## MEETING OF THE BOARD
### 12 December 2018

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

<table>
<thead>
<tr>
<th>CMDHB BOARD MEMBERS</th>
<th>CMDHB MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Gosche – Chairman</td>
<td>Margie Apa – Chief Executive Officer</td>
</tr>
<tr>
<td>Dr Lyn Murphy</td>
<td>Margaret White – Chief Financial Officer</td>
</tr>
<tr>
<td>Apulu Reece Autagavaia</td>
<td>Dr Gloria Johnson – Chief Medical Officer</td>
</tr>
<tr>
<td>Dr Ashraf Choudhary</td>
<td>Jenny Parr – Chief Nurse &amp; Director of Patient &amp; Whaanau Experience</td>
</tr>
<tr>
<td>Catherine Abel-Pattinson</td>
<td></td>
</tr>
<tr>
<td>Colleen Brown</td>
<td>Dinah Nicholas – Board Secretary</td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td></td>
</tr>
<tr>
<td>George Ngatai</td>
<td></td>
</tr>
<tr>
<td>Katrina Bungard</td>
<td></td>
</tr>
<tr>
<td>Pat Snedden</td>
<td></td>
</tr>
<tr>
<td>Kylie Clegg</td>
<td></td>
</tr>
</tbody>
</table>

### PART 1 – Items to be considered in public meeting

**AGENDA**

<table>
<thead>
<tr>
<th>BOARD ONLY SESSION (8.00 – 9.00am)</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. GOVERNANCE</strong></td>
<td></td>
</tr>
<tr>
<td>9.10 – 9.15am</td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Apologies</td>
</tr>
<tr>
<td>1.2</td>
<td>Disclosures of Interest</td>
</tr>
<tr>
<td>1.3</td>
<td>Specific Interests</td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Confirmation of Minutes of the Meeting of the Board – 31 October 2018</td>
</tr>
<tr>
<td>2.2</td>
<td>Action Items Register</td>
</tr>
<tr>
<td>2.3</td>
<td>Minutes Community &amp; Public Health Advisory Committee – 26 September &amp; 7 November 2018 (Colleen Brown)</td>
</tr>
<tr>
<td>2.4</td>
<td>Minutes Hospital Advisory Committee – 29 August &amp; 7 November 2018 (Lyn Murphy)</td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Auckland Primary Care Leaders Group</td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>Chief Executive Officer’s Report (including Patient Story) (Margie Apa)</td>
</tr>
<tr>
<td>4.2</td>
<td>Corporate Affairs and Communications Report (Donna Baker)</td>
</tr>
<tr>
<td>4.3</td>
<td>Health and Safety Performance Report (Elizabeth Jeffs)</td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>NRLTIP Portfolio of Work (Les Greef, healthAlliance)</td>
</tr>
<tr>
<td>5.2</td>
<td>RISSP (Les Greef, healthAlliance)</td>
</tr>
<tr>
<td>5.3</td>
<td>MRI Finance Overspend (Ian Dodson)</td>
</tr>
<tr>
<td>5.4</td>
<td>HR Workforce Report /SAPS Report (Elizabeth Jeffs)</td>
</tr>
<tr>
<td>5.5</td>
<td>Finance and Corporate Business Report (Margaret White)</td>
</tr>
<tr>
<td>5.6</td>
<td>Establishment of Executive Committee of the Board (Mark Gosche)</td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>RESOLUTION TO EXCLUDE THE PUBLIC</td>
</tr>
</tbody>
</table>

**Morning Tea Break (10.00– 10.20am)**

**EXECUTIVE REPORTS**

| 10.20 – 10.35am | 4.1 Chief Executive Officer’s Report (including Patient Story) (Margie Apa) |
| 10.35 – 10.45am | 4.2 Corporate Affairs and Communications Report (Donna Baker) |
| 10.45 – 11.00am | 4.3 Health and Safety Performance Report (Elizabeth Jeffs) |

**DECISION ITEMS/PERFORMANCE REPORTS**

| 11.00 – 11.10am | 5.1 NRLTIP Portfolio of Work (Les Greef, healthAlliance) |
| 11.10 – 11.20am | 5.2 RISSP (Les Greef, healthAlliance) |
| 11.20 – 11.30am | 5.3 MRI Finance Overspend (Ian Dodson) |
| 11.30 – 11.45am | 5.4 HR Workforce Report /SAPS Report (Elizabeth Jeffs) |
| 11.45 – 11.55am | 5.5 Finance and Corporate Business Report (Margaret White) |
| 11.55 – 12.00pm | 5.6 Establishment of Executive Committee of the Board (Mark Gosche) |

**RESOLUTION TO EXCLUDE THE PUBLIC**

164-166
# Board Member Attendance Schedule 2018

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>28 Feb</th>
<th>Mar</th>
<th>4 Apr</th>
<th>16 May</th>
<th>27 Jun</th>
<th>July</th>
<th>8 Aug</th>
<th>19 Sep</th>
<th>31 Oct</th>
<th>Nov</th>
<th>12 Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Gosche (Chair)**</td>
<td></td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colleen Brown</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Lyn Murphy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reece Autagavaia</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Ngatai</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catherine Abel-Pattinson</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katrina Bungard</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Ashraf Choudhary</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kylie Clegg***</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pat Snedden***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabin Rabindran*</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Darrow*</td>
<td></td>
<td>X</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appointed effective 14.8.2018
***Appointed effective 3.5.2018
*No longer on the Board effective 2.5.2018

**Appointed effective 3.5.2018
***Appointed effective 14.8.2018
*No longer on the Board effective 2.5.2018
## BOARD MEMBERS’ DISCLOSURE OF INTERESTS
### 12 December 2018

**New items in red italics**

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| **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, Director, various single purpose property owning companies  
• Co-Chair, National Party Health Policy Committee |
| **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  
• Director and Shareholder, Travers Brown Trustee Limited |
<table>
<thead>
<tr>
<th>Name</th>
<th>Positions and Roles</th>
</tr>
</thead>
</table>
| Dianne Glenn     | • Member, NZ Institute of Directors  
                     • Life Member, Business and Professional Women Franklin  
                     • Member, UN Women Aotearoa/NZ  
                     • President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
                     • Life Member, Ambury Park Centre for Riding Therapy Inc.  
                     • Member, National Council of Women of New Zealand  
                     • Justice of the Peace  
                     • Member, Pacific Women’s Watch (NZ)  
                     • Member, Auckland Disabled Women’s Group  
                     • 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  
                     • Director & Shareholder, BDO Marketing & Business Solutions Limited (TBC)  
                     • Director & Shareholder, Ngatai Bhana Limited  
                     • Director & Shareholder, Family Care Limited |
| 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 |
| Kylie Clegg      | • Deputy Chair, Waitemata District Health Board  
                     • Trustee (ex officio) - Well Foundation (charity supporting Waitemata District Health Board)  
                     • Director, Auckland Transport  
                     • Director, Sport New Zealand  
                     • Director, High Performance Sport New Zealand Limited  
                     • Trustee & Beneficiary, Mckyla Trust  
                     • Trustee & Beneficiary, M&K Investments Limited (includes a share of less than 1% in Orion Health Group). Orion Health Group has commercial contracts with healthAlliance and may have commercial contracts with Counties Manukau District Health Board. |
Dr Lyn Murphy
• Director and Shareholder, Bizness Synergy Training Ltd
• Director and Shareholder, 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

Pat Snedden
• Chair, Auckland District Health Board
• Chair, The Big Idea Charitable Trust
• Director, Te Urungi o Ngati Kuri Ltd
• Chair, National Science Challenge – E Tipu E Rea
• Chair, Manaiakalani Education Trust
• Director, Ports of Auckland (and subsidiaries)
• Trustee, Emerge Aotearoa Trust (and subsidiaries)
• Director & Shareholder, Snedden Publishing & Management Consultants Ltd
• Director & Shareholder, Ayers Contracting Services Ltd
• Director & Shareholder, Data Publishing Ltd
• Director, Ngati Kuri tourism Ltd*
• Director, Te Paki Ltd*
• Director, Waimarama Orchards Ltd*
• Director, Wharekapua Ltd*
* subsidiaries of Te Urungi o Ngati Kuri Limited

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)
• Crown Monitor, Waikato District Health Board
# BOARD MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

## Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 31 October 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>Pat Snedden</td>
<td>Ophthalmology Regional Strategy</td>
<td>This is a regional strategy and he is the Chair of ADHB.</td>
<td>19 September 2018</td>
<td>That Pat Snedden’s specific interest be noted and that he may remain in the room but will be excluded from the discussion and any voting, if applicable.</td>
</tr>
<tr>
<td>Mark Gosche</td>
<td>Funder Contract Price Increase Recommendations for 2018/19 Social Investment Board Quarterly Report</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></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 he 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>
</tr>
</tbody>
</table>
Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 31 October 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
Catherine Abel-Pattinson
Colleen Brown
Dianne Glenn
Katrina Bungard
Kylie Clegg
Lyn Murphy
Pat Snedden

ALSO PRESENT
Margie Apa (Chief Executive)
Gloria Johnson (Chief Medical Officer)
Margaret White (Chief Financial Officer)
Jenny Parr (Chief Nurse and Director Patient & Whaanau Experience)
Dinah Nicholas (Board Secretary)
Ken Whelan (Crown Monitor)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
There were no media present at this meeting.

APOLOGIES
Apologies were received and accepted from Apulu Reece Autagavaia and George Ngatai.

WELCOME
Mr Snedden opened the meeting with some reflections noting how inspired and refreshed he was by the commitment of people to do the right things in the circumstances.

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

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

AGENDA ORDER AND TIMING
Items were taken in the same order as listed on the Agenda.
2. BOARD MINUTES

2.1 Minutes of the Meeting of the Board 19 September 2018

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

That the Minutes of the Board Meeting held on the 19 September 2018 be approved.

Carried

2.2 Action Item Register

Noted.

2.3 Draft Minutes Community & Public Health Advisory Committee – 15 August 2018

The minutes were taken as read.

*South Seas Whaanau Ora approach* - there is a meeting with Pacifica providers on 6 November. The Board Chair noted that he has excluded himself from this activity, both from the CMDHB Board side and the other side, and has delegated to Colleen Brown & George Ngatai to work on his behalf.

*Hospital in the Home* – this is operational but in the very early stages. They have started taking referrals as part of a prototype so very small numbers. The executive team are expecting to receive a business case that builds off the learning of the prototype by the end of November which will provide a view on what a wider and larger investment might look like. An update will be provided to the 12 December Board meeting.

*POAC* - has been very useful but it is less clear if it has been useful in the admission avoidance spectrum. Mr Snedden noted that as an operational principle the Board receive some evaluative work on investments which are attempting to reduce admissions through the front door - not a polished version, a frank and straight forward version.

*Healthy Weight Action Plan* – the feasibility of scoping for a pilot to assess growth (height and weight) at the year 8 dental check has not occurred due to insufficient staffing resource. The priority is preventative restorative dental treatment.

3 PRESENTATION

3.1 Scott Recladding (Chester Buller and Craig Treloar, Hawkins)

The Board was taken through a presentation outlining the methodology of the Scott Recladding.

As the main contractor for the Scott Building Refurbishment project; Hawkins will be replacing the existing cladding with a new high pressure laminate system known as Fundermax, inclusive of any timber repairs as identified during construction.

Daily contact sessions will be held assess work areas and work activities prior to work commencing to determine and assess the noise impact on the ward/s. Daily sound readings will be recorded during construction activities and sound impact will be monitored and reviewed.

Hawkins will do continuous air monitoring based on construction activities.
Hawkins understand the requirements of an operating hospital and the expectations set by the DHB around patients, public and staff welfare. All work will be well planned, communicated and executed by an experienced team.

Any health and safety risks will be reviewed through the Major Capital Works Oversight Sub-Committee.

The expected timeframe to completion, if Council signs off within the next month, would be August 2021.

4 EXECUTIVE REPORTS
4.1 Chief Executive’s Report (Margie Apa)

The report was taken as read and the Board heard a patient story from Lelani Jackson.

Young Nurse of the Year - the Board asked that a letter of congratulations be sent to Annie Stevenson as joint winner of the New Zealand Nurses Organisation Award.

Site Activity - there is quite a lot of activity planned on the Middlemore site between now and Christmas with the opening of the new Tiaho Mai unit on 22 November, the Scott recladding is imminent, and the new MRI suite is opening on the 11 November.

Census Concerns – Board members have previously expressed concern in relation to the last census that it will not provide us with good information about our population. Our concerns have been raised with the national DHB CEOs who have sent a letter to the Minister of Health inviting him to lead a piece of work, assisted by the national DHB sector, looking at the wider range of administrative data sets that might give the MoH more insights that better reflect where the population is and utilisation. Stats NZ has expressed some interest in resolving some of the discrepancies between the administrative data and the official population estimates in the future however, this is not their immediate work plan. We will progress this work with the MoH supported by national DHB CEOs.

Resolution (Moved: Mark Gosche/Seconded: Colleen Brown)

That the Board:

Receive the Chief Executive’s Report.

Carried

4.2 Health and Safety Performance Report (Elizabeth Jeffs and Maree Weston)

The report was taken as read. Highlights included:

Incident Reporting – high incident reporting in BBFE and aggression and violence with moving and handling being slightly less.

ACC Accreditation Audit – begins Monday 5 November with four auditors on site who will be auditing AMHU, Ward 10 Orthopaedics and the Orderly Service.
Violence in ED: looking at putting in better cameras in ED and still maintain privacy. Mr Snedden noted that ADHB is struggling in this area as well and a regional working group has been set up to look into this particular topic. Ms Jeffs confirmed she has engaged with Queensland Health on this.

Health & Safety Training: it was noted that the health & safety rep training is at 89.5% v target of 100%. Training of the remaining 10% will be undertaken.

SAPS: Ms Abel-Pattinson requested an assurance report on the incidents in SAPS (Surgical & Anaesthetic Perioperative Service) to close off the Director liability.

Flu Vaccinations: Jenny Parr has an action to talk to the College of Midwives about the lack of midwives being vaccinated regionally.

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

That the Board:

Receive the Health and Safety Report.

Carried

4.3 Corporate Affairs and Communications Report (Donna Baker)

The report was taken as read.

Bowel Screening: Pacific launch being held on Saturday 17 November in Mangere Town Centre.

Ministerial visits: 21 November, the Prime Minister and Minister of Health are visiting Middlemore to make some capital announcements and look at the cladding that has been removed on the Scott building, followed by a visit to Ward 2 Scott building to view the hoarding in place, and to talk to patients and staff.

22 November, the Minister of Health is visiting to officially open the new Tiaho Mai building.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: Lyn Murphy)

That the Board:

Receive the Corporate Affairs and Communication Report for the period 31 August – 28 September 2018.

Carried
5 PERFORMANCE REPORTS
5.1 Finance and Corporate Business Report (Margaret White)
The paper was taken as read. Margaret White summarised the following areas:

Continuing to take a 4 quarter approach to the year. Q1 closed slightly favourable to the full year forecast ($53m) deficit.

The Turn Around Plan is behind schedule as many of the projects are phased. As with 17/18, non-front line vacancies will continue to be held throughout the year to offset delay to secure TAP savings. Need to keep the pressure on.

Resolution (Moved: Kylie Clegg/Seconded: Catherine Abel-Pattinson)

That the Board:

Receive the Finance and Corporate Business Report.

Carried

5.2 Turn Around Plan Progress Report (Pauline Hanna/Mary Seddon)
The paper was taken as read. The following areas were highlighted:

Of the $18m committed to save, $15m comes under the Financial Workstream.

*Acute Patient Flow* – by putting an SMO at Triage at the ED front door it has resulted in a 40% drop in the number of patients going through the assessment unit and a 30% improvement in the ‘to be seen’ times. Acute medical rapid clinics have started in the AMU to get people out quicker.

*Non-acute Patient Flow* - this workstream is ramping up with a very clear plan starting in the ORL clinic.

*Ward 21* – has stopped taking patients last Friday, currently has 22 patients and should close by the end of this week.

*Lambie Drive* – meeting with the landlord on Friday to seek agreement to give notice to exit on a month’s notice.

*MoH contracts* – it is unlikely that we will receive the $5m and therefore this will be removed from the plan. The TAP programme is being reviewed and refreshed as at the end of Q1. We are staying with the $18m total at this stage and believe $13m is achievable. It is however, too early to say how we will mitigate the $5m.

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

That the Board:

Receive the Turn Around Plan Report.
5.3 Appointment of Audit Risk & Finance Committee – Ratification of Circular Resolution

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

That the Board:

Formally ratify the approval of the Resolution below, which was approved by the Board by Circular Resolution on the 23 August 2018:

Resolution

That the Board:

Note with the resignation of Mr Rabin Rabindran and Mr Mark Darrow from the Counties Manukau District Health Board, effective 2 May 2018, the Audit Risk & Finance Committee has been without two of its members.

Note the Minister of Health’s announcement dated 14 August 2018, appointing Mr Pat Snedden and Ms Kylie Clegg to the Counties Manukau District Health Board effective immediately.

Appoint Mr Pat Snedden as Chair of the Audit Risk & Finance Committee, effective immediately.

Appoint Ms Kylie Clegg as a member of the Audit Risk & Finance Committee, effective immediately.

Carried

6 CORRESPONDENCE

6.1 Manawhenua Letter – Regional MHAC Process (Mark Gosche)

The letter was taken as read.

A letter has been received from Manawhenua who are concerned that the Governance Treaty partnership with CMDHB is not being honoured with the regionalisation of the Maaori Health Committee.

Resolution (Moved: Mark Gosche/Seconded: Lyn Murphy)

That the Board:

Receive and note the letter from Manawhenua dated 3 October 2018.

Carried
6.2 Ministry of Health Letter - Appointment of CMDHB Deputy Board Chair (Mark Gosche)

The letter was taken as read.

A letter has been received from the Hon Dr David Clark, Minister of Health, appointment Mr Pat Snedden as Deputy Chair of the Counties Manukau District Health Board. This appointment is for a term of office commencing on the date of notification in the NZ Gazette and ending on 4 December 2019.

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

That the Board:

Receive and note the letter from the Ministry of Health dated 18 October 2018.

Carried

7. RESOLUTION TO EXCLUDE THE PUBLIC

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

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 19 September and 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>Public Excluded Minutes of the Audit Risk &amp; Finance Committee and Community &amp; Public Health 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. [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>Category</td>
<td>Description</td>
<td>Reason for Withholding</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Meredith Connell Advice</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(ii)) of the Official Information Act 1982.</td>
<td>Public Interest - The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)(ii)]</td>
</tr>
<tr>
<td>Remuneration &amp; Appointments 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)(ii)) of the Official Information Act 1982.</td>
<td>Commercial Activities - The disclosure of information is not in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td>Microbiology Laboratory – Molecular Testing Contract</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(ii)) of the Official Information Act 1982.</td>
<td>Negotiations - The disclosure of information is not in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S9(2)(j)]</td>
</tr>
<tr>
<td>Dialysis &amp; Cardiac Cath Lab 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)(ii)) of the Official Information Act 1982.</td>
<td>Commercial Activities - The disclosure of information is not in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(j)]</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Exemption Basis</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>AOG Reticulated Gas Contract</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Negotiations</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.</td>
<td>[Official Information Act 1982 S9(2)(j)]</td>
</tr>
<tr>
<td>AMHU Stage II Procurement</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Negotiations</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations.</td>
<td>[Official Information Act 1982 S9(2)(j)]</td>
</tr>
<tr>
<td>Commercial Activities</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
<td>[Official Information Act 1982 S9(2)(i)&amp;(j)]</td>
</tr>
<tr>
<td>2018/19 Annual Plan and Statement of Performance Expectations Final Drafts</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Confidentiality of Advice by Officials</td>
<td>The disclosure of information is necessary to maintain the constitutional conventions for the time being which protects the confidentiality of advice tendered by officials.</td>
<td>[Official Information Act 1982 S9(2)(f)(iv)]</td>
</tr>
<tr>
<td>2017/18 Annual Report Final Draft</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Confidentiality of Advice by Officials</td>
<td>The disclosure of information is necessary to maintain the constitutional conventions for the time being which protects the confidentiality of advice tendered by officials.</td>
<td>[Official Information Act 1982 S9(2)(f)(iv)]</td>
</tr>
<tr>
<td>Topic</td>
<td>Confidentiality of Advice by Officials</td>
<td>Commercial Activities</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Governing Body, Fraud Questionnaire</td>
<td>Confidentiality of Advice by Officials: The disclosure of information is necessary to maintain the constitutional conventions for the time being which protects the confidentiality of advice tendered by officials.</td>
<td>Commercial Activities: The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Enhanced Residential Care Pharmacy Services Business Case</td>
<td></td>
<td>Commercial Activities: The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Long Term Conditions Redesign</td>
<td></td>
<td>Commercial Activities: The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>AMHU Stage 1 Completion – ratification of circular resolution</td>
<td></td>
<td>Commercial Activities: The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>CEO Update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional DISAC Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointments</td>
<td>the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest.</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mental Health Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
</tbody>
</table>

**Carried**
The public meeting closed at 11.35am.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 31 OCTOBER 2018.

---

**BOARD CHAIR**

12 December 2018
## Counties Manukau District Health Board
### Action Items Register (Public)

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 October 2018</td>
<td>CEO Report</td>
<td>Provide an assurance report on the incidents in SAPS (Surgical &amp; Anaesthetic Perioperative Service) to close off the Director liability.</td>
<td>12 December</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 5.1 on today’s agenda.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Send a letter of congratulations to Anne Stevenson for being the joint winner of the NZ Nurses Organisation award.</td>
<td></td>
<td>Board Secretary</td>
<td>A letter of congratulations was sent 20 November.</td>
</tr>
<tr>
<td>31 October 2018</td>
<td>CPHAC Mins 15.8.2018</td>
<td>Hospital in the Home update</td>
<td>20 February</td>
<td>Margie Apa</td>
<td>Deferred to 20 February.</td>
</tr>
<tr>
<td>19 September 2018</td>
<td>CEO Report</td>
<td>Maaori Immunisation – come back to the Board with some fresh ideas for a different approach to target these families.</td>
<td>20 February</td>
<td>Aroha Haggie/ Carmel Ellis</td>
<td></td>
</tr>
<tr>
<td>8 August 2018</td>
<td>Health Equity Campaign</td>
<td>16% of the Counties Manukau population are Maaori but only 6% are employed by CM Health; and 21% of the Counties Manukau population are Pacific but only 11% are employed at the DHB. <em>Provide a quarterly update on how we are tracking with increasing the numbers of Maaori and Pacific staff across our workforce broken down by workforce group.</em></td>
<td>12 December</td>
<td>Elizabeth Jeffs</td>
<td>Refer Item 5.1 on today’s agenda.</td>
</tr>
<tr>
<td>31 January 2018</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 discuss their new strategy and structure. A copy of the MMF Constitution to be provided at this time.</td>
<td>20 February</td>
<td>Margie Apa</td>
<td></td>
</tr>
<tr>
<td>6 December</td>
<td>Health and Safety Report</td>
<td><em>Way Finding</em> – the Board asked that a review of the Middlemore campus is undertaken by a traffic/transport management expert.</td>
<td>20 February</td>
<td>Pauline Hanna</td>
<td>Working on Recommendations based on a 2018 review. A full report will be provided on 20 February.</td>
</tr>
<tr>
<td>DATE</td>
<td>ITEM</td>
<td>ACTION</td>
<td>DUE DATE</td>
<td>RESPONSIBILITY</td>
<td>COMMENTS/UPDATES</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------</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 December</td>
<td>Doone Winnard</td>
<td>Refer Item 4.1 on today’s agenda.</td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee
Held on Wednesday, 26 September 2018 at 9.00am – 12.30pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

ALSO PRESENT

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

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present at this meeting.

APOLOGIES

There were no apologies to note.

WELCOME

The meeting was opening with a prayer from Aupulu Reece Autagavaia. Ms Kate Yang, Primary Care Business Manager, was introduced to the committee.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted, including a change for Mr Ngatai. There were no amendments to the Disclosure of Specific Interests.
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 15 August 2018.

A change to the name of South Seas Trust was noted and will be amended.

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

That the minutes of the Community and Public Health Advisory Committee meeting held on 15 August 2018 be approved.

Carried

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

The RSA has been sold. Ms Brown has asked a local real estate agent to keep their eyes open for any new suitable properties. All other items noted as being on track.

NOTE: A change in the order of the agenda was required due to Dr Pete Watson having another meeting to attend across town and the delay in Dr Pat Tuohy’s flight from Wellington to Auckland.

As such a preparation discussion was held prior to the conversation later in the agenda with Dr Tuohy’s visit.

The difficulty of navigating the B4SC system was noted as being one of the drivers for wanting to meet with Dr Tuohy.

Access to data, in particular data that shows that assistance has been offered and taken up by whaanau, continues to be an issue for the DHB.

The Southern Initiative (TSI) will be undertaking some research and have advised that they will be using the B4SC data as a base for the study. Apulu Reece advised the committee that he had notified TSI of the limitations with the data.

A major concern for this committee is the missing link where whaanau have been referred, which is recorded, but there is not data collection that shows whether or not that referral has been followed up on.

The DHB would like to ask Dr Tuohy if he is open to a flexible approach in terms of CM Health being able to test some different methods of assessment, also looking for a more holistic approach.

A provisional date of 5 November 2018 has been identified for an additional CPHAC meeting with the Asian Community. The committee will hear from 6 different groups based on 2 criteria, current health care needs and the biggest bang for buck. The meeting will comprise patients, whaanau and providers discussing being Asian in South Auckland and accessing healthcare.
It was suggested a separate meeting for South Asian/Indian which is doable if agreed to. Potentially a meeting for those that have been in NZ for many years and a different meeting for those that are new to NZ. Will hold the initial big picture meeting and then drill down to meeting with small, more specific groups.

3. **BRIEFING PAPER**

3.1 **Healthy Families New Zealand** (Rachael Enosa, Chief Executive & Annie Ualesi, Partnership & Engagement Manager, et al)

An introduction to Healthy Families NZ was provided by Ms Enosa. She advised that 275,000 community are covered by this mahi looking at the social determinants and the primary causes of health issues for the community. They are currently focussed on a on a set of risk factors: movement, nutrition, smoking, alcohol. The intention is to gather intelligence through lived experiences and data, applying a systems thinking lens to determine what parts of the system are having the impact and what are the inter-relationships. Currently working with communities in regard to a leverage point. Move to co-design with communities and stakeholders to look at solutions.

Democratise the voice of community to influence equitable investment. South Auckland is a national priority and requires a system to be responsive to the aspirations of this community. A collective impact approach will be used. A working group has been established: walking/cycling. Key messages are around equitable provision and earlier investment. This has been up and running since January 2018. Input has been given into the submission process, influencing where funding will go.

Safe Healthy Streets Working Group is working with community, supporting CLM, etc. The cycle lane alongside the motorway in South Auckland, these are seen out west but nothing in South Auckland. This is a shame that with all the work that is being undertaken along the motorway, there are no cycle lanes. The working groups are aware of this and continue to make noise in regard to this at various forums.

The committee asked if CM Health and CPHAC can help and agreed to an open door with HFNZ to enable them to alert the DHB/CPHAC when there are issues that the DHB can lend their support to.

*Maori Responsiveness Strategy*

70 reasons were given as to why Maori cannot achieve health equity in South Auckland. This information was whittled down to 8 key themes. Maori in South Auckland: need to address historical trauma/mental health – wairua centred approach, challenging western ideologies. For example, Hayman Park, looking to activate this space. Clean up the waterway has been a need identified from the community. This is the next agenda for the Council.

Creating connectivity for certain communities to the land that is currently available but not accessible. Focus on the environment and maximise the benefits that fall out of that.

Mr Ngatai raised the Treaty obligation of healthy lifestyles for their Treaty partner. The Committee advised that they were enthused by the work that is being undertaken by HFNZ. The committee are aware of the complexities of all the different organisations that need to be worked with in order to facilitate change for the areas such as Puhinui Stream and Hayman Park.
HFNZ meet regularly with the Manukau Locality Project Manager. CM Health would like to encourage more influential activities between the two. Engage with Doone Winnard and Marianne Scott as Population Health & Planning leads.

HFNZ invited CPHAC to an open home, where they can see firsthand the work that is being undertaken in the lab. This will provide an opportunity to meet the people and have an interactive experience.

**Action**

HFNZ to return in 6 months’ time to determine what progress has been made.

The conversation continued around 0-5 years in ECEs. There is more to the issues than nutrition and physical activity.

Key themes noted were health and wellbeing in multicultural environments don’t include nutrition and physical activity.

ECE teachers are struggling to see what the role of an ECE would be for families in vulnerable situations.

HFNZ are using design thinking to shift the mindsets. Have co-designed and early years design challenge. There were some interesting findings. The greatest impact was from ECEs that operated within a cultural framework, greater buy in from whaanau. They were taught value of replacing sugary drinks, taught science of water. If it is a non-cultural framework, there is slower buy in, less buy in.

Excellent benefits was seen from peer learnings. Currently deep-diving into the cultural frameworks, in particular for Pacific Islanders. Wellbeing of ECE teaching staff is a consideration. There is a lack of investment of ECE professional development in regard to complex whaanau situations. Need to get investment for tailored professional development.

Professional development for ECE centres is being asked for along with workplace wellbeing and is deeply exploring the impact of cultural frameworks.

The Committee thanked HFNZ for the work that they are undertaking and look forward to working together more collaboratively. Analysis of data would be most beneficial to CPHAC. Story telling is paramount, changing the narrative: tell the good stories of change.

HFNZ is also looking forward to working together.

**4. PRESENTATION**

**4.1 Otago Dental School – Joint Venture with CM Health** (Peter Cathro, Senior Lecturer, Joint Associate Dean (Clinical Services), and Head of Discipline of General Practice Dentistry)

Otago is looking to work collaboratively with CM Health.

Student preparation for dealing with communities of different cultures is required and there is an expectation that students will be aware. Otago is happy to build this early into the curriculum and Dr Cathro is keen to work collaboratively.

Students are currently growing in Maaori numbers, a lot of Asian coming through, however trends show low Pacific numbers.
Otago is looking to work in a supplementary way with clinics in South Auckland. Mobile units are preferred in South Auckland, however, the logistics of transportation etc, will be worked through.

Accommodation for students will be factor. This has not currently been addressed to date and is a risk, but investigation is underway into suitable properties within the area. It was suggested that a meeting with Auckland Council would be beneficial to gain information around transport routes, facilities in the area, etc.

The committee advised that community have asked if it is safe to be treated by students and Dr Cathro said these students are year 5, in their final year of study and will be under supervision. Established referral pathways will be in effect.

CPHAC is looking forward to this project coming to fruition.

11.10am: Ms Parr and Miss Apa left to attend/present at the Staff Forum.

5. BRIEFING PAPER

5.1 Quarter 4 2017/2018 Population Health Performance Report (Ms Marianne Scott, Master Planner & Ms Alanna Soupen, Planning & Reporting Advisor)

The Report was taken as read.

2018/19 reporting: consolidate population health plan reports into the annual plan reports. The Annual Plan report has stratified performances targets by ethnicity. Each population group will have a ‘road map’.

Ms Scott advised that Q4 is a good reflection of the year. Standouts to note are ASH rates for skin infections which have seen a 6% reduction for Maaori 0-4 and 7% reduction for Pacific 0-4.

The focus will shift to respiratory for 18/19 and similar methods will be used in working with vulnerable communities.

Action

SLM Improvement Plan to be made available to CPHAC. Marianne Scott

Pacific breastscreening rates have remained high for South Auckland.

Maaori Immunisations: a paper is to be taken to ELT in regard to how we can improve these numbers.

Action

Ms Tafau to investigate if this paper can be made available to CPHAC.

CPHAC talked to the possibility of the implementation of a Maaori Strategy put forward to address this issue. If we are to continue supporting the current methods, the numbers may well not change.

The issue of the East Asian and South Asians was raised again and the need for the separation of the data collected.

Action

Cervical Screening with home kits – CPHAC would like to know where this has got to.

Mortality data to be presented to CPHAC – prevalence of cervical cancers in women. Pacific, Maaori, South Asian, East Asian.
It was brought to the attention of the committee that due to the Government not requiring Asian data, this data is not provided to the DHBs. Also to note is that the MoH holds a lot of these contracts, not the DHB, but the DHB are the ones responsible for the performance of these contracts.

Equity Targets: rest of the country is Māori/Non-Māori and this is not helpful for CM Health. CM Health chose to put up NZ European as the comparator as this better reflects the true equity gap. If we chose the National Equity targets, our results would be much better. From 18/19 it will revert to the National Target.

The committee is interested to know how do we address the poor picture that is presented for Māori? How can we influence the support and invest into these challenges? The Chair advised that when our need meets with the focus of the Government and we can secure targeted funding, this is when changes can be seen. For example Mana Kids, Rheumatic Fever, this model of care tailored for our communities.

Next report should be on 5 December 2018.

CPHAC noted their deep concern for the challenges facing Māori/Pacific/Asian in our communities. Of particular note is the lack of data for Asian health and further the lack of definition for East Asian and South Asian.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Dr 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:

<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 Minutes of the CPHAC meeting (Public Excluded) held on 15 August 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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td>3.1 Postvention Suicide Brief</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
</tbody>
</table>

Carried
7. DISCUSSION

7.1 Child & Youth Health Priorities (Dr Pat Tuohy, Chief Advisor Child & Youth Health, MoH)

**Notes from the Discussion**

The Well Child Framework ends with B4SC. Dr Tuohy was asked if this a well-being check or a health check for 0-5? Dr Tuohy responded as with all services, they have a history, this is what shapes them. He is aware that the Well Child programme is intended to be more holistic than just health, helping parents to assist their children to thrive. The B4SC part has advanced the most in this area as it looks a broad sub-set of a child’s well-being, linking closely to ECE, forming a seamless hold. It has been variable in its implementation and the potential has not been realised in many places.

The Well child programme is in need of reconfiguring. Literacy and oracy are critical. The intention is for them not to be in the WCP as they would be in other forums. This is not always the case.

The programme as a whole: clear that as well as B4SC needing to lift its game, the system as a whole needs to lift its game. It will take a whole of government approach to address the multiple issues for vulnerable whaanau.

This committee talks about numbers that are vast. Entire extended whaanau all living in deprivation. This committee is struggling with the ineffectiveness of B4SC, where it could be so effective.

Any approach will need to be a whole of system across agencies. New changes to information sharing are coming up. A consultation document is currently being prepared.

The Child wellbeing strategy is being prepared for consultation within the next month or so. The intention is to start with more vulnerable whaanau.

Within the DHBs we have to move away from children coming through the front door, work more in the communities. Working around Family violence and child protection: get providers on board with the Alert System. Dr Tuohy has some funding that will enable health professionals to have visibility of these alerts. It is a critical intervention point. Expectation from Dr Tuohy is that an MDT is undertaken, looking at family, child and extended family.

The statutory threshold is higher in CM than the rest of the country. We are not able to access the services that are required to help the vulnerable whaanau. Counties Manukau has a huge volume to contend with as well. It is a Board decision at CM Health to decide where funding for services go, not the MoH. The issue for the DHB is that it has no influence over the contracts that are delivering services in our communities.

Ministry are testing whether or not new born hearing testing can also be used in 3 year olds. There is no doubt that the delivery of services in Counties Manukau should be different than in other DHBs. Vision and oral testing, etc is still important. Other factors are also critical to look at in Counties Manukau including family violence, housing.

We need to keep a universal service: bump up the middle level (community level). The MoH should be trying to find the money to do this. On top of the Well Child programmes issues is the issue of challenges for Maaori children. In order to change statistics for Maaori children, CM Health need to be able to opt out in order to fund Maaori providers as they have the wrap around services.
For Māori by Māori and for Pacific by Pacific. This committee believes this is a key factor. Dr Tuohy advised that there should not be a default provider of choice. Money should follow the parents. The choice of provider shouldn’t make a difference to the outcome for the patient, but MOH knows that it can.

B4SC nurses are not social workers and often not able to address the issues vulnerable families are facing. CM Health queries if this needs to be looked at, and a change made. Capability of workforce and validity of tests also need to be looked at. Evidence shows that children at 5 or 6 are presenting with issues that should have been picked up much earlier. Dr Tuohy feels that it’s a delivery issue not a tools issue.

PEDS questions should be asked at every contact with the nurse providing the checks. It is apparent that we cannot identify families just through the B4SC. Outreach immunisation, whilst expensive, is proven to work. Making a difference for whaanau in Counties Manukau will be expensive and intensive and as such we need to cease funding services that are proven not work.

The Plunket ratios of 1:150 is not working, not effective. Needs to be adjusted to 1:15 and this will be expensive. There does need to be a fundamental shift in thinking and an upskilling of the current workforce. Dr Tuohy agreed that a refresh is required. Unfortunately there has been no increase over the last 5 years in funding to the WCP.

Need a service that can flex up to the needs of the community/whaanau and can flex down when things are going well. Dr Tuohy is keen to bring Family Start in but is also aware that their kaupapa is not suitable for everyone.

Provision of health services in ECEs was raised. Dr Tuohy said there was nothing outside School Based Health Services. There is no formal relationship between ECE and MoH. If WCP and ECE worked closely, then Plunket and Oranga Tamariki could link in.

The committee advised Dr Tuohy the would like to see a significant change for children in Counties Manukau.
Ms Brown asked Dr Tuohy to return to CPHAC to continue this conversation. Dr Tuohy agreed a change was necessary and that services needed to reflect the requirements of whaanau in the community and this will vary from DHB to DHB.

The committee thanked Dr Tuohy for his attendance.

Meeting concluded at 13.11pm.


Colleen Brown
Committee Chair
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee
Held on Wednesday, 7 November 2018 at 9.00am – 12.30pm
Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Chair)
Dr Ashraf Choudhary
Dianne Glenn
Apulu Reece Autagavaia
John Wong

ALSO PRESENT

Margie Apa (Chief Executive)
Karyn Sangster (Deputy Chief Nurse)
Kate Yang (Business Manager, Primary Care)
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 from Katrina Bungard, George Ngatai and Jenny Parr (Karyn Sangster is attending on her behalf) and Margie Apa for lateness, Apulu Reece Autagavaia for early departure.

WELCOME

The meeting commenced at 9.07am with a welcome from the Chair, Ms Brown.

The Chair thanked Kate Yang, Kitty Ko and the rest of the team that put together the Asian Health CPHAC meeting on Monday, 5 November. Was a very successful meeting and CPHAC appreciated the candour of the community that engaged with the committee and the wonderful musical presentation at the end.

A CPHAC Youth meeting will be organised for early 2019.
DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest amendments were noted, including a change for Ms Brown and Apulu Reece Augatavaia. There were no amendments to the Disclosure of Specific Interests.

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 26 September 2018.

An amendment to the spelling of Apulu Reece Autagavaia’s name was noted.

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

That the minutes of the Community and Public Health Advisory Committee meeting held on 26 September 2018 be approved.

Carried

2.2 Action Items Register/Response to Action Items

Action Item
Women in Prisons: Health Services not providing Vision and Hearing screening tests. Report back on health services that are provided to all Prisons in SA – breast screening, cervical, prostate, bowel, vision & hearing. Early next year.

Action Item
The Chair would like to meet with at least three to four Youth leaders, prior to a more extensive meeting in 2019. Ms Yang will investigate the possibility of convening a meeting prior to Christmas for The Chair to attend.

Dr Choudhary and Ms Yang will look to organise an additional CPHAC meeting in early 2019 for the South Asian community.

Community Hub Vaccinations Update: These hubs are an extension of MSC. In order to vaccinate in any space, there are a lot of legalities to be sorted before this can be done. Ms Sangster mentioned that there are many clinics that can already vaccinate in walking distance from all of the Hubs.

3. BRIEFING PAPER

3.1 Fluoridation Position Paper (Dr Doone Winnard, Clinical Director, Population Health, CM Health & David Sinclair, Medical Officer of Health, ARPHS)

The paper was taken as read.

This is an important issue from an equity perspective and for oral health. Dr Winnard advised that this paper was not asking for any decisions, it is a position statement. Fluoridation will become a hot topic. CM Health is clear around the evidence base and the importance for the Counties Manukau population.
Whilst most Watercare supplies are already fluoridated the DHB support the fluoridation of all community water supplies to ensure that the non-fluoridated communities get fluoridated water.

Work is being undertaken around the promotion of the message that tap water is safe, healthy and good for your teeth. ARPHS are working with Watercare, Auckland Transport and Auckland Council.

Reviews of research sometimes produces questions around Fluoride Safety. No solid evidence has been produced in regard to any health issues with the level of fluoride used in New Zealand. For those that stand against fluoride, it is mostly a long-held personal belief, rather than fact based.

**Resolution**

The Community & Public Health Advisory Committee:

**Recommended** to the CM Health Board that they endorse the position on Community Water Fluoridation in Appendix 1.

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

4. **PRESENTATIONS**

4.1 **Franklin Locality Update** (Penny Magud, GM Locality Services)

Geographically the largest locality. Since 2013 the population has grown by a further 9,000. 15% of the population is over 65, and this number is expected to double in the next 20 years. 34% are under 25 yrs. The overall Franklin population is expected to grow 30% by 2033. A population the size of Hamilton will be in Franklin over the next 30 years – estimated 140,000 people.

Locality leadership – it was advised that one General Manager now works across four localities. Each locality does have Champions. This allows the DHB to meet local requirements and provide services with a local flavour.

Locality Leadership Group (Andy Baker): are currently reviewing their TOR to reflect the changes that are happening within the locality.

Ms Magud advised that the Principles Meeting (Dr Mark Eustace) has been reconvened – looking at the role of Primary Care and working around how we manage the community and deliver care (even acute care) closer to home.

There are also nursing forums and social work forums for the Franklin locality. Ms Magud is looking to replicate this type of activity in other localities.

Community Central – this is the single point of referral for all four localities. 3000 requests for service per month. An emerging trend is the number of patients needing to be seen between 2 to 48 hours (33%). The acuity of the patients that are being managed in the community would previously have been admitted to hospital. Mastectomy patients now only require a night in hospital and are then managed at home. Patients that would normally have had their chemo ports deactivated in hospital, can now be managed at home.

Transition of care from hospital to home is seamless. This information is disseminated to the patients.
Establishing relationships with current health providers in the Franklin area is key to the success of treating patients in their home.

Community central requests for referrals average approximately 160 per week day, less over the weekend. Peak of over 200 per day was in May 2018.

Routine/Low risk referrals need to be transferred from Community Central back to Primary Care. Work will be undertaken in the localities to help this. If we introduce more services into Franklin, eg orthopaedics, the DHB would need to consider the cost of this.

Innovative thinking is being undertaken across all services around how we can provide better, more convenient services closer to home, if not in the home. This will allow the hospital to be used effectively, and to understand the acute patient flow better.

There is a need to remember that Franklin does have pockets of serious deprivation, when looking at the whole of the locality. There is also a need to look at more outpatient services, up-skill the local providers and ensure they are sustainable in order to take from the DHB those services that can easily be managed by Primary Care.

The DHB is moving away from some of the original perceptions - make our resources flexible and agile, be smart around what questions we are asking in order to be able to collect the data that we require in order to make smart decisions.

4.2 Engaging with the Asian Community (Kate Yang, Business Manager, Primary Care)

There are those within Asian communities that are isolated and have no support. The level of engagement from Asian communities is low. New migrants can be seen to be healthy however may not have disclosed all health issues prior to coming to New Zealand and this can create stress for families.

Discussion took place around:
- How does CPHAC want to engage in a sustainable and meaningful way?
- How can CPHAC support and leverage already existing infrastructure?
- How can CPHAC take lessons from engaging with Maaori and Pacific to become leaders in innovation when working with the Asian community?

Local Council flats, look to ensuring that Councils know best how to engage and support the tenants.

4.3 Asian Health Overview (Kitty Ko, Asian Health Gain Advisory)

Ms Ko spoke to the committee around her own health journey as part of her presentation.

Some common barriers to accessing health care for the Asian communities are:
- Oral health of Asian children - lower percentage of Asian children aged 5 years who are caries free;
- Cancer screening - lower percentage of Asian women aged 25-69 years received a cervical screen;
- Primary care - lower percentage of Asian population enrolled in a PHO;
- Long Term Condition (Cardiovascular disease) - Indian people have a higher prevalence of risk factors associated with cardiovascular disease, and Indian aged 35-74 years had higher CVD hospitalisation rates as compared to the European/Other group in Counties Manukau;
• Long Term Condition (Diabetes) - Prevalence, morbidity and mortality rates from diabetes are higher for Indian than other groups; and
• Mental health & Addictions - lower access rate to mental health services.

• Practical barriers - lack of English language proficiency, inadequate knowledge and awareness of existing health services
• Cultural barriers - intense stigmatisation around mental illness that exists among many Asian cultures, religious beliefs, and cultural differences in the presentation as well as treatment of mental illness
• Systemic barriers - lack of interpreter services or culturally / linguistically appropriate health information, lack of bilingual health professionals, incompatible Western health treatment models, and lack of cultural competence in health care

CM Health has a 33% Asian workforce, which is reflective of the population. There is a need to think innovatively around a culturally responsive workforce and culturally responsive services.

As mentioned at Monday’s Asian Health meeting, there is a strong need to produce resources that demystify the health service and allow new migrants access to the services that they require. The committee was advised that there are resources out there.

Action
A report back to the committee on what resources are already out there, is it factually correct and how we can disseminate this information on a larger scale to the Asian communities.

5. BRIEFING PAPER

5.1 Quarter 4 2017/2018 Non-Financial Summary Report (Alanna Soupen, Planning & Reporting Advisor)

The Report was taken as read.

Not a lot of new data. CM Health have achieved four out of six health targets. As a result of ongoing work by various teams, equitable achievement was gained too.

Māori immunisations, breast screening and cervical screening continue to be a struggle to achieve higher rates.

Cervical outcomes – the last needs assessment was undertaken in 2008. Asian women are similar to Pacific women. Asian women have lower hospitalisation. The committee was advised that Asian/South Asian women may return to the country of origin to have their women’s health needs looked after.

New work is being undertaken looking at innovations to boost immunisation results. (Note: if numbers are very small they aren’t recorded as not meaningful on a quarterly basis.)

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Colleen Brown/Seconded: Dr 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:

Counts Manukau District Health Board – Community & Public Health Advisory Committee 5 December 2018
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 Minutes of the CPHAC meeting (Public Excluded) held on 26 September 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. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
</tbody>
</table>

**Carried**

Meeting concluded at 12.00pm.


Colleen Brown  
Committee Chair
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Wednesday, 29 August 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)
Dr Ashraf Choudhary
Ms Dianne Glenn
Catherine Abel-Pattinson

ALSO PRESENT

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

A media representative was present for the public section of this meeting.

WELCOME

The meeting commenced at 1.15pm with a welcome from Dr Murphy. The committee welcomed Dr Mary Seddon, who was attending to observe proceedings.

APOLOGIES

Apologies were received from Catherine Abel-Pattinson and Vanessa Thornton.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted and no changes were required.

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

1. AGENDA ORDER AND TIMING

2. COMMITTEE MINUTES
2.1 **Confirmation of the Minutes of the Hospital Advisory Committee meeting held on 18 July 2018.**

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

That the minutes of the Hospital Advisory Committee meeting held on 6 June 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:

Support from the Board around winter planning (ELT too) has helped and resulted in less bed occupancy and less people in ED.

Counting down to spring and end of winter. Additional ward has helped.

SLM report shows a lower ED presentation rate and a lower readmission rate.

40% of bed rate is chronic care. With a concerted effort we would like to see a lot of these patients managed in the community. PHOs and individual GPs submitted data which was helpful in planning ahead.

Elective discharges: despite challenges we were able to deliver by the end of the year.

Mental Health patients with the flu had the flu prior to admission. Usual precautions were taken.

Paediatric admission numbers were lower by approximately 6% than last year.

The subject of Evening discharges with script was bought to the attention of the Committee: script can’t be filled due to the time. The committee was advised that CM Health is Looking at better planning for discharges and earlier communication with the pharmacy.

In future reporting Philip Balmer is to insert the graph that shows Ophthalmology tracking.

**Resolution**

The Hospital Advisory Committee:

**Received** this paper as information.

**Carried**

**Balanced Scorecard – Provider Arm**

The report was taken as read.

ELT have decided that rather than looking at what is working, they will put together a focussed plan for the challenges. Bowel screening, ophthalmology radiology, paediatrics, report turn-around times. Ko Awatea provides the support for Hospital Services to lead change innovatively. Ko Awatea is in the process of creating a prioritisation funnel for new projects. Currently have 156 that they are involved with.
Evaluation of projects is critical to determine if something is not working, then a decision can quickly be made to change tact.

**Finance Report – Provider Arm**

The report was taken as read.
If electives are not delivered, funding can be reduced. CM Health is addressing this area early to ensure we remain on track to achieve electives.
Relationship meeting with MoH here at Middlemore: successful day (9am to 6pm). An open session was held with frank discussions in regard to improvements that could be made. Improvement programmes deserve credit.

**Emergency Department, Medicine and Integrated Care (Brad Healey)**

The report was taken as read.
Mr Healey advised that National Bowel screening is now underway. It will continue to monitored for the next six months. Very pleasing results to date and engagement has been strong. There is a focus on equity, taking lessons from BreastScreening. Strong disappointment has been expressed to the MoH re the Maaori & Pacific resources that have been produced nationally and CM Health have offered their assistance. Numbers will show any early trends.
Acute flow work: successful launch of the acute flow programme on 23 August. Positive engagement has been noted from a wide cross section of staff across CM Health. Working on ED and Medical Assessment to ensure patients are getting to the right place, making use of every hour, not admitting if not required. Long stay and frail patients are also a focus.
Gastroenterology: 70% in June rose to 85% in July.

**Surgery, Anaesthesia & Perioperative Services (Mary Burr)**

The report was taken as read.

Of particular note:
The year finished well. 101% for acutes was achieved. 2.62 over-contract for electives. All funding has been received.
Cataracts: our service is the 2nd busiest service in the country. Dr Burr noted that it would be helpful if there is a national threshold rather than different thresholds for each area. Cataract intervention rate is high for CM Health.
Currently tracking well below the acute targets for the year. This is due, in part, to the 8 extra post-surgical beds approved by ELT and Board.
85% of our own patients were treated here at CM Health. Outsourced only 4.4%.
10,500 operations – 5th busiest elective centre at MSC.

**Central Clinical Services (Phillip Balmer)**

The report was taken as read.

Of particular note:
Completed phase one of Medchart. Project delivery and rollout are seeing good results. Currently moving into an evaluation phase. Outcomes: better patient safety in terms of adverse drug events. Minimisation of prescribing errors, signature, hand hygiene, don’t exist in the electronic system. Benefits with efficiency for pharmacy, no legibility issues for nurses.
Food services: pleasing to see more positive results.
Kidz First & Women’s Health (Phillip Balmer)

The report was taken as read.

Of particular note:
The end of year report shows similar results to the previous year. Neonate movements are still an area of pressure for CM Health. Acuity and complexity continues to increase. Maori Midwifery: recruitment and retention of Maori midwives has improved greatly. College of Midwifery open to looking at supporting RNs into midwifery training on a case by case basis.

Adult Rehabilitation & Health of Older People (Phillip Balmer)

The report was taken as read. Overall year achievement for stroke services is definitely worth a mention. Huge achievements have been made in this year. These are outlined in the report.

Mental Health & Addictions (Tess Ahern)

The report was taken as read. AMHU: disappointed at the disruption but have been well supported by the ELT and new builders on site already. Experiencing a challenging recruitment environment. A new build is working in the favour of recruitment.

Middlemore Central (Phillip Balmer)

The report was taken as read. Goal within patient flow is to discharge earlier in order to meet the peak demand.

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 Jill Clendon and Andy Simpson from the MoH visited CM Health. Overall this was a successful visit and gave an opportunity to provide context for the MoH. Patient Safety lead to be announced shortly. EC presentations: continuing to have higher presentations than ever before, team is working really well with managing these presentations. Vacancy report has been put together by Mr Anand and his team. This is very helpful for understanding staffing requirements. Fictional Library: Auckland Library has gifted a lot of books to CM Health, this is great for long term patients. LIBBY is also being looked at – an online service. Nursing staff focusing on positives: CCDM positive engagement from charge nurses. Teams are keen to see a light at the end of the tunnel. It has been helpful to have a final agreement. In response to pressures for nursing staff, despite it not being in the budget, extra nurses were supplied to address demand.

4.2 Patient Experience & Safety Report (David Hughes)

The report was taken as read.
87% of the hospital is working to or above the targets set for hand hygiene.

4.3  **HR Report** (Phillip Balmer)

The report was taken as read.

6.  **RESOLUTION TO EXCLUDE THE PUBLIC**

Resolution (Moved: Dianne Glenn/Seconded: Dr Lyn Murphy)

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>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></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td></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 3.30pm.


Dr Lyn Murphy
Chair
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Wednesday, 7 November 2018 at 1.00pm
Lecture Theatre 1, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT
Dr Lyn Murphy (Chair)
Dianne Glenn
Dr Ashraf Choudhary
Catherine Abel-Pattinson

ALSO PRESENT
Margie Apa (Chief Executive)
Dr Gloria Johnson (Chief Medical Officer)
Mr Avinesh Anand (Deputy CFO, Provider)
Ms Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Mr Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Ms Rebecca Ellis (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
No media representative was present for the Public section of this meeting.

WELCOME
The meeting commenced at 1.10pm with a welcome from Dr Murphy.

APOLOGIES
Dr Murphy apologised to the Committee for arriving late.

 Disclosures of Interest/Specific Interests
The Disclosures of Interest were noted and no changes were required.
There were no Specific Interests to note regarding the agenda for this meeting.
1. **AGENDA ORDER AND TIMING**
   Items were taken in the same order as listed on the agenda.

2. **CONFIRMATION OF MINUTES**

2.1 Confirmation of the Public Minutes of the Hospital Advisory Committee meeting held on 29 August 2018.

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

   That the minutes of the Hospital Advisory Committee meeting held on 29 August 2018 be approved.

   **Carried.**

2.2 **Action Items Register – Public**

   Refer Action Items Register for actions of the Public meeting held on 7 November 2018.

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

3. **PROVIDER ARM PERFORMANCE REPORT**

3.1 **Executive Summary (Margie Apa)**

   The reports were taken as read.

   Ms Apa provided key highlights:
   - Winter demand has seen very different results to last year with flu rates having been observed as coming through later in the year and reduced numbers of patients.
   - Ward 21 – the extra 30 bed ward has now closed.
   - Operational targets – targets have not been met but should be achieved by June next year.
   - MRI opening – the MRI unit was opened on Tuesday 6 November 2018, it was unfortunate that there was a miscommunication with the date of the opening as members of the Committee would have liked to have attended the opening.
   - Midwives Strike – no formal notice strike notice has been received but it is expected to be received shortly. Planning for this event has started with services and communications being notified. Proposing to start the strike on 22 November 2018, for two hours, twice per day. The Chair questioned whether independent Midwives would be affected by the strike action. Ms Parr said that only those on a MECA would be affected. It would have been preferred to have them strike for a whole day as there is considerable pressure on services such as electives and those with life preserving measures.

3.3.1 **SLM Complex Conditions Improvement Programme**

   This work is part of the Auckland Metro SLM Improvement Plan and supports the Healthy Together strategy to improve health outcomes for our population and is similar to the work that Dr Mary Seddon is currently working on.
**3.1.2 2017/18 Hospital Services Work Plan**

This report has been superseded by Dr Seddon’s report and has been discussed at both the Audit Risk & Finance Committee (ARF) and Board. The report will continue to evolve with further updates to the overall savings programme.

The Spinal Unit was discussed at length. A Business Case is to be presented to ARF and the Board to determine whether to move the entire unit to Middlemore (MMH) or retain where it currently is. Dr Johnson advised that a report had been written some time ago and would seek to have the report revisited. The Committee questioned whether it would be fair and reasonable for other DHBs to assist with the capex cost and funding, and suggested writing to other DHBs. Dr Johnson advised that this had been raised many times previously, both nationally and regionally.

The Chair advised the Executives to consider all options available to relocate the Spinal Unit, whether to relocation to Pukekohe or within MMH etc., etc. Ms Apa advised all viable options would be discussed with ELT and considered.

**3.2 Balanced Scorecard (Margie Apa)**

The report was taken as read.

The team have maintained the level of service, some balancing issues around risk and looking at metrics and monitor next year.

**3.3 Finance Report – Provider Arm (Avinesh Anand)**

The report was taken as read.

August report showed a favourable result of $1.6m with Provider Arm savings of $1.7m target. Somewhat up on elective volumes lost due to the nurses’ strike as a result of a higher level of outsourcing and increased theatre volumes, volumes being 16% higher than previous months.

Tahitian Burns Contract – working around costings has shown the cost margin is down by 10% as more cases have come through.

**Action:** Mr Anand to review the Tahitian Burns Contract in terms of costings and end date of the contract. An update is to be provided at the Public Excluded meeting due to the sensitiveness.

**3.4 Emergency Department, Medicine and Integrated Care (Brad Healey)**

The report was taken as read.

Mr Healey provided key highlights:

- Emergency Department has been business as usual.
- Ward 21 closed on 2 November 2018 as agreed with the Board, some potential challenges with this closure in terms of the team. This was always set up as an experiment with no
expectations that it was not to close. Redeploying the teams into other areas so no redundancies but some challenges with integrating the teams.

- Home based ward set up has been a long time in the making, some issues with rostering and medical leads for wards, but monitoring and managing, predicated on efficiency gains.
- Red and Green Day’s initiative now well established and consistently achieving over 85% on a daily basis.
- Hospital in the Home idea / discharge lounge – looking at maximising this area but clear criteria is required with select people with certain conditions and patient groups. Some future challenges with this to be worked through.
- Bowel Screening – the programme commenced on 10 July 2018 and is working well and tracking as expected. The largest issue is the pacific population as the expectation is that these numbers will continue to grow but this is not to be unexpected. The kits were issued by the National Co-ordination Centre. GPs are notified but do not run the programme, nor does MMH. Ms Glenn questioned whether bowel screening was done in prisons. Ms Apa advised that the Department of Corrections runs their own screening programme.

**Action:** Ms Apa to provide Ms Glenn with contact details for the Department Of Corrections in regard to bowel screening in prisons.

- Emergency Care App – the app is downloaded by patients on arrival to ED and shows wait times, the patient can then decide to either remain at ED or leave and visit an A&E clinic. It is the patients’ choice as to whether they remain or stay and wait. Since the programme started, 442 patients have chosen to leave ED, however further data analysis is yet to come. Feedback received to date has been very positive. The app however, does not take into account hyphenated names or those with an apostrophe.

**Action:** Mr Healey to check the app and report back with regard to the Emergency Care app not accepting hyphenated names or those with an apostrophe.

### 3.5 Surgery, Anaesthesia & Perioperative Services (Mary Burr)

The report was taken as read.

Ms Burr provided key highlights:

- Surgical services have been quite buoyant, good acute flow with a reduction in pre-op stay, reduced acute stay and on track to meet WIES targets and monitoring closely.
- A letter has been received with very positive comments from Health Quality & Safety Commission with regard to CM Health’s qualify safety markers for the surgical safety checklist in use. The checklist has been rated very highly by the Commission and shows us in a positive light.
- Critical care – slight increases in this area but managing well, volumes have increased but should reduce.
- Ophthalmology is tracking down; positive steps have been taken towards recruitment in this area.
- Anaesthetists shortage – Dr Johnson commented that the entire structure of the anaesthetist service should be revisited as was set up some considerable time ago. The service needs to be reviewed and possibly divided into sub-specialities, which is currently in the planning for the Manukau Health Park.
- Cx Bladder Project – 90 patients have been sent forms, SMOs currently reviewing and yet to determine whom will upload to the clinical portal. The Chair questioned whether there was confidence in the accuracy of clinical coding. Ms Burr advised that SMOs are currently
working on two clinical coding projects to ascertain this data and this will be rolled out to other services.

3.6 Central Clinical Services (Ian Dodson)
The report was taken as read.

MRI Suite has now opened and has been very well received. The new machines have advanced technology and a bigger bore size to enable larger patients to be seen. The machines will be fully operational in two weeks time.

Wait time for patients continues to be an issue, reviewing how we can deliver to maximise efficiencies.

The main risk to MRI is long term constraints due to recruitment, but looking at other alternative options within the radiology workforce which should address these items on rosters.

The Chair asked whether patients from Manukau Clinical Trials were seen. Mr Dodson advised that these patients were pushed to private clinics.

The Committee asked whether strategies could be considered such as considering internship programmes in a range of different services, whereby CM Health pays tertiary students to work at MMH as an incentive during their holiday break, with a view to ‘bonding’ them to work at MMH once they have graduated. Ms Apa said that work is already underway with Auckland Uni / Unitech and others with regard to undergraduate degrees rather than postgraduate degrees.

3.7 Kidz First & Women’s Health Clinical Services (Nettie Knetsch)
The report was taken as read.

Ms Knetsch provided key highlights:

- No notice with regard to the Midwives strike has been received as yet. This comes at a period of high demand and considerable risk. The strike will continue for a fortnight.
- Recruitment of Midwives – over a period of two months a number of people have resigned and now have five vacancies.
- Birthing numbers have not risen and have been very stable.
- Neonatal numbers are sitting higher across the region. A regional action plan with guidelines for transfer and support of the patient is currently been written. Any transfer is treated as a serious event and requires CEO approval. The Chair asked when the last transfer from MMH had occurred. Ms Knetsch said that the last transfer was in August this year. Discussions occur each Friday (or sooner if required) with GMs and Clinical Leads as to whether a patient requires to be transferred.
- Ms Apa commented that Ward 21 was being considered for gynaecology and maternity services to free up capacity and currently working through how best to reuse this resource.
- The Chair asked whether dads were able to stay overnight. Ms Knetsch advised that usually if it is a single room then dads are able to stay, otherwise if it is a common room, they are not permitted due to safety issues in general.
3.8 **Adult Rehabilitation & Health of Older People (Dana Ralph-Smith)**
The report was taken as read.

Ms Ralph-Smith provided key highlights:
- Every hour counts programme is progressing well.
- Spinal rehabilitation production planning has challenges due to nursing workforce, equipment demands and increasing wait times.

*Action: Ms Ralph-Smith to review the Spinal Rehabilitation paper that was developed some time ago for the relocation of the spinal unit with a view to reconsidering all options and opportunities for relocation.*

3.9 **Mental Health & Addictions (Tess Ahern)**
The report was taken as read.

Ms Ahern provided key highlights:
- The new Mental Health Unit is due to open on the 22 November 2018. The facility will operate with staff initially before patients are brought in. Currently working through closed tender process for Stage 2.
- Service reconfiguration – working to align Community Mental Health with teams and this should reflect across the community and is working well.
- Significant workforce shortages but working through this with change management.
- Suicide prevention – working with schools / police / local boards and communities to work through at risk people.

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

4. **CORPORATE REPORTS**

4.1 **Director Patient Care, Chief Nurse and Allied Health Professions Officer (Jenny Parr)**
The report was taken as read.

4.1.1 **CM Health: An Excellent Experience – September 2018**
Inpatient experience report – significant improvements have been seen coming through. Patient survey has started but not finished, however will redevelop the order of questions and look to remove any mandatory fields to ensure more user friendly. Procurement process is to be reviewed in the New Year as may be some opportunities to save money. The Chair said that the report was presented well.

4.2 **Patient Experience & Safety Report (David Hughes)**
The reports were taken as read.

4.2.1 **Dashboard & Variance Report**
No comments were made on this report.
4.2.2 Perceptions of Clinical Governance Report – 2018
Third reiteration of the report, CM Health is sitting ‘middle of the road’ in terms of clinical governance space which may have effect on the validity of numbers. Staff are working on improving care for patients.

4.2.3 CRAB CM Health Annual Report – 2017/18
CRAB Software package shows the rate of mortality and provides statistical analysis. Reviewing the numbers to ensure confidence with the data issued.

4.3 Human Resources Report (Elizabeth Jeffs)
The report was taken as read.

Ms Jeffs provided key highlights:
• Annual leave is tracking normally and within acceptable hours. Sick leave is up to end July but now reducing due to warmer weather. Turnover rates are also tracking normally.
• The Chair questioned whether appropriate training and staff development is in place for non-clinical staff. Ms Jeffs advised that there are a number of programmes that are run internally and some external conferences that staff are able to attend. Those on MECA agreements also receive staff development and training.
• Funding for training sits within the RC code of the individual. In terms of the lower echelon staff such as cleaners and orderlies, CM Health have a number of step up programmes in place. Professional development will continue to be offered across the organisation as a whole.
6. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution:** (Moved: Dianne Glenn / Seconded: Dr 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:

<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 7 November 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 3.15pm

Next meeting to be held on 5 December 2018

Signed as a true and correct record of the Counties Manukau District Health Board Hospital Advisory Committee meeting held on 7 November 2018.

Dr Lyn Murphy
Chair
Recommendation

It is recommended that the Board:

Receive the Chief Executive’s Report.

Prepared and submitted by: Margie Apa, Chief Executive Officer

Introduction

This report covers the period from 1st November – 11th December. During this period, several large projects have come to successful completion, including the opening of the new Tiaho Mai. As the year draws to a close, staff have also been busy with initiatives to set CM Health up for success in the new year. This includes opening of a new Magnetic Resonance Imaging (MRI) unit and allocation of additional nursing resources from Care Capacity Demand Management.

News and Events

Academic Health Alliance between CM Health and University of Auckland

Although working together for many years now, officially recognising the partnership between CM Health and the University of Auckland (UoA) has been high on the agenda. On 31 October 2018, the opportunity came when representatives from the UoA met with CM Health Board members to sign a Health Alliance agreement. This alliance formally recognises the benefits of working collaboratively in the areas of research, as well as generally.

Here’s to many more great years of teamwork.

Professor John Fraser, University of Auckland and CMDHB Board Chairman, Mark Gosche
**Care Capacity Demand Management (CCDM)**

The additional funding provided by the Safe Staffing Accord signed in July has been approved. The staffing allocation was a partnership between New Zealand Nurses Organisation, Care Capacity Demand Management Council, General Managers, Clinical Directors and Clinical Nurse Directors and union delegates. Robust data decisions were made with agreement between all stakeholders. The plan has been submitted and agreed with the Ministry of Health. This will provide an additional 50 nursing and health care assistant positions across clinical areas.

**Nursing and Midwifery Research Seminar**

The inaugural Nursing and Midwifery Research Seminar was held on 25 October 2018. This seminar was designed following discussions with staff on a master’s pathway to support them and others involved in postgraduate study considering further academic study, or those in practice interested in investigating clinical questions. The seminar had 36 participants and sessions were led by Professor Merryn Gott (Director of Research, School of Nursing - University of Auckland), Dr Jackie Robinson, (Professional Teaching Fellow – University of Auckland) and Professor Liz Smythe, (Programme Leader DHSc (Doctorate of Health Science) and Associate Head of School of Clinical Sciences – Auckland University of Technology (AUT)). Topics included ‘Building research capacity in nursing: the benefits of combining research with clinical practice’ and ‘Understanding methodological choices from a philosophical lens’. It is planned to hold these seminars 6-monthly, with the next seminar scheduled for 27 March 2019.

**Our People**

**Congratulations Dr Joanna Sinclair**

Dr Joanna Sinclair was awarded the Ray Hader Award for Pastoral Care for 2018. The award is presented annually by the ANZ College of Anaesthetists to a doctor who promotes compassion and a focus on the welfare of anaesthetists, other colleagues, patients and the community and takes the form of a certificate and grant for training or educational purposes.

Joanna is an anaesthetist at CM Health and she has recently led the way for workplace wellness for doctors in our organisation, undertaking and analysing doctor surveys, visiting departments throughout the hospital discussing burn out and stress, offering advice and strategies to enable people to manage and raising a general awareness about self-care and looking after others around you. Her passion has led her to establish a SMO Health Committee for CM Health.

We are all extremely proud of Joanna and her achievement.

**Surgery Team win award at the Health Round Table, Melbourne**

The Surgery, Anaesthesia and Perioperative Services team of Jacqui Wynne Jones, Robyn Hughes and Aloy Rayen attended the Health Round Table (HRT) Surgical Seminar in Melbourne last week. The team presented two projects and was awarded one of the four awards for the presentation about the Perioperative Surgical Unit at Middlemore. This unit was set up by a dedicated group of nurses initially as a pilot in 2017 and then as a permanent eight bed ward in 2018 led by Kim Dittmer (ACNM).

In the short time it has been open, 620 patients have been through the unit and over 500 bed days saved. The unit has promoted patient flow from the ED by freeing up inpatient beds for more complex patients. Australian HRT colleagues were most impressed and are keen to do the same in their hospitals.

Well done to the team for representing CM Health and for their commitment to excellence.
‘Selfie with the Prime Minister’ 21 November 2018

Congratulations to Mary Namala, Chetan Reddy, Anne Frewin, Shavreena Ali, Stewart Hawkins, and Joanne Western for capturing a ‘selfie’ with the Prime Minister during her recent visit. voucher for the photographer.

Some of the winning selfies

Rousing Farewell for Dot McKeen

Middlemore Central General Manager, Dot McKeen was surrounded by family and friends on 30 November as she received a rousing Māori powhiri and farewell from her CM Health colleagues.

The popular GM is retiring after more than four decades of service at Middlemore Hospital, and was joined by husband Derek and children for the emotional farewell. The respect for Dot was obvious with a large turnout by current and former colleagues, including CEO Fepulea‘i Margie Apa, close nursing friends and staff from across CM Health.

She became a part of the fabric of CM Health through her work as a nurse, senior manager, trouble-shooter and as GM Middlemore Central, where she held prominent planning roles for a number of key events, including the hospital’s 50th golden anniversary celebrations, and during industrial action periods.

Dot is looking forward to spending more time with family and her grandchildren. We wish you well, Dot!

Counties Manukau District Health Board 12 December 2018
Facilities

_Tiaho Mai Phase One Opening - 22 November 2018_

The Minister of Health, the Hon. David Clark officially opened the new Tiaho Mai on 22 November 2018. It is a state of the art design with a focus on light, space and fresh air with innovative features that include a unique courtyard design, single rooms with ensuites and a robust focus on safety.

The newly designed _Nga Whetu Marama Whare_ is a key feature to Tiaho Mai, and sits very proudly and appropriately at the forefront of the unit. This sets a strong focus for how we have implemented a model of care to reflect Sir Mason Durie’s Te Whare Tapa Wha Maaori health model. This describes the four cornerstones of Maaori health – taha tinana (physical health), taha wairua (spiritual health), taha whaanau (family health), and taha hinengaro (mental health).

_MRI Opening - 14 November 2018_

The new state-of the-art Magnetic Resonance Imaging (MRI) machine was recently installed within the hospital’s Harley Gray building. The 3T is the first of its kind to be installed in a New Zealand public hospital and will provide greater diagnostic capability than earlier models and will therefore reduce the time patients need to spend in the scanner. The addition of a third scanner will boost MRI capacity by 50 per cent and significantly reduce waiting times for patients.

The number of MRIs being performed at Middlemore is increasing each year by an average of 10 per cent. In the last year, CM Health has performed an average of 800 MRI scans per month and this number is expected to grow.

The new machine offers higher quality examinations which can be personalised for all patients and reduce the need for re-scans. Other features will enhance patient comfort, including a 97% reduction in sound levels, and a design, within the suite, of illuminated ceiling murals of skies and trees to help patients who experience claustrophobia.
**Dawn Blessing for New Dental Facility – 21 November 2018**

As dawn broke over Manukau this morning and the rain stayed away, representatives from Manawhenua, the University of Otago, Savory Construction, and CM Health blessed the site of the new dental facility to be built on the grounds of the Manukau SuperClinic.

Now that the sod has been turned, construction can start on the site which is expected to begin in December with completion in time for the first academic semester of 2020.

The dental facility is a partnership between the University of Otago and CM Health.

**Future Focus**

**Counties Manukau Health welcomes $80 million investment – 21 November 2018**

CM Health has welcomed today’s the Government announcement of an $80 million investment for capital works at Middlemore Hospital and the Manukau SuperClinic. The investment is a significant step in CM Health’s ability to fix critical infrastructure problems.

The funding means we will be able to focus on business cases for four projects; namely recladding the Kidz First Building, relocating the radiology department to the Harley Gray Building, establishing a radiology hub at the Manukau SuperClinic site, and critical infrastructure work at the Manukau SuperClinic.

**Nursing and Midwifery Strategy Workshop**

A workshop was held on 14 November 2018 to commence development of a Nursing and Midwifery strategy. The workshop was attended by 39 nurses and midwives from CM Health, Lead Maternity Carers (LMCs) and PHO Nurse Leads. The workshop outcomes are being synthesised to develop a series of high
level aims and actions to be delivered over a 3-year period to address six domains of leadership, equity, workforce, patient experience, quality, and research.

**CIO Report**

We are making good progress growing our capability in new clinical applications, analytics and mitigating risks of existing systems, with an emphasis on clinician leadership.

The key areas of focus for the HTT team are the implementation of TrendCare (patient acuity system which reflects nursing need and matches staff capacity to demand), further roll-out of inpatient ePrescribing (MedChart), patient bed location (which creates source of truth to integrate to systems such as Medchart and Trendcare), Electronic Ward Whiteboards and Hospital at a Glance.

Following an analytics review, two business cases are now being developed to grow our analytics capability: to replace the end-of-life data warehouse and introduce the advanced BI tool, Qlik Sense. The BI Team is working with the Clinical Director of Cancer Services to develop a visualisation of clinically meaningful metrics.

A Clinical Director of IS has been appointed and will be announced once the contract is finalised.

A risk review of the top 25 clinical applications has been completed and will inform which proposals are inclusion in the hA IT capital plan for FY19/20.

**Updates**

**Alcohol Harm Minimisation Programme**

The CM Health position statement ‘reducing harms from alcohol in our communities’ was adopted a year ago. The position statement is a brief, evidence-based, high level statement which demonstrates the DHB’s commitment to working collaboratively to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm. The position statement provides a strong foundation for CM Health’s alcohol harm minimisation programme.

Work has been underway since 2016 to develop and implement the CM Health Alcohol Harm Minimisation Programme. The programme focusses on alcohol as a key determinant of population health and wellbeing outcomes, is underpinned by an equity approach, and prioritises prevention and early intervention actions. A key component of the programme is implementing the Alcohol ABC Approach (Assessment, Brief advice, and referral for Counselling or help) in general practice, Middlemore Hospital ED and community-based settings (including with smokefree coaches, social workers, and Police). Further work is planned in the inpatient ward setting and with midwives. This work requires adaptation of the Alcohol ABC model to each setting, development of supporting systems and processes, and customised training and sustained support for front-line staff to enable them to have skilled and empathetic conversations with people and whaanau about alcohol use.

Other components of the programme include working collaboratively with communities, health agencies and other cross-sector partners to influence the social and environmental determinants of alcohol-related harm (such as availability, price, and advertising, marketing and sponsorship of alcohol). The Alcohol Harm Minimisation Team convenes a two-monthly CM Health Alcohol Advisory Group meeting, for the purposes of providing leadership, guidance and support for the Programme and improving alignment, collaboration and co-ordination across the CM health system with regard to alcohol harm minimisation actions.

Work is also underway to improve CM Health data and information on hazardous alcohol use and alcohol-related harm. CM Health has this year published a report presenting a profile of hazardous alcohol use and
It frames alcohol-related harm from a Te Tiriti o Waitangi perspective, explores various data sources (mainly health datasets), and describes selected indicators of alcohol-related harm. Of particular note and great concern are inequities in alcohol-related harms, with Māori, males, young people, and people living in socio-economically deprived areas being most affected. It is clear that there is much work to be done to achieve equitable reduction and prevention of hazardous alcohol use and alcohol-related harm.

**Performance and Outcomes Priorities**

**Health Target Summary – Q1 2018/19**

<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Final results</th>
<th>Achievement Quarter 1 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Departments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>September 2018:</strong> 84% total population (Māori: 84%, Pacific: 83%) (target 95%)</td>
<td><strong>NOT ACHIEVED</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Patient volume and bed demand mean the hospital has been unable to reach the six hour target achieving 84% for September against the target of 95%. This is due to a variety of factors including, high consistent surge presentation rates and consistently high hospital occupancy particularly in General Medicine. Steps we are taking to improve our performance included hospital wide flow project that seeks to understand constraints in the system as a whole.</td>
<td></td>
</tr>
<tr>
<td><strong>Elective Surgery</strong></td>
<td><strong>Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region- Counties Manukau Health to deliver 20,930 Elective Surgical Discharges (ESD).</strong></td>
<td><strong>ACHIEVED</strong></td>
</tr>
<tr>
<td></td>
<td><strong>September 2018:</strong> Against the year to date total planned volumes of 5,278 ESD, actual delivery was 5,391. There was a positive variance of 113 or 102.1% of planned.</td>
<td></td>
</tr>
<tr>
<td><strong>Faster Cancer Treatment</strong></td>
<td><strong>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.</strong></td>
<td><strong>NOT ACHIEVED</strong></td>
</tr>
<tr>
<td></td>
<td><strong>September 2018 (six-month result):</strong> 89% (target 90%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> The FCT data is reported by the MoH on a 6 month rolling basis. The net impact of the technical changes has meant that CM Health has met the 90% target for 3 of the past 6 months. For the Q1 period 1.04.18 – 30.09.18 CMH has 89% performance with technical changes applied for 62 day and 91% for 31 day patients. Overall performance without application of the changes is 76% for the same time period.</td>
<td></td>
</tr>
</tbody>
</table>

1 CM Health Alcohol-Related Harm Profile: [https://countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/20180710-CMH-Alcohol-Related-Harm-Profile.pdf](https://countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/20180710-CMH-Alcohol-Related-Harm-Profile.pdf)
Breath data is collated for all patients that do not meet the 62 or 31 day timeframes and the pathway is broken down to provide narrative details that inform service change and pathway improvement. Clinical consideration remains a reason for the majority of breaches and all breaches are investigated to ensure breach reasons are accurately captured and recorded appropriately. Factors associated with capacity delays include: reduced coordination and tracker monitoring of patients from the start of the pathway because of staff vacancy and a relaxing of effort to achieve the 62 day target.

### Immunisation

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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 Maori and Pacific population groups).</strong></td>
<td>September 2018: 93% total population (Maori: 84.5%, Pacific: 95%) (target 95%)</td>
</tr>
<tr>
<td><strong>Note:</strong> The total coverage at eight months is 93%, remaining the same as last quarter, with a slight improvement (+0.5%) in eight month immunisation coverage for pepe Maori. We not achieve the 95% target in total or for pepe Maori. The focus on achieving equity for Maori has become more purposeful in that referrals have been marked to be easily identifiable by the Outreach Immunisation Service (OIS) team, which attempts to connect prioritised whaanau. Maori babies are being monitored and referred to OIS by seven to eight weeks if the general practice are not engaged with the whaanau.</td>
<td></td>
</tr>
<tr>
<td><strong>The Immunisation Nurse Leader along with the OIS and the NIR Team have also fostered a closer working relationship with the Maori Child Health team at CM health. This will support wider collaboration with community-based Maori health services as a way to better understand their role, as well as develop our understanding of how we may strengthen immunisation promotion and engagement with whaanau.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Raising Healthy Kids**

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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</strong></td>
<td>August 2018: 100% total population (Maori: 100%, Pacific: 100%) (target 95%)</td>
</tr>
</tbody>
</table>

### Tobacco

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</strong></td>
<td>September 2018: 89% total population (Maori: 88%, Pacific: 90%; Asian: 92%) (target 90%)</td>
</tr>
</tbody>
</table>
Note: In Quarter 1 CM Health was just below the 90% target for Better Help for Smokers to Quit for the total population, with performance at 89%. The target was met for our Pacific and Asian populations.

We are concerned to note that performance for Maaori is not as high as other ethnicities and did not reach the target (whereas performance was at 91.3% for Maaori at the end of Q4). We believe that the activities in the Metro Auckland SLM Improvement Plan, many of which are particularly focused on engaging with Maaori, will help increase performance.

Maternity

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

September 2018: 92% total population (Maaori 93%, Pacific: not reported) (target 90%)

Note: CM Health has continued to achieve the 90% maternity Better Help for Smokers to Quit target in Q1, for Maaori women and for the total population.

In addition to maintenance of the brief advice and support target, there have also been improvements in the acceptance of cessation support and smoking prevalence. Between Q4 2017/18 and Q1 2018/19, the percentage of women who accepted cessation support increased from 57% to 65% for Maaori women and from 55% to 71% for the total population. During this period there was also a drop in smoking prevalence, from 53% to 46% for Maaori and from 22% to 20% for the total population.

A key success has been trialing of an opt-out system for the smokefree maternal incentives programme by DHB community midwives (30 midwives), which began in May 2018. This has resulted in a doubling of referrals and a doubling in the number of women that engaged with the system, both in total and for Maaori women. All midwives including independent midwives are now being encouraged to refer all of their women to the programme.

ACHIEVED: Final results indicate the target was met in Quarter 1 2018/19.
NOT ACHIEVED: Final results indicate the target was not met in Quarter 1 2018/19.

* 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
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 28 September – 28 November 2018.
Prepared and submitted by Donna Baker, General Manager Communications and Engagement and Pauline Hanna, Acting Director Strategic Development and Facilities.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 28 September – 28 November 2018.

External Communications

Prime Minister & Minister of Health Visit

External Communications supported the GM, Communications and Engagement in planning and facilitating two significant events in November; the Prime Minister and Minister of Health’s visit to Middlemore Hospital for a capital funding announcement and the opening of Stage One Tiaho Mai Mental Health Unit. The events received extensive national and local media coverage.

Proactive Media

The Communications team proactively promoted and pitched an increasing number of positive story ideas throughout this period. These included media releases on a mental health wellness programme, the Libby App, the retirement of GM Middlemore Hospital, joint winner of the Young Nurse of the Year award, opening of the new MRI suite, Bowel Screening Programme Awareness Day, Patient Safety Week, Nocturnal dialysis, and Mental Health First Aid workshops.
One story in particular, featuring long serving orderly Ivy Tauhinu, a 50 year veteran at Middlemore Hospital, resulted in considerable social media activity and an interview on Maori TV.
News stories and information about the Dawn blessing for the new dental facility to be built on the SuperClinic site and Transgender Awareness Week also featured on the CM Health external website.

Counties Manukau DHB referral to Serious Fraud Office

External Communications managed the release of a CMDHB statement stating the board’s intention to refer matters of concern following the release of the Beattie Varley report. Requests were received from a number of media including Radio NZ, Newshub and Mediaworks. The release received widespread coverage in the media.
**Explosion at De La Salle College**
A BBQ explosion at De La Salle College resulted in a number of media inquiries regarding injuries to students and teachers. Requests were received from Newstalk ZB, Radio NZ, TVNZ, NZ Herald and Stuff.

**High profile features on CM Health**
Communications and OIA Specialist provided information for a number of stories during October, including Ophthalmology (HDC case) and Echocardiogram and Dermatology wait times.
In November the NZ Herald wrote about the experience of a patient who was expecting to be referred for an urgent Echocardiogram but received a letter which contradicted this and erroneously omitted the patient’s priority assessment rating, which had been reviewed. Communications worked on response with specialists.

**OIA - Official Information Act (1982)**
Agencies have 20 working days to advise a decision on release of information requested under the OIA. This means that there is a rolling response from receipt in one month to response in next month. Requests will vary in their complexity, scope and considerations.
We are working with the external Legal Counsel to assess the impact of the Serious Fraud Office Investigation on a number of current OIA requests, including any further grounds for withholding information due to the investigation. The Office of the Ombudsman has requested a copy of the SFO notice.

For reference: Completed the 2017/18 OIA statistics for Health Select Committee review:

<table>
<thead>
<tr>
<th>Question 56: Refer to Table</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>OIA received</td>
<td>127</td>
<td>128</td>
<td>195</td>
<td>164</td>
<td>215</td>
</tr>
<tr>
<td>Within 20 days</td>
<td>96</td>
<td>98</td>
<td>173</td>
<td>133</td>
<td>179</td>
</tr>
<tr>
<td>Beyond 20 days (extend or overdue)</td>
<td>31</td>
<td>30</td>
<td>22</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>OIA transferred</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>OIA declined - in full</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

# Note: the 24 overdue responses occurred in May 2018 related to Facilities issues and alignment with Ministry of Health response dates.

<table>
<thead>
<tr>
<th>Question 57: Refer to Table</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>OIA response time&quot;</td>
<td>17.3 days</td>
<td>18.5 days</td>
<td>18.6 days</td>
<td>21 days</td>
<td>18.9 days</td>
</tr>
</tbody>
</table>

# Note: this includes total response times where a response extension of time was notified beyond 20 working days, and does not include those requests transferred within 10 working days (10 cases).

More information on the OIA process and a form to submit requests is available: https://countiesmanukau.health.nz/about-us/official-information-act-requests/
Copies of recent OIA releases on common topics are also now on the website. https://countiesmanukau.health.nz/about-us/official-information-act-requests/publicly-released-oias/
Routine Sector Communications

**Connect+**

**Connect+ Christmas Edition**
Work continues on the development of the Christmas edition of Connect+ which will be published in December.

**Internal Communications**

**Midwifery Employee Representation and Advisory Service (MERAS) strike action**
Weekly communications teleconference calls with National office are taking place. Internal Communications has worked in collaboration with Auckland DHB and Waitemata DHB to ensure consistency of messaging. Internal and External Communications are supporting the contingency planning group by participating in daily meetings. All staff emails from the CEO and Chief Medical Officer have been sent to update staff on the situation. A separate page has been established on Paanui to post daily updates.

**Safety Awareness Day**
Middlemore Hospital’s Emergency Response team held a ‘Safety Awareness Day’ on 10 October, in line with Get Ready Week. Local emergency management organisations were invited to hold stalls and educate staff and the public about how best to manage an emergency. Organisations present included Red Cross, CM Health’s Security, Emergency Response and Fire Service, as well as healthAlliance, St John and Counties Police. Internal Comms helped communicate the event details, and with the printing and designing of collateral for use on the day.

**healthAlliance**

**Cyber Smart Week**
Cyber Smart Week was celebrated from 8 – 12 October. Internal Comms worked with healthAlliance to ensure the newly created Cyber Smart Week awards were communicated to all staff. One of the recipients’ our very own Dr Sarah Wadsworth, was announced as one of the winners and featured in the Daily Dose and Paanui.
Secure USBs Roll Out
healthAlliance worked with Internal Comms to communicate the change in USB usage across the DHB.

Language Weeks
During October we celebrated the last four language weeks for 2018: Tuvaluan, Fijian, Niuean, and Tokelauan. Internal Comms helped celebrate these language weeks through the internal channels, Daily Dose, Facebook, and Paanui.

Patient Safety and Antibiotic
Internal Comms was central to supporting and assisting the Patient Safety Week working group. The working group comprises of up to 70 attendees of clinical and non-clinical service managers.

Common themes for this year’s campaigns have been promoted together as follows:
- Infection Prevention and Control ‘Focus on Good Hand Hygiene’
- Infection Control Week
- Antibiotic Awareness Week
- Patient Safety Week

Internal Comms developed a communications plan, and designed and developed collateral to build awareness internally and externally. The collateral included posters, banners, screensaver, leaflets for patients and GP cards, which went to all GP’s with the campaign’s key messages. Channels utilised for the campaign were social media which included video, also TV monitors in Ko Awatea and Paanui button.

Bed space activation was set up in the middle of Paataka Place to educate public and staff how easily germs can make their way into the hospital bed space, the risk this poses to patients, and promoting the key messages of hand hygiene.

Events
Internal Comms supported and publicised the following events by sharing stories, photos and videos on social media and internal channels.
- 07/11/2018 MRI Opening Suite
- 21/11/2018 Prime Minister Visit
- 22/11/2018 Tiaho Mai Opening

Staff Forum
The final staff forum for 2018 will be held 19 December. Work is underway to design and disseminate the collateral to promote the event.

Scott Building Recladding Project
Internal Comms filmed ‘the experts’ talking about key aspects of the Scott recladding project. Each expert spoke about their key area, reiterating that every safety precaution has been taken into account throughout the project. The facilities team are awaiting consent from Auckland Council to begin the
recladding work. We have been working with the facilities project team to finalise collateral including the translation of an information brochure into languages reflective of the Counties population.

Every Hour Counts
Ongoing support and working with the project team on the 4 acute patient flow work streams; ED, Zero Days, Frail Elderly and Long Stay.

Organisational Development (OD) plans for 2019
Internal comms are working with OD Team to develop a communications plan to support a number of key initiatives, with a particular focus on our people, these include:
* Welcome & introduction of new staff
* Embedding and re-energising our organisational values – Values in Action (ViA)
* Health and wellbeing
* Refresh of our Speak Up programme
* Diversity and Inclusion

Youth Employment Pledge (YEP)
Internal Comms and Organisational Development continue to collaborate in the roll out of the Youth Employment Pledge (YEP). Three videos of youth currently employed through the YEP programme have now been finalised. Internally the videos will be used to highlight the benefits of employing youth, and externally to highlight the opportunities available to youth within the healthcare environment. We have also developed resources to further promote the YEP including pop up banners and posters for use within the DHB and at external events/schools etc.

Employee Value Proposition
Internal Comms is providing on-going support for HR in the development of questions to help understand why people choose to work at Counties, what they value most, and what qualities people need to display to be successful in delivering excellent services. A cross section of the workforce will be surveyed with no more than 10 quick fire questions. Once analysed, results will be used to help inform development of an employee value proposition.

Stakeholders & Communities Communications

University of Otago Dental Facility at Manukau SuperClinic
The Stakeholder Comms team supported UoO and Manawhenua in the blessing and ‘turning of the sod’ ceremony at the SuperClinic at dawn on Wednesday, 21 November. Construction can now begin on the site.

New Names for MH&A Community Teams
We have produced a reference guide for new names and meanings. This will be promoted within CM Health.

Recruitment (Midwives)
The team is supporting the development of imagery and a video to attract midwives to work at CM Health.

Proactive Stories
The Stakeholders and Communities Communications team has developed a number of proactive stories over the past two months. These include:
Mental Health First Aid Programme: Promoting the free programme to local media and on our internal and external channels.

Emergency Q: Promoting the trial of the digital system in the Emergency Department. Since the trial started in August, more than 500 patients who presented with less serious conditions have chosen to seek treatment at a local A&M clinic.

Smokefree: Promoting how a group of DHL employees have stopped smoking with the help of our Smokefree team.

Bowel Screening Programme Community Event (17 November): Supported the bowel screening team on advertising in local papers and ethnic paper’s The Samoan Times and Kaniva (Tongan media), a notice for local radio stations, collateral for the event, a video for social media, and a media release which went out to local media and Pacific media.

Safe Sleep Day (SUDI team): Created collateral for Safe Sleep Day on 7 December, including a video for social media/internal and external channels.

Promoting the Birthing Units: Supporting the Maternity team’s work on promoting the units. A video on the Papakura Birthing Unit will be shot in mid-December and released in late January. We will then move onto the other birthing units in the New Year.

Promoting Falls Prevention Programme: Developing a suite of collateral to cover internal channels to promote the programme. We’re also working on a video with a Manurewa local who is taking part in one of the programmes. This will be released in late January/early February.

Alcohol Harm Minimisation: Preparation is underway for an Alcohol Harm Awareness Week promotional activity from 3-9 December in preparation for increased presentations in ED and the hospital due to excess drinking during the festive season. The Health Promotion Agency has requested the artwork we developed to share with other NZ DHBs.

Every Hour Counts, non-acute patient workflow project: Ongoing support with the project team on this workstream.


Medinz: As part of our representation on the Medinz Steering Group we have supported the development of an evaluation plan for recipients and publishers to assess the value of Medinz and identify possible enhancements. The survey is now live.

Patient Letters: We have rewritten and redesigned outpatient radiology letters and the service will trial these letters with patients to evaluate if the redesigned letters increase patient compliance to preparation, discharge instructions and appointment confirmation.

Ko Awatea: Supporting the internal promotion of research and evaluation workshops.

Digital Channels

Website (www.countiesmanukau.health.nz)

In October we saw a large drop in traffic vs. the previous reporting period, which is to be expected nearing the end of winter. Of interest this month was the 4% increase in returning visitors – a very unusual spike in a normally consistent stat. Mobile usage is becoming increasingly popular, growing by 2.6% this period and now accounting for 48% of our traffic.

In November traffic was steady when compared to last period. We noticed an anomaly this period; a 43% increase in traffic to our ‘Hot Jobs’ page; hopefully this was a result of us profiling Ivy, an orderly who has worked at Middlemore Hospital for 50 years.
Social Media

October results across our social media channels were mixed. We saw an increase in per-post engagement and impressions on our CM Health Facebook page, but unfortunately saw a decrease in metrics for all other channels. The cause for this decrease is likely linked to posting fewer messages across these channels. Previously a slight decrease in messaging was beneficial; however we were too conservative in our approach this period.

In November we increased the number of messages sent across all channels and consequently saw an increase in impressions and engagements. However, a small drop in per-post impressions and per-post engagements is common when we post more than 20 messages per channel.
Total Fans Gained | 206 | -23.7%

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

**CM Health Facebook**
The CM Health Facebook Page was once again our best performing channel, with reach over 90,000. A visit from our PM and the opening of our new Tiaho Mai facility were our two most popular posts, reaching 24,000 people combined. The opening of the new MRI suite achieved a massive 50% engagement rate.

**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 we welcomed Prime Minister Jacinda Ardern and Health Minister Dr David Clark to Middlemore Hospital where the Prime Minister announced Counties Manukau are to receive additional funding of $80million to...</td>
<td>454</td>
<td>7</td>
<td>30.27%</td>
<td>13,365</td>
</tr>
<tr>
<td></td>
<td>It’s been a wonderful day celebrating the opening of our new Tiaho Mai Unit. We are incredibly blessed to have such a beautiful new Unit for those who will walk through our doors on their journey to recovery.</td>
<td>358</td>
<td>25</td>
<td>26.2%</td>
<td>10,707</td>
</tr>
<tr>
<td></td>
<td>After many months of hard work, persistence, and teamwork, today we are proud to open the new MRI suite which will be a huge benefit to the Counties population...</td>
<td>234</td>
<td>6</td>
<td>50.08%</td>
<td>3,648</td>
</tr>
<tr>
<td></td>
<td>Our Workforce Development teams hosted MAPAS students from The University of Auckland last week. They got to tour different departments throughout the hospital and listened to presentations from our GM for Maaori Health Development...</td>
<td>244</td>
<td>0</td>
<td>49.96%</td>
<td>3,391</td>
</tr>
</tbody>
</table>

**Healthy Together Facebook**

Our Healthy Together Page has bounce back strongly, more than doubling per-post engagements. The bowel screening campaign continues to be a strong performer with the video promoting the community event achieving our highest engagement rate for the period, 32%, and reaching more than 6,000 people.

**Top 3 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>“It’s also good to see the diversity, and so many different cultures represented across the hospital today, we are like a rainbow of different colours.” Check out the story</td>
<td>502</td>
<td>28</td>
<td>26.90%</td>
<td>5,290</td>
</tr>
<tr>
<td></td>
<td>Our awesome bowel screening team are holding a community event this Saturday (17 November), 10am-12pm at the Mangere Town Centre. There will be guest speakers, cultural performances, and giveaways. Come speak to Lorenzo (video below) and the team about...</td>
<td>392</td>
<td>4</td>
<td>31.75%</td>
<td>6,054</td>
</tr>
<tr>
<td></td>
<td>Do you live in the Counties Manukau area? Did you know that you can access free Mental Health First Aid workshops?</td>
<td>70</td>
<td>--</td>
<td>8.98%</td>
<td>2,316</td>
</tr>
</tbody>
</table>

**CM Health LinkedIn**

After a great period of growth for our LinkedIn channel, we see it return to a normal rate gaining 46 new followers this period. Stories popular on other channels appear to be popular across the board; we see the Tiaho Mai opening, the opening of the new MRI suite and Ivy’s story take out the winning spots.
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>It’s a big day for us at CM Health as Stage One Tiaho Mai has been blessed and officially opened! A powhiri was held this afternoon, with special guest Health Minister Hon. Dr David Clark on site to view the beautiful new facility...</td>
<td>151</td>
<td>1</td>
<td>37.42%</td>
<td>4,399</td>
</tr>
<tr>
<td></td>
<td>After many months of hard work, persistence, and teamwork, today we are proud to open the new MRI suite which will be a huge benefit to the Counties population. We’ve come a long way since the first MRI unit was installed in south Auckland 25...</td>
<td>145</td>
<td>6</td>
<td>24.78%</td>
<td>5,088</td>
</tr>
<tr>
<td></td>
<td>“It’s also good to see the diversity, and so many different cultures represented across the hospital today, we are like a rainbow of different colours.”...</td>
<td>54</td>
<td>5</td>
<td>6.46%</td>
<td>1,765</td>
</tr>
</tbody>
</table>

Figure 11 LinkedIn Top Posts by engagement

CM Health Twitter

A steady period for Twitter this November. Messaging around the visits from David Clark and Jacinda Adern were strong performers giving us a 20% increase in engagement.

Top 5 Posts by impressions:

<table>
<thead>
<tr>
<th>Tweets</th>
<th>Top Tweets</th>
<th>Tweets and replies</th>
<th>Promoted</th>
<th>Impressions</th>
<th>Engagements</th>
<th>Engagement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health @omdhb. Nov 22</td>
<td>The opening of Stage One Tiaho Mai is underway! A beautiful powhiri was held this afternoon, with special guest Health Minister Dr David Clark to view the beautiful new facility. The new adult mental health facility is a New Zealand first! Read more: bit.ly/2FIDx83 pic.twitter.com/x3y2I7er0Z/S</td>
<td>3,480</td>
<td>25</td>
<td>0.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health @omdhb. Nov 9</td>
<td>This week we are celebrating Diwali, the Festival of Lights. May this Diwali brighten up your life with the light of happiness, bliss, wealth, prosperity and devotion. Shubh Deepawali! Diwali pic.twitter.com/Fb2w0W6T4</td>
<td>1,633</td>
<td>20</td>
<td>1.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health @omdhb. Nov 10</td>
<td>The next Emergency Mobile Alert test will take place this coming Sunday, 25 November. Find out more: bit.ly/2QbNl95 facebook.com/countiesmanuka...</td>
<td>1,242</td>
<td>1</td>
<td>0.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health @omdhb. Nov 9</td>
<td>We’re committed to the #safety and #quality of care for all of our patients and their whanau. The Patient Safety Leadership walk around today had a focus on hand hygiene and antibiotic awareness... facebook.com/countiesmanuka...</td>
<td>1,169</td>
<td>16</td>
<td>1.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health @omdhb. Nov 21</td>
<td>Today we welcomed Prime Minister Jacinda Ardern and Health Minister David Clark to Middlemore Hospital where the Prime Minister announced additional funding of $380million to address some of our most needed building projects. #KaPaI everyone who helped make this event a success! pic.twitter.com/Vy2TVhTMM</td>
<td>1,155</td>
<td>95</td>
<td>8.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Listening

Peaks:

- Late November: Prime Minister’s Visit & Tiaho Mai Opening.

Figure 12 Social volume, sentiment and sources
Figure 13 Social reach and hours
Figure 14 social influence, topics and weekdays
Counties Manukau District Health Board

Figure 15 social volume, sentiment and sources

News/Media Listening

Peaks

November 9
Car crash
1 in 8 kiwis on anti-depressants

November 14
Multiple car crashes
8 week old baby seriously injured in South Auckland

November 22
Prime Minister’s Visit
Tiaho Mai Opening

Mentions
911
-10.77%

Sentiment (News)

Volume

Sources

11/01/2018 to 11/28/2018 (News)

Positive: 8
Neutral: 802
Negative: 101

Facebook
Web
News
Blogs
Forums

November 9
Car crash
1 in 8 kiwis on anti-depressants

November 14
Multiple car crashes
8 week old baby seriously injured in South Auckland

November 22
Prime Minister’s Visit
Tiaho Mai Opening

Counts Manukau District Health Board

12 December 2018
068
Figure 16: Hours and reach from 11/01/2018 to 11/28/2018 (News)
Figure 17 influence, topics, and weekdays
Counties Manukau District Health Board
Occupational Health and Safety Performance Report

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period ending 31 October 2018.

Prepared and submitted by Marie Townsley, Acting Health and Safety Manager and Elizabeth Jeffs, Director Human Resources

Purpose

The purpose of the Health and Safety 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 notifiable event in November. Acute Mental Health patient punched attending nurse, causing damage to eye and face areas. Nurse was admitted for observation following assessment at ED. Reported to WorkSafe who reviewed and advised no further action to be taken by them. Incident investigation underway, with the MH Service in conjunction with H&S and Quality teams.

- **Incident Reporting in October:**
  Incident reporting remained consistent with September figures at 133, with a consistent increase in reporting across the full 12 month period. Incidents primarily reported as, violence and aggression; moving and handling and BBFE. All of these categories are being activity investigated and supported by the OHSS team. The ACC audit commended our work within both the moving and handling project and the initiatives within Acute Mental Health relating to violence and aggression. Trips, slips and falls have decreased to a 12 month low reflecting the education programme undertaken with the support services.

Current Issues Update:

- **ACC AEP Audit preparation (November 2018):**
  - ACC Audit undertaken by ACC auditor, Martha Rowbotham with CMH preliminary result being the retention of tertiary level ACC accreditation. The Auditor commended CMH on the new Tiaho Mai facility and the employee representation from the CMH services reviewed being: Acute Mental Health; Orthopaedic and the Orderly services. Draft report attached for reference.
  - Projects still continuing with the Facilities and Engineering (F&E)/External Contractors:
    - Contractor Management – contractor pre-qualification process rolled out to existing contractor base and continuing the programme to completion to reach compliance.
    - Hazardous Goods Management – continuation on programme with F&E to finalise register, on site chemical audit of services are work in progress.
    - Worker Participation – National programme signed off and CMH alignment framework being completed for presentation to ELT in December/January, delay due to ACC audit process.

- **OHSS Team Resource:**
  - 1 x H&S Team Leader/Business Partner vacancy to be recruited in New Year.
  - H&S Contractor working on key project work and covering vacancy until February 2019.
Performance Scorecard

Health and Safety Scorecard

October 2018

### Lagging Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Reported Incidents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>180</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Visitor</td>
<td>3</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Number of Injury claims</td>
<td>20</td>
<td>&lt;35</td>
<td></td>
</tr>
<tr>
<td>Lost time incidents</td>
<td>5</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Lost time injury frequency rate</td>
<td>13.21</td>
<td>&lt;10</td>
<td></td>
</tr>
<tr>
<td>Cost of Injury claims</td>
<td>$158</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Lost time injury severity rate</td>
<td>171.49</td>
<td>&lt;630</td>
<td></td>
</tr>
</tbody>
</table>

### Leading Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at H&amp;S Orientation</td>
<td>98%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Pre employment health screening completed</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Staff hand hygiene</td>
<td>85%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

### Comment on Variations

#### Indicators in Red

- **LTIFR**
  - 12 month rolling average figure remains above the target at 14 vs 10.
  - Moving and Handling project will positively impact LTI figures.

#### Indicators in Blue

- **Attendance at H&S Orientation**
  - Attendance at orientation improved with only 1 participant being unable to attend. 43 out of 44 attended.
LTIFR

LTIFR Figure of 13.21 is tracking lower than the previous three month which were over 14. In reviewing the 12 month rolling figure, it still is impacted by the January-February 18 peak. Severity remains lower from March-September, corresponding with the average days lost figure.
Injury Claim Data

**INJURY CLAIM DATA**

<table>
<thead>
<tr>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total</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>233.21</td>
<td>21,768.29</td>
<td>16,906.72</td>
<td>28,497.95</td>
<td>67,172.96</td>
</tr>
</tbody>
</table>

**WellNZ benchmarking data for Quarter ending 30 June 2018**

The above graphs detail the WellNZ benchmarking of Average costs of claims between CMH on the left in both graphs and other healthcare providers have higher average costs across both claims and entitlements cover the last four complete and fifth part year periods.

Please note the report (for each year) covers the period 1 July to 30 June for the corresponding year. Each of the years up to 2018 cover a full 12 month period and the year noted as 2019 covers July 2018 month figures.
Key Health and Safety Risks

CM Heath key H&S risks with update/status of management of the risk, including key initiatives to reduce risk.

<table>
<thead>
<tr>
<th>Risk: Occupational Health &amp; Safety - Aggression and Violence (Emergency Department, Mental Health, Community Mental Health)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Report Action</strong></td>
</tr>
<tr>
<td>• Steering group recommendation paper on Queensland health’s Taskforce and CMH implementation programme to Board.</td>
</tr>
<tr>
<td>• ED staff presented Code Orange initiative to Board and following approval have started implementation. Steering group met to discuss further development of team outside of ED to support, including Security alert protocols.</td>
</tr>
<tr>
<td>• ED incident reporting has continued outside Riskpro. Discussions on capturing reporting, investigations and process as impacting reporting figures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk: Hazardous Substances and New Organisms (HSNO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Action Point</strong></td>
</tr>
<tr>
<td>• H&amp;S Contractor presented initial gap analysis of current hazardous goods management against WDHB programme and recommended action points including updating WDHB process and site inspections.</td>
</tr>
<tr>
<td>• F&amp;E H&amp;S Advisor updating Hazardous Goods on site.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk: Occupational Health and Safety - Safe Moving and Manual Handling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Action Point</strong></td>
</tr>
<tr>
<td>• M&amp;H opened training room and commenced M&amp;H training for graduate nurses.</td>
</tr>
<tr>
<td>• Steering groups meeting with update on progress against action points.</td>
</tr>
<tr>
<td>• M&amp;H incident reporting remains high and expected reduction as training; equipment and improved practices implemented.</td>
</tr>
</tbody>
</table>
### Risk: Blood and Body Fluid Exposure (BBFE)

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Graduate Nurse Induction OHN and Manager, OHSS presented BBFE prevention and process as part of induction.</td>
<td>• BBFE still tracking higher than previous month and higher than 12 month comparison figure. Lack of concentration and incorrect technique key reasons.</td>
</tr>
<tr>
<td>• BBFE tracking for 3 month period indicated key issues, reported through to ELT/Board</td>
<td>• BBFE also caused through not using sharps bin and OHSS team follow up with operating theatres to understand reasons.</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>• Emergency team had a number of incidents, due to busy service and wet floors. Administration and Management team contributed to these figures.</td>
<td>• Lowest incident rate for last 24 months.</td>
</tr>
<tr>
<td>• Cleaning team incidents remain low in compared to last year’s figures.</td>
<td>• Continuing discussion with Orderlies/Cleaners who remain at lower than previous years’ results.</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>• H&amp;S training delivered in Sep and next session in Oct.</td>
<td>• H&amp;S Rep training continues and now caught up on full year target figures.</td>
</tr>
<tr>
<td>• Presentation by Manager, OHSS to Foundations of management, Welcome Day and Graduate Nurses induction.</td>
<td>• Recommended H&amp;S training plan to be presented in next Board meeting in Feb 2019, with training to commence in March 2019.</td>
</tr>
<tr>
<td>• H&amp;S training &amp; Resourcing plan to be developed and delivered in Nov for approval and rollout in 2019.</td>
<td>• Resourcing plan to be presented to ELT following agreement on training plan for 2019.</td>
</tr>
</tbody>
</table>

### 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>• Manager, OHSS attended National Mental Health Conference in Wellington with feedback on programme presented by Lead H&amp;S Government Advisors.</td>
<td>• Mental Health Awareness Week included:</td>
</tr>
<tr>
<td>• MH Awareness Week preparation on activities including EAP Works representation and OHN involvement. Working closely with MH team.</td>
<td>o EAP/Mental Health First Aid presentations</td>
</tr>
<tr>
<td>• Staff Forum feedback on Flu Campaign with final figure of 72% uptake.</td>
<td>o BBQ for staff at MSC</td>
</tr>
<tr>
<td>• Peer Vaccinator ‘thank you’ for work on flu campaign (132 nurses) scheduled for Oct.</td>
<td>o Mindfulness session</td>
</tr>
<tr>
<td></td>
<td>o Mental Health client art exhibition</td>
</tr>
<tr>
<td></td>
<td>• Flu campaign close out presentation as part of CEO Staff Forum.</td>
</tr>
<tr>
<td></td>
<td>• Peer Vaccination awards celebration completed.</td>
</tr>
<tr>
<td></td>
<td>• OHP presentation to Junior Doctors on fatigue management/sleep management.</td>
</tr>
<tr>
<td></td>
<td>• Campaign supporting hand hygiene.</td>
</tr>
<tr>
<td>Risk: Physical environment (ventilation, lighting, noise, equipment)</td>
<td>Previous Action Point</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>• Manager referrals remain high and impacting OH Clinician bookings.</td>
<td>• Air conditioning being fitted to Western Campus by F&amp;E following incident reports on excessive heat in upper floor.</td>
</tr>
<tr>
<td>• Awaiting delivery of audiometers.</td>
<td>• Audiometers delivered and roll out of annual hearing tests to commence.</td>
</tr>
<tr>
<td>• Asbestos Management Plan rolled out to wider organisation by F&amp;E H&amp;S Advisor.</td>
<td>• Asbestos removal commenced at Galbraith Building with F&amp;E supervision.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk: Compliance - Worker Participation</th>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Worker Participation agreement framework being finalised and will be presented to ELT/Unions/Board in Oct/Nov aligned with National WPA agreement.</td>
<td>• Worker Participation Agreement (WPA) draft framework to be presented to ELT/Board and then consulting with Unions early 2019.</td>
<td></td>
</tr>
<tr>
<td>• H&amp;S Rep training on going.</td>
<td>• H&amp;S rep training completed for 2018.</td>
<td></td>
</tr>
<tr>
<td>• Assessing current H&amp;S Committees and recommending further plans for improving H&amp;S Committees/work group representation as part of framework.</td>
<td>• Further discussion on workgroups, additional H&amp;S Committees to be consulted with Unions.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Communication from H&amp;S Committees through to ELT H&amp;S Committee/Union to be finalised following consultation with Unions.</td>
<td></td>
</tr>
</tbody>
</table>
Reported Incidents

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

Previous 13 months – 112
Current 13 months – 120

Increase in rolling average figure – due to consistent increase in reporting of aggression and violence and M&H incidents.

**Key Observations:**

- **Aggression and Violence (35):** Remains highest reported incident category. Slight decrease from September figure of 39. Code Orange initiative, swipe card pilot study all working to reduce the incidents, at this stage still encouraging capture of all incidents.

- **BBFE (30):** Increase from Sep figure of 27 and remains higher. OHSS team tracking trends and following up with services.

- **Other (25):** ‘awkward position/posture’ was high. Safe moving of objects/equipment contributory factor.

- **Moving & Handling (18):** Sharp decrease from September figure of 29.

Notifiable Events

<table>
<thead>
<tr>
<th>Date Reported to WSNZ</th>
<th>Type of Incident</th>
<th>Injury Sustained</th>
<th>Date of Incident</th>
<th>Outcome/ Recommendations Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Event in November</td>
<td>Aggression and Violence</td>
<td>Eye area bruising and lacerations. Face bruising, crushing or fracture injury and potential head injury requiring specialist review underway.</td>
<td>24/11/2018</td>
<td>Nurse was attacked by MH patient who had shown no previous aggressive behaviour. Clinical and service review on controls. Personal alarm did not work to alert other staff.</td>
</tr>
</tbody>
</table>
BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly average comparison:

Previous 13 months – 23.2
Current 13 months – 25.6
- BBFE incidents remain higher than previous 24 month results for same period.
- SAP services are the highest incidents, with the ED services also increasing. Main causation incorrect technique, working too fast and distraction.
- OHSS tracking trends and following up with services to reduce reoccurrence.
- Cleaning services experiencing BBFE as a result of SAPs not placing used needles in sharps bin.

Aggression and Violence

Rolling year-on-year monthly average comparison:

Previous 13 months – 23
Current 13 months – 29.5
- Consistent with previous 12 month figure and remains higher than previous quarter, consistent with the increase in reporting.
- ED figures are less than actual incident figure as a number of lower level incidents captured outside Riskpro system.
- ED rolling out ‘Code Orange’ trial and including Security Services to enable better control of elevated behaviour.
- Mental Health remains highest area for reported incidents.
- Causation profile:
  Behaviour – Aggressive/Violent: 26;
  Behaviour – Inappropriate/Sexual: 7;
  Assault – Verbal/Gesture: 2
Moving and Handling

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

Previous 13 months – 21.3
Current 13 months – 19.3

- Slight decrease in reporting year on year rolling average, with a significant decrease when compared to October 2017 incidents.
- M&H training programme rollout out with weekly programmes being delivered and train the trainer reviews from WDHB team.
- MMC services have the highest reported M&H incidents.
- Causation profile:
  Awkward posture/equipment malfunction/job factors/action/behaviour of employee or patient/affiliate/human factors: 12;
  Lifting/carrying/load size: 5;
  Repetitive handling/movement: 1

Stress/ Fatigue

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

Previous 13 months – 7
Current 13 months – 5

- Decrease in reporting year on year rolling average. There was a significant increase when compared to October 2017 incidents.
- Causation profile:
  Assistance unavailable, job factors/work arrangement/organisation: 4;
  Action/behaviour of employee/affiliate: 4
Slips, Trips and Falls

Rolling year-on-year monthly average comparison:

Previous 13 months – 13.5
Current 13 months – 12

- Slips, Trips and Falls incidents have decreased when compared with the year on year rolling average of 2016/2017.
- While the Facilities Services have the highest incidents at 2 the Cleaning team incidents still remain low compared to previous figures as a result of the focus the service have on reducing this incident type.
- Nursing/Midwifery/HCA are the main group represented in the figures.
- Causation profile: Falls contributed in all of the incidents.

Reported Incidents Summarised by Workforce and Division
Occupational Health Service Update

- Key focus for the H&S team has been preparation and completion of the ACC Audit, both with supporting the services being reviewed and compiling the evidence to present to the Auditor.
- The OHN team have delivered all pre-employment screening on time and contributed to the success of Mental Health Awareness Week with involvement in a number of the activities and raising the visibility of the team with the wider MSC staff.

OCC Service Activity for October 2018

<table>
<thead>
<tr>
<th>Case and Claims Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury Management claims managed as high risk through WellNZ or low risk through Injury Case Manager at CMH.</td>
</tr>
<tr>
<td>Pending Claims claims requiring initial assessments and further investigation before a cover decision is made.</td>
</tr>
<tr>
<td>Complex claims may remain as pending up to 21 days, when a decision/or extension (awaiting further evidence with assessed by an OHP) pending decision to accept/decline claim.</td>
</tr>
<tr>
<td>ACC Audit reviewed Case Management and CMH retain tertiary accreditation for injury case management.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccinations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccination programmes as part of the pre-employment screening programme have increased.</td>
</tr>
<tr>
<td>OHSS Nursing staff took part in the Mental Health Awareness week initiatives in conjunction with the Mental health teams and as part of the Wellness initiative.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinic Appointments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in clinic appointments following September figure of 134 with increase in vaccinations following increase in pre-employment screening.</td>
</tr>
<tr>
<td>Staff booking and not attending clinic appointments has increased significantly. Follow up phone calls to identify key reasons for missing appointments are being conducted, although illness has contributed to this figure.</td>
</tr>
<tr>
<td>The Occupational Health Clinics have been full, due to the increase in referrals and the complexity of cases resulting in longer close out periods.</td>
</tr>
</tbody>
</table>
**Glossary for Monthly Performance Scorecard and Report**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lost time incidents</strong></td>
<td>Any injury claim resulting in lost time.</td>
</tr>
<tr>
<td><strong>Lost time injury Frequency Rate</strong></td>
<td>No of lost time Injuries per million hours worked. <strong>LTIFR (Lost Time Injury Frequency Rate)</strong> = (Number of Lost Time Injuries / Hours Worked) * 1,000,000.</td>
</tr>
<tr>
<td><strong>Injury Severity Rate</strong></td>
<td>Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked. <strong>LTISR (Lost Time Injury Severity Rate)</strong> = (Number of Lost Hours / Hours Worked) * 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 capsise; 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>
</tbody>
</table>
| **Reasonably Practicable**               | Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.e.g the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
</tr>
<tr>
<td>ARF</td>
<td>Audit, Risk and Finance</td>
</tr>
<tr>
<td>BBFE</td>
<td>Blood and/or Body Fluid Exposure</td>
</tr>
<tr>
<td>CCS</td>
<td>Central Clinical Services</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Programme (Counselling)</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>EMIC</td>
<td>Emergency Medicine &amp; Integrated Care</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSNO</td>
<td>Hazardous Substance New Organisms Act</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
</tr>
<tr>
<td>IRS</td>
<td>Incident Reporting System</td>
</tr>
<tr>
<td>JCC</td>
<td>Joint Consultative Committee</td>
</tr>
<tr>
<td>LTI</td>
<td>Lost Time Injury</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MMC</td>
<td>Middlemore Central</td>
</tr>
<tr>
<td>OHSS</td>
<td>Occupational Health and Safety Service</td>
</tr>
<tr>
<td>PHCS</td>
<td>Primary Health &amp; Community Services</td>
</tr>
<tr>
<td>PEHS</td>
<td>Pre-Employment Health Screening</td>
</tr>
<tr>
<td>SAP</td>
<td>Surgical, Anaesthesia &amp; Perioperative</td>
</tr>
<tr>
<td>SPEC</td>
<td>Safe Practice and Effective Communication</td>
</tr>
<tr>
<td>WellINZ</td>
<td>Injury Management Third Party Administrator</td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
NRLTIP Portfolio of Work – Focus, Oversight and Governance

Recommendation:

That the Board:

Receive the NRLTIP Programme of Work - Focus, Oversight and Governance Paper.

Note the Northern Region Long Term Investment Plan, agreed by Boards in February and March 2018, has now been formally released.

Note this paper was endorsed by the Audit Risk & Finance Committee on 21 November to go forward to the Board.

Approve the signalled changes to the Northern Region Long Term Investment Plan (NRLTIP) Portfolio of work focus, oversight and governance

Prepared by: Dale Bramley (CEO WDHB), Gloria Johnson (CMO CMDHB); Tony Phemister (Portfolio Manager NRA) and endorsed by: Regional Executive Forum: Yes: Date: Friday, 21 September 2018.

Purpose

This paper is concerned with ensuring the NRLTIP portfolio of work has appropriate governance and oversight to ensure successful work delivery. The NRLTIP is the regional mechanism to align DHB efforts to ensure ‘the best health gain for the people living in our Northern Region’ The NRLTIP has a strong alignment with each of the Board’s Strategic Goals.

Executive Summary

This paper seeks Board agreement to changes to the oversight and delivery arrangements for progressing The Northern Region Long Term Investment Plan. The changes are refinements to the oversight and delivery arrangements published in the NRLTIP, agreed by the four Northern Region Boards in February to March 2018, and as detailed in the NRLTIP released by the Prime Minister and Minister of Health on Friday 19th October 2018.

The oversight changes are required to better:

- Align subject matter expertise and oversight to NRLTIP specific programmes and areas of work
- Clarify the relationships between programmes of work; in particular which programmes ‘set direction’ or define ‘output and process expectations’.

This paper also informs DHB Boards that the next NRLTIP will be renamed ‘The Northern Region Long Term Health Plan’ to better reflect the plan’s emphasis upon health gain and regional health service strategic direction; in addition to the investment that will be required to enable progress along the Region’s direction of travel.

Appendix

1. Northern Region DHB Board paper.
To Northern Region DHB Boards
From Dale Bramley, Gloria Johnson and Tony Phemister
Date 26 October 2018
Subject NRLTIP Portfolio of Work – Focus, Oversight and Governance

Recommendations

It is recommended that the Northern Region DHB Boards:

- **Agree**: The signalled changes to the Northern Region Long Term Investment Plan (NRLTIP) Portfolio of work focus, oversight and governance
- **Note**: The next NRLTIP will be named ‘The Northern Region Long Term Health Plan’ This name change to better reflect that the plan has a focus on health gain and regional health service strategic direction, not just the enabling investment requirements
- **Note**: The Northern Region Long Term Investment Plan, agreed by Boards in February and March 2018, has now been formally released

Introduction

The Northern Region Long Term Investment Plan (NRLTIP) agreed by Northern Region DHB Boards during February and March 2018, has just been released following announcements by the Prime Minister and Minister of Health on Friday 19th October 2018.

The next steps section of the released NRLTIP, titled: ‘Progressing Regional Work’ (refer Attachment One), outlined a Portfolio, Programme and Project delivery structure comprising three programmes of work:

- Regional Health Planning
- ISSP
- Capital Investment.

The intent was that all the ongoing NRLTIP work would be coordinated through a NRLTIP Portfolio Steering Group (PSG). To enable prompt commencement of the 2018/19 work the NRLTIP PSG continued from March 2018 with, mainly, the same PSG membership that delivered the first NRLTIP. This PSG has been meeting to progress the ongoing work throughout the year to date.

NRLTIP Portfolio and Programmes – Key Accountabilities

As this year’s NRLTIP work has progressed, the delivery structure for the NRLTIP Portfolio of work has been clarified, both in terms of required areas of accountability, as well as areas that require strengthened oversight.

The latest ‘Accountability View’, as discussed at the NRLTIP PSG on 30 August 2018, is shown in the following Figure.
Potential Changes to Portfolio Focus, Oversight and Governance

Discussion at the August NRLTIP PSG considered, and reinforced, the following thinking regarding potential changes to focus, oversight and governance of the NRLTIP Portfolio of work:

1. The NRLTIP work currently underway, together with the next regional plan to be delivered across the Portfolio of three programmes of work, should be rebranded as a 'Northern Region Long Term Health Plan' (NRLTHP).

2. The NRLTHP will refine the NRLTIP#1 Strategic Direction of Travel to ensure ‘the best health gain for the people living in our Northern Region’. This Direction of Travel will make explicit reference to:

   a) **Health Service Planning** areas of particular focus, as detailed in Figure One. The Health Service Planning work will define, or refine, models of care in the areas of interest. (this work will support the identification of enabling investment requirements).

   b) The key enabling areas of:
      - Capital investments for facilities and infrastructure
      - Information systems investment

---

1 NRLTIP#1 had the strapline ‘Setting the direction for future investment that secures the best health gain for the people living in our Northern Region’
Each of these enabling areas will have a focus upon clarifying and detailing the enabling investment requirements; the Region’s development commitments; and delivery mechanisms, while also recognising the appropriate approval requirements.

3. It was noted that ‘Workforce’, currently embedded within Health Service Planning would likely be extracted as another delivery ‘enabler’ in subsequent NRLTHPs (post 2018/19)

4. The Portfolio, Programme and Project oversight arrangements should be modified to recognise that:
   
a. The Regional Executive Forum is the appropriate forum for the Regional oversight of the NRLTHP Portfolio of work, placing a particular focus on the functions as indicated in Figure One namely:
      
      • Quality assurance
      • Strategy and alignments
      • Process streamlining

b. The current NRLTIP Portfolio Steering Group membership could well be better applied to help steer the work of the specific programmes, splitting the membership according to the member’s particular expertise and area of interest. This would provide strengthened ‘tactical’ oversight of both the Health Service Planning Programme of work and the Capital Investment Programme of work, each of which would benefit from increased Programme level oversight and focus.

c. The accountability for the Information systems programme of work would remain invested in the ISSP programme delivery team which currently receives oversight from the ISSP Programme Steering group. The ISSP programme team is proposing to separate the oversight of the delivery aspects of the programme from the execution aspects of the programme. The strategy, design and prioritisation functions would be sit beneath the NRLTIP (NRLTHP), as it is the IS design component that is delivering to the health plan.

d. The Capital Investment Programme of work needs a strengthened oversight function which should sit with a Regional Capital Investment Design Authority. The Terms of Reference and membership of the current Regional Capital Group, chaired by Rosalie Percival, should be reviewed to reflect the need for Programme level oversight of:

   • The Capital Planning System Sub Programme of work; with an initial focus on quality assurance and process improvement initiatives. These are expected to cross capital planning processes from Concept, through Approval, Procurement, Build and Commission. This Capital Planning oversight will impact on all processes relating to capital, or ‘near capital’ investments relating to IS/IT; Facilities and Infrastructure, Clinical equipment etc. This programme of work will therefore impact on IS and Capital Investment programmes of work

   • The ‘Capital Build and Works’ sub programme which relates to Facilities and Infrastructure delivery, with an initial emphasis upon the options for regional organisation structure and those ‘in-house’/’out-of-house’ capacity and capability arrangements required to successfully deliver the NRLTIP investment plan

   • Process for, and delivery of, Asset Management Planning in an integrated manner across our Region

   • Continuation of the current Regional Capital Group function relating to review and approval of all Business Cases (to meet national expectations of regional endorsements and approvals)
e. The Chair of the Regional Capital Investment Design Authority, Rosalie Percival should join the current NRLTIP/NRLTHP Executive Sponsors: Dale Bramley; Gloria Johnson; and Andrew Brant, and this Executive Group should continue to provide, a **REF delegated**, ongoing: oversight; quality assurance; and alignment function for all the NRLTIP/NRLTHP related Portfolio and Programme deliverables that will be brought to the REF table. This includes oversight of the itemised Portfolio level workstream deliverables relating to:
   i. Production of the next NRLTHP; and
   ii. Communications and stakeholder engagement associated with the NRLTHP Portfolio of work.

**Implications for Governance and Oversight of Ongoing Work**

The discussions regarding the strengthened oversight of the NRLTIP (NRLTHP) Portfolio of work, together with recommendations from the ISSP Program Team, suggest an oversight and governance structure as represented in the following Figure (Figure Two: Required Governance and Oversight of the NRLTIP (NRLTHP) Portfolio of Work).

In effect, the oversight arrangements outlined in the figure:

- Streamline the Portfolio oversight, utilising the existing Executive Forums and Sponsors,
- Enables better distribution of Steering Group expertise and time to best support and focus the three programmes of work upon delivery to regional requirements

The most significant changes shown in this figure relate to:

- The proposed function of the **IS Programme oversight** group. This changes from a Steering group with oversight of both ‘Design’ and ‘Delivery’ to an **IS Design Group**; with ‘Delivery’ functions being subject to oversight and governance delivered under a different oversight and governance mechanism

- The **Regional Capital Investment Design Group** function and form. This group will be an expansion of the role of the current ‘Regional Capital Group’. The Regional Capital Group currently meets monthly and typically has a full agenda considering business cases requiring regional approvals. Realigning the function and work-plan for this group across the three outlined sub-programmes, plus a modified current regional business case endorsement function, will require:
  - Commitment and input from already stretched DHB senior financial staff and capital planners
  - Additional representation with additional skill sets and expertise to reflect the areas of work requirement, noting that:
    - Under the NRLTIP Portfolio regional resource has been secured to assist with the Capital Build and Works sub-programme
    - Treasury is leading work on national Asset Management Planning and our Region should be able to leverage from this work
    - The Capital Process Improvement is a large piece of work and requires further planning to prioritise which elements of ‘joined up’ work should be done first to achieve regional improvements.
Other Key Regional Groups and Forums

There are several other regional groups and forums that have functions that are relevant to the NRLTIP portfolio or work and that undertake work in parallel to the NRLTIP programme with support from the NRA. The work programmes of these groups are primarily focussed on operational service matters but do also involve some strategic considerations. Key among these other groups and forums are the:

- Service Review Program Advisory Group (SRPAG); this group comprises a mix of DHB Chief Operating Officers and General Managers. This group currently reports to Regional Executive Forum
- Regional Funding Forum This comprises the DHB Funders and Planners and reports to the Regional Executive Forum
NRLTIP Programme of Work - Attachment One

Extract from: NRLTIP Jan 2018
Section 7: ‘Progressing Regional Work on the Long Term Investment Plan’

'We will manage regional delivery to an agreed scope and sequence of work by providing an appropriate management focus on:

- Doing the right things – a key focus for Portfolio management
- Realising the benefits – a key focus for Programme management
- Doing things in the right way – a key focus for Project management

To progress the NRLTIP, we will structure the ongoing work within three Programmes which will clarify, progress and implement the Region’s investment directions in the coming year. Each Programme will be managed within an overall ‘Northern Region Long Term Planning’ Portfolio of work (as outlined in Figure 37 below).

Figure 1: Oversight framework for ongoing regional long term planning

The ‘Northern Region Long Term Planning Portfolio’ will collate, align, coordinate and report on the key implementation plans and the key actions being progressed by each Programme in the short, medium and longer term. Communication plans relating to each Programme of work will be coordinated through the Portfolio oversight structure. The Long Term Planning Portfolio will report on the progress of each Programme via the Regional Executives Forum, to the Regional Governance Group.'
Counties Manukau District Health Board

Regional Information Systems Strategic Plan Update and Proposed Information Systems Governance Arrangements

**Recommendation**
That the Board:

**Receive** the Regional Information Systems Strategic Plan update and proposed Information Systems governance arrangements paper.

**Note** this paper was endorsed at the 21 November Audit Risk & Finance Committee meeting to go forward to the Board.

**Note** healthAlliance reporting will provide visibility of ISSP delivery activity and progress (as part of the regular healthAlliance Board to DHB FRACs and regular programme reporting).

**Note** DHB approvals will be sought for funding requests, in accordance with the DHB delegated authority policy and Ministry of Health approval requirements.

**Note** that approval is being sought by all four northern DHB and the hA boards.

**Note** in light of the new governance arrangements, a review of the composition of hA Board will be undertaken.

**Approve** the Regional Information Systems Strategic Plan (ISSP) version 2, Regional Road maps version 1.

**Agree** that the governance arrangements, including the Terms of Reference for the ISSP Design Authority and ISSP Delivery Programme SG, are revisited by RGG.

**Prepared and submitted by:** Les Greeff (ISSP Programme Director) on behalf of Andrew Brant (ISSP Sponsor, WDHB CMO and Deputy CEO)

**Background**

The Northern Region developed an Information Systems Strategic Plan (ISSP) to ensure that investments are aligned with key health service requirements and will enable future model of care changes as outlined in the Long Term Investment Planning (LTIP) and associated health services planning. The first version of the ISSP and the LTIP were approved by the four northern region DHB boards at the end of 2017.

Our systems are currently not fit for purpose to deliver to our LTIP plan. We have ageing infrastructure, complex environment and a very large application ecosystem. Our information systems are a key enabler to help us deliver to our plan and to achieve our vision of an integrated, patient centred health system in the Northern Region.

**Appendices**

1. Northern Region DHBs Board paper.
2. Proposed Governance Arrangements.
3. Existing Programme Governance.
4. ISSP v2 Executive Summary *(the full report is available in the Board Diligent Resource Centre)*
5. ISSP v1 Roadmap Executive Summary *(the full report is available in the Board Diligent Resource Centre)*
6. ISSP v1 Delivery Charter Overview *(the full report is available in the Board Diligent Resource Centre)*
To: Counties Manukau District Health Board  
From: Andrew Brant  
Date: 12 December 2018  
Subject: Regional Information Systems Strategic Plan update and proposed Information Systems governance arrangements

**Recommendations**

It is recommended that the Counties Manukau District Health Board

- **Receives** the Regional Information Systems Strategic Plan update and proposed Information Systems governance arrangements paper.
- **Approves** Regional Information Systems Strategic Plan (ISSP) version 2, Regional Roadmaps version 1, and programme delivery charter with associated proposed regional IS governance arrangements.
- **Approves** the new regional Information Systems Governance arrangements encompassed within the programme charter. The arrangements include the healthAlliance Board providing oversight on the programme delivery of the ISSP.
- **Notes** that healthAlliance reporting will provide visibility of ISSP delivery activity and progress (as part of the regular healthAlliance Board to DHB FRACs and regular programme reporting).
- **Notes** that approval is being sought by all four northern DHB and the hA board.
- **Notes** that the terms of reference for ISSP Design Authority and ISSP Delivery Programme SG have not yet been decided and are not presented for approval.

**Background**

The Northern Region developed an Information Systems Strategic Plan (ISSP) to ensure that investments are aligned with key health service requirements and will enable future model of care changes as outlined in the Long Term Investment Planning (LTIP) and associated health services planning. The first version of the ISSP and the LTIP were approved by the four northern region DHB boards at the end of 2017.

Our systems are currently not fit for purpose to deliver to our LTIP plan. We have ageing infrastructure, complex environment and a very large application ecosystem. Our information systems are a key enabler to help us deliver to our plan and to achieve our vision of an integrated, patient centred health system in the Northern Region.

The delivery of the ISSP is a large piece of work and in order to deliver this regionally, three new streams of work have now been completed along with the associated artefacts:

1. **Strategy** - an updated Regional ISSP V2.0.
2. **Design and Prioritisation** - a Regional ISSP Roadmap V1.0 which outlines the programme of work that needs to be undertaken.
3. **Delivery** - an ISSP Programme Charter Vs 1.0.

The programme charter incorporates the proposed new regional information systems governance arrangements. The new arrangements provide clarity on two key functions, strategy and design, and programme delivery and is summarised in **Appendix A**, with the existing arrangements in **Appendix B**.

All three documents, including the proposed regional IS governance arrangements, have been endorsed by Regional Executive Forum on 21 September 2018 and Regional Governance Group (RGG) on 4 October 2018. This paper is to seek approval of the three documents, including the new regional IS governance arrangements.
These are living documents which will be updated regularly to reflect the Region’s changing priorities and direction. All three documents have gone under extensive review from within the Region, subject matter experts, Ministry of Health and Treasury.

**ISSP V2.0**

The Information Systems Strategic Plan outlines the direction of investments for the Region’s Health and Business Information Systems and how these investments will enable the Northern Region DHBs to achieve over time the goals documented in the LTIP. The ISSP direction is informed by the Ministry of Health’s Digital Health Strategy. The strategic plan can be summarised as:

- Modernise and strengthen our ICT foundations
- Simplify, harmonise and rationalise our layers of applications
- Become experts at interoperability to improve the way we share data and connect systems together
- Work together as a capable region

**What has changed since version 1?**

The document now has been updated to reflect the following changes:

- LTIP
- MoH NZ Digital Strategy
- Fy18/19 Capital Funding
- ISSP Regional Roadmap direction and Domain Working Groups
- The major change is in section 4 – Making it Happen– which is updated and aligned to the ISSP Programme Charter.

The document has been completed, endorsed by the ISSP Programme Steering Group, the Information Governance group (IGG), Regional Executive Forum (REF) and Regional Governance Group (RGG). The summary is in **Appendix C** and the full document is in Diligent Boardbooks resource centre.

**Regional Roadmap v1.0**

The Regional Roadmap sets a course for the IS investment, planning and decisions that we need to make to realise the vision outlined in the ISSP. It is pragmatic and realistic, with the combined view of both clinical and IS subject matter experts from across the region. For example; it describes the progression of Regional Coordinated Community Care and the Hospital Administration Replacement Project in 2018/2019. **Appendix D has a diagram outlining the roadmaps and the full document is within Diligent Boardbooks resources.**

**ISSP Programme Delivery Charter V1.0**

The ISSP Programme Charter is a key document that defines the scope, delivery approach and associated methods, programme governance and management, implementation time line, delegated authorities, and quality assurance approach, that will be employed for the delivery of the ISSP Programme. It defines how we will work as a capable region to deliver the ISSP programme of work. **Appendix E outlines the components of the ISSP programme charter and the full programme is within Diligent Boardbooks resources.**

**Proposed Regional IS governance arrangements**

Redesign of the governance mechanisms in the region is an essential step in implementing the Programme Charter. Our current IS governance environment is complicated, has many groups with overlapping roles and responsibilities, no clear accountability for overall outcomes, and the processes are not well understood or aligned. We need to rationalise our approach to deliver such large, complex and multi-year programme of work as the ISSP need to reduce risk and improve overall effectiveness.

The ISSP Programme Charter provides a detailed description of the proposed new governance structure, roles and responsibilities. In summary, governance is focused in two primary areas:
1. **Strategy and Design** – with a key focus on the development and governance of the ISSP, roadmaps, and critical design elements including regional architecture, privacy / security, data and investment prioritisation.

2. **Programme Delivery** – oversight of the execution of prioritised investments in line with design principles and standards.

The structure has been developed in consultation with key regional stakeholders including a working group made of members from healthAlliance and all DHBs within the Northern Region, which have reviewed the proposed approach over a 3 month period. The recommended approach is informed by proven methods and disciplines from other industries and is well understood by central government agencies, including Treasury and the Department of Internal Affairs. **Appendix A** demonstrates the new proposed governance arrangements and draft Terms of References. Please note that the arrangements are in line with the proposed arrangements for portfolio focus, oversight and governance of the LTIP. **Appendix B** indicates existing IS governance arrangements with a background on the Regional Governance Groups.

The implications of implementing the proposed structure are as follows:

- **The existing Information Governance Group (IGG) and the Clinical and Business Application Group (CBAG) will cease to operate.** Their current functions would be subsumed into healthAlliance Board and the ISSP design authority

- **A new ISSP Delivery Programme Delivery Steering Group will be established**, reporting to the healthAlliance Board. The key focus of this group will be programme governance of delivery of all sub-programmes and projects within the ISSP Programme.

- **A new ISSP Design Authority will be established reporting to an Executive Sponsor Group.** The ISSP design authority is informed by the regional health services design authority. It will provide strategic design oversight across the ISSP programme of work and ensure that coordination of all ISSP design activities. It will undertake prioritisation and sequencing of key initiatives, and at times leading review of future ISSP strategy and design. This ISSP Design Authority will be supported by three design councils, and two advisory boards, i.e. to accommodate design of the health system, enterprise support services, technical architecture, data, privacy, and security.

- **The existing ISSP Programme Steering Group will cease to operate** when its last deliverable (Roadmap V2) has been completed. It is anticipated that this will occur between January and March, 2019.

The immediate next steps in establishing the governance structure once approved are:

- Formalising the terms of reference for each group. The first drafts of the terms of reference for the ISSP Programme Governance element of the hA Board, the ISSP Design Authority, and the ISSP Delivery Programme Steering Group are provided as per **Appendix A**.

- Identifying the membership of each group.

- Forming the groups and addressing immediate priorities e.g. the ISSP Design Authority needs to address how the core systems (HARP, CCC, EMR, PMS review) will be fit together.

Subject to approval it is expected that these activities will be completed by December, 2018.

**Next steps:**

1. It is planned to submit the 3 documents identified within this paper to the healthAlliance Board and regional DHB Boards for approval as per the timeline below:

<table>
<thead>
<tr>
<th>Document</th>
<th>For Review</th>
<th>For Endorsement</th>
<th>For Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISSP Regional Roadmap V1.0</td>
<td>✓ Apr 2018</td>
<td>✓ July 14/6/18</td>
<td>✓ 21/9/18*</td>
</tr>
<tr>
<td>ISSP V 2.0</td>
<td>✓ June</td>
<td>✓ July 13/9/18</td>
<td>✓ 21/9/18</td>
</tr>
<tr>
<td>ISSP Delivery Programme Charter &amp; Execution Plan</td>
<td>✓ 13/3/18</td>
<td>✓ 13/9/18</td>
<td>✓ 21/9/18*</td>
</tr>
</tbody>
</table>
Appendix A – Proposed ISSP Programme Governance Arrangements
Appendix A – Proposed ISSP Programme Governance Arrangements

Key Focus – NRLTIP Portfolio Oversight
Work and process quality assurance
Strategy and alignments
Process streamlining / improvement

Key Focus - Regional Strategy and Direction: Will be responsible for the development of the future state strategy and vision for the Northern Region Health System, to accommodate Buildings and Infrastructure, Clinical Equipment, and the IS Programme. In doing so, will ensure that appropriate alignment is provided to central Government and/or MoH guidance. Will serve as the escalation point for all key design decisions escalated by the Design Councils and/or Project Steering Committees.

Key Focus - Regional Design Councils: The development of the future state strategy and vision for the Health System, Enterprise Support Services, the enabling Data System, and Enabling Technology Architecture. The development of design and architecture principles, standards and reference architectures for all Agencies within the Region. In doing so, will ensure that appropriate alignment is provided to central Government and/or MoH guidance. Will serve as the escalation point for all key design decisions escalated by the PSGs and/or Integrated Project Teams.

Key Focus - Regional Design Authority: Within the guidance provided by the LTIP PSG - the ISSP Design Authority will provide overall oversight of design and architecture strategies, principles, standards and reference architectures for all DHBs within the Northern Region. Will serve as the escalation point for all key design decisions escalated by the Design Councils and/or Integrated Project Teams. Will also lead the annual capital prioritisation process for the Northern Region with CFO input, as a key input into the Annual IS Capital Planning process. Following the dissolution of the ISSP PSG will provide overall oversight of updates to the ISSP Strategy and Roadmaps.

Key Focus – Regional PMO

Key Focus – hA: hA will be accountable for the delivery and success of the ISSP Programme across the Northern Region. hA will coordinate the delivery of all programmes, sub-programmes and projects within the Northern Region, to ensure alignment with the approved ISSP. hA will safeguard the ISSP, and will review and endorse ISSP investment decisions. hA will have delegated decision rights and will be authorised to provide assurance to the DHB Boards that sub-programmes and/or projects are aligned with the ISSP and agreed road maps. In conjunction with the DHBs will lead the annual IS Capital Planning & prioritisation process, including the provision of the required prioritisation frameworks, and modelling of impacts on cash flow, depreciation, SOI, etc.

Key Focus – Programme Steering Group: Will provide executive management and oversight of the approved Programme. Will be accountable for the success of a Programme and/or Sub-Programmes, i.e. within the scope of the ISSP, and within the programme governance oversight of hA. Will function as the escalation point for issues escalated by the DHB Integrated Project Teams and/or Project Steering Committees. Will have delegated authority to approve changes (scope, milestones, benefits, finances, design) within tolerances defined in the Programme Charter. Will provide oversight of quality assurance activities. Will ensure that solution designs have been reviewed, endorsed and/or approved by the required design authorities.

Note: the ISSP Program Steering Committee will include a sub-group of the hA.

Key Focus – Project Steering Committees: Will provide executive management and oversight of an approved Project. Will be accountable for the success of the Project, i.e. within the scope of the ISSP, and within the programme governance oversight of hA. Will function as the escalation point for issues escalated by the DHB Integrated Project Teams. Will have delegated authority to approve changes (scope, milestones, benefits, finances, design) within tolerances defined in the Project Charter.
ISSP Design Authority (ISSP Design Authority) (“True North”)

Role
The ISSP Design Authority will provide executive authority for governing and controlling all design components associated with the Programme, and the Northern Region. The ISSP Design Authority will have the authority to ratify any decisions relating to the designs developed by the ISSP Programme, i.e. within the authorities delegated via the approved ISSP Programme Charter.

The Design Authority will be executed via one ISSP Design Authority, four Design Councils and two Advisory Groups, i.e. as follows:

- **ISSP Design Authority (ISSP DA)** – which will focus on design decisions and guidance associated with future state services and business processes for the LTIP and the ISSP Programme, i.e. related to the Northern Region Health Services. This council will also validate, and arbitrate on, all design matters that are raised by the remaining Design Councils and/or Advisory Groups.

- **Health System Design Council (HSDC)** – which will focus on design decisions and guidance associated with future state business processes for the Northern Region Health System.

- **Enterprise Support Services Design Council (ESSDC)** – which will focus on design decisions and guidance associated with future state business processes for the LTIP and the ISSP Programme, i.e. related to Enterprise Support Services.

- **Regional Data Design Authority** – which will focus on design decisions and guidance associated with future state data and information architecture and design matters for the LTIP and the ISSP Programme.

- **Regional Architecture Group (RAG)** - which will focus on design decisions and guidance associated with future state technical and solution architecture and design matters for the LTIP and the ISSP Programme.

- **Regional Privacy Advisory Group (RPAG)** - which will focus on design decisions and guidance associated with privacy matters.

- **Regional Information Security & Risk Group (ISRG)** - which will focus on decisions associated with information security matters.

This Terms of Reference is focussed on the **ISSP Design Authority (ISSP Design Authority)**.

Responsibilities
Within the guidance provided by the LTIP PSG - the **ISSP Design Authority** will be responsible for:

- Providing strategic design authority oversight across the ISSP Programme, and ensuring that all associated designs are compatible with, and align to, approved Health Services strategies, standards, policies, and roadmaps.
- Leading the review and approval of the ISSP Roadmaps, and providing all guidance associated with prioritisation of key themes and initiatives. This will include leading the short, medium, and long term prioritisation process associated with the selection and approval of key ISSP initiatives, as a key input into the Annual IS Capital Planning process.
- Providing assurance to the LTIP PSG and the hA Board that the ISSP Programme is delivering anticipated outcomes and designs that are aligned with key design principles and approved Health Services design strategies.
- Reviewing and approving design principles, strategies, standards, and options presented and making appropriate design decisions, including the endorsement and/or approval of key design documents and direction.
- The ISSP Design Authority will also coordinate the inputs periodically provided by reference groups.

Selected Roadmaps:
- The ISSP Design Authority Roadmap
- The LTIP Roadmap
- The Regional Roadmap

Membership: proposed
The **ISSP Design Authority**’s membership and administrative requirements are as follows:

**Full Members:**
- 1 x DHB CMO (proposed as chair)
- 1 x DHB CEO
- 4 x DHB Clinical Leads:
- 1 x Consumer representative
- 1 x HA CEO
- 1 x PHO Representative
- 1 x WDHB CIO
- 1 x NDHB CIO
- 1 x ADH CIO
- 1 x CMHB CIO

**Support Members:**
- ISSP Programme Director – Les Greeff
- ISSP Design Lead – Matt Hector-Taylor
- George Smith (Secretariat)

**Guests:**
- By invitation - to be confirmed for each meeting, within the context of the agenda.
- The ISSP Design Authority meetings will be supported by a Programme Co-ordinator from the ISSP Programme Management Office.

**Quorum:** Chair + 1 full member representative from each DHB.

**Consensus:** Sufficient consensus will be reached if all full members in attendance agree.

**Frequency:** Fortnightly and/or monthly as required.

- **Note 1:** All members will have the right of escalation, i.e. to the LTIP Executive Sponsors, and to REF.
- **Note 2:** Key Design Decisions made at the Design Councils will be submitted to the ISSP Design Authority for ratification.
- **Note 3:** All Strategy Documents will be submitted to the hA Board for endorsement, and to the LTIP Executive Sponsors, and to REF for ratification.
## ISSP Health System Design Council

**Role**
The Health System Design Council (HSDC) will provide design guidance of all design components associated with the health system elements associated with the ISSP Programme. The Health System Design Council will have the authority to approve certain design decisions relating to the designs developed by the ISSP Programme, that are related to the Northern Region Health System, within the authorities delegated via the approved ISSP Programme Charter.

The Health System Design Council will make recommendations on key design components, including high level requirements, design principles, and enterprise-level architecture for the health system for the Northern Region, i.e. for submission to the ISSP Design Authority for approval. In so doing the Health System Design Council will engage with reference groups and/or domain working groups as required.

**Membership: proposed**
The HSDC’s membership and administrative requirements are as follows:

### Full Members:
- **NDHB:** Alan Davis (Clinical Director) - Dr. Andrew Miller
- **ADHB:** Greg Williams (Service Clinical Director), Anil Nair (Clinical Director)
- **WDHB:** Robyn Whittaker (Assoc. Professor & Clinical Director Innovation)
- David Ryan (Clinical lead core clinicals IS Clinical Change Manager)
- Lara Hopeley (Clinical lead CPU, Clinical Advisor Digital Innovation)
- **CMH:** Stuart Barnard (Clinical Director Radiology)
- **Consumer:** Chris Baty
- **hA:** Karl Cole (Chief Clinical CIO, GP)
- **CIOs:** 1 x CIO to be nominated by the DHB CIO functions

### Support Members:
- Secretariat to be provided.

### Guests:
- By invitation - to be confirmed for each meeting, within the context of the agenda.
- The Design Council meetings will be supported by the Governance Co-ordinator from the ISSP Programme Management Office.

**Quorum:** Chair + 1 full member representative from each DHB.

**Consensus:** Sufficient consensus will be reached if all full members in attendance agree.

**Frequency:** Fortnightly and/or monthly as required.

Note 1: All members will have the right of escalation, i.e. to the ISSP Programme Design Authority.

Note 2: Key Design Decisions made at the Design Council s will be submitted to the ISSP Design Authority for ratification.

Note 3: All Strategy Documents will be submitted to the ISSP Programme Design Authority for endorsement, and to the LTIP PSG for ratification.

### Responsibilities

The HSDC will be responsible for:

- Assisting the ISSP Design Authority in providing strategic design authority oversight across the ISSP Programme, and ensuring that all associated designs are compatible with, and align to, approved Health Services strategies, standards, policies, and roadmaps.
- Providing assurance to the ISSP Design Authority that the ISSP Programme is delivering anticipated outcomes and designs that are aligned with key design principles and approved Health Services design strategies.
- Assisting the ISSP Design Authority with the development of the future state design for the Health System for the Northern Region.
- Reviewing and endorsing design principles, strategies, standards, and options presented and making appropriate design decisions, including the endorsement and/or approval of key design documents and direction.
- Reviewing Health System design principles, strategies, standards, and options presented and making appropriate design recommendations, including the endorsement and/or approval of key design documents and direction.

---

Appendix A – Proposed ISSP Programme Governance Terms of References

Draft

Vs 1.0/11/2018

Regional Governance Group

099
## Appendix A – Proposed ISSP Programme Governance Terms of References

### hA Board:

<table>
<thead>
<tr>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>From an ISSP Programme Governance perspective the role of the hA Board will be to provide executive governance oversight of the ISSP Programme across all DHBs within the Northern Region.</td>
</tr>
</tbody>
</table>

This role includes ensuring that the portfolio of sub-programmes and projects within the ISSP Programme remain aligned with the LTIP, and the ISSP.

This role includes assurance that the portfolio of sub-programmes and projects within the ISSP Programme have effective management controls, accountability, and are effective in terms of delivering all specified outcomes and benefits within the scope, funding, time line approved in all associated business cases.

<table>
<thead>
<tr>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>From an ISSP Programme Governance perspective the hA Board will be responsible for:</td>
</tr>
<tr>
<td>- Governing sub-programmes and projects within the Northern Region’s ISSP Programme investment portfolio;</td>
</tr>
<tr>
<td>- Ensuring sub-programmes and projects within the ISSP Programme are managed well and remain healthy from cost / benefit, timeline, quality and risk / issue perspectives;</td>
</tr>
<tr>
<td>- Ensuring that the Investment Objectives in all sub-programmes and projects within the ISSP Programme are met;</td>
</tr>
<tr>
<td>- Raising sub-programme and project execution issues by reporting to the REF and the DHB Boards when sub-programme and project delivery exceeds, or are forecast will exceed, the delivery tolerances specified for each project and/or programme;</td>
</tr>
<tr>
<td>- Ensuring that timely, accurate and adequate reporting on the status of the portfolio of sub-programmes and projects within the ISSP Programme is provided to the respective DHB Boards, and to MoH and Treasury as required;</td>
</tr>
<tr>
<td>- Ensuring that relevant quality assurance processes are adhered to by all sub-programmes and projects within the ISSP Programme; and</td>
</tr>
<tr>
<td>- In conjunction with the DHBs will lead the annual IS Capital Planning &amp; prioritisation process, including the provision of the required prioritisation frameworks, and modelling of impacts on cash flow, depreciation, SOI, etc.</td>
</tr>
</tbody>
</table>

### Membership

The hA Board’s membership and administrative requirements are as follows:

#### Full Members:

- **Chair:** Independent: Clayton Wakefield (Proposed).  
- **CMH:** Catherine Abel-Pattinson  
- **WDHB:** Andrew Brant (Proposed)  
- **NDHB:** Meng Cheong  
- **ADHB:** Rosalie Percival  
- **FPSC:** Paul Harper  
- **Independent:** Russell Jones  
- **Independent:** Roger Jones

#### Invitees:

- hA CEO and Management Team.

#### Support Members:

- **ISSP Programme Director – Les Greeff**  
- **George Smith (Secretariat)**

#### Guests:

- By invitation - to be confirmed for each meeting, within the context of the agenda.

### Quorum/Consensus/Frequency:

Per shareholders Agreement.
# Appendix A – Proposed ISSP Programme Governance Terms of References

## ISSP Delivery Programme Steering Group

### Role

The role of the ISSP Delivery Programme Steering Group (ISSP Delivery PSG) is to provide executive programme governance oversight of the ISSP Programme across all DHBs within the Northern Region.

The ISSP Delivery PSG will be accountable for the success of all sub-programmes and projects within the scope of the ISSP, and within the programme executive governance oversight of hA Board. The ISSP Delivery PSG will function as the escalation point for issues escalated by the DHB Integrated Project Teams and/or Project Steering Committees. The ISSP Delivery PSG will have delegated authority to approve changes (scope, milestones, benefits, finances, design) within tolerances defined in the ISSP Programme Charter. The ISSP Delivery PSG will provide oversight of all quality assurance activities required for the ISSP Programme. The ISSP Delivery PSG will ensure that the portfolio of sub-programmes and projects within the ISSP Programme remain aligned with the LTIP, and the ISSP.

This role of the ISSP Delivery PSG includes assurance that the portfolio of sub-programmes and projects within the ISSP Programme has effective management control, accountability, and are effective in terms of delivering all specified Investment Outcomes and benefits within the scope, funding, time line approved in all associated business cases.

### Membership: proposed

The ISSP Delivery PSG’s membership and administrative requirements are as follows:

**Full Members:**
- 1 x Independent from the hA Board (well versed in large scale delivery) – proposed as chair – To Be Confirmed
- 1 x DHB CEO (represented on the ISSP Design Authority)
- 1 x CMO / Clinical Lead
- 1 x DHB CIO
- 1 x hA CEO
- 1 x hA CFO

Note it is recommended that we have 1x DHB role to represent each DHBs at table

**Advisory Members:**
- As required

**Support Members:**
- ISSP Programme Director – Les Greeff
- ISSP Design Lead – Matt Hector-Taylor
- Secretariat to be provided by the ISSP Programme Office

**Guests:**
- By invitation - to be confirmed for each meeting, within the context of the agenda.
- The ISSP Delivery PSG meetings will be supported by the Governance Co-ordinator from the ISSP Programme Management Office.

**Quorum:**
- Chair + 1 full member representative from each DHB.

**Consensus:**
- Sufficient consensus will be reached if all full members in attendance agree.

**Frequency:**
- Fortnightly and/or monthly as required.

### Responsibilities

The ISSP Delivery PSG will be responsible for:

- Providing executive programme governance oversight of all sub-programmes and projects within the Northern Region’s ISSP Programme investment portfolio;
- Ensuring that all sub-programmes and projects within the ISSP Programme are managed effectively from cost / benefit, timeline, scope management, quality and risk / issue perspective, i.e. compliant with the scope and commitments made in all approved business cases. Where required the ISSP Delivery PSG will provide guidance and/or instruction to the sub-programme and/or project PSGs and/or SROs for any remediation required where delivery performance is not effective;
- Raising programme and/or project execution issues by reporting to the hA Board and the DHB Boards when sub-programme and/or projects delivery exceeds, or are forecast will exceed, the delivery tolerances specified for each sub-programme and/or project;
- Ensuring that timely, accurate and adequate reporting on the status of the portfolio of sub-programme and/or projects within the ISSP Programme is provided to the respective DHB Boards, and to MoH and Treasury as required; and
- Ensuring that solution designs have been reviewed, endorsed and/or approved by the required design authorities, and relevant programme and/or project quality assurance processes are adhered to.
Appendix B - Background on Northern Regional Governance Groups

A northern regional governance manual sets out the governance arrangements in place to ensure their effective governance over the work that is being undertaken regionally. It describes how the different regional entities relate to each other and how they will work together. The lead body is Regional Governance Group and is supported by the Regional Executive Forum at which the four CEO and CMO and at times CFOs meet to oversee the delivery of regional strategy and plans. In addition to hANZ, the Northern Regional Alliance is also a limited liability companies with its own board of directors.

The accompanying diagram outlines the governance arrangements and major groupings of work including information systems.
The information systems governance is led by the Information Governance Group. The group was established to

- Ensure there is a regionally agreed information strategy that is aligned with regional clinical and business drivers
- Ensure that the regional work plan and investments are aligned to deliver solutions that can be afforded and have been through robust prioritisation process
- Oversee and provide guidance and support to the delivery of key regional programmes of work
- Receive regular updates on Information and Communication Technologies (ICT) and non ICT work plans and service delivery
- Act as a point of escalation for issues and risks

The group is comprised of DHB executives, DHB CIO, clinical IS representative, primary care, and hANZ executive members. The group seeks technical advice from regional advisory groups (architecture, privacy and security) and is also supported by an ICT group, a clinical and business applications group and steering groups for key regional projects. It should be noted that each DHB also has its own local information systems governance arrangements.
Northern Region Information Systems Strategic Plan

2017-2027

Updated August 2018

Executive Summary

<table>
<thead>
<tr>
<th>Version</th>
<th>2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>06/08/18</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Comments</td>
<td>Executive Summary for Regional endorsement/approval</td>
</tr>
</tbody>
</table>
About this document

The Northern Region is shifting to a more integrated, collaborative health system centred around the patient, their whānau and population health. The Northern Region’s Information Systems Strategic Plan 2017-2027 (ISSP) and supporting Roadmap underpin the Region’s Long-Term Investment Plan (LTIP). These documents have been finalised under the guidance of the ISSP Programme Steering Group (chaired by Dr Andrew Brant) with inputs from ISSP Domain Working Groups and other stakeholders. The Information Systems Strategic Plan outlines the direction of investments for the Region’s Health and Business Information Systems and how these investments will enable the Northern Region DHBs to achieve over time the goals documented in the LTIP. The ISSP direction is informed by the Ministry of Health’s Digital Health Strategy.

2018 Update:

Version 2.0 of the ISSP is an update to V1.0 (released in February 2018) to reflect the following changes:

- The Northern Region’s Long Term investment Plan has been approved and released providing regional direction and key themes to guide our strategic thinking;
- The Ministry of Health’s draft New Zealand Digital Health Strategy has been published;
- The Regional Roadmap has been developed for five of the nine applications domains, and for our ICT Foundations and Data Sharing & Interoperability portfolios;
- The Region’s Domain Working Groups have:
  - Agreed the scope of each of the domains that collectively comprise the functions within the sector;
  - Confirmed the issues with our current technology and support of current and potential models of care; and
  - Recommended the priorities for change within each domain.
- The Region has developed a costed Roadmap for technology change based on these initiatives; and
- The Region has confirmed the capital plan for FY18/19 and refined our requirements for subsequent years, including the requirement for central funding.

It is therefore appropriate for a new version of the ISSP to be developed. June 2018 marks the end of Year 0 of the ISSP, as the key building blocks have now been established to mobilise for delivery.
Contents

Executive Summary 4

1 Where are we now? 17

2 An IS strategy for the Northern Region 26

3 Horizon 1 – Building Strong Foundations 35

4 Making it Happen 47
Executive Summary

ISSP and Roadmap Overview Summary

The Northern Region, through its Long-Term Investment Plan and Regional Health Plan, is committed to working together to provide health care that makes best use of available resources, is sustainable, equitable and improves access to services. These plans focus on improving health outcomes and reducing disparities for the 1.87m people living in the Northern Region. System-wide integration, collaboration and joined up models of care across our clinical networks and care settings are central to achieving our goals in a context of increasing demand.

Health Information Systems are an underpinning foundation to the Northern Region’s ability to deliver a collaborative whole of system approach to health service delivery. A key goal for our Region is to improve the continuity of care for patients across settings and ensure care can be delivered to those who need it (improving access). This relies on consistent and reliable access to core clinical information for all involved in a person’s care regardless of setting. Our information system developments are key enablers for us to achieve our clinical and business objectives.

The Northern Region Information Systems Strategic Plan (ISSP) considers the needs, current state position and potential contributions of the Northern Region DHB stakeholders (Appendix A). The ISSP also aligns to central government Digital and IS related Strategies and has had input from a range of health care consumers. The purpose of the ISSP is to describe the technology related investments required over a 7-10 year period to assist in achieving the goals within the Long Term Investment Plan and health services plan.

A large focus of the ISSP is on advancing the region’s clinical and operational systems, providing better access to health data, and the ability to share data more effectively across the health system. Early on in the plan, there is also pressure to remediate immediate Clinical IS Application and Infrastructure related risk (end of life). It is clear that the region’s current Information technology and systems can not adequately support its health services goals as much of our technology inventory is either not fit for purpose, is end of life, or is a gap.

A fundamental design and implementation principle for the ISSP is that any initiative should be clinically-led (business-led) and technology-enabled. The complexity and size of the Region shapes our delivery approach. ‘Big bang’ implementations will be avoided and projects will be delivered in increments, following an agreed methodology, design and decision-making framework to lower the implementation risks. Senior Responsible Officers (SROs) appointed to deliver Regional initiatives will have the requisite background and support to deliver those initiatives and central government assurance processes will be used. Consumers will have input into designs to help bring an equity, access and patient focus to ISSP delivery.

Working across four investment portfolios and three time horizons, the Northern Region Information ISSP sets out a pragmatic sequence of initiatives and improvements to deliver the following benefits:
- **Our consumers/patients** will be able to access their own information and be confident that their treating clinicians have the information they need, wherever they are in the health system, to make the best decisions.
  - The ISSP makes provision for completing the Regional Roll-out of a Clinical portal for DHB staff, improved information sharing and access for primary and community care providers and delivery of a regional Patient Portal leveraging and extending existing capability in the health system.
  - Key ‘foundational’ investments will be required to achieve sector-wide collaboration and consumer access, including a Regional Identify and Access Management System and a Data Sharing Platform. Users will be securely authenticated; data will stored safely and be made readily accessible to authorised people in a safe way.
  - For those consumers and other users without access to appropriate technology, alternative approaches will be developed to ensure inequity is not increased.

- **Our region** will be less constrained by current boundaries, and will work more effectively to deliver joined-up care across settings and Districts, enabled by shared data and more consistent approaches to care.
  - The ISSP will enable the region to access, analyse, share, and make better use of its data, and other agreed and trusted government agencies’ and /or health providers’ data where it makes sense to through the use of its Data Sharing Platform, including API’s. Using data in this way that supports the future models of care that see the region wanting to deliver care closer to home, address the social determinants of health status and inequity and enable greater multi-disciplinary team-based care.
  - One critical initiative is Collaborative Community Care where a regional platform will be implemented to support patient-centred care delivery across settings, enabling new models of joined up care and improved collaboration between consumers and providers across the continuum of care.
  - Delivering a technology environment to support working as a whole system is a change to our current approach and requires some foundational investments e.g. Identity and Access Management, establishment of a regional Service Provider Directory and rationalisation/ enhancement/ augmentation of key data repositories e.g. TestSafe and patient demographic information.

- **Our population-based initiatives** will be more pro-active and targeted, with more effective use of resources, generating demonstrable health outcome improvement and addressing inequity.
  - The ISSP places strong investment emphasis on regional Data Governance, improving our Business Intelligence and Analytics capability, information management processes and data quality.
  - These will provide the basis for greater data-driven analysis and decision-making at all levels, including Precision Medicine, Population Health Management, forecasting, planning and resource optimisation.

- **Our workforce** will enjoy the direct benefit of more modern tools and better data, which should generate better engagement scores and better patient care.
  - The ISSP and Regional Roadmaps prioritise a range of applications and foundational tools to help improve the way people work. These include rollout of modern devices, improved...
‘tap on/ tap off’ workflow, mobile access to data and secure provider to provider communication tools. Network infrastructure is a key enabler to ensure the benefits of these technologies are delivered equitably across our system.

- We will also address some of the core applications challenges we face, including replacement of ADHB’s Hospital Administration Systems, selection and implementation of a regional Clinical Information System to support our core clinical workflows and addressing enterprise and clinical specialty systems gaps over time.
- The consumer/ patient will be at the centre of what we do. A critical design challenge will be to ensure that these core ‘building block’ applications work effectively together to support a person’s journey across settings and enable informed care at each interaction while not increasing disparities.

- Our healthcare delivery will gain from greater access to current patient information, improved collaboration tools, advanced analytics, business intelligence and support tools.
  - Rapidly evolving technology, coupled with the drive for new models of care mean that flexibility, change and data-driven innovation will be critical over the next decade. The ISSP emphasises the importance of making data available for reuse, laying foundations for working across boundaries and providing communication, collaboration tools as critical enablers for the evolution of healthcare delivery over the next decade.

- Our Government and Ministry will have access to better data to assure them that the Region is acting as a responsible steward of taxpayer assets and funds, and is consistently delivering the standards of care for which it is funded.

After a decade of underfunding, full implementation of the ISSP to make a step change in our technology enablers will require additional funding beyond the region’s current available capital. Funding for the ISSP requires the region to prioritise within its existing balance sheet and address the shortfall with business cases for central government support.

A balanced investment plan underpins the ISSP to enable us to:

- **Fix** – focus on remediating the highest immediate areas of risk where consequences are critical to ongoing service delivery
- **Future-proof** – start to lay foundations that address long-term risk and enable the region to improve the way it operates
- **Accelerate** – put in place the capability that enables future models of care to maximise health outcomes

**Horizon One Plan**

The plan for Horizon One – FY18-19-FY20-21 is summarised below:

**Investment Portfolio 1: Modernise and strengthen our ICT foundations: ‘Making sure our IS environment is well maintained and fit for purpose.’**

We will continue to focus on our stabilisation programmes that allow us to ‘keep the lights on’ while new foundations and capabilities are put in place e.g. transition to ‘as a service’ providers.
The table below presents key initiatives and outcomes for users and the health system as a whole.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Increasing network connectivity (coverage and performance) to end users regardless of location and improving voice and collaboration/ productivity tools. |  - Improved network coverage – access to applications and data regardless of location  
  - Greater network performance – higher speed and more reliable access  
  - Reduced risk of phone system failure – systematic replacement of voice/ phone technology  
  - Improved collaboration/ productivity – support for new forms of communication and productivity support e.g. single directory, location |
| Moving data storage and infrastructure provision to approved ‘cloud’ service providers |  - Reduced infrastructure risk – current data centres are high risk, not fit for purpose and unable to scale  
  - Improved infrastructure performance – infrastructure performance provided within contracted service levels  
  - Reduced cost – data storage and management savings over ‘internally hosted’ option. |
| Modernising devices and operating systems                                   |  - Improved mobility – users will be able to access data on mobile devices  
  - Improved flexibility – users will be able to move from device to device and maintain their ‘session’  
  - Rapid access – users in high speed areas e.g. ED will have a proximity logon solution (tap on/ tap off) to speed up system access  
  - Improved support – the current desktop support model will be improved and made more efficient  
  - Improved security – security patches will be easier to apply and end user devices (laptops, tablets, smartphones and connected medical devices can be tracked and managed) |
| Proactively addressing cyber-security threats on a ‘whole of system’ basis   |  - Improved response to events – a co-ordinated and rehearsed response to major incidents  
  - Early identification of threats/ attacks – improved threat detection and response delivery  
  - Enhanced prevention – more consistent application of policy and process and reduction of attack vectors |
| Implementing a regional identity and access management capability           |  - IAM Governance - Establishing the elements (i.e., alignment and coordination of disparate teams and activities) required to minimise information security risk.  
  - Access Management- Securing access to applications, systems and services using authorisation services, and single sign on across the region. (DHBs, Patient, Primary Care, Community etc.)  
  - Password Management - Managing the lifecycle of user passwords. This includes policy based password rules, securely storing and transmitting passwords and offering users intuitive processes for recovering lost or forgotten passwords. Privileged Access Management (PAM)- Managing access to privileged accounts such as admin rights.  
  - Access Certification - The integrated reporting of user access ,audits of that access and any actionable steps to resolve identified issues.  
  - Enable regional application projects– Deliver external IAM capability for these projects to leverage.  
  - Single sign on – authentication and access rights across DHBs. |
Enhanced security/ reduced risk – improved processes, controls and visibility of user access to regional systems. ‘Whole of system’ controlled access – enables secure patient and third party (GP, Community, NGO etc.) access to approved data/systems.

- Improved information sharing – authorisation of access to information for sharing between providers and patients
- Identify and manage remote devices and clinical equipment – devices can be identified, authenticated and authorised to contribute data into appropriate system and records.

**Investment Portfolio 2: Simplify, harmonise and rationalise our layers of applications ‘Reducing complexity, cost and risk while improving coverage.’**

The applications portfolio is our most complex and poorly understood. We are using our recently established Regional Roadmap process to help us bring some structure and boundaries to our nine applications domains as discussed below. In the first year of the ISSP we focused initially on the five domains with applications addressing the ‘core’ patient care processes. We will address the other four domains - including Clinical Specialties, Workforce Services & Management (HR, Payroll etc.), Business Services & Information (Finance, Supply Chain) and Knowledge Management (Intranet and other resources) - in FY18/19. A summary of the Roadmap for the five completed Application Domains is provided below:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Initiative</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community, Public Health, Integrated Care and Self-care Domain</td>
<td>• Select and progressively implement a regional ‘Collaborative Community Care’ platform (including self-care, shared care, community services, public health, Mental Health services) to enable a more patient-centred and team-based health system (addressing ‘burning platform’ application issues at Northland, Auckland and Counties Manukau). Establish patient engagement capability through a regional Patient Portal strategy.</td>
<td>• Patient-centred solution – one patient record across services • Enables new models of care – flexible, web-based, patient and team focus, enabling continuity and collaboration • Platform to enable patient involvement in own care – add own data and interact with care team • Reduces complexity and application risk – progressive replacement of up to 100 applications</td>
</tr>
<tr>
<td>Core Hospital Clinical Solutions Domain</td>
<td>• Select and implement a regional ‘Core Hospital Clinicals Solution’ – regional Electronic Medical Record (EMR) to address clinical workflow/care delivery in hospitals and outpatient clinics In years 2-3 of the ISSP. • In the meantime, establish a regional EMR Centre to develop an interim “Clinical Console” to improve clinical workflow in hospitals and outpatients that leverages regional best practice and innovation.</td>
<td>• Supports move to digital hospital – move towards a ‘paper-light’ environment • Enhanced clinical workflow – provide tools to support and enhance manual and paper-based processes • Improved digital maturity – fill in gaps in functionality to deliver better outcomes • Leverages current innovation and investments – expand use of MyPatient List and leverage Canterbury DHB ‘Clinical Cockpit’ initiatives • Simplifies environment – standardise and optimise current clinical systems</td>
</tr>
</tbody>
</table>
| Hospital Administration Domain | • Replace ADHB’s Patient Administration System and address regional resource management optimisation (e.g. beds, clinic scheduling, and theatres). • NB – the selection of an ADHB Patient Administration System (PAS) is de-coupled from selection of a future Electronic | • Reduced risk at ADHB – replace end of life solution • Opportunity for redesign of services and processes – within ADHB and with potential for regional resource management • Potential for improved collaboration/
Medical Record (EMR) ie there is no dependency on the EMR vendor being the same as the PAS vendor or for other DHBs to replace their PAS.

**Telehealth & Communications Domain**

- Implement core Telehealth and Communications enablers to support whole of system secure communication, including video, voice, on-line for clinical, non-clinical, critical and non-critical communications. **NB:** due to the current state being poor we need to invest in these tactical initiatives (and networks) as a priority over potential strategic initiatives.

- **Cheaper, more flexible videoconferencing** – modern, web-based tool
- **Increased access to videoconferencing capability** – web-based and flexible removes reliance on fixed locations
- **Support for transition to virtual health service delivery** – growing knowledge-base on moving services into a virtual health model
- **Unified approach to communication** – improved and simplified communication tools at point of use.

**Shared Health Information Domain**

- Move quickly to improve access and structure to the elements of the Shared Health Record we currently have (including Test Safe) by addressing key enablers (e.g. privacy, audit, access), filling information gaps and improving usability. This Domain will ultimately become part of Portfolio 3 below.

- **Improved ease of use and access to data in TestSafe** – consistent login, easily identify what data changed, access more comprehensive information.
- **Enhanced access to primary care data through Clinical Portal 8** – one single DHB clinical portal to access a wider range of available data
- **Evolution of processes and policies to support ‘whole of system’ information sharing** – continued stewardship and enhancement of governance, policy and operational framework to support more data, more access, more uses.

**Clinical Specialities Domain**

- The Roadmap for this Domain will be developed in the first half of Financial Year 18/19.

- **TBD**

**Workforce Information Domain**

- The Roadmap for this Domain will be developed in the first half of Financial Year 18/19.

- **TBD**

**Business Information Domain**

- The Roadmap for this Domain will be developed in the first half of Financial Year 18/19.

- **TBD**

**Knowledge Management Domain**

- The Roadmap for this Domain will be developed in the first half of Financial Year 18/19.

- **TBD**

For each domain we will balance our investment in current state risk reduction, strategic initiatives identified through the domain roadmaps and subsequent rationalisation and harmonisation of applications through the Application Portfolio Management process.

**Investment Portfolio 3:** Become experts at interoperability to improve the way we share data and connect systems together: ‘Putting data and the patient at the centre.’

With more than 2,000 applications currently, interoperability between systems is as critical to our long-term success as filling functional gaps with applications. Building on progress made to date (Mulesoft
implementation) and key current information sharing capabilities e.g. Test Safe, we are in a good position to implement our Data Sharing Platform and develop standard ‘connectors’ (Application Programming Interfaces or API’s) to support improved interoperability.

We will also strengthen data management and governance (including adoption of standards), extend the types of interoperability we can support (including social data) to deliver more effective data sharing, mobile application development, business intelligence and analytics.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| A Data Sharing and Interoperability Platform – which will provide the ability (people, process, technology) to capture, process, store, exchange and distribute relevant and comprehensive patient and operational data at point of care/ point of use across settings. | • Improved data sharing – real-time access to shared health data at point of care e.g. development of shared problem lists  
• Enhanced trust in data – consistent approaches to privacy, improved data quality, provenance and audit  
• Increased data availability for innovation – use of modern data exchange technologies to enable data rapid re-use in apps and other innovations |
| Establishment of a Service Provider directory to facilitate information sharing and communication between providers across the system | • Ease of access – address details for communication between providers available on-line and in context  
• Improved decision-making – identify appropriate providers for referrals, service requests, care team participation etc.  
• Cost savings – reduced reliance on messaging services |
| Rationalisation of Patient Demographic reference data sources regionally | • Improved patient demographic data quality and availability – comprehensive and trusted demographic data (including eligibility and other service use data) maintained and available in connected systems  
• Reduced duplication and rework as patients access services across DHB and setting boundaries – reduces current manual workarounds and duplicated processes as operate in siloed-systems  
• Reduced integration complexity – master data managed in one place simplifying subsequent integration to reduce cost and risk |
| A Northern Region Business Intelligence and Analytics Platform – which will provide the capability required to capture, process, analyse, store, exchange and report on comprehensive patient, population, operational and business information for reporting and insight purposes. | • Address risk in current systems – upgrade and refresh end of life systems.  
• Rationalised toolsets – standardise capability regionally to develop shared expertise  
• Reduce duplication in operational reporting – move to remove inefficiencies in current operational reporting processes |
| A Northern Region Data Management capability to improve the governance, management, maintenance and enhancement of the Northern Region’s information assets. | • Improved use of standards – consistent implementation of data standards regionally e.g. NZULM.  
• Improved data quality – data can be reused for multiple purposes and exchanged easily |
Investment Portfolio 4: A capable region: “Working well together to deliver on our IS Strategy, investments, operations and delivery”

Delivering the ISSP challenges us to work more effectively as a region than we have done in the past and to adapt to changing IS operating and delivery models. The table below summarises the key initiatives and outcomes in this area.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplified regional IS Governance for strategy, investment, delivery and operations</td>
<td>A single plan – resources, effort and reporting are focused</td>
</tr>
<tr>
<td></td>
<td>Transparent investments – better understanding of design and trade-off decisions, management of budgets and contingency</td>
</tr>
<tr>
<td></td>
<td>Better delivery performance – improved outcomes and more value delivered</td>
</tr>
<tr>
<td>Maintain the ISSP and Regional Roadmap</td>
<td>Relevant and current – a living strategy that adapts as the region evolves</td>
</tr>
<tr>
<td></td>
<td>Informed by delivery – roadmaps direct investment and are re-prioritised based on what is delivered</td>
</tr>
<tr>
<td></td>
<td>Transparent and informed by the sector – regional participation in planning and prioritisation</td>
</tr>
<tr>
<td>Streamline operational delivery to support the transition to ‘As a Service’ models</td>
<td>Measurable performance – track operational performance based on agreed and contracted metrics and service levels</td>
</tr>
<tr>
<td>Support a culture of DHB-led innovation and faster deployment of data-related initiatives through API development</td>
<td>Business focused change – DHB and sector-led innovation moves from POC to scale</td>
</tr>
<tr>
<td></td>
<td>On-going enhancements – delivery times are reduced</td>
</tr>
<tr>
<td>Establish a regional Reference Architecture and Regional Architectural Governance Group</td>
<td>Clarity of technology direction – an agreed technology approach reduces duplication and conflict</td>
</tr>
<tr>
<td></td>
<td>Improved design and integration – proactive and structured design informs projects and solutions</td>
</tr>
<tr>
<td></td>
<td>Less waste – rework is avoided</td>
</tr>
</tbody>
</table>

**Strategic context**

This IS Strategic Plan (ISSP) sets the direction for the Northern Region’s future IS investment to enable the Northern Region Health Services direction and vision.

The Northern Region ISSP is set at the regional level, driven by national strategies and the future vision of the Northern Region’s healthcare system (as articulated in the Region’s Long Term Investment Plan) and the current strategic plans of the Region’s District Health Boards. The level of detail and delivery focus increases towards the bottom of the pyramid below:
To realise the LTIP vision, the Region will implement a range of initiatives to:

– improve health status and reduce inequality
– achieve greater patient centricity and outcomes,
– better meet the needs of a rapidly growing, aging and changing population, and
– bend the demand curve for health services (particularly acute services).

Information technology is a key enabler for many of the key initiatives in that plan, and this ISSP provides the strategy to guide our technology investments over the next 10 years.
The ISSP and its four IS Investment Portfolios sit firmly in the context of the region’s Long Term Investment Plan and tie through to the Triple Aim, New Zealand Digital Health Strategy and the Northern Region’s identified business objectives, as described in the table below (including some of the major ISSP initiatives for Horizon 1):

<table>
<thead>
<tr>
<th>ISSP</th>
<th>Major Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>HARP</td>
<td>Replace ADHD’s Patient Administration System and address Regional resource management optimisation (e.g. beds, eligibility, theatres &amp; clinic scheduling, theatres). This project reduces risk and application complexity and in subsequent phases could provide the platform for enhanced regional resource management and optimisation</td>
</tr>
<tr>
<td>NCCC</td>
<td>Delivery of a patient-centred platform supporting services provided outside of the hospital/ outpatient settings that can be used by the region to replace progressively the 110 applications in this space, starting with ‘naming platforms’ particularly NHDIN’s Jade Community &amp; Mental Health system.</td>
</tr>
<tr>
<td>DHI</td>
<td>Implement data sharing across the region for point of care and analytics. Sharing of patient health information in a timely manner will result in improved coordination and collaboration across care settings</td>
</tr>
<tr>
<td>IEP</td>
<td>Migration of unsupported legacy interfaces. Build modern interfaces and APIs that are re-usable for future rapid deployment. Mulissoft is a key element of the region’s Data Sharing Platform and provides the capability to exchange data with third parties.</td>
</tr>
<tr>
<td>TEK</td>
<td>Increasing network coverage and performance to clinicians and other staff regardless of location and improving voice and collaboration/ productivity tools.</td>
</tr>
<tr>
<td>IAM</td>
<td>Modernising devices and operating systems. Implement Windows 10 to replace Windows 7 which ran out of support in 2020. Implement Office 365 and Unified Communications</td>
</tr>
<tr>
<td>IAM</td>
<td>Implementing a regional identity and access management capability. Implement secure management of regions passwords, allow users to securely and efficiently access the Northern Region’s Systems and Data using Trusted Digital Identity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LTIP</th>
<th>Value and High Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
<td>Strategic</td>
</tr>
<tr>
<td>Health status is extremely variable and there are significant inequities for some population groups and geographic areas as well as a large burden of ill health across the region</td>
<td>Optimize health outcomes (prevent, intervene early, planned proactive care is targeted to need)</td>
</tr>
<tr>
<td>Improved health outcomes and equity for all populations</td>
<td></td>
</tr>
<tr>
<td>Health services are not sufficiently centered around the patient and their whānau, and in certain areas the quality, safety and outcomes of care are not optimal</td>
<td>Optimize patient experience</td>
</tr>
<tr>
<td>Health services deliver best value for public resources</td>
<td>Optimize quality, safety and experience of care</td>
</tr>
<tr>
<td>The needs of a rapidly growing, ageing and changing population cannot be met in a clinically of financially sustainable way with our current capacity and models of care</td>
<td>Optimize efficiency and productivity</td>
</tr>
<tr>
<td>Investment in fit for purpose resources (workforce, facilities, clinical equipment and IT)</td>
<td></td>
</tr>
<tr>
<td>NZ Health</td>
<td>Business Objectives</td>
</tr>
<tr>
<td>• Prioritise investments which result in the best health outcomes throughout the continuum of care settings</td>
<td>• Improve data management capability</td>
</tr>
<tr>
<td>• Target resources for communities which face the greatest health challenges</td>
<td>• Enhance clinical quality and safety</td>
</tr>
<tr>
<td>• Wellness will be promoted across environments where people live, work and play</td>
<td>• Achieve a single virtual system</td>
</tr>
<tr>
<td>• All care transitions are planned and supported</td>
<td>• Improve decision support, business information and analytics</td>
</tr>
<tr>
<td>• Patient and whānau experience is the starting point for how we act and invest</td>
<td>• Enable multi-agency and inter-sectoral collaboration and co-ordination</td>
</tr>
<tr>
<td>• Care is provided as close to home as clinically appropriate</td>
<td>• Enable connectivity &amp; information sharing</td>
</tr>
<tr>
<td>• Enable patient engagement and person-driven care</td>
<td>• Improve staff experience</td>
</tr>
<tr>
<td>• Services will be configured to deliver the best quality and outcomes (e.g. consolidate specialty services, separate planned versus acute care, outsourcing)</td>
<td>• IS Portfolio Investment Objectives</td>
</tr>
<tr>
<td>• Services will be configured to deliver the best quality and outcomes (e.g. consolidate specialty services, separate planned versus acute care, outsourcing)</td>
<td>• Reduce application risk and duplication</td>
</tr>
<tr>
<td>• Ensure effective governance process to support investment decision making and delivery</td>
<td>• Manage the application lifecycle proactively across the portfolio of core, common and unique applications</td>
</tr>
<tr>
<td>• Workforce will be appropriately trained and operate at top of scope</td>
<td>• Simplify and strengthen core applications that:</td>
</tr>
<tr>
<td>• Ensure the resilience of existing assets</td>
<td>- Support planned, proactive, productive service delivery</td>
</tr>
<tr>
<td>People</td>
<td>Work effectively as capable and deployable</td>
</tr>
<tr>
<td>Health services deliver best value for public resources</td>
<td>- Support flexible and rapidly available urgent care</td>
</tr>
<tr>
<td>Workforce is at top of scope</td>
<td>- Manage capacity and capability to meet need</td>
</tr>
<tr>
<td>Workforce is appropriately trained and operate at top of scope</td>
<td>- Promote health and wellness</td>
</tr>
<tr>
<td>Ensure the resilience of existing assets</td>
<td>- Support self-care</td>
</tr>
<tr>
<td>Workforce is at top of scope</td>
<td>- Improve patient experience and access</td>
</tr>
<tr>
<td>Workforce is appropriately trained and operate at top of scope</td>
<td>- Reduce health inequities</td>
</tr>
</tbody>
</table>

| Problem | Strategic |
| Close to Home | Smart System | One Team | People |
| Improved quality, safety and experience of care | Optimise efficiency and productivity | Optimize health outcomes (prevent, intervene early, planned proactive care is targeted to need) | Work effectively as capable and deployable |
| Improved quality, safety and experience of care | Optimise efficiency and productivity | Optimize patient experience | Work effectively as capable and deployable |
| Improved quality, safety and experience of care | Optimise efficiency and productivity | Optimize patient experience | Work effectively as capable and deployable |
| Improved quality, safety and experience of care | Optimise efficiency and productivity | Optimize patient experience | Work effectively as capable and deployable |
| Improved quality, safety and experience of care | Optimise efficiency and productivity | Optimize patient experience | Work effectively as capable and deployable |
A 10-Year Horizon aligned to the LTIP

The ISSP will be delivered as a 10-year programme of innovation, investment and implementation across three time horizons that identify short, medium and long-term IS goals for the Northern Region and enable the vision and direction for the region’s healthcare presented in the Long-Term Investment Plan. The horizons are:

ISSP Strategy Development and Regional Roadmap (Year 0)

In this first year, prior to allocating capital to strategic initiatives, we developed the IS Strategic plan and the Regional Roadmap and started building business cases for foundational elements of our strategy. These set the course for our strategy and Horizon 1 mobilisation respectively. The ISSP is delivered over three time Horizons as described below:

Horizon 1 – Building strong foundations (Years 1-3)

In this Horizon, the Northern Region is working in each of the four investment portfolio areas, as described above, to address risk, put the foundations down for the future and establish an effective way of working together. The purpose of this phase is to get us into a better position to use IS effectively and build a reputation for delivery with funders, providers and other stakeholders so we can invest more heavily and strategically in the future, once the foundations are secure.

Horizon 2 – Transform (Years 4-7)

Following the ‘Foundation’ years, and led by the direction provided in the LTIP, the Region will be in a better place to accelerate and extend improvements in ‘core’ and ‘common’ applications and data-sharing capability based on regional strategy. By then, but potentially earlier, the Region will have a clearer picture of regional models of care and programmes including digital hospitals, virtual care, integrated care and self-care. These initiatives are likely to drive requirements for a range of channels for accessing information and potentially large scale technology and business change. In this horizon, most networking, hosting and telephony will be delivered ‘as a service’.

Horizon 3 – Extending (Years 8-10)

The Extend phase builds upon the Foundation and Transform horizons. As the LTIP direction is implemented, we will embed and extend the necessary technical and operational capability to support it. There will be a greater focus on innovation both from a clinical and operational and a technology perspective, and an improved ability to introduce emerging technologies to improve clinical outcomes. The focus will be on rapid, continuous incremental improvement. Clinicians and patients will be able to access a shared electronic health record at point of care across the Northern Region – across digital hospital and community settings - that is aligned to and integrates with national systems, including the National Electronic Health Record. Technology will support the region’s on-going model of care evolution.
Strategic Investment Portfolios

Within each of the Investment Objectives, programmes of work have been identified to deliver the digital health capability we need.

Each investment portfolio includes a series of projects and work packages to achieve the outcomes identified. Engagement with stakeholders, business case development, resource allocation and delivery will occur at the project level. The four portfolios with their associated Horizon One initiatives are shown in the diagram below:

**Northern Region ISSP - 4 Investment Portfolios**

**ICT Foundations**
- Network consolidation
- Datacentres migration and exit
- Cyber and security
- Mobile devices and desktop
- ICT Service Management
- Secure Access

**Capable Region**
- Simplified IS governance
- Grouped capital, prioritisation and decision-making
- Agreed IS Operating Model
- Regional reference architecture
- Improved IS capability to deliver
- Strategic sourcing and partnership

**Portfolio 1: Modernise and Strengthen ICT Foundations**

**Portfolio 2: Simplify, harmonise and rationalise our layers of applications**

**Portfolio 3: Become experts at Interoperability the way we share data**

**Portfolio 4: Capable Region: working well together to deliver high quality services**

**Rationalise Applications**
- Stabilisation and risk remediation
- Strategic innovation
- Strategic Application Portfolio Management
- Core Systems Roadmap

**Data Sharing and Interoperability**
- Information management and governance
- Data Mapping
- Core platforms
- API development and delivery
- Interoperability certification
- Data intelligence, reporting and analytics
- Transparent, outcomes focussed, data driven performance

**Delivery**

To support the realisation of this ISSP we have developed a Regional Roadmap, which provides details of the costed implementation initiatives we have identified, and sets out a clear map of the roles and responsibilities and priority initiatives in Horizon 1 required to deliver the ISSP goals. Delivery of the ISSP needs to be business-led (DHB) and co-ordinated across the region. A single plan, supported by a single capital plan and simplified governance will enable the ISSP Programme to achieve the goals that have been articulated in the ISSP.

The final section of this document (‘Making It Happen’) addresses the setup actions we must take to ensure the effective delivery. It considers such matters as governance, delivery methods and operating principles, which are critical success factors for this ISSP.

**ISSP Funding**

The Northern Region is grappling with some significant financial challenges as it considers how it will support a growing and aging population with an increasing demand for care and greater expectations of access to and involvement in their care. The Region’s challenge is how simultaneously to fix our degraded foundations, future-proof our capacity and capability, and support an accelerated programme to introduce the new models of care – all within a highly constrained resourcing envelope.

Operating the way we currently do (i.e. not recognising and funding the ‘true’ cost of IT) has led to significant degradation of our ICT assets. We consequently now face two significant challenges:

- Overcoming the accumulated technical debt from years of IS underfunding and
• investing in new capability that will provide us with the step change we need

Implementation of initiatives and approaches within the ISSP framework should enable us to use our current allocated funds more efficiently, but this level of funding will not be enough to make the step change required – additional funding will be needed for the full realisation of the ISSP.

This will require:

• Careful prioritisation of depreciation-funded initiatives to ensure best value, best strategic fit, and least regrettable spend (although some will be required to bridge current gaps);
• Central funding for those aspects of the strategy that relate to significant new assets/activities, based on a prioritised backlog of new initiatives.

Value Proposition (Outcomes)

Whilst much of our short-term planning revolves around non-optional remediation of our foundations, the ISSP delivers or enables a wide variety of benefits including the following:

• Our consumers/patients will be able to access their own information and have confidence that their treating clinicians have the information they need, wherever they are in the health system, to make the best decisions.
• More people can be empowered and engaged in their own care.
• Our region will be less constrained by our boundaries, and will work more effectively to deliver integrated care across settings enabled by shared data and more consistent approaches to care.
• Our population-based initiatives will be more pro-active and targeted, with more effective use of resources, generating demonstrable health outcome improvement.
• Our workforce will have more modern tools and better data, which should generate better decision making.
• Our acute facilities should benefit from reduced demand per capita, because earlier and more targeted interventions will reduce acute admissions.
• Our funding will be better spent, targeted to where it will do the most good because our clinicians and primary care personnel will be able to actively target at-risk sections of the populations before health issues emerge.
• Our risk profile will be easier to manage because we will have better access to information, and we will reduce silos of care.
• Our ICT risks will diminish because we will have fewer assets to manage, and we will have asset management plans for those we retain.
• Our vendors will be able to provide better service because we will be working with them in a partnering way to deliver better service levels and best value pricing.
• Our Government and Ministry will have access to better data to assure them that the Region is acting as a responsible steward of taxpayer asserts and funds, and is consistently delivering the standards of care for which it is funded.
Northern Region Information Systems Strategic Plan (ISSP) Regional Roadmap

2018 | Part of the Northern Region ISSP

V1.0

Executive Summary
About this document

Our vision over the next decade is for the Northern Region to become a ‘joined up’ integrated health system. To achieve this we need to have a strategic approach to our IS investment to support the healthcare needs of our regional population. The ISSP Regional Roadmap is a clearly articulated description of what we need to do with our core systems to enable the direction outlined in the Information Systems Strategic Plan (ISSP), and is aligned with the Northern Region’s Long Term Investment Plan (LTIP). The Roadmap is intended to reflect regional needs and priorities along with the systems required to satisfy those needs. It provides a framework to understand the benefits, risks and dependencies of our IS environment and a mechanism to help plan, fund and forecast technology investments.

The Regional Roadmap:

- Is owned by the Northern Region, is flexible to adapt to emerging demands yet takes into account current constraints
- Is a continuous process and this first version of the roadmap will be refreshed regularly as new information emerges such as the LTIP, ISSP and the Ministry of Health (MoH) Digital Strategy are updated and released.
- Considers regional IS capital investment priorities and decisions from the DHBs, healthAlliance and other sources
- Is a considered way to co-ordinate and communicate our technology initiatives.
## Executive Summary

Regional Roadmap Planning Context
Northern Region Environment
The Case for Change
Costed Roadmap

## Introduction

Purpose

### Portfolio 1

Strengthen and modernise our ICT Foundations

### Portfolio 2

Simplify, harmonise and rationalise our complex applications environment

### Portfolio 3

Become experts at interoperability and data sharing

### Portfolio 4

Become a capable region
Executive Summary

This Regional Roadmap proposes an investment direction for the Northern Region’s Information Systems (IS) technology, with a time horizon of the next five to seven years. It is the first iteration of a living document, which will be updated regularly to reflect the Region’s changing priorities and direction.

The Roadmap sets a course for the IS investment, planning and decisions that we need to make to realise the vision of a ‘joined up’ Northern Region population to live well, stay well, get well (as represented in the Northern Region IS Strategic Plan). It is pragmatic and realistic, and is informed by the combined view of both clinical and IS subject matter experts from across the Region.

An extended period of underfunding, combined with emerging pressures arising from a growing, older population and new models of care, means that significant investment is needed in our technology. This is required to support the future that is envisaged in the Long Term Investment Plan (LTIP) and the various business changes that are inherent in working together as a joined up region.

The intended audience for this Roadmap includes:
- The Northern Region – DHBs, healthAlliance, Primary & Community Care and Consumers
- The New Zealand Government - Ministry of Health and Treasury

This Roadmap provides a series of prioritised, strategic and tactical initiatives. It recognises the need to build foundations first, before moving ahead with transformative changes. The initial focus has been on the next two to three years, on the assumption that subsequent iterations of the Roadmap will provide greater detail for later years.

The near-term initiatives that have been identified as our priorities are described below:

<table>
<thead>
<tr>
<th>ISSP Portfolio</th>
<th>Summary of Priority initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLICATIONS</td>
<td></td>
</tr>
<tr>
<td>Simplify, Harmonise and Rationalise</td>
<td>1. <strong>Population Health Management Domain (to be renamed)</strong> - Select and progressively implement a ‘Collaborative Community Care’ platform (including self-care, shared care, community services, public health, Mental Health services) to enable a more patient-centred and team-based health system (addressing ‘burning platform’ application issues at Northland, Auckland and Counties Manukau). Establish patient engagement capability through extended Patient Portal strategy.</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Core Hospital Clinical Solutions Domain</strong> - In year 2-3 of the ISSP, initiate acquisition of a regional ‘Core Hospital Clinicals Solution’ (regional Electronic Medical Record) to address clinical workflow/care delivery in hospitals and outpatient clinics. In the meantime, establish a regional EMR Design Authority and develop an interim “Clinical Console” to improve clinical workflow in hospitals and outpatient that leverages regional best practice and innovation.</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Hospital Administration Domain</strong> - Replace ADHB’s Patient Administration System and establish a vision for regional resource management and optimisation (e.g. beds, clinic scheduling, theatres). A key point to note is that the selection of an ADHB PAS is de-coupled from selection of a future EMR (i.e there is no dependency on the EMR vendor being the same as the PAS vendor) and other DHB’s do not need to change their PAS within the ISSP timeframe (7 years).</td>
</tr>
<tr>
<td></td>
<td>4. <strong>Telehealth &amp; Communications Domain</strong> - Implement core Telehealth and Communications enablers to support whole of system secure communication, including video, voice, on-line for clinical, non-clinical, critical and non-critical communications. <strong>NB</strong> due to the current state being poor we need to invest in these tactical initiatives as a priority over potential strategic initiatives.</td>
</tr>
<tr>
<td></td>
<td>5. <strong>Shared Health Information Domain</strong> - Move quickly to improve access and structure to the elements of the Shared Health Record we currently have (including TestSafe) by addressing key enablers (e.g. privacy, audit, access), filling information gaps and improving usability.</td>
</tr>
</tbody>
</table>
Implementing the Regional Roadmap will provide us with some of the IS tools that will help us improve the way we deliver health outcomes to our population and address the growing demand for services. The clinical and operational priorities during this period include relieving the demand on acute facilities, broadening the reach of community services and providing better ways of working for our healthcare professionals.

The Regional Roadmap represents a deliberate change in our current way of working – a single plan with aligned investment and governance. Failure to make this change will mean we continue to operate in a fragmented way, making future change and the delivery of an integrated regional health system more difficult to implement and afford. Recognising the complexity and challenges inherent in the Region, there has been a deliberate attempt to minimise the implementation risks associated with this Roadmap. We need to strive to strike the balance between addressing the root causes of the challenges we face and providing immediate benefit to our providers and patients.
Regional Roadmap Planning Context

Relationship between Regional Plans

The Regional Roadmap provides the means of operationalising the ISSP that is a subset of the Northern Region’s LTIP as below:

<table>
<thead>
<tr>
<th>Long Term Investment Plan</th>
<th>ISSP</th>
<th>Roadmap</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Region’s goals are: to improve health status and reduce inequality; achieve greater patient centricity and outcomes; better meet the needs of a rapidly growing, ageing and changing population; and to bend the demand curve.</td>
<td>The ISSP vision is “Helping a ‘joined up’ Northern Region population to live well, stay well, get well’” The ISSP recognises the critical role of IS/IT as an enabler of health service delivery and the potential it provides to change the way we work.</td>
<td>The ISSP roadmap sets out the key decisions to be made and steps to be taken across the four ISSP portfolios to achieve the Region’s goals. It is the Region’s first iteration of a roadmap and needs to be refreshed based on delivery and direction refinement.</td>
</tr>
</tbody>
</table>

It should be read within the context of both documents, which collectively prescribe the future direction for the Region’s healthcare systems.
Northern Region Environment

Regional ISSP vision

The Northern Region LTIP helps define our regional clinical and operational priorities to address the pressures we face. These include doing more for our population, significantly increasing our focus on health outcomes, continuously driving for quality improvement, providing greater value for money and working more closely together as an integrated health system.

**ISSP vision: ‘Helping a ‘joined up’ Northern Region population to live well, stay well, get well.’**

The ISSP V1.0 has been written to address the needs of four different stakeholder groups:

- **Patients, carers and their families** – the population of the Northern Region.
- **Our people** – the range of individuals employed in and across our DHBs.
- **DHBs, primary and community care** – the organisations that manage the resources in our health system.
- **Government** – the Ministry of Health and Treasury that provide the policy context and funding for the system.

The vision, target outcomes for each of our stakeholders and underpinning ISSP principles are shown in the table below:

This initial ISSP Roadmap has been written to cover the first two Horizons in the Plan - years 2-7 of the ISSP (FY18-23). The target outcomes in those periods are shown in the table below.
Our Roadmap has been designed to achieve these outcomes.

Regional context

The Northern Region healthcare system is complex and, as a region, we have a number of challenges that influence our strategic direction. Factors such as population growth, an ageing population, funding limitations, and inequalities in health outcomes for our people across all care settings, are all placing the healthcare system under immense pressure.

We have the largest and fastest growing population in New Zealand, with 1.83 million people living in the Northern Region, which is predicted to grow by nearly a million more people in the next 30 years. There is a real challenge to grow our healthcare system to cope with the needs of this population. Our current systems are at breaking point from underfunding and population growth. It is well understood that we have an ageing population and 42% of hospital beds are currently occupied by frail elderly. In the future this will grow to 80% over the next 20 years. Chronic disease is on the rise as well as long term conditions such as cancer survivorship and dementia. People want to be in control of their health outcomes and make informed decisions throughout their lives. Access to health information and records is not readily available across all settings of care to be able to make this a reality.

In order to address these challenges, significant investment will be required, from both DHBs and our central government in order to make a difference. This means we will need to plan our investments carefully and make sure that the decisions made are aligned to addressing these challenges and our strategic direction. Hand in hand with population growth, investment in our healthcare professionals will need to grow to support the demand for services. Operational expenditure is already under pressure with the current workforce and clinical and administrative staff working long hours to maintain current service levels.

Overall health outcomes in the Region are above the national average, however there is significant variation within our region linked to ethnicity and deprivation particularly for our Maori and Pacific Island populations. Healthcare services do not reach far enough into our communities so that early healthcare intervention can reduce demand for acute services and reduce preventable deaths from disease.

Two ways of understanding this complexity are through the lenses of HealthCare Services and Information Services (as an enabler of care), as shown below:
The ‘ecology of the health system’ model (below) reinforces the importance of considering the health system holistically to influence health outcomes. It highlights the need for comprehensive health/ wellness and social care information systems that span all settings of care, and a person-centred approach to joining up care.

The diagram below provides an illustration of the range of care settings that our Region’s health services are delivered in, and that our back office support needs to service.

The scope of the Region’s Roadmap is set by these settings of care and the services delivered in each. A patient’s journey across these settings is the ultimate test of the Roadmap’s effectiveness.

The following model describes the foundational building blocks that define the scope and underpin the ISSP & Roadmap. The building blocks are organised into the four portfolio areas of the ISSP.
This diagram is used consistently throughout the document to identify where a Domain or Foundation fits within the overall architecture. It is also used to show the inter-relationships between components and their dependencies.
The Case for Change

Why are we doing this?

We need to look at IS in a new way of working that engages with our people, and supports healthcare systems by setting the strategic direction. The ISSP Regional Roadmap sets a course for the investment and decisions that we need to make to realise the vision of a ‘joined up’ Northern Region population to live well, stay well, get well. We have some very real challenges ahead and the Roadmap is written with an eye on the future of the Region and our healthcare system as a whole.

Traditionally, demand for IS projects has been driven from individual DHBs and a regional approach is often not considered. This has resulted in disparate systems being implemented for the same function or Domain and the potential benefits from a single approach being lost. Whilst it is recognised that there are also differences in individual operating models – which still need to be resolved from a clinical perspective - there are definite advantages (both financially and operationally) in having a single approach to IS systems that support like clinical functions in the Northern Region. Each DHB has a different starting point. Some have made recent investments and are justifiably reluctant to move away from them, whilst others are almost a whole cycle ‘behind’, investment priorities and timeframes are quite different. Convergence and alignment will take time and commitment at all levels, and will require discussion and (potentially) compromise.

The only hope we have of affording a better healthcare system and IS future is through working together as a single region.

Another driver to change our way of working is the influence of vendors on our IS, where solutions are often sold into our DHBs that do not fit our clinical settings, do not fit the models of care or do not integrate with existing systems easily. This has created an environment of workarounds and bespoke solutions that are not fit for purpose and are difficult to manage and maintain without costly re-engagement with these vendors. With a regional roadmap to inform investment decisions we can be more in charge of our direction and ensuring our investments in IS are strategic, financially sound and match the needs of our clinicians and patients across healthcare settings.

We operate in a fiscally constrained environment where we need to ensure that every dollar spent on IS is enabling patient outcomes for our region. A pragmatic approach is required, and delivery of the ISSP - on anything other than ‘keeping the lights on’ - requires a significant injection of capital over many years from central agencies. The only hope we have of affording a better healthcare system and IS future is through working together as a single region. Adopting the investment lenses of “Fix”, “Future Proof” and “Accelerate” provides clear guidelines for the decisions we need to make. There is a real opportunity to improve, to do better with the money we have and to deliver the future we want.
A key driver for the ISSP is placing the patient at the centre of care to improve the patient experience and improve their health outcomes. The first version of LTIP has identified a series of 'deep dives' to explore how services could be configured in the future:

- Frail elderly
- Oncology
- Radiology
- Elective surgery

Subsequent iterations will work on a number of other ‘deep dive’ areas. The outcomes from these ‘deep dives’, particularly the ‘patient journey’, can help define the IS enablers we need to provide.

To demonstrate how the Roadmap can impact care quality for people in the Region we have mapped a high level patient journey for a frail elderly patient (Geetha) against initiatives identified in the Roadmap. Issues currently experienced by the patient and her family are identified in the journey. Clinical issues are also identified where they impact on a clinician’s ability to provide quality care to Geetha.

Each of the five applications domain roadmaps will have a positive impact on the patient experience and care, shown (at a high level):

**Hospital Administration**
- Simplified and joined up access to patient demographic information
- Consumers/patients will be able to manage their own scheduled appointments
- Bed management can reduce the waiting times for appropriate beds
- Clinic check-ins will be faster

**Core Hospital Clinical Solutions**
- Improved clinician workflow and decision-making
- Reduced care variability
- Improved visibility of data in secondary care

**Shared Health Information**
- Improved access to patient data at point of care
- More Core data available
- Standardised data (rather than documents) core supports better clinical decision-making and analysis
- Improved trust and confidence in health information

**Population Health Management**
- Consumers/patients will be supported closer to home
- Patients are part of their care planning
- Consumers/patients will be able to see and manage their own data, including who has access to it
- Consumers will be able to access quality self-care educational resources
- Proactive interventions can delay/reduce acute demand

**TeleHealth & Communications**
- Care (including clinical consultations) can be provided much closer to home, enabled by technology - the need for travel will be reduced
- Smart devices can monitor key health indicators, and enable informed care or interventions as needed
Costed Roadmap

The various initiatives that have been proposed by the Domain Working Groups and other reference groups are presented overleaf in Gantt chart form.

Separate charts have been developed for each of the four portfolios that have been consistently applied in the ISSP and this document:

- Develop solid foundations
- Simplify, rationalise and harmonise our layers of applications
- Become experts at data sharing and interoperability
- Work effectively as a capable region

Within the charts we have shown the individual initiatives by domain.

We have estimated the cost of each initiative, where we have sufficient information to do so, and have also indicated the likely funding source for each one. Where there is uncertainty over either the cost or the funding source we have marked it as “TBA”.

All Year Two initiatives that have been funded through the base regional funding have been aligned with the FY18/19 Capital Plan.

Details of each initiative are shown in each of the following sections of this Roadmap.
### Roadmap Initiatives Schedule – Portfolio 1 (*Modernise & strengthen our ICT foundations*)

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Domain</th>
<th>Initiative</th>
<th>FY 18/19</th>
<th>FY 19/20</th>
<th>FY 20/21</th>
<th>FY 21/22</th>
<th>FY 22/23</th>
<th>FY 23/24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundations</td>
<td>DTaaS</td>
<td>Infrastructure as a Service Migration</td>
<td>7,500</td>
<td>7,500</td>
<td>7,500</td>
<td>7,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DTTaaS</td>
<td>8,300</td>
<td>8,300</td>
<td>8,300</td>
<td>8,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DTaaS (Other)</td>
<td>4,100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communications as a Service Connectivity, Unified Communications, Management Security</td>
<td>1,900</td>
<td>1,900</td>
<td>1,900</td>
<td>1,900</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identity &amp; Access Management</td>
<td>Phase One</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phase Two</td>
<td>27,088</td>
<td>3,900</td>
<td>7,496</td>
<td>8,277</td>
<td>8,268</td>
<td>4,268</td>
</tr>
<tr>
<td></td>
<td>Security</td>
<td>Foundational</td>
<td>350</td>
<td>350</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capability</td>
<td>360</td>
<td>360</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Threat Management</td>
<td>450</td>
<td>450</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>End User</td>
<td>400</td>
<td>400</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cloud Security</td>
<td>350</td>
<td>350</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Devices, Channels, Workspaces</td>
<td>Workspace</td>
<td>35,000</td>
<td>5,000</td>
<td>5,000</td>
<td>20,000</td>
<td>10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Channels</td>
<td>6,000</td>
<td></td>
<td>4,000</td>
<td>2,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>300</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Annual upgrade programmes</td>
<td>5,000</td>
<td>5,000</td>
<td>5,000</td>
<td>20,000</td>
<td>10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3,080</td>
<td></td>
<td></td>
<td>2,136</td>
<td>2,136</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total Capex</td>
<td></td>
<td>136,594</td>
<td>55,576</td>
<td>47,995</td>
<td>31,477</td>
<td>11,348</td>
<td>4,248</td>
<td>0</td>
</tr>
</tbody>
</table>

*Legend: Funding Sources Assumed*

- **FY 18/19 Capital Plan**
- **Other Internal**
- **Central Funding**
- **TBC**

*Draft Version 1.1 – subject to further refinement*
## Roadmap Initiatives Schedule – Portfolio 2 (Simplify, harmonise & rationalise our layers of applications)

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Domain</th>
<th>Initiative</th>
<th>SK</th>
<th>Year 2 (FY 18/19)</th>
<th>Year 3 (FY 19/20)</th>
<th>Year 4 (FY 20/21)</th>
<th>Year 5 (FY 21/22)</th>
<th>Year 6 (FY 22/23)</th>
<th>Year 7 (FY 23/24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Administration</td>
<td></td>
<td>Hospital Admin Replacement Project</td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
<td>9,000</td>
<td>9,000</td>
<td>9,000</td>
<td>9,000</td>
</tr>
<tr>
<td>Regional SPI and MPI</td>
<td></td>
<td></td>
<td>0</td>
<td>Included in HA1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applications</td>
<td>Centre for Development</td>
<td></td>
<td>200</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional EMR solution</td>
<td></td>
<td>200</td>
<td></td>
<td>4,000</td>
<td>7,000</td>
<td>7,000</td>
<td>7,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Console</td>
<td></td>
<td>350</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Converge applications</td>
<td></td>
<td>11,250</td>
<td>1,280</td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
<td>2,500</td>
<td></td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Regional Collaborative Community Care platform</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Models of Care</td>
<td></td>
<td>750</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop &amp; implement regional patient portal strategy</td>
<td></td>
<td>100</td>
<td></td>
<td>250</td>
<td>250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional videoconference</td>
<td></td>
<td>150</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional communications platform</td>
<td></td>
<td>450</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse Call &amp; order fulfillment, tracking &amp; monitoring, other strategic Telehealth initiatives</td>
<td></td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend: Funding Sources Assumed**
- FY 18/19 Capital Plan
- Other Internal
- Central Funding
- TBO
# Roadmap Initiatives Schedule – Portfolio 2 (cont)

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Domain</th>
<th>Initiative</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical Speciality</td>
<td>Develop domain roadmap</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workforce Information</td>
<td>Develop domain roadmap</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Business Information</td>
<td>Develop domain roadmap</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knowledge Management</td>
<td>Develop domain roadmap</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All</td>
<td>Domain roadmap initiatives</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual risk stabilisation</td>
<td>4,697</td>
<td>4,297</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Applications</td>
<td></td>
<td>Annual upgrades</td>
<td>18,276</td>
<td>18,276</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shared Health Information</td>
<td>Shared Health Record</td>
<td>500</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>enablers and reset</td>
<td>500</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CPU 8 Upgrade</td>
<td>6,000</td>
<td>5,000</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing SHI improvements</td>
<td>100</td>
<td>100</td>
<td>1,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3,000</td>
<td>500</td>
<td>2,500</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

## Total Capex
- FY 18/19: 133,713
- FY 19/20: 33,273
- FY 20/21: 15,500
- FY 21/22: 24,950
- FY 22/23: 23,000
- FY 23/24: 2,500
- Total: 13,500

### Notes
- **Legend:**
  - FY18/19 Capital Plan
  - Other Internal
  - Central Funding
  - T&O

### Additional Information
- **Draft Version 1.1 – subject to further refinement**
# Roadmap Initiatives Schedule – Portfolio 3 (Become experts at interoperability & data sharing)

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Domain</th>
<th>Initiative</th>
<th>$k</th>
<th>FY 2019/20</th>
<th>FY 2020/21</th>
<th>FY 2021/22</th>
<th>FY 2022/23</th>
<th>FY 2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Information</td>
<td>Programme establishment &amp; business case</td>
<td>0</td>
<td>0</td>
<td>800</td>
<td>2,000</td>
<td>500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Platform</td>
<td>establishment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Business value stream</td>
<td>23,000</td>
<td>5,000</td>
<td>6,000</td>
<td>6,000</td>
<td>6,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IEP (Mulesoft)</td>
<td></td>
<td>4,577</td>
<td>4,577</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information Management</td>
<td>Establish Information Management capability</td>
<td>1,500</td>
<td>1,500</td>
<td>2,000</td>
<td>1,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2,000</td>
<td>2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3,500</td>
<td>2,000</td>
<td>1,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,500</td>
<td>1,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BI &amp; Analytics</td>
<td></td>
<td>Business Intelligence &amp; Analytics</td>
<td>200</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Capex</td>
<td></td>
<td></td>
<td>39,577</td>
<td>6,877</td>
<td>11,200</td>
<td>9,500</td>
<td>6,000</td>
<td>6,000</td>
</tr>
</tbody>
</table>

**Legend: Funding Sources Assumed**
- FY18/19 Capital Plan
- Other Internal
- Central Funding
- T&CE

*Draft Version 1.1 – subject to further refinement*
## Roadmap Initiatives Schedule – Portfolio 4 (Work effectively as a capable region)

<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Domain</th>
<th>Initiative</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Effectively as a Capable Region</td>
<td></td>
<td>hA XaaS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>IS Capability Improvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional IS Governance Model</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional Enterprise Architecture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Innovation, ISSP &amp; Roadmap</td>
<td>4,250</td>
<td>Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5,500</td>
<td>Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4</td>
</tr>
<tr>
<td></td>
<td>Vendor Engagement</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regional Ownership</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient-Centricity Advocacy</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hA/NRA/FPSC</td>
<td>14,500</td>
<td></td>
</tr>
</tbody>
</table>

### Horizon 1: Foundations

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 18/19</td>
<td>FY 19/20</td>
<td>FY 20/21</td>
<td>FY 21/22</td>
<td>FY 22/23</td>
<td>FY 23/24</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
</tbody>
</table>

### Horizon 2: Transformation

<table>
<thead>
<tr>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6</th>
<th>Year 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 20/21</td>
<td>FY 21/22</td>
<td>FY 22/23</td>
<td>FY 23/24</td>
</tr>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
</tbody>
</table>

### Total Capex

<table>
<thead>
<tr>
<th>FY 18/19 Capital Plan</th>
<th>Other Internal</th>
<th>Central Funding</th>
<th>TRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>14,500</td>
<td>2,000</td>
<td>2,500</td>
<td>2,500</td>
</tr>
</tbody>
</table>

**Legend:** Funding Sources Assumed
- FY18/19 Capital Plan
- Other Internal
- Central Funding
- TRC

**Draft Version 1.1 – subject to further refinement**
Introduction - Charter Overview

The Northern Region ISSP Programme has now completed its Strategy and first draft of its Regional Roadmap, and is ready to commence Mobilisation to deliver the Programme.

This Charter defines the overall scope and objectives for the Mobilisation Phase, and for the Horizon 1 Design and Implementation Phase of the Programme, together with the associated objectives, scope, approach and structure for this phase of work.

In doing so the Charter accommodates the following:

a) It provides all stakeholders with a clear and consistent understanding of what the Northern Region ISSP Programme will deliver and the process and governance structure through which delivery will be achieved;

b) It identifies all component projects and priorities that are associated with the Programme, including their interdependencies, and

c) It sets the context within which all elements within the Programme will be governed, planned and executed.

The table of contents of the Charter is provided overleaf. The full Charter is provided as a separate document.
# Index & Table of Contents

| 1 | Introduction  |
|   | Provides an introduction to the Programme and the purpose of the document. |
| 2 | Programme Strategy and Roadmap  |
|   | Provides an overview of Ministry of Health strategy and objectives, the Northern Region DHB’s strategies, hA’s strategy, hA’s Target Operating Model and the ISSP outcome roadmap. |
| 3 | Programme Objectives  |
|   | Defines the ISSP Programme goals and objectives, and defines the key capabilities and benefits that will be delivered. |
| 4 | Programme Risks and Challenges, & Critical Success Factors & Key Principles  |
|   | Identifies the key Programme risks, challenges, and Critical Success Factors. |
| 5 | Programme Scope  |
|   | Defines the major components and scope of the Programme, from a process, system and organisational perspective. Provides an overview of dependencies outside of the Programme. |
| 6 | Programme Approach, and Method  |
|   | Provides an overview of the Programme approach, and the key delivery methods and methodologies. |
| 7 | Programme Plan and Validation Approach  |
|   | Provides an overview of the Programme delivery plan, including the key dates, release options, impact and capability assessment, and validation approach. |
| 8 | Programme Governance, Reporting and Communications  |
|   | Outlines governances principles, the governance model, the approvals and key roles/responsibilities, as well as regular Programme reporting, contract management, communications and quality assurance requirements. |
| 9 | Programme Costs, Benefits and Capability Assessment  |
|   | Provides a summary of the Programme costs and benefits, and the background and approach for the Capability Assessment approach. |
| 10 | Programme Quality Assurance Approach  |
|   | Provides an overview of the quality assurance approach that will be applied to ensure that the Programme objectives are realised. |
| 11 | Key Appendices  |
|   | Includes key appendices, covering supporting details, including delegated authorities. |
Decision Paper
Counties Manukau District Health Board
Harley Gray MRI Finance Update

Recommendation

It is recommended that the Board:

**Receive** this update on the financial status of the Harley Gray MRI Suite Project.

**Note** this paper was endorsed by the Audit Risk & Finance Committee on 21 November to go forward to the Board.

**Note** there is a forecast overspend of $233k upon completion of the Harley Gray MRI project, this is a 2.9% variance on the total budget of $8,032,573.

**Note** that the cost of the project has been closely monitored by the MRI Project Steering Committee on a monthly basis.

**Note** that the risk of cost escalation was signalled to the asset and capital committee and the potential cost overrun was escalated to the Board in previous facilities updates.

**Note** that $147k of the forecast overspend has already been called from CFO contingency in 2017/18, the remaining capital of ~$86k will be called from the CFO contingency in 2018/19.

**Approve** the anticipated overspend on the Harley Gray MRI project, as per the terms of section 3.5 of the Delegated Authority Policy for projects exceeding budget by greater than 2%, and delegate to the Chief Financial Officer, authority to sign off the remaining expenditure.

Prepared and submitted by: Ian Dodson, General Manager Central Clinical Services

Glossary
MRI – Magnetic Resonance Imaging
QS – Quantity Surveyor

Purpose

The purpose of this paper is to notify the ELT of the forecast overspend at the completion of the Harley Gray MRI Project. The overspend is set to be greater than 2% of the original approved budget and in terms of the Delegated Authority Policy requires approval by the CM Health board as the spend is greater than 2% of the total approved budget.

Background

The Harley Gray MRI project was initially approved by the CM Health board in May 2016. Following detailed design and procurement of the MRI’s and the main construction contractor further approval was sought from the CM Health Board for an increase in funding to complete the project. Approval was gained from the CM Health Board in December 2017 to proceed with the MRI Project with total funding of $8,033m.

The project got underway in February 2018 and has proceeded on track with the proposed timelines and reached practical completion on the 19th of October 2018. The CM Health MRI team started training and
service migration on the 23rd of October. The first MRI is due to be fully operational on 12 November 2018 with the second MRI due to be fully operational on 26 November 2018.

**Financial Overspend**

As it stands on 1 November 2018 the forecast cost to completion is $8,265,869 against an approved budget of $8,032,573, resulting in an anticipated final cost overrun of 2.9% for the total project. This is not the final cost, the final account is yet to be presented but no other significant variances are expected. Some variations remain under review and debated. The figures include a QS allowance to close out the final account.

Table 1 below notes the key spend categories, the variance to budget and commentary on the sources of variation.

<table>
<thead>
<tr>
<th>Table 1: Summary of Cost Overrun for Harley Gray MRI Project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breakdown</strong></td>
</tr>
<tr>
<td>Construction (incl. hA IT)</td>
</tr>
<tr>
<td>Professional fees and Consents</td>
</tr>
<tr>
<td>Equipment</td>
</tr>
<tr>
<td>MRI Contract</td>
</tr>
<tr>
<td>CM Health Costs</td>
</tr>
<tr>
<td>Sub-totals</td>
</tr>
</tbody>
</table>

There were 3 key overarching reasons for the cost overrun: extended procurement process; key equipment exclusions and architectural design issues.

**Extended Procurement Process**

Between the initial Board Approval in May 2016 and the subsequent approval in December 2017 there was an additional procurement process run due to the recommended construction not being endorsed.
and a subsequent round of procurement taking place. This incurred direct additional costs of $47k.

**Key Equipment Exclusions**

There were 2 key items that were not included in the original project budget. A ferromagnetic sensor that scans the patient for safety before they enter the MRI room was not included and cost an additional $47k. The second item was the chiller configuration for cooling the MRI’s. A split chiller supply was installed as part of the MRI installation. This was a modification to the agreed contract. The change to the original configuration was not agreed by CM Health or hA as per the agreed process. It should be noted that although this was not agreed in advance the split chiller configuration is safer and provides risk mitigation in the event that one chiller fails. There was also a significant under budgeting of equipment by the radiology service that put significant pressure on the equipment budget.

**Architectural and Professional Services Design**

There were 3 notable items that resulted in additional cost of $90k that were due to architectural errors or professional services issues. These led to modifications having to be made during construction which added significant additional cost. CM Health sought claims/resolutions against these 3 items with one of the claims for additional cost for $15k was resolved at no cost to the DHB. Procurement of equipment late in the design phase resulted in some scope variations that added additional cost. A learning for future projects would be to perform a formal sign off as a design coordination review step.

Overall the key cost overruns can mostly be traced back to the planning and design phases with key equipment and building design elements having been missed or excluded. The construction and execution went very well and according to plan. In addition a construction contingency of 5% was lean, this was applied by the QS as this was an internal fit-out rather than a green field build.

An initial project cost overrun was escalated to the MRI project Steering Committee, to the Asset and Capital Committee and flagged as a potential risk in Board facilities updates. The initial forecast cost overrun was approved by the CFO to fund $146,747 from CFO contingency in the 2017/18 year. The remaining overspend of ~$86k has been endorsed in principle by the CFO to be funded from the 2018/19 CFO contingency once approved by the Board. Other than the cost overrun the project has run to schedule with the project being delivered to scope and on time.

The following reviews are scheduled:

1. **Lessons learned exercises**
   - Week of the 12 November 2018, led by RCP, that will look at the business case, the brief, design, procurement of contractors, construction
   - Week of 19 November 2018, DHB and healthAlliance review of business case, planning, MRI procurement
2. **Project Close Out Report** due for completion by 20 December 2018 – will include feedback from the lessons learned meetings and all accounts should be closed out.
3. **Post Implementation Review** is to be conducted following 6 months of operation with a final report due on the 30 June 2019
Counties Manukau District Health Board
Workforce Ethnicity Report

Recommendation

It is recommended that the Board:

Receive the Workforce Ethnicity reports for the period ending 30 June 2018.

Prepared and submitted by Elizabeth Jeffs, Director HR

Purpose

The Board requested a quarterly update on how we are tracking with increasing the numbers of Maaori and Pacific staff across our workforce broken down by workforce group.

Appendices

1. Workforce Ethnicity Pacific Report June 18
2. Workforce Ethnicity Maaori Report June 18
Report Observations:

**Junior Doctors:** Whilst there has been a net increase (4%) in the total number of Pacific junior doctors employed across the region this quarter, the 59 employed in the current quarter (Jun-18) is comparable with the 60 employed Jun-17.

**Nurses:** The total number of Pacific nurses employed has remained relatively static this quarter compared with the last. It’s worth noting that the increase from one year ago is still substantial (558 Jun-18) vs 485 (Jun-17).

**Dental therapists:** Whilst there has been no net change in the number of Pacific dental therapists this quarter the percentage employed has increased to 8.2% (Jun-18) from 7.1% (Mar-18) due to an overall net reduction in the total number of dental therapists employed from 182 (Jun-18) to 158 (Mar-18).

---

![Current Quarter Snapshot - % Pacific Employed](chart)

**Current Quarter New Starts and Leavers**

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Doctor</td>
<td>1.5%</td>
<td>5.5%</td>
<td>2.9%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Nurse</td>
<td>11.5%</td>
<td>5.8%</td>
<td>10.4%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Midwife</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>0.0%</td>
<td>8.2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dietitian</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.0%</td>
<td>1.3%</td>
<td>3.8%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0.0%</td>
<td>5.7%</td>
<td>0.0%</td>
<td>2.8%</td>
</tr>
<tr>
<td>All Workforce</td>
<td>1.3%</td>
<td>5.4%</td>
<td>8.3%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

---

---

![Historical Trend](chart)

**2025 % Pacific Target**

| 2025 % Pacific Target | 2.4% | 7.0% | 9.2% | 21.0% |

---

**Notes:**

1. Dental Therapist for Waitemata, Auckland, and Counties Manukau all have their own different target of 12% due to Waitemata operating a metro Auckland dental service and would employ dental therapists for the metro DHBs.

---

**Current Quarter New Starts and Leavers**

- **Northland**
  - Junior Doctor: -4
  - Nurse: -6
  - Midwife: -2
  - Dental Therapist: -1
  - Dietitian: -1
  - Occupational Therapist: -1
  - Physiotherapist: -1
  - All Workforce: -25

- **Waitemata**
  - Junior Doctor: -4
  - Nurse: -6
  - Midwife: -11
  - Dental Therapist: -8
  - Dietitian: -5
  - Occupational Therapist: -3
  - Physiotherapist: -7
  - All Workforce: -27

- **Auckland**
  - Junior Doctor: -4
  - Nurse: -6
  - Midwife: -11
  - Dental Therapist: -11
  - Dietitian: -10
  - Occupational Therapist: -10
  - Physiotherapist: -9
  - All Workforce: -61

- **Counties Manukau**
  - Junior Doctor: -4
  - Nurse: -6
  - Midwife: -3
  - Dental Therapist: -7
  - Dietitian: -1
  - Occupational Therapist: -7
  - Physiotherapist: -28
  - All Workforce: -28

---

**Notes:**

2. Net changes are the combination of new starts, leavers and other reasons such as retrospective change in ethnicity recorded for existing employees.
Notes

1. Data is sourced from HWIP data extracts submitted by DHBs to DHSS.
2. Figures and calculations of percentages are based on headcount, not FTE.
3. The target is based on the working age population projection (aged between 20 and 64) for the year 2025, sourced from MoH Population Projection 2017 Update.
4. Only permanent employees are included. Casuals, locums and employees with zero contract hours are excluded. Casual employee is identified by field 'Paid Employment Status' and locum is identified by field 'Job Title'.
5. Employees left during the current quarter is counted in the leavers but not the total employed workforce for the quarter.
6. Where employees have secondary positions within the same ANZSCO code and identifiable by the same employee number, it is counted only once.
7. Employees with unknown ethnicity is excluded from the denominator in the calculation of percentage by ethnicity and deriving the extra required.
8. Dental therapists in metro DHBs are mostly employed at Waitemata. The target and extra required for this group is based on the ethnicity distribution of the metro Auckland population.

Workforce Groups

The workforce groupings are based on ANZSCO codes, mapped by DHSS to the major workforce groups. The mapping table can be obtained from the Central TAS template named "DHB-Self-analysis-template-YYYY-QC.xlsx"

ANZSCO codes for Priority workforce group are:

<table>
<thead>
<tr>
<th>Grouping</th>
<th>ANZSCO Code &amp; Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Doctor</td>
<td>253112 Resident Medical Officer</td>
</tr>
<tr>
<td>Nurse</td>
<td>134212 Nursing Clinical Director, 254211 Nurse Educator, 254212 Nurse Researcher, 254311 Nurse Manager, 254411 Nurse Practitioner, 254412 Registered Nurse (Aged Care), 254413 Registered Nurse (Child &amp; Family Health), 254414 Registered Nurse (Community Health), 254415 Registered Nurse (Critical Care &amp; Emergency), 254416 Registered Nurse (Developmental Disability), 254417 Registered Nurse (Disability &amp; Rehabilitation), 254418 Registered Nurse (Medical), 254421 Registered Nurse (Medical Practice), 254422 Registered Nurse (Mental Health), 254423 Registered Nurse (Perioperative), 254424 Registered Nurse (Surgical), 254425 Registered Nurse (Paediatrics), 254499 Registered Nurses nec, 411411 Enrolled Nurse, 411412 Midwifery Nurse</td>
</tr>
<tr>
<td>Midwife</td>
<td>254111 Midwife</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>411214 Dental Therapist</td>
</tr>
<tr>
<td>Dietitian</td>
<td>251111 Dietitian</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>252411 Occupational Therapist</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>252511 Physiotherapist</td>
</tr>
</tbody>
</table>

Ethnicity

1. Population projections contain ethnicity groups of Māori, Pacific, Asian and Other.
2. The HWIP data extracts submitted by DHBs to DHSS are grouped to match the population projections (i.e. Māori, Pacific, Asian, Other).
3. The HWIP technical documents (https://tas.health.nz/assets/SWS/HWIP/2018/HWIP-Code-Set-2018-V.9.pdf) state that "Ethnicity data must be recorded at level 4 (the most detailed level of the classification)". Codes and descriptions are included in the technical document at level 4. A full list of levels 1 - 4 can be found on the Ministry of Health website.

MoH Level 2 codes are grouped as follows:

<table>
<thead>
<tr>
<th>Ethnicity Group</th>
<th>Level 2 Ethnicity Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>21 Māori</td>
</tr>
<tr>
<td>Pacific</td>
<td>30 Pacific Island NFD, 31 Samoan, 32 Cook Island Māori, 33 Tongan, 34 Niuean, 35 Tokelauan, 36 Fijian, 37 Other Pacific Island</td>
</tr>
<tr>
<td>Asian</td>
<td>40 Asian NFD, 41 Southeast Asian, 42 Chinese, 43 Indian, 44 Other Asian</td>
</tr>
<tr>
<td>Other</td>
<td>10 European NFD, 11 NZ European/Pakeha, 12 Other European, 51 Middle Eastern, 52 Latin America/Hispanic, 53 African, 54 Other MELAA, 61 Other</td>
</tr>
<tr>
<td>Ethnicity Not Stated</td>
<td>94 unknown dimension, 95 Declined to state, 97 Unspecified, 99 Not stated, No value recorded</td>
</tr>
</tbody>
</table>
Report Observations:

Junior Doctors: Across the region, there is a net decrease (10) in the number of Māori junior doctors employed this quarter. The 78 employed in the current quarter (Jun-18) is less than the 88 in the previous quarter (Mar-18) but higher than the 52 employed Dec-17. It’s worth noting that the increase from one year ago is still substantial 53 (Jun-18) vs 434 (Jun-17).

Nurses: Across the region, there is a net decrease (28) in the number of Māori nurses employed this quarter. The 553 employed in the current quarter (Jun-18) is less than the 581 in the previous quarter (Mar-18) but higher than the 528 employed Dec-17. It’s worth noting that the increase from one year ago is still substantial 553 (Jun-18) vs 434 (Jun-17).

Midwives: There has been a continuing upward trend for the number and percentage of Māori midwives employed. There are 41 (7.6%) employed in the current quarter (Jun-18) compared with 37 (7.2%) in Mar-18 compared with 27 (5.6%) a year ago in Jun-17.

Dental therapists: Whilst there has been a net decrease in the number of Māori dental therapists employed this quarter there has been an increase in the percentage employed to 13.7% (Jun-18) from 13.0% (Mar-18) due to an overall net reduction in the total number of dental therapists employed from 207 (Jun-18) to 182 (Mar-18) . This maintains the percentage of Māori employed for dental therapist over the 11.6% 2025 regional target and neither NDHB nor WDHB need any extra for their individual targets.

Current Quarter Snapshot - % Māori Employed

<table>
<thead>
<tr>
<th>Workforce Category</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Doctor</td>
<td>6.3%</td>
<td>4.2%</td>
<td>6.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Nurse</td>
<td>15.4%</td>
<td>4.2%</td>
<td>4.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Midwife</td>
<td>8.5%</td>
<td>7.5%</td>
<td>4.6%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Occupation Therapist</td>
<td>33.3%</td>
<td>10.8%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>5.1%</td>
<td>3.8%</td>
<td>2.3%</td>
<td>4.2%</td>
</tr>
<tr>
<td>All Workforce</td>
<td>17.8%</td>
<td>6.7%</td>
<td>4.8%</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

2025 % Māori Target: 34.9% - 8.6% - 7.2% - 14.1%

(1) Dental Therapist for Waitemata, Auckland, and Counties Manukau all have its own different target of 10% due to Waitemata operating a metro Auckland dental service and would employ dental therapists for the metro DHBs.

Current Quarter New Starts and Leavers

<table>
<thead>
<tr>
<th>Workforce Category</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Doctor</td>
<td>-7</td>
<td>4</td>
<td>-22</td>
<td>25</td>
</tr>
<tr>
<td>Nurse</td>
<td>-13</td>
<td>-8</td>
<td>-2</td>
<td>7</td>
</tr>
<tr>
<td>Midwife</td>
<td>-1</td>
<td>-1</td>
<td>-1</td>
<td>1</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>-1</td>
<td>-2</td>
<td>-1</td>
<td>1</td>
</tr>
<tr>
<td>Dietitian</td>
<td>-1</td>
<td>-1</td>
<td>-1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>-1</td>
<td>-2</td>
<td>-1</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>-1</td>
<td>-3</td>
<td>-1</td>
<td>1</td>
</tr>
</tbody>
</table>

(2) Net changes are the combination of new starts, leavers and other reasons such as retrospective change in ethnicity recorded for existing employees.
Notes
1. Data is sourced from HWIP data extracts submitted by DHBs to DHBSS.
2. Figures and calculations of percentages are based on headcount, not FTE.
3. The target is based on the working age population projection (aged between 20 and 64) for the year 2025, sourced from MoH Population Projection 2017 Update.
4. Only permanent employees are included. Casuals, locums and employees with zero contract hours are excluded. Casual employee is identified by field “Paid Employment Status” and locum is identified by field “Job Title”.
5. Employees left during the current quarter is counted in the leavers but not the total employed workforce for the quarter.
6. Where employees have secondary positions within the same ANZSCO code and identifiable by the same employee number, it is counted only once.
7. Employees with unknown ethnicity is excluded from the denominator in the calculation of percentage by ethnicity and deriving the extra required.
8. Dental therapists in metro DHBs are mostly employed at Waitemata. The target and extra required for this group is based on the ethnicity distribution of the metro Auckland population.

Workforce Groups
The workforce groupings are based on ANZSCO codes, mapped by DHBSS to the major workforce groups. The mapping table can be obtained from the Central TAS template named “DHB-Self-analysis-template-YYYY-QQ.xlsx”

ANZSCO codes for Priority workforce group are:

<table>
<thead>
<tr>
<th>Grouping</th>
<th>ANZSCO Code &amp; Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Doctor Nurse</td>
<td>253112 Resident Medical Officer 134212 Nursing Clinical Director, 254211 Nurse Educator, 254212 Nurse Researcher, 254311 Nurse Manager, 254411 Nurse Practitioner, 254412 Registered Nurse (Aged Care), 254413 Registered Nurse (Child &amp; Family Health), 254414 Registered Nurse (Community Health), 254415 Registered Nurse (Critical Care &amp; Emergency), 254416 Registered Nurse (Developmental Disability), 254417 Registered Nurse (Disability &amp; Rehabilitation), 254418 Registered Nurse (Medical), 254421 Registered Nurse (Medical Practice), 254422 Registered Nurse (Mental Health), 254423 Registered Nurse (Perioperative), 254424 Registered Nurse (Surgical), 254425 Registered Nurse (Paediatrics), 254499 Registered Nurses nec, 411411 Enrolled Nurse, 411412 Mothercraft Nurse</td>
</tr>
<tr>
<td>Midwife</td>
<td>254111 Midwife</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>411214 Dental Therapist</td>
</tr>
<tr>
<td>Dietitian</td>
<td>251111 Dietitian</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>252411 Occupational Therapist</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>252511 Physiotherapist</td>
</tr>
</tbody>
</table>

Ethnicity
1. Population projections contain ethnicity groups of Māori, Pacific, Asian and Other.
2. The HWIP data extracts submitted by DHBs to DHBSS are grouped to match the population projections (i.e. Māori, Pacific, Asian, Other).
3. The HWIP technical documents (https://tas.health.nz/assets/SWS/HWIP/2018/HWIP-Code-Set-2018-V.9.pdf) state that “Ethnicity data must be recorded at level 4 (the most detailed level of the classification)”. Codes and descriptions are included in the technical document at level 4. A full list of levels 1 - 4 can be found on the Ministry of Health website.

MoH Level 2 codes are grouped as follows:

<table>
<thead>
<tr>
<th>Ethnicity Group</th>
<th>Level 2 Ethnicity Code and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>21 Māori</td>
</tr>
<tr>
<td>Pacific</td>
<td>30 Pacific Island NFD, 31 Samoan, 32 Cook Island Māori, 33 Tongan, 34 Niuean, 35 Tokelauan, 36 Fijian, 37 Other Pacific Island</td>
</tr>
<tr>
<td>Asian</td>
<td>40 Asian NFD, 41 Southeast Asian, 42 Chinese, 43 Indian, 44 Other Asian</td>
</tr>
<tr>
<td>Other</td>
<td>10 European NFD, 11 NZ European/Pakeha, 12 Other European, 51 Middle Eastern, 52 Latin America/Hispanic, 53 African, 54 Other MELAA, 61 Other</td>
</tr>
<tr>
<td>Ethnicity Not Stated</td>
<td>94 unknown dimension, 95 Declined to state, 97 Unspecified, 99 Not stated, No value recorded</td>
</tr>
</tbody>
</table>
Countsies Manukau District Health Board
Surgery, Anesthesia and Perioperative Services (SAPS)
Workplace Incidents August 2018

Recommendation

It is recommended that the Executive Leadership Team:

**Receive** a review of August 2018 Incidents for SAPS Workplace Incidents.

**Note** this report was endorsed by the Executive Leadership Team on 4 December to go forward to the Board.

**Note** that the high number of employees in the SAPS Division can result in higher numbers of workplace incidents.

Prepared and submitted by: Mary Burr on behalf of Elizabeth Jeffs, Director of Human Resources.

Purpose

The purpose of this paper is to examine the workplace incidents reported by the SAPS Division in August 2018.

Background

SAPS Division has the highest number of FTE (by Division) in the organisation at approximately 1700 employees. By the nature of our work, it is imperative that we have strong work safe practices. Our work environments provide fast paced, complex, high volume work settings often with heavy workloads requiring manual handling, working with equipment, hazardous material, drugs and patients often impaired by anaesthetic or illness. Theatre and CSSD (Central Sterile Services Department) are particularly complex environments which require strong workplace safety practices for all participants in all activities i.e. clinical staff, support staff and patients.

As a Division we encourage staff to report any actions that may be considered incidents (as described by Risk Pro criteria and under the H & S Act). We recognize this is the best way to ensure improved health and safety practices in our workplace. We work closely with Occupation Health and Safety and have both and HR and H & S Business Partners as integral members of our Management Team.

Investigating and Monitoring

Severity 1 and 2 incidents are reported to General Manager (GM) and the Clinical Director (CD) by an alert email and investigated by the line manager and Quality Manager (QM) immediately. All other incidents are reviewed, investigated and resolved by line managers and Service Managers on a regular basis and reported monthly.

The General Manager receives weekly and monthly reports about all incidents. The GM receives a monthly report and meets with the QM to discuss all SAPS incidents. The purpose of this meeting is to discuss the number, type and trends related to incidents. The QM then reports on all incidents and H & S trends in person at each SAPS Management Meeting (fortnightly) and monthly to SAPS Governance Meeting.

The QM audits and reports on all incidents and trends in the Divisional monthly report.

August 2018 SAPS Workplace Incidents
During August 2018, 40 Health & Safety related incidents were reported throughout the SAPS Division. Table One shows incidents reported throughout CMDHB and the level of incidents in SAPS compared to other Divisions. Table Two shows where the incidents occurred within the SAP Division and Table Three outlines the type of incidents that have occurred.

The fact that the SAPS Division employs more people than most other divisions and that reporting is actively encouraged results in a higher level of reporting.

Table One – Workplace Incidents at CMDHB

Table Two- SAPS Workplace Incident by Location

Most incidents for August have been reported in the Theatre environment and these are made up of a non-sterile instrument report (removed from service), two times insect bites, three Blood Body Fluid Events (protocol followed), a lifting strain and a fall in the car park. Each incident has been investigated and closed.

Ward 8 also has a high number of incidents. These related to staffing shortage on three shifts (Ward 8 has extra staff planned through the Care Capacity Management (CCMD) Accord), use of hand gel and subsequent irritation, staff member hit hand on door and another flicked an object into her eye.
Table Three- SAPS Workplace Incident by Incident Type August 2018

Overall the most reported event is musculo/skeletal event at 11. No unit is over represented in this category and there are no serious severity events reported.

Table Four – Reported Severity August 2018

Table Four- Resolved /Unresolved as at 1 Nov 2018
A review of all unresolved incidents in August 2018 is shown below. Each has been investigated and awaits follow up from employee and manager (time related conclusion).

<table>
<thead>
<tr>
<th>Incident No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>131759</td>
<td>Wrist twisted. OHSS investigation underway.</td>
</tr>
<tr>
<td>131624</td>
<td>Instrument cracked - noted at time of cleaning - returned to the company. Awaiting result.</td>
</tr>
<tr>
<td>131641</td>
<td>Laptop stolen from employee’s home. No patient information stored on laptop. Police and organisation notified.</td>
</tr>
<tr>
<td>131441</td>
<td>BBFE protocol followed following splash in eye. OHSS investigated and closed.</td>
</tr>
<tr>
<td>131515</td>
<td>Slight rash on employee after pulling an empty wheelchair. Did not seek medical attention. OHSS reviewed. Referred to Manager.</td>
</tr>
<tr>
<td>131858</td>
<td>Crush injury by Theatre doors. OHSS investigation completed. Review by Theatre Manager needs to be completed</td>
</tr>
<tr>
<td>131781</td>
<td>Insect bite/ OHSS investigate</td>
</tr>
<tr>
<td>131120</td>
<td>Staff member hit elbow in door as she walked through. OHSS review. CNM to follow up.</td>
</tr>
<tr>
<td>131969</td>
<td>Highlighting an issue with staffing. Investigated by OHSS. Referred to OM. Ward 11 is a recipient of CDM Accrued staffing increase.</td>
</tr>
<tr>
<td>131129</td>
<td>Burned elbow. Manager to review and document findings, corrective action and feedback to staff. No further OH&amp;S action at the time.</td>
</tr>
</tbody>
</table>

**Summary**

Workplace incident reporting for Surgery, Anaesthesia and Perioperative Services is encouraged and provides a strong basis for our work safe practices. Each incident is investigate by a line manager and reviewed by a manager responsible for service provision and employee management.

August 2018 provides no particular trends in incidents occurring in either place or category. Thirty incidents have been investigated fully and ten remain waiting for resolution based on OHSS protocols (i.e. BBFE, Police follow up, remediation).

The Division has the highest number of employees and encourages the reporting of incidents and therefore would expect to have a higher number of incidents report when compared to other divisions.
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 21 November 2018.

Prepared and Submitted by: Margaret White – Chief Financial Officer

Glossary

ARDS Auckland Regional Dental Service  
ATR Authority to Recruit  
CFIS Crown Financial Information System  
CIC Capital Investment Committee  
CPI Consumer Price Index  
DBC Detailed Business Case  
DIA Department of Internal Affairs  
DFA Delegated Financial Authority  
ESPI Elective Services Performance  
FPSC Finance, Procurement Supply Chain  
FSA Food Service Agreement  
IDF Inter District Flows  
JPA Joint Partnership Agreement 
LSP Licencing Solution Partners  
MECA Multi-Employer Collective Agreement  
NOS National Oracle Solution  
NRLTIP Northern Region Long Term Investment Plan  
PAYE Pay As You Earn  
PBFF Population Based Funding Formula  
PO Purchase Order  
POAG Procurement Organisation Advisory Group  
RFP Request for Proposal  
TAP Turnaround Savings Programme  
WIES Weighted Inlier Equivalent Separations  
WIP Work in Progress  
YTD Year to Date

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 21 November 2018.

1.0 Financial Result for the period ended 30 September 2018

The 30 September 2018 month consolidated result is $43k unfavourable (YTD $102k favourable) to budget. Performance by operating arm is presented in table 1 below.

Table 1: Statement of Performance by Operating Arm for the period ended 30 September 2018

<table>
<thead>
<tr>
<th>Net Result</th>
<th>September 2018</th>
<th>Full Year Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Year to Date</td>
</tr>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Hospital Provider</td>
<td>3,697</td>
<td>3,007</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(2,630)</td>
<td>(2,674)</td>
</tr>
<tr>
<td>Total Provider</td>
<td>1,067</td>
<td>333</td>
</tr>
<tr>
<td>Funder</td>
<td>(1,632)</td>
<td>(794)</td>
</tr>
<tr>
<td>Governance</td>
<td>68</td>
<td>6</td>
</tr>
<tr>
<td>Net Surplus / (deficit)</td>
<td>(497)</td>
<td>(454)</td>
</tr>
</tbody>
</table>
Provider
Hospital Provider Position is $690k favourable (YTD $2.273m favourable) to budget. The key drivers are the reduced volumes costs associated with a milder winter as well as the impact of vacancies, plus additional ACC revenue.

Funder
The Funder Arm is $839k unfavourable (YTD $2.924m unfavourable) to budget, driven by a $1.9m IDF wash up provision not budgeted and turn-around-plan (TAP) revenue generation initiatives that are yet to crystalize $1.3m YTD.

Governance
Governance Arm is $62k favourable (YTD $640k favourable) to budget primarily due to a gain on disposal of assets $377k (land sale that was not accounted for in 2017/18).

The full Financial Variance Report for the period ended 30 September 2018 is presented in Appendix 1 of this report.
Appendix 1 – Financial Report for the period ended 30 September 2018

The YTD 30 September 2018 consolidated result is $102k favourable to budget.

Statement of Revenue and Expenditure for the period ended 30 September 2018

<table>
<thead>
<tr>
<th>Net Result</th>
<th>September 2018</th>
<th>Year to Date</th>
<th>Full Year Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
</tr>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>142,380</td>
<td>141,582</td>
<td>799</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>3,410</td>
<td>2,905</td>
<td>505</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>145,790</td>
<td>144,486</td>
<td>1,304</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>52,247</td>
<td>53,147</td>
<td>900</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,164</td>
<td>775</td>
<td>(389)</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>6,636</td>
<td>6,078</td>
<td>(558)</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>63,116</td>
<td>61,100</td>
<td>(2,017)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>10,262</td>
<td>10,617</td>
<td>355</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>6,565</td>
<td>6,952</td>
<td>388</td>
</tr>
<tr>
<td><strong>Operating Expenditure</strong></td>
<td>139,990</td>
<td>138,670</td>
<td>(1,320)</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>5,800</td>
<td>5,817</td>
<td>(16)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>3,207</td>
<td>3,163</td>
<td>(44)</td>
</tr>
<tr>
<td>Interest</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>3,091</td>
<td>3,108</td>
<td>17</td>
</tr>
<tr>
<td><strong>Net Surplus/(Deficit)</strong></td>
<td>(497)</td>
<td>(454)</td>
<td>(43)</td>
</tr>
</tbody>
</table>

Commentary on Major Variances:

Crown Revenue
September 2018 month was $799k favourable to budget (YTD $1.428m favourable), reflecting the following:

- $1m additional MoH funding to PHO for ‘System Level Measures’ and 2017/18 SLM washup;
- TAP revenue initiatives shortfall $445k unfavourable (YTD $1.343m unfavourable);
- PHO capitation shift to IDFs with matching cost variance $362k favourable (YTD $644k favourable);
- Mental Health unbudgeted pay equity $64k favourable (YTD $677k favourable) with matching additional costs in provider payments; and
- Additional ACC arrears revenue $702k favourable (YTD $1.7m favourable).
Other Revenue
September 2018 month was $505k favourable to budget (YTD $1.392m favourable), reflecting the following:

- Favourable timing of Pacific contract revenue (offset by cost) $189k favourable (YTD $548k favourable);
- Retail pharmacy sales $113k favourable (YTD $279k favourable);
- Tahitian burns additional billing $128k favourable (YTD $199k favourable);
- Interest received $76k favourable (YTD $254k favourable) due to better than Budget cash position; and
- Donations $273k favourable (YTD $187k unfavourable).

Personnel and Outsourced Personnel
Net personnel costs for September are $511k favourable (YTD $3.217m favourable). Continued vacancies across the services (combination of lower acute demand and services holding vacancies where appropriate) and the impact of the nursing strike has resulted in FTE and dollar costs under budget, with partial offsets in YTD unrealised TAP savings and outsourced personnel. Actual FTE’s including outsourced were 141 FTE favourable YTD.

Outsourced services
Outsourced Clinical Services were $558k unfavourable (YTD $1.802m unfavourable) primarily due to pacific regional contract delivery (with revenue offset) and unrealised TAP savings in the Provider $369k (YTD $1.254m).

Provider Payments
September was $2.017m unfavourable to budget (YTD $3.933m unfavourable), reflecting the following:

- IDF wash up provisioning greater than budget, primarily ADHB $744k unfavourable (YTD $2.6m unfavourable);
- Mental Health unbudgeted pay equity $64k (YTD $677k unfavourable), offset by revenue; and
- PHO capitation shift to IDFs $362k unfavourable (YTD $644k unfavourable) offset by revenue.

Clinical supplies
Unrealised TAP savings in Provider of $296k month (YTD $792k).

Infrastructure costs
September was $388k unfavourable to budget (YTD $118k unfavourable), reflecting the following:

- Cost of goods sold increase due to higher pharmacy sales (offset by revenue) $110k (YTD $288k);
- Unbudgeted legal and consultant costs (inc Ebert) $20k (YTD $450k); and
- Offset by gain on sale of land in August (YTD $377k) that was not accounted for in 2017/18.
### Statement of Financial Position as at 30 September 2018

<table>
<thead>
<tr>
<th></th>
<th>Act  $'000</th>
<th>Budget $'000</th>
<th>Var $'000</th>
<th>Aug-18 $'000</th>
<th>Movement $'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Bank</td>
<td>32,262</td>
<td>(6,639)</td>
<td>38,901</td>
<td>34,719</td>
<td>(2,457)</td>
</tr>
<tr>
<td>Trust</td>
<td>2,820</td>
<td>2,811</td>
<td>9</td>
<td>2,817</td>
<td>3</td>
</tr>
<tr>
<td>Prepayments</td>
<td>3,049</td>
<td>637</td>
<td>2,412</td>
<td>3,146</td>
<td>(97)</td>
</tr>
<tr>
<td>Debtors</td>
<td>61,163</td>
<td>68,803</td>
<td>(7,640)</td>
<td>57,665</td>
<td>3,498</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,916</td>
<td>8,840</td>
<td>(924)</td>
<td>7,963</td>
<td>(47)</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>5,320</td>
<td>5,320</td>
<td>-</td>
<td>5,320</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td>112,538</td>
<td>79,780</td>
<td>32,758</td>
<td>111,638</td>
<td>900</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>629,205</td>
<td>678,196</td>
<td>(48,991)</td>
<td>629,679</td>
<td>(474)</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,824</td>
<td>1,824</td>
<td>-</td>
<td>1,824</td>
<td>-</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,162</td>
<td>4,178</td>
<td>(16)</td>
<td>4,178</td>
<td>(16)</td>
</tr>
<tr>
<td>Information Software</td>
<td>662</td>
<td>693</td>
<td>(31)</td>
<td>693</td>
<td>(31)</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>4,753</td>
<td>4,850</td>
<td>(97)</td>
<td>4,753</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>853,026</td>
<td>902,161</td>
<td>(49,135)</td>
<td>853,547</td>
<td>(521)</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(190,667)</td>
<td>(190,872)</td>
<td>205</td>
<td>(187,462)</td>
<td>(3,205)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>662,359</td>
<td>711,289</td>
<td>(48,930)</td>
<td>666,085</td>
<td>(3,726)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>79,934</td>
<td>30,268</td>
<td>49,666</td>
<td>75,341</td>
<td>4,593</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>742,293</td>
<td>741,557</td>
<td>736</td>
<td>741,426</td>
<td>867</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>46,445</td>
<td>53,239</td>
<td>(6,794)</td>
<td>46,126</td>
<td>319</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>901,276</td>
<td>874,576</td>
<td>26,700</td>
<td>899,190</td>
<td>2,086</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>105,287</td>
<td>91,732</td>
<td>13,555</td>
<td>105,085</td>
<td>202</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>6,618</td>
<td>6,429</td>
<td>189</td>
<td>6,760</td>
<td>(142)</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>17,100</td>
<td>13,065</td>
<td>4,035</td>
<td>16,798</td>
<td>302</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>17,100</td>
<td>14,275</td>
<td>2,825</td>
<td>27,930</td>
<td>(10,830)</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>114,381</td>
<td>108,399</td>
<td>5,982</td>
<td>101,333</td>
<td>13,048</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>260,486</td>
<td>233,900</td>
<td>26,586</td>
<td>257,906</td>
<td>2,580</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(147,948)</td>
<td>(154,120)</td>
<td>6,172</td>
<td>(146,268)</td>
<td>(1,680)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>640,790</td>
<td>640,676</td>
<td>114</td>
<td>641,284</td>
<td>(494)</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>22,948</td>
<td>22,948</td>
<td>-</td>
<td>22,948</td>
<td>-</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>2,820</td>
<td>2,810</td>
<td>10</td>
<td>2,817</td>
<td>3</td>
</tr>
<tr>
<td>Insurance Liability</td>
<td>1,155</td>
<td>1,155</td>
<td>-</td>
<td>1,155</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>26,923</td>
<td>26,913</td>
<td>10</td>
<td>26,920</td>
<td>3</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>408,990</td>
<td>408,990</td>
<td>-</td>
<td>408,990</td>
<td>-</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>291,395</td>
<td>291,398</td>
<td>(3)</td>
<td>291,395</td>
<td>-</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(86,518)</td>
<td>(86,625)</td>
<td>107</td>
<td>(86,021)</td>
<td>(497)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>613,867</td>
<td>613,763</td>
<td>104</td>
<td>614,364</td>
<td>(497)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>640,790</td>
<td>640,676</td>
<td>114</td>
<td>641,284</td>
<td>(494)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- Closing bank was $38.901m favourable to budget. Net cash flows from operations (revenue, expenses and payroll) was $30m favourable to budget. Fixed assets cash spend was $8.5m favourable to budget representing the delayed timing of capital spend for major capital projects. (refer cash flow variance explanation for further details).

- Debtors were $7.64m lower than Budget as a result of improved collections and timing differences.

- Net Fixed Assets and Investment in Associates are $6m lower than budget reflecting timing of major capital projects spend (including an assumption regarding IT assets planned to be transferred to healthAlliance in September 2018 however the workings regarding the transfer is still in progress).

- GST and PAYE was $4.035m higher than budget due to timing differences in payments.

- Employee entitlements were $5.982m greater than budget mainly reflecting provisions for expired MECA settlements.

- Favourable working capital $6.172m is mostly attributable to the timing matters detailed above.
## Statement of Cash flow for the period ended 30 September 2018

<table>
<thead>
<tr>
<th>Category</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act $ 000</td>
<td>Budget $ 000</td>
</tr>
<tr>
<td><strong>Cash flows from Operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>138,701</td>
<td>136,422</td>
</tr>
<tr>
<td>Other</td>
<td>3,309</td>
<td>2,810</td>
</tr>
<tr>
<td><strong>Cash was applied to:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(90,182)</td>
<td>(103,717)</td>
</tr>
<tr>
<td>Employees</td>
<td>(50,028)</td>
<td>(52,502)</td>
</tr>
<tr>
<td>Capital charge</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Operations</strong></td>
<td>1,800</td>
<td>(16,987)</td>
</tr>
<tr>
<td><strong>Cash flows from Investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(4,073)</td>
<td>(5,315)</td>
</tr>
<tr>
<td>Investments</td>
<td>(319)</td>
<td>(100)</td>
</tr>
<tr>
<td>Interest rec.</td>
<td>135</td>
<td>58</td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(4,254)</td>
<td>(5,357)</td>
</tr>
<tr>
<td><strong>Cash flows from Financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Non-Current Liability</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>(2,454)</td>
<td>(22,344)</td>
</tr>
<tr>
<td>Opening cash</td>
<td>37,544</td>
<td>15,713</td>
</tr>
<tr>
<td><strong>Closing cash</strong></td>
<td>35,090</td>
<td>(6,631)</td>
</tr>
</tbody>
</table>

### Reconciliation Summary

<table>
<thead>
<tr>
<th>Item</th>
<th>Act $ 000</th>
<th>Budget $ 000</th>
<th>Var $ 000</th>
<th>Act $ 000</th>
<th>Budget $ 000</th>
<th>Var $ 000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Surplus/(Deficit)</strong></td>
<td>(497)</td>
<td>(454)</td>
<td>(43)</td>
<td>(11,556)</td>
<td>(11,659)</td>
<td>102</td>
</tr>
<tr>
<td>Add/(Less) non-cash items</td>
<td>3,207</td>
<td>3,163</td>
<td>44</td>
<td>9,489</td>
<td>9,489</td>
<td>-</td>
</tr>
<tr>
<td>Depn</td>
<td>2,710</td>
<td>2,709</td>
<td>1</td>
<td>(2,067)</td>
<td>(2,170)</td>
<td>102</td>
</tr>
<tr>
<td>Add/(Less) items Classified as Investing or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financing activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on Disposal</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Add/(Less) Movements in Financial Position</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>items</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors and Other Receivables</td>
<td>3,401</td>
<td>(5,217)</td>
<td>8,618</td>
<td>7,125</td>
<td>(12,528)</td>
<td>19,653</td>
</tr>
<tr>
<td>Inventories</td>
<td>(47)</td>
<td>(100)</td>
<td>53</td>
<td>(611)</td>
<td>(313)</td>
<td>(298)</td>
</tr>
<tr>
<td>Creditors</td>
<td>3,354</td>
<td>(14,379)</td>
<td>17,733</td>
<td>2,446</td>
<td>(9,340)</td>
<td>11,786</td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>(7,618)</td>
<td>-</td>
<td>(7,618)</td>
<td>(830)</td>
<td>-</td>
<td>(830)</td>
</tr>
<tr>
<td></td>
<td>(910)</td>
<td>(19,696)</td>
<td>18,786</td>
<td>8,130</td>
<td>(22,181)</td>
<td>30,311</td>
</tr>
<tr>
<td><strong>Net Cash flow from Operations</strong></td>
<td>1,800</td>
<td>(16,987)</td>
<td>18,787</td>
<td>6,063</td>
<td>(24,351)</td>
<td>30,414</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- Cash-flow from Crown Revenue is $2.279m favourable to budget mainly from additional Crown Revenue in relation to SCI payments (offset by additional expenditure); PHO capitation payments (offset by additional expenditure) and additional ACC revenue.

- Payments to suppliers were $13.535m lower than budget mainly as a result of variations to the planned timing of supplier payments in the budget.

- Employee Payments were $2.474m favourable to budget representing net favourable personnel costs for the month and the timing of the payment of payroll accruals.

- Fixed Assets $1.242m favourable to budget representing the delayed timing of capital spend for major capital projects.
Counties Manukau District Health Board
Establishment of Executive Committee of the Board

Recommendations

It is recommended that the Board:

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

- **Decide** membership of the Executive Committee.

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

- **Note** that all decisions made by the Executive Committee will be reported back to the Board at its meeting on 20 February 2019.

- **Agree** that the Executive Committee be dissolved as at 20 February 2019.

Prepared by: Vui Mark Gosche, Board Chairman

Glossary

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

Purpose

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

Background

The final normal scheduled meeting of the Board for the year is today, 12 December 2018. The next meeting is on 20 February 2019. There might be some items of business requiring approval at Board level that need to be processed during this period.

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

Proposal

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

It is expected that, by their nature, any items referred to this Committee are likely to need to be taken in public excluded session. The date and agenda items of any meeting(s) would, as soon as confirmed, be advised to all Board members and meeting(s) publicly notified if they involve any open meeting agenda reports.
# Counties Manukau District Health Board 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 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>Risk Workshop</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Confidentiality of Advice Tendered by Officials The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. [Official Information Act 1982 S9(2)(f)(iv)]</td>
</tr>
<tr>
<td>Public Excluded Minutes of 31 October and 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>Public Excluded Minutes of the Audit Risk &amp; Finance Committee and Community &amp; Public Health 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. [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>NOS Risk Mitigation Strategic Assessment</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td>Department/Project</td>
<td>Request</td>
<td>Reason for Withholding Information</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>ePA Phase 2 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>Commercial Activities&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td>Specialised Rehabilitation Centre IBC Scope &amp; Options/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>
<td>Commercial Activities&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td>Expansion of Gastro Procedural Capacity</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
</tr>
<tr>
<td>Manurewa High School</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Negotiations&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial negotiations. [Official Information Act 1982 S9(2)(j)]</td>
</tr>
<tr>
<td>Regional Primary Acute Care Service</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities &amp; Negotiations&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i) &amp; (j)]</td>
</tr>
</tbody>
</table>
| Microsoft G2018 Licence Renewal – Ratification of Circular Resolution | Commercial Activities | Commercial Activities
| --- | --- | ---
| 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. | The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. | [Official Information Act 1982 S9(2)(i)]
| [NZPH&D Act 2000 Schedule 3, S32(a)] |  |
| CEO Update | Public Interest | Public Interest
| 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. | The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. | [Official Information Act 1982 S9(2)(ba)(ii)]
| [NZPH&D Act 2000 Schedule 3, S32(a)] |  |
| Acute Mental Health Phase II Procurement & Funding | Commercial Activities & Negotiations | Commercial Activities & Negotiations
| 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. | 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 and negotiations. | [Official Information Act 1982 S9(2)(i) & (j)]
| [NZPH&D Act 2000 Schedule 3, S32(a)] |  |
| Primary & Community Contracted Services | Commercial Activities & Negotiations | Commercial Activities & Negotiations
| 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. | 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 and negotiations. | [Official Information Act 1982 S9(2)(i) & (j)]
| [NZPH&D Act 2000 Schedule 3, S32(a)] |  |
| Long Term Conditions Model of Care Update | Commercial Position | Commercial Position
| 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. | The disclosure of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information. | [Official Information Act 1982 S9(2)(b)(ii)]
| [NZPH&D Act 2000 Schedule 3, S32(a)] |  |