new intake of nursing and Junior Doctors.</td>
<td>• Review with Nurse Educators for hazard/preventive training at Induction.</td>
</tr>
<tr>
<td><strong>Risk: Hazardous Substances and New Organisms (HSNO)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Facilities &amp; Engineering team are following up on close out plan for action points.</td>
<td>• Engaging a resource to work alongside Facilities &amp; Engineering team to implement a Hazard goods programme.</td>
</tr>
<tr>
<td></td>
<td>• Hazard Registers on site to be updated</td>
<td></td>
</tr>
</tbody>
</table>
following above actions and regular reviews to ensure continued compliance.

• Reviewing the WDHB programme as part of process.

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Steering group meeting and 3 work groups updating on progress against project deadlines on track.</td>
<td>• Project Plan reviewing M &amp; H injury reporting through Riskpro to improve reporting experience and reporting capability.</td>
</tr>
<tr>
<td>• Increase in M&amp;H injury reporting as result of TROPHI tool roll out to other services.</td>
<td>• Paper presented to ELT on project resource recommendations.</td>
</tr>
<tr>
<td>• Draft implementation plan on ELT agenda to be presented to in June.</td>
<td>• Training programme/facilitators identified and included in resourcing recommendations.</td>
</tr>
</tbody>
</table>

### Risk: Compliance - Contractor Management and Procurement Management

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contractor project plan to be implemented.</td>
<td>• Contractor Management system scope and timeframe on multi-tiered system to be presented to ELT/Board in August 2018.</td>
</tr>
<tr>
<td>• H&amp;S monitoring major works projects underway KA2 and Tiaho Mia.</td>
<td>• Scott Re-clad Steering group committee meeting – Margie Apa Chair with quarterly meetings.</td>
</tr>
<tr>
<td>• H&amp;S/F&amp;E working on Scott re-clad project plan.</td>
<td>• H&amp;S reviewing the Hawkins H&amp;S Safety Plan for Scott Re-clad.</td>
</tr>
<tr>
<td></td>
<td>• Tiaho Mai finishing and KA2 to be finished in August.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Progress on development of H&amp;S orientation on track.</td>
<td>• H&amp;S Training programme for remainder of 2018 under review.</td>
</tr>
<tr>
<td>• H&amp;S Induction training reworked to cover fewer areas and include Manager/H&amp;S Rep in follow up in service.</td>
<td>• H&amp;S Rep training delivered by external accredited supplier from Aug onwards.</td>
</tr>
<tr>
<td>• H&amp;S Rep training to be delivered via an external resource from August due to resignation of accredited trainer.</td>
<td>• H&amp;S Induction and Foundations of Management training will be delivered by H&amp;S team from Aug onwards.</td>
</tr>
</tbody>
</table>

### 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 further update.</td>
<td>• Follow up on cleaner briefing on keeping themselves and others safe, reduction in reported injuries for June.</td>
</tr>
</tbody>
</table>
Wet weather use of ‘umbrella bags’ continues on heavy rain period, effective preventive measure in common areas.

### Risk: Wellness – Employee Health and Wellbeing Programme (stress, fatigue, depression )

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Daptiv project action plan on track.</td>
<td>• Paanui ‘Wellness’ page updated with easier access to information/links.</td>
</tr>
<tr>
<td>• Flu vaccination programme phase 67%</td>
<td>• CMO engaging SMO’s to focus on SMO Wellbeing.</td>
</tr>
<tr>
<td>• Flu vaccination programme flow chart/ process to be documented for next year.</td>
<td>• Flu vaccination programme at 69% with targeted email to staff to encourage further uptake and emphasis on Women’s Health; KidzFirst and ARHOP services. Daily Dose updates and General Manager/Charge Nurses championing with services.</td>
</tr>
<tr>
<td>• Speak up campaign launched with communication plan and rollout to all of business including unions.</td>
<td>• EAP Works usage continues with Service specific support following critical events.</td>
</tr>
<tr>
<td>• OD Manager part of working group to look at Regional ‘wellbeing’ strategy.</td>
<td>• OD Manager working with Regional group on ‘wellbeing strategy’.</td>
</tr>
<tr>
<td>• GM HR wellbeing website launched.</td>
<td></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>• Draft checklist prepared and reviewing with online hazard walkthrough model to monitoring environmental aspects to be referred to F&amp;E.</td>
<td>• New Audiometers order for OHSS to enable noise hazard monitoring to continue.</td>
</tr>
<tr>
<td>• Health monitoring plan for staff identified as being exposed to environmental hazards.</td>
<td>• Asbestos Management Plan with health monitoring follow up recommendations to be finalised.</td>
</tr>
<tr>
<td>• Surveys of buildings complete and an Asbestos Management Plan draft produced by F&amp;E for review.</td>
<td></td>
</tr>
</tbody>
</table>

### Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health and Safety Rep training completed in May with June/July cancelled recognising occupation rate in hospital.</td>
<td>• National DHB Worker Participation draft signed off with CEO endorsement by early Aug.</td>
</tr>
<tr>
<td>• National Participation: still awaiting update on Union feedback.</td>
<td>• CM Health draft Worker Participation Policy/Guideline to be finalised Aug/Sep to be presented to ELT/Board aligned with National WPA and HSWA (2015).</td>
</tr>
<tr>
<td>• Review of H&amp;S Orientation Day with presentation aligned with new online tool and co-facilitation with H&amp;S Rep to explain in service H&amp;S Rep role.</td>
<td>• JCC update on key H&amp;S issues.</td>
</tr>
</tbody>
</table>
## Reported Incidents

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

Previous 13 months – 104.4  
Current 13 months – 115.2  

Increase in rolling average figure – result of increased reporting over last 12 months within violence and aggression, M&H and seasonal BBFE.

### Key Observations:

- **BBFE (31):** highest incident type with SMO’s and New graduate nurses being key groups represented in the statistics. Key area for safety message.

- **Aggression and Violence (29):** steady with slight increase from May figure of 23. Continues to be focus as highest reported incident type. ED pilot study concluded significant under-reporting of low level incidents resulting from difficulty in use of incident reporting system; contributing factors the acuity of patients presenting with complex needs, waiting time in ED when busy and ability to move out of ED because of full wards key factors.

- **Other (23):** ‘hitting/moving/falling objects’ is highest category represented. Key ‘housekeeping’ and safe moving of objects as follow up.

- **Moving & Handling (13):** Slight reduced, but steady between 13-17. ACC claims still delayed in coming through so injury figures still elevated.

- **Slips, trips and falls (8):** reduced back from normal levels from May report which given the period of wet weather represents an improvement and reflects the effect of briefing session with Cleaning staff.
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</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/6/2018</td>
<td>Patient fall (Unwitnessed)</td>
<td>Sustained injury to the jaw requiring surgical attachment of a small plate to the jaw.</td>
<td>5/5/2018</td>
<td>Investigation/No further action from WorkSafe.</td>
</tr>
</tbody>
</table>

NB: This patient incident investigation conducted by the Quality & Risk Manager, and escalated to the Adverse Events Committee for review. WorkSafe notified in compliance with regulations.

BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly average comparison:

- Previous 13 months – 22.7
- Current 13 months – 24

- BBFE incidents steady with year on year increase compared with June 2017.
- Of 31 BBFE incidents in June, 18 occurred in Medicine and 10 in Nursing/Midwifery due to increase in SMO injuries and graduate nurse intake with the majority occurring in SAP.
- BBFE notification has follow up; tracking and screening or treatment completed by OHN for clinical assessment of risk. The work area managers are contacted to ensure process improvement and reduction of injury rate.
- Key causation reported is distraction due to incorrect technique and job factors.
Aggression and Violence

Rolling year-on-year monthly average comparison:
Previous 13 months – 21
Current 13 months – 27.1
- Slight increase, year on year comparison as a result of the ED pilot and the ‘Speak up’ campaign.
- ED pilot highlighted under-reporting at lower level violence and aggression and recommendations on improved controls including the personal security alarm to be implemented in Q3.
- Security team have a presence in the ED, which has resulted in some change in behaviour.
- Incidents remain highest in EMIC.
- Acute Mental Health and Community Mental Health key areas for further focus.
- Causation profile: Assault – Physical: 11; Assault – Verbal/Gesture: 8; Behaviour – Aggressive/Violent: 7; Behaviour – Inappropriate/Harassment: 3

Moving and Handling

Rolling year-on-year monthly average comparison:
Previous 13 months – 19.8
Current 13 months – 18.8
- Steady reporting on year on year rolling average, but a significant decrease when compared to June 2017 incidents.
- Moving and Handling incidents have normalised following an increase in April aligned with the TROPI tool rollout.
- ACC backlog of incident referrals continues to impact the injury data with a number relating to Moving and Handling.
- Moving and Handling steering group to present a project plan & recommendations to the Board in May/June.
- Causation profile: Awkward posture/ equipment malfunction/ job factors/ action/ behaviour of employee or patient/ affiliate, human factors: 9; Lifting /carrying/load size: 2; Assistance unavailable: 1; Stepping/kneeling/sitting on: 1
Rolling year-on-year monthly average comparison:
Previous 13 months – 13.2
Current 13 months – 13
- Slips, Trips and Falls incidents are consistent for the rolling year and compared to June 2017.
- Significant reduction from May to June with 50% less reported.
- Reduction in slips, trips and falls reported by cleaning staff following briefing session.
- Causation profile: Fall resulting in 7 and Walking on wet/slippery surface resulting in 1.

Reported Incidents Summarised by Workforce and Division
Workplace Inspections

- The workplace inspection programme is a key component of the CM Health Health and Safety management system providing an operational hazard management process, ensuring a regular assessment of the efficacy of the control measures in place within the services to minimise the effect of hazards. The process provides a key link between incident management, hazard identification and continuous improvement within CM Health.
- The process was introduced following the H&S Representative training (180 trained in 18 month period) as a means of active participation by both the service management and H&S Reps in maintaining hazards within the service areas. The frequency of the workplace inspections will be reviewed and potentially moved to quarterly following feedback from the service managers and H&S Reps at the next H&S Rep hub meeting in Aug 2018.
- Compliance level of the inspections for the May/June 2018 period is 98% with the next inspections due Aug 2018.
- Key stakeholders ensure corrective actions are closed out within the reporting period, or a plan in place if a longer time frame is required with issues requiring Engineering and Facilities maintenance being completed for all reported issues with broken equipment removed or replaced.
- Process improvement through combination of Facilities & Maintenance/H&S Workplace inspections into one tool with draft presented and finalised by end Aug 2018.

![Workplace Inspections Conducted per Division: May / June 2018](image)

Occupational Health Service Update

- **2018 Flu Campaign**
  
  As at 30 June 2018 CM Health staff vaccination at 69% with the programme being delivered in the service areas via 130 peer vaccinators, the OHN team and MMC. Email update to non-vaccinated staff to be sent in July to encourage participation and update OHSS if already vaccinated through GP or provide formal decline.
**OCC Service Activity for June 2018**

**Case and Claims Management:**

- Current Claims are categorised as low or high risk claims and are currently being managed by OHSS.
- Pending Claims include new claims requiring initial assessments and further investigation before a cover decision is made.
- A new complex claim may remain as a pending claim up to 21 days at which point a decision is made or an extension required if further evidence is required, an employee is booked to see an OHP for review and a recommendation to either Accept/Decline to claim.

**Vaccinations**

**Vaccinations:**

Vaccination programmes for pre-employment screening have decreased slightly and in addition 26 flu vaccines were administered in the clinic in June 2018.

Occupational Health Nurse staff have been involved in flu vaccinations and filling out the roster for the Independent Vaccinators.

**Clinic Appointments**

**Clinic Appointments:**

Decrease in clinic and physician bookings with relative to decrease in vaccinations due to pre-employment screening.

A slight decrease in the number of staff not attending clinic appointments, with decrease from 48 in May to 39 in June 2018. Follow up phone calls to identify key reasons for missing appointments.

Increase in the complexity of cases being referred to Occupational Health Clinicians and taking longer period of time to close out.
**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. LTIFR (Lost Time Injury Frequency Rate) = (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. LTISR (Lost Time Injury Severity Rate) = (Number of Lost Hours / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td><strong>Notifiable Injury/illness</strong></td>
<td>(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.</td>
</tr>
<tr>
<td><strong>Notifiable Incident</strong></td>
<td>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 capsiz; or any other incident declared by regulations to be a notifiable incident.</td>
</tr>
<tr>
<td><strong>Notifiable Event</strong></td>
<td>Death of a person, notifiable injury or illness or a notifiable incident.</td>
</tr>
<tr>
<td><strong>Pre-Employment</strong></td>
<td>Health screening for new employees.</td>
</tr>
<tr>
<td><strong>Worker</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Reasonably Practicable</strong></td>
<td>Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters. eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/minimise the risk and the cost associated with elimination of the hazard/risk.</td>
</tr>
</tbody>
</table>
Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 1 June - 20 July 2018.

Prepared and submitted by Donna Baker, General Manager Communications and Engagement and Margie Apa, Director Population Health & Strategy.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 1 June – 20 July 2018.

External Communications

Nurses Strike

The Communications team proactively supported contingency planning for the nurses’ strike, including facilitating media requests for interviews in the lead up to the nurses’ strike. A detailed joint internal and external communications plan was developed and regular updates issued in accordance with the plan. These comprised all staff emails from the CEO and on Paanui; a dedicated portal was established where staff could access all information ‘at a glance’. Communications worked with stakeholders and developed collateral to support service areas. On strike day, the team provided support to the EOC, visited wards taking photographs of volunteers/helpers in action.

Attacks on Staff

There has been significant media interest in relation to attacks on staff, due in part to an agenda item in the Board’s June meeting. The Communications team facilitated a number of requests for interviews and information in relation to this topic.

IT and Cyber Security

There has been media interest in relation to IT and cyber security, and how health information systems and data is protected. This was prompted by an operational report released under OIA which mentioned the 2017 international ransomware incident. Communications worked with our shared IT service provider healthAlliance to address queries.

Condition of Hospital Buildings

A large amount of information about the CM Health buildings has now been released to multiple media outlets through the OIA process. Media coverage has reduced although there have been follow-up queries mostly relating to the process involved in recladding the Scott building, the seismic status of the Galbraith building and future use.

Media & OIA Requests
Routine Sector Communications

Connect+ June/July Edition Published

The June/July edition of Connect+ has been published online at ISSUU.com, as well as on the Communications webpage on Paanui. This edition has been well received.

On ISSUU.com: Four minutes spent reading the magazine online, with a total of 105 reads.
Internal Communications

Flu Campaign

The free staff flu campaign continues. Staff can have the flu vaccine 24/7 through Middlemore Central, via a peer vaccinator near them (list available on Paanui), or by booking an appointment with the Occupational Health and Safety Team. During the last reporting period, the overall percentage of staff vaccinated was at 64%. As at 18 July, this has increased to 71%. We will continue to promote this campaign to staff via Paanui, Daily Dose and posters.

New HealthAlliance Services Portal

With the launch of the new healthAlliance Services Portal, internal communications support was delivered through a screensaver, Paanui News piece and through phased messaging in the Daily Dose. The initial phase highlighted that the new portal was coming soon, followed by messaging on new features and how to access them.

Turn Around Plan

Internal communications support has been provided to project managers through developing communications plans to support key projects.

Raising the Facilities Team Profile

Since June, internal communications have been meeting with members of the facilities and engineering teams. Focus has been on individual roles and responsibilities; and how the teams are supporting service users both in terms of maintenance and new development projects. The purpose of this brief is to help raise the morale of the team in general and to showcase the excellent work and dedication of the team as a whole. In the same week as Ward 21 opened its doors, Communications published a blog featuring Nathan Linton (clerk of the works) and three team members talking about the part facilities played in this success story.

Logo Hunt Competition

To support an internal brand refresh project, a logo hunt competition was devised. Staff were asked to find logos from any CM Health project, programme or department and send them through to Communications. The logos gathered are being used to create a logo family tree, giving us a better perspective of collateral that is not on brand.

Volunteer Week

During June we celebrated National Volunteer Week. This was an opportunity to showcase our wonderful volunteers and thank them for their dedication, time and continued support. The Rainbow Volunteers at Middlemore hospital and the Manukau SuperClinic were thanked with a morning tea. We also profiled four Rainbow Volunteers and two Manukau SuperClinic mailroom volunteers. These profiles featured in the Connect+ magazine, and on the CM Health Facebook page.

Youth Employment Pledge

CM Health, along with the other metro Auckland DHBs, previously signed off on Auckland Council’s Youth Employment Pledge (YEP). To date, no work has been done on this Pledge in supporting more youth through CM Health’s doors, and into employment. Internal communications developed a communications plan aimed at recruiting, retaining and developing youth into health careers. As an extension of the YEP, CM Health has developed a programme that will bring current youth-focused initiatives under its umbrella for a more cohesive approach. Through this programme, working closely with HR and Organisational
Development, we will also seek to form career development opportunities for youth in roles such as orderlies, cleaners, Sterile Supply Technicians, and Trainee Anaesthetic Technicians. Work is also being done to develop further entry level roles for youth.

**Recruitment Video**

As an extension of the current CM Health Welcome Day induction, a recruitment video was requested with similar messaging aimed at staff who have accepted their offer of employment but are yet to start at CM Health. The video is in its final sign off stages.

**Stakeholder and Communities Communications**

**Bowel Screening Programme**

The National Bowel Screening Programme is being rolled out in the Counties Manukau area from 10 July (when the invitation letters started to be sent out to residents). Over the next two years, bowel screening will be offered to everyone aged 60 to 74 eligible for publicly funded healthcare and who are residents in the Counties Manukau area. We are continuing to work with the National Screening Unit, Ministry of Health, and other involved DHBs on raising awareness in our areas and rolling out information.

Our Monthly Maternity (OMM) e-update was published in early July.

**World Hepatitis Day (28 July)**

Working collaboratively with the Northern Regional Alliance to increase general public awareness of Hep C to support diagnosis and treatment, with a call to action for risk groups to get tested. The NRA will distribute posters and other collateral in the community and primary care. An Auckland metro radio ad with seven different messages is currently running on radios: Mai FM, 531PI, Hauraki, The Sound, Live, Rock and Tarana. The ads will run until August 17. An animation is currently being produced by NDHB and will be shared with the other Northern region DHBs to support the campaign on social media.

**Mental Health First Aid Programme**

Comms support continues, producing flyers for the programme and creating a new webpage on CM Health website that will be used to promote the programme; also in the process of finalising promotional video to encourage young Maaori to start a career as a mental health nurse.

**Emergency Q**

Supporting internal communications for the pilot starting at the end of July in ED and also collateral (posters) for patients.

**Integrated Care**

Comms supported the Quality Improvement Symposium with photos, article and quotes for use in their communications.

**Research Week 2018 (18-21 June)**

Comms produced collateral and supported the event internally and externally on social media (Ko Awatea Twitter and CM Health Facebook). An article on Paanui highlighted the event and emerging researcher Karaponi Okesene-Gafe.

**Branding**
Comms is working with Ko Awatea on the plan to transition Ko Awatea’s website to CM Health’s website and also on aligning Ko Awatea’s brand to CM Health’s brand.

**Alcohol Harm Minimisation**

As part of the communications plan to support the work of the Alcohol Harm Minimisation team, the Communications team promoted participation in Dry July via our internal communication channels. On 25 July there will be an interactive Dry July stand in the reception area of MMH to promote our current alcohol harm minimisation projects.

**University of Otago Dental Training Facility at Mental Health Park (MSC)**

Comms has had input into the UOO’s communications plan for this project.

**Digital Channels**

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

Traffic to our website is consistent with the previous reporting period. We do notice that the visits are spread more evenly seeing an increase in Thursday / Friday traffic but a decrease on other days. In comparison to the previous year, traffic is lower which we hope is due to better ‘Right care for you’ messaging.

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

**Social Media**

This period we saw an impressive 207% increase in followers compared to the previous reporting period. Our Healthy Together out-performed the CM Health Facebook page for the first time with per post impressions and engagements almost doubling last period’s numbers – the bowel campaign was dominant in this success.
Figure 6 Summary of Reach and Engagement Metrics for each social media channel

<table>
<thead>
<tr>
<th>Channel</th>
<th>Total Fans</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Totals</strong></td>
<td>24,745</td>
<td>+1.68%</td>
</tr>
<tr>
<td><strong>New Facebook Fans</strong></td>
<td>121</td>
<td>+0.7%</td>
</tr>
<tr>
<td><strong>New Twitter Followers</strong></td>
<td>24</td>
<td>+0.8%</td>
</tr>
<tr>
<td><strong>New LinkedIn Followers</strong></td>
<td>240</td>
<td>+4.4%</td>
</tr>
<tr>
<td><strong>Total Fans Gained</strong></td>
<td>409</td>
<td>+1.0%</td>
</tr>
</tbody>
</table>

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

CM Health Facebook

Celebrating staff and positive initiatives continues to be popular with our audience. Although per post engagement and impressions are down slightly from the last period, we are still pleased with the numbers that we’re seeing. World Environment Day, featuring one of our doctors and one of our nurses, was the most popular this month amassing almost 1000 reactions.
Top 4 Posts by Reactions

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Today is #worldenvironmentalday, with ‘beat plastic pollution’ as the theme. It’s important for us to look at everything we do, from an environmental lense. It’s often the simple things that we use and do every day that can be changed to make our world a little more greener. Registered Nurse Helen and Dr David are doing great things to make our...</td>
<td>991</td>
<td>13</td>
<td>15.9%</td>
<td>6,214</td>
</tr>
<tr>
<td></td>
<td>It was an exciting #ResearchWeek this week. Thanks to everyone who participated and congratulations to the prize winners! #Excellent</td>
<td>962</td>
<td>16</td>
<td>27.7%</td>
<td>3471</td>
</tr>
<tr>
<td></td>
<td>A wonderful team effort from Ward 6, who have reached 100% uptake for the flu vaccination! Congratulations to the whole team of Flu Fighters- especially their wonderful peer vaccinators Jatinder and Sarita. If you still haven’t had your free staff flu vaccine, now’s your opportunity!</td>
<td>630</td>
<td>8</td>
<td>20.2%</td>
<td>3,108</td>
</tr>
<tr>
<td></td>
<td>Manager (Full Time), Population Health Programmes, CM Health Counties Manukau Health (CM Health) serves a growing, vibrant multi-ethnic population of over 550,000 people who face many challenges to their health and well-being. The impacts of the social determinants of health are evident across a wide range of health outcomes for CM Health communities. This role will have responsibility for operational management and coordination, administration and monitoring of key population...</td>
<td>496</td>
<td>3</td>
<td>16.7%</td>
<td>2,976</td>
</tr>
</tbody>
</table>

Figure 8 Top 4 CM Health Facebook Posts by reactions

Healthy Together Facebook

Our Healthy Together Facebook page stole the show this reporting period with per post impressions up 89% and per post engagement up 122%. The National Bowel Screening video received positive feedback with more than 15,000 people watching the video.

Our wahakura post was also extremely popular with our community. More than 50 people shared this with their networks. There were numerous people asking where they could purchase wahakuras which is positive to see and will hopefully contribute to a reduction in SUDI in our community.
### Top 4 Posts by Reactions

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comment</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Healthy Together - Counties Manukau The National Bowel Screening Programme is now here at Counties Manukau! Bowel cancer can develop with no warning signs. Finding it early with the free bowel screening test could save your life...</td>
<td>2,572</td>
<td>28</td>
<td>16.9%</td>
<td>15,223</td>
</tr>
<tr>
<td></td>
<td>WIN A WAHAKURA To kick off Mataariki, CM Health has a cool prize to give away. Know someone who is about to have a baby or just had one? Want to hook them up with a wahakura that will help look after their precious little one? All you have to do is mention them (use @) in the comments...</td>
<td>2,513</td>
<td>269</td>
<td>18.9%</td>
<td>13,315</td>
</tr>
<tr>
<td></td>
<td>Healthy Together - Counties Manukau Please encourage whaanau aged 60 to 74 to do the bowel screening test!</td>
<td>1,228</td>
<td>5</td>
<td>10.8%</td>
<td>4,415</td>
</tr>
<tr>
<td></td>
<td>Papa Tom doing amazing work producing healthy kai for the South Auckland community, as well as teaching people to grow their own. #loveyourmahi</td>
<td>300</td>
<td>2</td>
<td>44.4%</td>
<td>676</td>
</tr>
</tbody>
</table>

**Figure 9 Top 4 Healthy Together Posts by reactions**

**CM Health Twitter**

Our new Twitter strategy appears to be working. Closely aligning our Twitter messaging with our Facebook content has provided numbers that are consistent with our last reporting period (in which we achieved a 591% increase).
We saw a sizeable increase in LinkedIn followers this period with 240 followers connecting with us. The opening of ward 21 was well received by our audience. Our recruitment messaging also continued to perform well.

**Top Posts by Engagement**

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We continue doing our utmost to ensure we are well prepared for the winter months, and that we have sufficient capacity in place to continue providing quality care for our patients, as well as reducing pressure on our staff. The new Ward 21 on Level 5 of the Galbraith building is now open, providing 30 much needed beds, our congratulations go out to everyone who has been involved in getting this ward up and running! Read more here: <a href="https://lnkd.in/gt7-6F3">https://lnkd.in/gt7-6F3</a></td>
<td>144</td>
<td>1</td>
<td>7.10%</td>
<td>2,026</td>
</tr>
</tbody>
</table>
| **Join the team** | Manager (Full Time), Population Health Programmes, CM Health  
Counties Manukau Health (CM Health) serves a growing, vibrant multi-ethnic population of over 550,000 people who face many challenges to their health and well-being. The impacts of the social determinants of health are evident across a wide range of health outcomes for CM Health communities. This role will have responsibility for operational management and coordination, administration and monitoring of key population... | 91        | 0        | 6.21%      | 1,465  |
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Receive this paper noting that it presents an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 25 July 2018.

Prepared and Submitted by: Margaret White – Chief Financial Officer

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>ADHB</td>
<td>Auckland District Health Board</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>ARF</td>
<td>Audit Risk &amp; Finance Committee</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>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CIC</td>
<td>Capital Investment Committee</td>
</tr>
<tr>
<td>CM</td>
<td>Counties Manukau</td>
</tr>
<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
</tr>
<tr>
<td>DBC</td>
<td>Detailed Business Case</td>
</tr>
<tr>
<td>DIA</td>
<td>Department of Internal Affairs</td>
</tr>
<tr>
<td>DFA</td>
<td>Delegated Financial Authority</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>ESPI</td>
<td>Elective Services Performance</td>
</tr>
<tr>
<td>FPC</td>
<td>Finance, Procurement Supply Chain</td>
</tr>
<tr>
<td>FSA</td>
<td>Food Service Agreement</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>JPA</td>
<td>Joint Partnership Agreement</td>
</tr>
<tr>
<td>KA</td>
<td>Ko Awatea</td>
</tr>
<tr>
<td>LSP</td>
<td>Licencing Solution Partners</td>
</tr>
<tr>
<td>MBIE</td>
<td>Ministry of Business Innovation &amp; Employment</td>
</tr>
<tr>
<td>MECA</td>
<td>Multi-Employer Collective Agreement</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>NRA</td>
<td>Northern Region Alliance</td>
</tr>
<tr>
<td>NRLTIP</td>
<td>Northern Region Long Term Investment Plan</td>
</tr>
<tr>
<td>NZ</td>
<td>New Zealand</td>
</tr>
<tr>
<td>NZHPL</td>
<td>New Zealand Health Partnerships</td>
</tr>
<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
</tr>
<tr>
<td>PAYE</td>
<td>Pay As You Earn</td>
</tr>
<tr>
<td>PBFF</td>
<td>Population Based Funding Formula</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>PO</td>
<td>Purchase Order</td>
</tr>
<tr>
<td>POAG</td>
<td>Procurement Organisation Advisory Group</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposal</td>
</tr>
<tr>
<td>TAP</td>
<td>Turn Around Plan</td>
</tr>
<tr>
<td>UoO</td>
<td>University of Otago</td>
</tr>
<tr>
<td>WDHB</td>
<td>Waitemata District Health Board</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>

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 25 July 2018.
1.1 Financial Report for the period ended 31 May 2018

YTD 31 May 2018 the consolidated result is $0.015m favourable to budget. Performance by operating arm is presented in Table 1.

| Table 1: Statement of Performance by Operating Arm for the period ended 31 May 2018 |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Net Result | Month May 2018 | Year to Date May 2018 | Full Year | |
| Act | Bud | Var | Act | Bud | Var | Bud Forecast | Var |
| $000 | $000 | $000 | $000 | $000 | $000 | $000 | $000 |
| Hospital Provider | 479 | 718 | (239) | 32,335 | 33,196 | (861) | 35,776 | 34,134 | (1,642) |
| Integrated Care | (3,898) | (3,731) | (167) | (40,411) | (41,007) | 596 | (44,734) | (44,084) | 650 |
| Ko Awatea | (1,200) | (1,366) | 166 | (12,380) | (14,122) | 1,742 | (15,347) | (13,851) | 1,496 |
| Provider | (4,619) | (4,379) | (240) | (20,456) | (21,933) | 1,477 | (24,305) | (23,801) | 504 |
| Funder | 284 | 412 | (128) | 3,317 | 4,529 | (1,212) | 4,942 | 5,017 | 75 |
| Governance | 253 | (47) | 300 | (852) | (602) | (250) | (650) | (1,258) | (608) |
| Surplus (deficit) | (4,082) | (4,014) | (68) | (17,991) | (18,006) | 15 | (20,013) | (20,042) | (29) |

Provider

Hospital Provider Position is $0.861m YTD adverse to budget. YTD acute demand has contributed to higher clinical costs and has displaced elective volumes necessitating a provision for under delivery of the MoH Elective discharge target. These costs have been offset by the one off contribution from the ACC arrears programme. Full year forecast reflects our commitment to increase clinical capacity in quarter four to respond to immediate demand pressures and prepare for 2018 winter and recover elective volumes.

Integrated care YTD $0.596m favourable to budget, reflecting management of contracts and FTE.

Ko Awatea YTD 2017/18 position is $1.742m favourable to budget reflecting structural changes together with crystalisation of APAC provisions in the month of February 2018.

Funder

YTD the Funder Arm is $1.212m adverse to budget, attributable to a continued provisioning for anticipated IDF wash-up exposure, mitigated by lower PHO enrolments than budget and Mental Health surplus over and above budget primarily due to delay of the commissioning of the new AMHU.

Governance

YTD Governance Arm is $0.250m adverse to budget. Full year forecast reflects a $3.0m cladding settlement offset by a write off of WIP (mainly costs from a document management system that could not be capitalised).

The full Financial Variance Report for the period ended 31 May 2018 is presented in Appendix 1 of this report.
Appendix 1 – Financial Report for the period ended 31 May 2018

YTD 31 May 2018 the consolidated result is $0.015m favourable to budget.

| Statement of Revenue and Expenditure for the period ended 31 May 2018 |
|------------------------|-----------------|-----------------|-----------------|-----------------|
|                        | Month           | Year to Date    | Full Year       |
|                        | Act  $000       | Bud  $000       | Var  $000       | Bud  $000       | Var  $000       | Bud  $000       | Var  $000       | Bud  $000       | Var  $000       |
| Revenue                |                 |                 |                 |                 |                 |                 |                 |                 |                 |
| Crown                  | 133,826         | 132,526         | 1,300           | 1,482,756       | 1,461,470       | 21,286          | 1,594,070       | 1,612,989       | 18,919          |
| Other                  | 3,780           | 3,095           | 685             | 37,284          | 34,173          | 3,113           | 37,478          | 43,817          | 6,339           |
| Total Revenue          | 137,606         | 135,621         | 1,985           | 1,520,040       | 1,495,643       | 24,397          | 1,631,548       | 1,656,806       | 25,258          |
| Expenses               |                 |                 |                 |                 |                 |                 |                 |                 |                 |
| Personnel              | 53,919          | 53,626          | (293)           | 565,232         | 569,237         | 4,005           | 621,256         | 617,354         | 3,902           |
| Outsourced Personnel   | 1,802           | 949             | (853)           | 19,726          | 10,408          | (9,318)         | 11,339          | 21,004          | (9,665)         |
| Outsourced Services    | 5,323           | 5,658           | 335             | 62,707          | 62,777          | 70              | 68,368          | 69,499          | (1,131)         |
| Funder Provider Payments | 58,935         | 57,515         | (1,420)         | 650,734         | 632,677         | (18,057)        | 690,191         | 703,446         | (13,255)        |
| Clinical Sup.          | 10,124          | 10,061          | (63)            | 109,512         | 107,545         | (1,967)         | 117,474         | 119,610         | (2,136)         |
| Infrastructure         | 6,124           | 6,144           | 20              | 65,250          | 68,505          | 3,255           | 74,751          | 75,702          | 9951            |
| Operating Exp          | 136,227         | 133,953         | (2,274)         | 1,473,161       | 1,451,149       | (22,012)        | 1,583,379       | 1,606,615       | (23,236)        |
| Operating surplus      | 1,379           | 1,668           | (289)           | 46,879          | 44,494          | 2,385           | 48,169          | 50,191          | 2,022           |
| Depn.                  | 2,724           | 2,661           | (63)            | 30,178          | 29,271          | (907)           | 31,932          | 32,759          | (827)           |
| Interest               | -               | 27              | 27              | 7               | 7               | 288             | 322             | 53             | 269             |
| Capital Chg.           | 2,737           | 2,994           | 257             | 34,685          | 32,934          | (1,751)         | 35,928          | 37,421          | (1,493)         |
| Net Surplus/(Deficit)  | (4,082)         | (4,014)         | (68)            | (17,991)        | (18,006)        | 15              | (20,013)        | (20,042)        | (29)            |

Commentary on Major Variances:

Crown Revenue

YTD was $21.286m favourable to budget, reflecting the following:

- favourable unbudgeted MoH funding for Disability Support Services Pay Equity (offset in Funder Provider Payments) $9.959m;
- favourable accrual for System Level Measures funding paid to PHO’s during the month (offset in Funder Provider Payments) $0.463m;
- favourable unbudgeted revenue for After Hours Service provided on behalf of other DHB’s and PHO’s (offset in Funder Payments) $1.920m;
- favourable Social Investment Board Funding from Sate Services Commission $1.740m (offset by expenditure);
- favourable IDF wash up adjustment on inflows $2.533m;
- LTS Chronic Health Conditions Pay Equity $0.934m (offset in Funder Provider Payments);
- on-going ACC arrears initiative $7.2m;
- capital charge funding $3.543m (offset in Capital Charge Cost); and
- Offset by a provision for $6.75m revenue claw back associated with under delivery of elective programme.
Other Revenue

YTD was $3.111m favourable to budget attributable to:
- favourable private patients $1.2m, predominantly Tahitian Burns and co-payments;
- favourable non-residents revenue $1.302m;
- additional revenue from bad debts recovered $0.423m;
- favourable research grants $0.686m;
- favourable Pacific and NZMAT revenue $0.702m (offset by additional expenditure);
- unfavourable $1.0m Pharmacy revenue (offset in infrastructure); and
- Reduction in donation revenue $0.719m.

Personnel and Outsourced Personnel

YTD net personnel costs for May are $5.313m unfavourable, part offset by $0.070m favourable outsourced services. This reflects under delivery of savings programme initiatives targeted at organisational redesign together with cost pressure from clinical demand - total FTEs are 6,455 (budget 6,366).

Funder Provider Payments

YTD was $18.057m unfavourable to budget, reflecting the following:
- unfavourable $9.959m accrual for Disability Support Services Pay Equity (offset in Crown Revenue);
- unfavourable $0.463m payments for System Level Measures paid to PHO’s during the month (offset in Crown Revenue);
- unfavourable $1.920m payments for After Hour costs (offset in Other Revenue);
- unfavourable $9.265m accrual for the current estimate of IDF shortfall for the 17/18 year;
- favourable $2.457m Mental Health spend lower than budget due to delay in commissioning of AMHU and NGO procurement; and
- favourable $1.965m PHO enrolments below budget.

Clinical Supplies

YTD was $1.967m unfavourable to budget, reflecting high clinical demand and significant increase in treatment disposables, instruments, equipment and pharmaceuticals together with delayed procurement savings.

Depreciation, Interest and Capital Charge

Depreciation and Capital Charge YTD is $2.37m unfavourable to budget reflecting timing in capitalisation of projects, and a revision in the capital charge (offset by capital charge funding).
Statement of Financial Position as at 31 May 2018

<table>
<thead>
<tr>
<th>Act / June 2017</th>
<th>Bud</th>
<th>Var</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<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>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Bank</td>
<td>45,302</td>
<td>33,236</td>
<td>12,066</td>
</tr>
<tr>
<td>Trust</td>
<td>832</td>
<td>894</td>
<td>(62)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>878</td>
<td>2,307</td>
<td>(1,429)</td>
</tr>
<tr>
<td>Debtors</td>
<td>51,724</td>
<td>51,026</td>
<td>698</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,668</td>
<td>7,484</td>
<td>184</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>5,320</td>
<td>5,320</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td>111,732</td>
<td>100,275</td>
<td>11,457</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>619,156</td>
<td>639,838</td>
<td>(20,682)</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,626</td>
<td>1,627</td>
<td>(1)</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,092</td>
<td>15,381</td>
<td>(11,289)</td>
</tr>
<tr>
<td>Information Software</td>
<td>561</td>
<td>561</td>
<td>-</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>4,416</td>
<td>4,516</td>
<td>(100)</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>842,271</td>
<td>874,343</td>
<td>(32,072)</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(178,667)</td>
<td>(180,977)</td>
<td>2,310</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>663,604</td>
<td>693,366</td>
<td>(29,762)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>79,310</td>
<td>74,059</td>
<td>5,251</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>742,914</td>
<td>767,425</td>
<td>(24,511)</td>
</tr>
<tr>
<td><strong>Investments in Assoc</strong></td>
<td>45,585</td>
<td>49,341</td>
<td>(3,756)</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>900,231</td>
<td>917,041</td>
<td>(16,810)</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>105,053</td>
<td>112,417</td>
<td>(7,364)</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>10,243</td>
<td>12,764</td>
<td>(2,521)</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>16,120</td>
<td>17,804</td>
<td>(1,684)</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>31,293</td>
<td>28,194</td>
<td>3,099</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>91,166</td>
<td>90,646</td>
<td>520</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>253,875</td>
<td>261,825</td>
<td>(7,950)</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(142,143)</td>
<td>(161,550)</td>
<td>19,407</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>646,356</td>
<td>655,216</td>
<td>(8,860)</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>18,717</td>
<td>18,717</td>
<td>-</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>832</td>
<td>898</td>
<td>(66)</td>
</tr>
<tr>
<td>Insurance Liability</td>
<td>931</td>
<td>931</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>20,480</td>
<td>20,546</td>
<td>(66)</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>407,635</td>
<td>424,288</td>
<td>(16,653)</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>291,395</td>
<td>283,552</td>
<td>7,843</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(73,154)</td>
<td>(73,170)</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>625,876</td>
<td>634,670</td>
<td>(8,794)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>646,356</td>
<td>655,216</td>
<td>(8,860)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- Bank was $12.066m favourable to budget. Net cash flows from operations (revenue, expenses and payroll) was $6.5m favourable to budget. Fixed assets cash spend was $31m favourable YTD to budget representing the delayed timing of capital spend for major capital projects. These have mainly been offset by the timing of the budgeted $24.5m funding from the Ministry of Health for the AMHU now being received in tranches, with $7.846 received in April.

- Total Fixed Assets were $32.072m lower than budget reflecting timing of major capital projects spend.

- Creditors were $7.364m lower than budget reflecting Capital spend being $6.098m lower than planned for the month and an adjustment to Capital Charge accrued being $0.725m.

- GST and PAYE were $1.684m lower than budget attributable to timing.

- Payroll Accrual & Clearing were $3.099m higher than budget reflecting timing of Salaries and Wages payments.

- Favourable working capital $19.407m is mostly attributable to delayed capital expenditure YTD $24.5m, $3m settlement for cladding, $3.7m delayed investment in Associates relating to NOS and capitalisation of HT2020 to healthAlliance, offset by timing variance $16.6m funding from the Ministry of Health for AMHU.
## Statement of Cash flow for the period ended 31 May 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>
</tr>
</thead>
<tbody>
<tr>
<td>Cash flows from Operating activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>136,998</td>
<td>133,143</td>
<td>3,855</td>
<td>1,478,550</td>
<td>1,464,028</td>
<td>14,522</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>4,218</td>
<td>2,878</td>
<td>1,340</td>
<td>38,809</td>
<td>31,792</td>
<td>7,017</td>
<td></td>
</tr>
<tr>
<td>Interest rec.</td>
<td>180</td>
<td>217</td>
<td>(37)</td>
<td>2,026</td>
<td>2,387</td>
<td>(361)</td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(92,073)</td>
<td>(76,351)</td>
<td>(15,722)</td>
<td>(906,985)</td>
<td>(873,553)</td>
<td>(33,432)</td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>(58,684)</td>
<td>(53,234)</td>
<td>(5,450)</td>
<td>(559,160)</td>
<td>(565,582)</td>
<td>6,422</td>
<td></td>
</tr>
<tr>
<td>Interest paid</td>
<td>(7)</td>
<td>(7)</td>
<td>(7)</td>
<td>(7)</td>
<td>(7)</td>
<td>(7)</td>
<td></td>
</tr>
<tr>
<td>Capital charge</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(18,665)</td>
<td>(17,964)</td>
<td>(701)</td>
<td></td>
</tr>
<tr>
<td>Net cash from Operations</td>
<td>(9,369)</td>
<td>6,653</td>
<td>(16,022)</td>
<td>34,568</td>
<td>41,108</td>
<td>(6,540)</td>
<td></td>
</tr>
<tr>
<td>Cash flows from Investing activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(4,545)</td>
<td>(10,643)</td>
<td>6,098</td>
<td>(43,397)</td>
<td>(74,192)</td>
<td>30,795</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>(36)</td>
<td>(174)</td>
<td>138</td>
<td>(3,033)</td>
<td>(7,507)</td>
<td>4,474</td>
<td></td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(54)</td>
<td>-</td>
<td>(54)</td>
<td></td>
</tr>
<tr>
<td>Net cash from Investing</td>
<td>(4,581)</td>
<td>(10,817)</td>
<td>6,236</td>
<td>(46,484)</td>
<td>(81,699)</td>
<td>35,215</td>
<td></td>
</tr>
<tr>
<td>Cash flows from Financing activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>28,423</td>
<td>28,423</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other Non-Current Liability</td>
<td>55</td>
<td>1</td>
<td>54</td>
<td>7,901</td>
<td>24,510</td>
<td>(16,609)</td>
<td></td>
</tr>
<tr>
<td>Net cash from Financing</td>
<td>55</td>
<td>1</td>
<td>54</td>
<td>36,324</td>
<td>52,933</td>
<td>(16,609)</td>
<td></td>
</tr>
<tr>
<td>Net increase / (decrease)</td>
<td>(13,895)</td>
<td>(4,163)</td>
<td>(9,732)</td>
<td>24,408</td>
<td>12,342</td>
<td>12,066</td>
<td></td>
</tr>
<tr>
<td>Opening cash</td>
<td>59,205</td>
<td>37,407</td>
<td>21,798</td>
<td>20,902</td>
<td>20,902</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Closing cash</td>
<td>45,310</td>
<td>33,244</td>
<td>12,066</td>
<td>45,310</td>
<td>33,244</td>
<td>12,066</td>
<td></td>
</tr>
</tbody>
</table>

### Reconciliation Summary

| Net Surplus/(Deficit) | (4,082) | (4,014) | (68) | (17,991) | (18,006) | 15 |
| Add/(Less) non-cash items |       |       |       |       |       |       |
| Impairment of Intangibles | -     | -      | -     | -      | -      | -      |
| Depn | 2,724 | 2,661  | 63    | 30,178  | 29,271  | 907   |
| (1,358) | (1,353) | (5)    | 12,187 | 11,265  | 922    |
| Add/(Less) Items Classified as Investing or Financing activities |       |       |       |       |       |       |
| Gain on Disposal | -     | -      | -     | -      | -      | -      |
| Add/(Less) Movements in Financial Position Items |       |       |       |       |       |       |
| Debtor and Other Receivables | 6,411  | 17     | 6,394 | (3,305) | (4,036) | 731   |
| Inventories | (454)  | -      | (454) | (184)   | -      | (184) |
| Creditors | (9,209) | 7,596  | (16,805) | 19,805  | 31,433  | (11,628) |
| Employee Entitlements | (4,759) | 393    | (5,152) | 6,065   | 2,446   | 3,619 |
| (8,011) | 8,006  | (16,017) | 22,381 | 29,843  | (7,462) |
| Net Cash flow from Operations | (9,369) | 6,653  | (16,022) | 34,568  | 41,108  | (6,540) |
| Net Cash from Investing | (4,581) | (10,817) | 6,236 | (46,484) | (81,699) | 35,215 |
| Net Cash from Financing | 55     | 1      | 54    | 36,324  | 52,933  | (16,609) |
| Net Increase / (Decrease) | (13,895) | (4,163) | (9,732) | 24,408  | 12,342  | 12,066 |
| Opening Cash | 59,205  | 37,407 | 21,798 | 20,902  | 20,902  | 0      |
| Closing Cash | 45,310  | 33,244 | 12,066 | 45,310  | 33,244  | 12,066 |
Commentary on Major Variances:

- YTD cash-flow from Crown Revenue is $14.522m favourable to budget, representing:
  - favourable $7.2m from the on-going ACC arrears initiative; and
  - favourable $9.959m Ministry of Health funding for Disability Support Services (offset in payments to suppliers).

- YTD payments to suppliers were $33.432m higher than budget, reflecting:
  - October payment of $11.8m for 2016/17 IDF wash-up; and
  - Unfavourable outsourced personnel, unfavourable clinical supplies together with the increased Funder Provider Payments.

- Employee Payments were $6.422m favourable to budget representing timing of the payment of payroll accruals.

- Fixed Assets $30.795m favourable to budget representing the timing of capital spend for major capital projects.

- Investments were $4.474m favourable to budget representing the NZHPL spend for NOS, not incurred in accordance with budget.

- Other Non-Current Liability $16.609m 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 of $7.846m received in April 2018 as forecast, balance now expected in the 2018/19 financial year.

Treasury Report – 31 May 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>$45,262</td>
<td>2.55%</td>
</tr>
<tr>
<td>Hypothecated Capital</td>
<td>$39,522</td>
<td>2.55%</td>
</tr>
<tr>
<td>Overdraft</td>
<td>$0</td>
<td>3.05%</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.
Information Paper

Counties Manukau District Health Board

Turn Around Plan: Stage One Close Out Report (December 2017-July 2018)

Recommendation

It is recommended that the Board:

Note this report was endorsed at the 25 July Audit Risk and Finance Committee meeting to go forward to the Board.

Receive the Turn Around Plan Stage One Close Out Report, December 2017 – June 2018 for information.

Prepared and submitted by: Dr. Kathryn de Luc, General Manager, Specialised Care Funding and Development (currently seconded to the role of Turn Around Programme Lead), endorsed by Gloria Johnson, Acting Chief Executive Officer

Glossary

TAP – Turn Around Plan
TAP 2 – Turn Around Plan July 2018 onwards
TAP SG – Turn Around Plan Steering group
IDF’s – Inter District Flows
CRG – Clinical Reference Group
ELT – Executive Leadership Team
SPMO – Strategic Project Management Office
FSA – First Specialist Assessment
FU – Follow-up Outpatient Appointment
ZBB – Zero Based Budgeting
PBFF – Population Based Funding Formula
NRLTP – Northern Region Long-term Plan
ALT – Alliance Leadership Team
HT20/20 – Healthy Together 2020

Executive Summary

Stage One of the Turn Around Plan (defined as December 2017 – June 2018) is now complete and, at its conclusion, has identified projects which could deliver between $61M (low estimate) and $70M (high estimate) of financial savings over three Financial Years 2018/19 – 2020/21. For FY 2018/19 the project to date has identified circa $18M.

Given that the TAP work has not identified sufficient opportunities to fully bridge the deficit, the Turn Around Plan now needs to be transitioned into Stage Two - a full (and longer term) Programme of activity post July 2018 to achieve its objective and focus on implementing the programme of work identified in Stage One. The working title for this next stage is TAP 2.

Recommendations for Programme Delivery are identified in order to minimise the risks associated with this large and complex programme of work. In particular there needs to be a measurement and monitoring plan which allows it to remain agile so that it can react as unexpected challenges are thrown into the mix along with unexpected opportunities. This savings plan is not ‘set in stone’ and will need to adapt.
The TAP project required us as an organisation, working with our stakeholders, to be really challenging of ourselves, ask searching questions and critique how we do things, so that we can get the best value from the resources we are using in providing services for our communities. This report summarises that critique and is part of an ongoing process to identify the things we need to do to improve the value of what we offer.

**Purpose**

This paper is reporting the progress achieved in the TAP Stage One (December 2017–July 2018) project. It builds on the information provided at the Board Finance Workshop held on 27th June 2018.

Detailed discussions are continuing regarding the transition arrangements to TAP 2.

**Background and Context to the Turn Around Project**

The Healthy Together 2020 (HT2020) Strategy, which CM Health has been implementing since 2015, built upon CM Health’s ongoing ambition to develop integrated care based on a whole-of-system approach achieved through collaborative working across the entire health system and with intersectoral partners. Its goal was to achieve healthy equity in key health indicators for Māori, Pacific and communities with health disparities by 2020.

While CM Health remains committed to achieving HT2020 objectives, it faces significant near to mid-term demand and financial challenges that require it to adapt its tactics and priorities.

In recent years, funding/revenue growth has been outpaced by population growth and increasing demand. The gap between revenue and the true cost of meeting extra demand has continued to grow.

The TAP project was established to identify a suite of financial ‘savings opportunities’ that focused on quality as well as efficiency, and that when implemented would enable CM Health to achieve a sustainable break-even budgetary position within three years.

Stage One of the Turn Around Plan (defined as December 2017 – July 2018) is now complete and, at its conclusion, is still some way from fully bridging the deficit within the specified timeframe. The Turn Around Plan now needs to be transitioned into Stage Two - a full (and longer term) Programme of activity to scope further initiatives to enable it to achieve its objective and to implement the work-plan identified in this first stage of TAP. This requires strategic prioritisation decisions to ensure alignment and minimisation of delivery risks.

**The Turn Around Plan Approach and Methodology**

The TAP team’s approach/methodology for identifying saving opportunities was endorsed by the Board in February 2018. It emphasised the need to develop a plan with sufficient rigour and transparency to meet the expectations of the NZ Public Health and Disability Act 2000 and standards of good practice in the management of public sector organisations.

In particular emphasis was placed on the following elements:

- Ensuring there was a strong clinical voice in the decision-making;
- Te Tiriti o Waitangi considerations were built into the decision-making processes at multiple levels;
- There was a strong equity focus;
- The approach used would be based on evidence and learnings from local, regional, national and international colleagues and literature.
The TAP Steering Group (subset of ELT) requested a strong emphasis be placed on engagement with staff and key stakeholders so that ownership of savings opportunities came from within the Health system – principally from the staff. This approach was premised on the belief that top-down management-led financial targets were not effective and ‘low hanging fruit’ efficiency gains had all but been exhausted. Our remaining option was to see if frontline staff, who understand the detail of the day-to-day operations, would be better able to generate fresh ideas. The aim of TAP was to ‘shake the tree’ really hard and check were we missing anything that could deliver financial savings quickly.

As part of CM Health’s goal of enhancing collaborative working across the northern region DHBs, TAP opportunities have been shared and discussed with the other regional DHBs through Regional forums. Ideas from the other DHBs have also been incorporated into the TAP opportunity list.

**Identified TAP Opportunities and Roadmap**

Using robust processes and tools the TAP project has provided both high and low estimates for the total opportunities identified. The high savings estimates are summarised as follows:

<table>
<thead>
<tr>
<th></th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$6,467</td>
<td>$6,167</td>
<td>$6,167</td>
</tr>
<tr>
<td>Cost Reduction</td>
<td>$11,323</td>
<td>$15,575</td>
<td>$16,080</td>
</tr>
<tr>
<td>Cost Avoided</td>
<td>$1,629</td>
<td>$3,385</td>
<td>$3,385</td>
</tr>
<tr>
<td><strong>Total TAP Benefits Identified</strong></td>
<td><strong>$19,418</strong>*</td>
<td><strong>$25,126</strong></td>
<td><strong>$25,631</strong></td>
</tr>
<tr>
<td>Opportunities yet to be Developed</td>
<td>$0.69</td>
<td>$4.78</td>
<td>$4.78</td>
</tr>
</tbody>
</table>

* This includes $1.4m Ward 21 Flex down adjustment

Through stakeholder engagement, nine ‘Priority Areas’ for savings opportunities were identified. To address issues of potential duplication and ensure alignment of implementation efforts, many individual opportunities were aggregated into these nine areas. These are outlined below, with their corresponding estimates of three year benefits.
### Table Two: High-Low of 3 Year Benefits Broken Down by Benefit Type ($000s)

<table>
<thead>
<tr>
<th>Benefit Priority Area</th>
<th>Cost Reduction</th>
<th>Revenue</th>
<th>Cost Avoidance / Capacity Release</th>
<th>Sum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Three Year Total (Low)</td>
<td>Three Year Total (High)</td>
<td>Three Year Total (Low)</td>
<td>Three Year Total (High)</td>
</tr>
<tr>
<td>Priority Area 1: Tackling Variation</td>
<td>$5,348</td>
<td>$5,465</td>
<td>$612</td>
<td>$750</td>
</tr>
<tr>
<td>Priority Area 2: Improving management of complex conditions</td>
<td>$2,623</td>
<td>$2,623</td>
<td>$2,022</td>
<td>$2,022</td>
</tr>
<tr>
<td>Priority Area 3: End of Life Care</td>
<td>$858</td>
<td>$858</td>
<td>$858</td>
<td>$858</td>
</tr>
<tr>
<td>Priority Area 4: Improving patient flow</td>
<td>$5,071</td>
<td>$5,071</td>
<td>$672</td>
<td>$672</td>
</tr>
<tr>
<td>Priority Area 5: Non-hospital alternatives to ED</td>
<td>$1,140</td>
<td>$1,140</td>
<td>$14,295</td>
<td>$17,750</td>
</tr>
<tr>
<td>Priority Area 6: Improving match between cost and revenue (including top loss procedures)</td>
<td>$360</td>
<td>$420</td>
<td>$4,144</td>
<td>$4,144</td>
</tr>
<tr>
<td>Priority Area 7: Outpatient remodeling</td>
<td>$17,472</td>
<td>$18,704</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td>Priority Area 8: Whole of Organisation/Corporate</td>
<td>$5,000</td>
<td>$7,500</td>
<td>$5,000</td>
<td>$7,500</td>
</tr>
<tr>
<td>Healthy Together Technology</td>
<td>$-897</td>
<td>$1,197</td>
<td>$897</td>
<td>$1,197</td>
</tr>
<tr>
<td>Additional TAP Initiatives outside of priority areas</td>
<td>$-1,400</td>
<td>$-1,400</td>
<td>$-1,400</td>
<td>$-1,400</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>$38,768</td>
<td>$42,977</td>
<td>$15,207</td>
<td>$18,800</td>
</tr>
</tbody>
</table>

### Ward 21 Flex Down Adjustment

- $1,400 - $1,400 - $1,400 - $1,400

### Adjusted Grand Total (including adjustment for ward 21)

- $37,368 - $41,577 - $15,207 - $18,800 - $7,664 - $8,399 - $60,239 - $68,776

A simple high, medium, low confidence assessment has been completed on all the individual projects in terms of the likelihood of delivering the full financial benefits identified. The following table summarises this assessment.

### Table Three: Confidence Levels on achieving the financial benefit

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th>Financial Value – total 3 years benefit (high)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>$10.7M</td>
</tr>
<tr>
<td>Medium</td>
<td>$23.8M</td>
</tr>
<tr>
<td>Low</td>
<td>$35.5M</td>
</tr>
</tbody>
</table>

It should be noted that this assessment has been completed on the basis of obtaining the full financial benefits for each project. It is often the case that partial financial benefit within individual projects is achieved. It is also considered unlikely that all of the ‘Low Confidence’ projects would fail to deliver any financial benefit.
Analysis, Roadmap Development and Delivery Risks

Delivery Risk 1: Volume of Change

CM Health is attempting an enormous volume of change. Attempting so much change concurrently presents the organisation with a number of risks, including:

1) *Failure to prioritise projects* resulting in high-value initiatives being lost in ‘delivery noise’.
2) *Failure to manage projects* because limited resources are spread too thinly over too many projects, across multiple levels and staff groups in the organisation. Management focus is also diluted, covering the projects at the same time as covering operational BAU (particularly 2nd and 3rd tier managers and clinical leaders).
3) *Failure to embed changed processes* because there is limited capacity within the organisation to receive and embed this amount of change in processes and systems all at once.

Some Non-TAP projects are being progressed for mandatory or essential reasons: these include projects like Bowel Screening and the Scott Building Recladding. Work is currently taking place within the organisation to review non-TAP projects which are not ‘must do’s as a matter of urgency to ensure the benefits identified outweigh the opportunity costs, before a decision is made to continue with them.

It is estimated that circa 65 FTE are required to deliver TAP initiatives (45 project delivery / coordination and 20 clinical / business). Note this would be on top of the requirements for the non-TAP initiatives, depending on how many of those are continued.

The TAP Steering Group have been clear that project resource must come from existing staff time within the organisation. Irrespective of the final numbers, trade-off decisions will need to be made. The balancing required is whether it is better to pursue a project which requires X amount of staff time, when the opportunity cost may translate into increased difficulty to meet our increasing clinical and business demands.

The Ko Awatea team will be supporting the organisation and business owners to deliver the Turnaround activity in many of the priority areas. The skill mix and roles within Ko Awatea are being re-profiled to ensure there is appropriate capacity and capability to meet the TAP plan’s resource needs. There are currently a number of vacancies in the improvement and change team in Ko Awatea and these will be used to support project, programme and coordinator resource requirements.

Delivery Risk 2: Project Delivery Performance

An analysis of historical project delivery for CM Health showed that over the past three years (FY 15/16, 16/17, 17/18) CM Health has over performed in the delivery of financial benefits relating to operational changes to budgets, where a percentage or dollar savings target was required to be met. However, the organisation has under-performed in achieving planned benefits from projects (all change initiatives including small improvement initiatives over the three years ranging from delivering between 38%-56% of expected financial planned benefit). This is not an uncommon situation for large, complex organisations like Counties District Health Board.

Using this data, coupled with resource costs, the team performed sensitivity analysis to test the impact on TAP benefits at various performance thresholds (e.g. what would the return look like if benefits were only delivered at 10%, 30% and 60%, figures in line with CM Health historic performance) for all of the TAP Priority areas and projects.

This analysis highlights the risks to benefit delivery based on historical change implementation performance. It shows that Priority Area Two - Improving outcomes for patients with chronic conditions...
and Priority Area Three - End of Life Care, both very important for improving population outcomes, equity and patient experience, require the highest net benefit return.

**Delivery Risk 3: Extracting the Benefits**

The most difficult element of a programme of work like this is to realise the benefit after a project has delivered its outputs. To minimise the risk of this happening TAP has modelled the benefits and translated them into what it would mean for the operation (i.e. the Operational Impacts). This is summarised below. The organisation will need to be very clear about how business operations will change so as to deliver the projected benefits.

**Table Four: Benefits Mapped to Operational Impacts**

<table>
<thead>
<tr>
<th>Group of projects</th>
<th>Outcomes required</th>
<th>Target Benefit (High) FY18/19</th>
<th>Operational Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexing down bed resources</td>
<td>Reduce ALOS Reduce 28 day and 6 month readmissions Reduce acute bed days and ED admissions and unnecessary treatment and diagnostics Capacity release clinical staff</td>
<td>$3.16M (inc. $1.4m additional medical beds = $1.76M (TAP))</td>
<td>Flexing down 36 resourced beds for eight months (over summer), this is in addition to the 29 beds to be flexed down in Medicine</td>
</tr>
<tr>
<td>Flexing down Emergency resources</td>
<td>Reduced ED demand pressures, admissions and readmissions</td>
<td>$0.33M</td>
<td>Avoiding budgeted ED cost growth</td>
</tr>
<tr>
<td>Outpatient resource cost management</td>
<td>Reduction in FSA and Follow-up volumes, more efficient pathways and models of care</td>
<td>$0.50M</td>
<td>Avoiding annual cost growth in clinical FSA and follow up services</td>
</tr>
<tr>
<td>Cost reduction/Revenue Gains</td>
<td>Improved payroll and leave management processes More accurate coding Validation and improvement of revenue flows for IDFs Cost reduction for clinical consumables &amp; medical services Cost reduction &amp; improved efficiency in usage of gas and electricity</td>
<td>$9.84M</td>
<td>Implementation of 32 initiatives to deliver targeted budgetary cost reductions and revenue improvements</td>
</tr>
<tr>
<td>Ministry of Health funding reviews</td>
<td>Four separately funded contracts services by the MoH</td>
<td>$5.34M</td>
<td></td>
</tr>
<tr>
<td>Contract Divestment</td>
<td></td>
<td>$0.26M</td>
<td>Withdrawing/divesting in contracts across service areas</td>
</tr>
</tbody>
</table>

**Te Tiriti o Waitangi commitments, population health and equity**

The CM Health commitments to Te Tiriti o Waitangi and improving health equity challenge us to ensure core services and programmes are delivering on Maaori health gain and development and addressing inequities. During the TAP process Mana Whenua identified that non-Maaori services that Maaori whaanau choose to access are one of their priorities. As part of TAP 2, we need to focus our core services and programmes on meeting these Te Tiriti o Waitangi and health equity commitments. It is recommended that the Evaluation Framework and impact and risk assessment processes established for TAP 1 continue to be used to support this.
Of the identified priority areas for TAP 2, most are not yet specific enough to enable detailed assessment of the equity impacts. Work will need to be done to understand what is driving the current disparities and identify how potential changes could reduce disparities at the same time as delivering financial savings. This will need to be done as each project is worked-up in more detail.

Addressing the Remaining Gap

Despite the work across the organisation as part of the TAP project, in Stage One of turn-around activity the organisation and its partners have not identified sufficient savings opportunities to address the structural financial gap. Alternative levers have been assessed by the TAP Team including:

- **Top-slicing budget** CM Health has historically used some ‘top-slicing’ budget reduction approach to make savings. The consensus is that there is relatively little left to reduce, without undertaking service/personnel cuts, when considered from the perspective of an individual service or department basis.

  Experience from other organisations suggests that this approach is tactically strong but strategically blunt: it does work in the short term but then frequently becomes sub-optimal or counter-productive.

- **Benchmarking and Independent Advice /Review**

  CM Health has the opportunity to benchmark itself with other similar organisations in a more focused and intensive way to learn from the experiences of others. As part of this approach we have also involved independent advisors as part of the TAP work and external advisors are currently looking at things like patient flow. Going forward we think there are opportunities to gain independent advice on our systems around payroll and leave management and a general review of options to extract costs from the system without affecting quality etc. The MoH Intensive Monitoring process also provides a further opportunity for us to learn from other DHB’s reviews.

- **Enhancing the Contracting Reporting framework and Commissioning Function**. The TAP project has highlighted that our contracting/reporting framework does not sufficiently identify the value and contribution of individual contracts against strategic goals. Work to enhance the current contracting framework has started (with an equity focus) and is being tested within the funder-arm of the organisation.

  This contracting work will force a review of what is considered ‘core’ whole of system DHB business. Of note the issue of what role CM Health has in funding more ‘social, well-being’ services has come up a number of times when assessing TAP opportunities. It is clear that as an organisation we lack an appropriate decision-making framework which assists us in assessing the contribution of these services and whether it is appropriate to fund them from the CM Health budget, given the population CM Health serves. Whilst this is considered important in relation to the integrity with which CM Health stewards its publicly funded revenue, it is hard to identify with any confidence a significant direct contribution progressing this work will make to bridging the financial gap in the short term.

  The development of an enhanced commissioning function by the funder within CMDHB is also planned for FY18/19. As this function develops it will strengthen transparency and our accountability framework which uses evidence to drive quality and the re-modelling of services. However, as with Contracting, it is unlikely on its own to deliver financial savings.

- **Discretionary Funding**. At the beginning of TAP consideration to reduce CM Health’s discretionary funding was considered and put to the Board. The Board requested a detailed analysis of the impacts with particular regard to equity, and consideration of the implementation challenges if
these financial savings were to be pursued. There remain some areas still to assess which needs to be completed as part of TAP 2.

- **Best Value for Money Approach - Zero-based budgeting (ZBB) or similar approach.** It should be noted that we are using the term ‘Zero Based Budget (ZBB)’ as a catch all term to describe a value-driven mechanism to assess, prioritise and evaluate budgets and budget performance.

  This approach assumes that all budgets must be validated and justified during the financial planning cycle – if we didn’t have this service, how would we describe the value it would bring and what would we pay to ‘buy it back’. This buy back approach flushes out areas where value is not being delivered. CM Health has very little experience with this type of approach which means we would have to ‘buy-in’ capability to apply this approach rigorously. However it does provide a real opportunity to build-in workforce re-design which has been identified as a key part of achieving a sustainable position. According to global management consulting firm McKinsey & Company, a well-implemented zero-based budget can save large corporations 10-25%, sometimes as early as in six months of implementation. Discussions are underway regarding undertaking a proof of concept exercise during FY 18/19.

It is clear that there isn’t any easy answer, or ‘silver bullet’, for the organisation to return to financial sustainability. The conclusion of the TAP Working Group is that we must focus on delivering the financial benefits we have already identified as we move into the implementation phase as well as continuing to explore areas TAP 1 has been unable to review due to lack of time. TAP 2 must have a hard look at what provides ‘value’ and may include re-evaluating ‘austerity options’ which have previously been considered unpalatable or not acceptable to the organisation.

### Programme delivery requirements

The TAP Working Group made a number of observations during the project which it believes require resolution in order to achieve the TAP goal of reaching financial sustainability as the second stage of the TAP process is commenced. These recommendations are summarised below:

**Organisational Strategy**

- The need to reaffirm our HT 2020 Strategy to the wider organisation and stakeholders has been identified, along with clarity that the work for TAP 2 will need to contribute to achieving our equity goals. During the TAP project, the question came up repeatedly from multiple levels within the organisation as to whether our strategy remained HT2020.

**Projects**

- Reduce the number of active projects.
- Develop project delivery skills, particularly in relation to the TAP prioritised Programme and Projects where there are limitations of capacity and skill.
- Grow and systematise our Data Intelligence systems to enable planning and delivery of TAP benefits.
- Simplify Project Governance and improve Project Management & controls.

**Clinical Governance**

- Clinical Governance should be strengthened and centralised to improve decision-making.
- Focus the use of clinicians’ non-clinical time on project delivery aligned to organisational priorities.

**Benefits Realisation**

- Improve Benefits identification and Benefits data, applying consistency where required.

• Be clear about how Benefits will be operationally realised and establish stronger continuous monitoring.

Te Tiriti o Waitangi and Equity
• Continue with the TAP processes and systems that ensure Te Tiriti o Waitangi and equity considerations occur at every level in the TAP work including continuing with the Evaluation Framework and impact and risk assessment process.

Contractual Framework
• Improve the Contract Management framework applied by CM Health and include KPIs which clearly describe ‘value’.

Discretionary Spend
• Define what we consider ‘core’, whole of system DHB business to be and what is discretionary including being clear about the place of social, well-being type contracts.
Decision Paper
 Counties Manukau District Health Board
 CMDHB/University of Auckland Academic Health Alliance

Recommendation

It is recommended that the Board:

Receive the CMDHB/University of Auckland Academic Health Alliance paper.

Agree to enter into an Academic Health Alliance with the University of Auckland.

Note that if the Board endorses the Alliance, a formal signing of the Alliance with the Dean and Vice Chancellor of the University of Auckland will take place at the CMDHB Board meeting on 31 October.

Prepared and submitted by: Dr Vanessa Thornton, acting Chief Medical Officer on behalf of the University of Auckland.

Summary

CMDHB and the Faculty of Medical and Health Sciences, University of Auckland have enjoyed a close working relationship for many years but there are opportunities for both organisations if the relationship is developed further along the lines of a formal Academic Health Alliance. Such an alliance represents a formal, long-term commitment to research and teaching, thus strengthening our workforces and enabling healthcare excellence through improved organisational performance. The alliance could expand to include faculties such as Engineering and Business, and would cover the whole of health system through inclusion of the School of Population Health.

Background

CMDHB and University of Auckland already collaborate to teach undergraduate students and have a number of joint research projects involving a range of staff with formal and informal academic/clinical appointments.

The key components of a formalised academic health alliance include clinical academic partnerships realised through integrated governance of academic activities with internationally recognised excellence in research and clinical practice, integrated research funding, joint research programmes and shared commercial expertise to enable translation of research findings into clinical practice. Internationally entities share these features although the terminology and governance arrangements vary. In essence all integrate research with patient care and teaching/education, and all aspire to excellence. These benefits extend beyond the hospital setting into the full continuum of healthcare delivery.

The Local Context

Both CMDHB and the University of Auckland (UoA) are legal entities and there is as yet no national health research strategy nor is there any prescribed framework to allow shared governance of health sciences research, teaching and patient care. There is however a great willingness on the part of each organisations’
professional and executive leadership, and the academic clinicians, to strengthen the relationship in order to benefit not only the respective organisations, but to improve patient care through translation of research findings and improved education and teaching.

CMDHB is committed to the Northern Region Health Plan with key work streams on patient safety, long term conditions and informed patient choices. Innovative and novel approaches are required to successfully deliver this plan, and capturing the benefits will require research across the health services continuum. A strong research ecosystem is integral to this. Between CMDHB and the UoA we have expertise in population health research, clinical and biomedical sciences research, management and leadership research all of which is supported by research governance and administration infrastructure.

Realising the Vision Towards Health Excellence

The brand ‘excellence’ cannot be self applied – it must be earned and so the path to health excellence means recognition through superior population health status, reduced health status disparities, improved access to services and improved organisational performance both financially and in terms of productivity. In strengthening the relationship with the UoA, initially through the Faculty of Medical and Health Sciences, both organisations can work towards increasing research outputs, strengthening research quality and complementing this with similar activities in respect of teaching and training.

Starting With Small Steps

In line with the notion that ‘excellence’ needs to be earned, this is not the place for large branding announcements but rather a careful laying of foundations and the consolidation of what we already have now. There are many large and small service groups in the DHB that could rightly claim excellence in research and or clinical service delivery but developing a model that is enduring will take time and piloting the concept with a smaller number seems sensible from both parties perspective.

Alliance Rather than Centre

Neither organisation has the mandate to change its status, nor is it prudent to consider a ‘centre’ appropriate when the DHB is responsible for a health system. Health science excellence, and the translation of such into clinical practice, does not require bricks and mortar but it does require strong relationships, hence the notion of an alliance as a framework to move forward. The pillars of such an alliance will be those that form the foundation of the English AHSCs (Academic Health Science Centres), namely research, education and training, and patient care. In the Auckland context it is suggested that the term Academic Health Alliance be used as the inclusion of ‘science’ implies that the translation of research findings is restricted to science when in effect management, engineering and legal research may well be of considerable value in this setting.

An Example of How This Might Work

An academic health alliance might require shared governance of research activity including review and approvals, grant applications and activities, dissemination, promotion and translation of research findings. Such research activities would include new drug development, clinical trials, population health surveys and health system improvements. In concert with this, shared approaches to teaching and training of under and post graduate students from relevant schools within the faculty, and shared interest in, and commitment to improve clinical and population health outcomes. That would mean that teaching might occur in the hospital or the university, and by hospital or university staff with a shared commitment to delivering a pre-agreed
curriculum. In time the CMDHB/FMHS Academic Health Alliance may become recognised as a university/health system partnership of excellence in training, research and patient care.

Much detail will need to be worked through including a clear understanding of the governance arrangements and limits, current and possible financial planning and monitoring, identification of measures of quality, productivity and success, stock-take of current and future facilities, infrastructure and workforce. Key stakeholders will need to be identified and consulted and key liaisons with primary care established through existing or new networks. A multi and inter-disciplinary approach across the health system and across the university campus is essential. The existing Joint Relations Executive would enable governance of the Alliance with a named “Relationship Manager” from each organisation mandated to direct and deliver an annual workplan in partnership with a core advisory group with membership from both institutions

Benefits

A flourishing culture of enquiry and research will lead to innovation, which in turn will potentially translate into clinical improvements and health system efficiency. Improved teaching and academic rigor will enhance student and staff satisfaction and potentially create magnet facilities. Both will potentially result in improved patient outcomes and population health status. Recognition of such benefits will ensure the notion of excellence. Complementing this, research and enquiry as an organizational principle in the broadest sense – in management, leadership, operational activity – will enable the aspiration of Healthcare Excellence to be achieved. For the UoA, the capture of research and other academic outputs adds value in terms of reputation and with that enhanced staff recruitment and retention, and subsequently, enrollments.

Next Steps

It is proposed that CMDHB and the Faculty of Medical and Health Sciences identify the relationship manager for each organization and instruct them to begin the work of developing working alliances that enable joint promotion and support of research activities, and shared transmission of results with translation into clinical practice or commercialization as appropriate. Oversight of this will be via the existing JRE and for the DHB, reporting of KPIs via the Executive Leadership Group and onto the Board reports.
Recommendation

It is recommended that Board:

Note this paper was endorsed at the 25 July Audit Risk & Finance Committee meeting to go forward to the Board.

Note that as part of the 30 June 2018 year end reporting requirements we are required to submit our audited monthly financial templates, the Crown Financial Information System (CFIS) template and income reconciliations to the MoH and Audit NZ by 11am Monday 13 August 2018.

Note as part of this reporting requirement we are required to submit a Joint Statement of Representation to our external auditors, Audit NZ, and the Director-General of Health by 11am Monday 13 August 2018, signed by the DHB Chair, acting Chair of the Audit Risk and Finance Committee, CEO and CFO.

Note the audit of our CFIS templates is performed at a materiality level that is a lot higher than the Annual Reporting requirements, and a further Statement of Representation will be required to be signed at the end of the 30 June 2018 audit in October 2018.

Approve the Joint Statement of Representation Letter and delegate to the Chair, the acting Chair of the Audit Risk and Finance Committee, the CEO and CFO, authority to sign the Joint Statement of Representation Letter for CFIS on or before the due date.

Prepared and submitted by: Timneen Taljard, Deputy CFO Corporate and endorsed by Margaret White, CFO

Background

The external audit, performed by Audit NZ, of our 30 June 2018 financial statements is due to commence on 30 July 2018. As part of the 30 June 2018 year end reporting requirements we are required to submit our audited monthly financial templates, the CFIS template and income reconciliations to the MoH and Audit NZ by 11am Monday 13 August 2018. These templates are required for the consolidated financial statements of the Government.

As part of this reporting requirement we are required to submit a Joint Statement of Representation to our external auditors and the Director-General of Health by 11am Monday 13 August 2018, signed by the DHB Chair, the acting Chair of the Audit Risk and Finance Committee, CEO and CFO.

The Joint Statement of Representation letter is given to the named parties in connection with our responsibility to provide audit clearance to the auditors of the Government’s financial statements, as to whether the financial information included in the DHB financial templates and attached schedules provided to the Ministry of Health, fairly reflects the financial position of Counties Manukau District Health Board as at 30 June 2018, and of the results of its operations and cash flows for the year then ended.

The audit of our CFIS templates is performed at a materiality level that is a lot higher than the Annual Reporting requirements, and a further Statement of Representation will be required to be signed at the end of the 30 June 2018 audit in October 2018.
Appendix 1 - Joint Statement of Representation

DATE (that on which CFIS audit clearance is received)

[Name of Appointed Auditor]  Dr Ashley Bloomfield
[Title]  Director-General of Health
[Audit Service Provider]  Ministry of Health
[Address]  PO Box 5013
[Address 2]  WELLINGTON

Dear [Name] and Ashley

Letter of Representation for the year ended 30 June 2018 – template provided to the Ministry of Health for the Government’s Financial Statements

This representation letter is given to you in connection with your responsibility to provide audit clearance to the auditors of the Government’s financial statements as to whether the financial information included in the DHB financial templates and attached schedules (the schedules) provided to the Ministry of Health fairly reflects the financial position of Counties Manukau District Health Board as at 30 June 2018 and of the results of its operations and cash flows for the year then ended.

The Board and management of Counties Manukau District Health Board confirm, to the best of our knowledge and belief, the following representations:

1  We accept responsibility for the preparation of the financial information included in the schedules provided to the Ministry of Health and the judgements made in the process of producing that template.

2  We accept responsibility for establishing and maintaining, and have established and maintained, a system of internal control procedures that provide reasonable assurance as to the integrity and reliability of the financial information in the schedules. We confirm that the system of internal control has operated adequately throughout the period.

3  We confirm that the following key financial information is fairly and appropriately reflected in the schedules:
   • Opening equity balance agrees to the closing balance of 2017;
   • Income in Advance;
   • Accruals for primary referred expenditure (particularly community pharmaceuticals);
   • Pharmac rebate accrual;
   • Accrual for Inter-district flows;
   • The carrying value of land and buildings does not materially differ from fair value; and
   • Revenue and expenses with other Crown owned entities (eg, Air New Zealand, New Zealand Post, energy companies).

In addition we verify that:

a. Consolidated Net Result for the financial year ending 30 June 2018 is .................

b. Consolidated total Crown Equity as at 30 June 2018 is .....................

c. The schedules contain information that accurately reflects our financial activities and cashflows during the period 1 July 2017 to 30 June 2018. Where the date of the information supplied........
differs from 30 June 2018, there were no significant movements in our net equity position up to 30 June 2018 that would affect the financial statements of the Government.

d. The amounts recorded in the schedules are complete.

e. We are satisfied that all guarantees, indemnities, securities and other contingent liabilities or assets that remain outstanding at 30 June 2018 have been included in the Contingencies Template.

f. We are satisfied that all contractual commitments have been disclosed accurately in the schedule on the Statement of Commitments.

g. The schedules have been prepared in accordance with the accounting policies of the Crown and Generally Accepted Accounting Practice (Public Benefit Entity Accounting Standards), as applicable for the year ending 30 June 2018, except for:

[INSERT DETAILS]

h. Transactions and balances with entities within the Crown reporting entity greater than $10 million have been confirmed with the other entity.

i. We confirm we used Treasury’s central table of risk-free discount rates and CPI assumptions for valuations to comply with PBE IFRS 4 Insurance Contracts and PBE IPSAS 39 Employee Benefits.

j. There have been no material events subsequent to 30 June 2018 that should be reported in the financial statements, except for:

[INSERT DETAILS]

k. We agree to notify Treasury, the Ministry of Health and the appointed Auditor immediately of any material amendments to the schedules, or subsequent events that should be reported in the financial statements, identified after this Statement of Representation is signed but prior to the finalisation of the financial statements of the Government on 30 September 2018.

l. There are no other matters that you should be aware of in the preparation of the financial statements of the Government for the year ended 30 June 2018.

These representations are made at your request, and to supplement information obtained by you from the records of Counties Manukau District Health Board and to confirm information given to you orally.

Yours sincerely

Margaret White
Chief Financial Officer
[DATE]

[NAME]
Board Member
[DATE]

Dr Gloria Johnson
Acting Chief Executive Officer
[DATE]

Vui MarkGosche
Board Chairman
[DATE]
## Counties Manukau District 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:

Mr Ken Wheelan, Crown Monitor now be allowed to remain for the Public Excluded section of this meeting.

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>Public Excluded Minutes of 27 June 2018 and 17 July 2018/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.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)] Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>Public Excluded Minutes of the Audit Risk &amp; Finance Committee, Community &amp; Public Health Advisory Committee and Hospital Advisory 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)] Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>Trendcare Business Case</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)] Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.</td>
</tr>
<tr>
<td>Supporting Patients with Long Term Conditions</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)] Negotiations The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.</td>
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Counties Manukau District Health Board  
8 August 2018  
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<tr>
<th>Title</th>
<th>Reason for Withholding Information</th>
<th>Relevant Information Act Section</th>
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<td>Totara &amp; Franklin Hospice Contracting</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>Specialised Rehabilitation Centre Concept Design Request</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>National Breast Screening Services Contract Variation</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>National Bowel Screening Programme Services</td>
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<td>OneLink Contract</td>
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**Negotiations**
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**Commercial Activities**
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**Official Information Act 1982 S9(2)(j)**

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<th>Neonatal Unit Concerns</th>
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<td>Protect Information subject to an Obligation of Confidence</td>
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<td>The disclosure of information would likely prejudice the supply of similar information in the future. [Official Information Act 1982 S9(2)(ba)(i)]</td>
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<td>Update on MFAT Agreement for Specialist Health Services</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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