MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD
Wednesday, 26 June 2019

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

CMDHB BOARD MEMBERS
Mark Gosche – Chairman
Dr Lyn Murphy
Apulu Reece Autagavaia
Dr Ashraf Choudhary
Catherine Abel-Pattinson
Colleen Brown
Dianne Glenn
George Ngatai
Katrina Bungard
Pat Snedden
Kylie Clegg

CMDHB MANAGEMENT
Margie Apa – Chief Executive Officer
Margaret White – Chief Financial Officer
Dr Gloria Johnson – Chief Medical Officer
Dr Jenny Parr – Chief Nurse & Director of Patient & Whaanau Experience
Dinah Nicholas – Board Secretary

PART 1 – Items to be considered in public meeting

AGENDA

BOARD ONLY SESSION (8.00 – 9.00am)

1. GOVERNANCE

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

2. BOARD MINUTES

9.15 – 9.20am
2.1 Confirmation of Minutes of the Meeting of the Board – 15 May 2019

9.20 – 9.25am
2.2 Action Items Register

9.25 – 9.30am
2.3 Report on RDISAC Minutes 4 April 2019 – verbal (Colleen Brown)

9.30 – 9.35am
2.4 Report on CPHAC Minutes 10 April & Draft 22 May 2019 – verbal (Colleen Brown)

9.35 – 9.40am
2.5 Report on HAC Minutes 2 May & Draft 5 June 2019 – verbal (Lyn Murphy)

Morning Tea Break (9.40 – 9.50am)

3. EXECUTIVE REPORTS

9.50 – 10.00am
3.1 Chief Executive Officer’s Report (including Patient Story) (Margie Apa)

10.00 – 10.30am
3.1.1 Deep Dive 1 – Community Stroke Rehabilitation (Dana Ralph-Smith, Geoff Green & Nick Henzell)

10.30 – 11.00am
3.1.2 Deep Dive 2 – Impact of Body Size on Service Delivery -Obesity & Orthopaedics (Matthew Tomlinson, Michelle McCallum-Jones & Gary Jackson)

11.00 – 11.10am
3.2 Corporate Affairs and Communications Report (Donna Baker)

11.10 – 11.20am
3.3 Health and Safety Performance Report (Elizabeth Jeffs)

11.20 – 11.30am
3.4 Finance and Corporate Business Report (Margaret White)

4. DECISION PAPERS

11.30 – 11.40am
4.1 1st Draft Northern Region Service Plan (Margie Apa)

11.40 – 12.00pm
4.2 Smokefree Policy (Gary Jackson & Basil Fernandes)

5. RESOLUTION TO EXCLUDE THE PUBLIC

Lunch Break (12.00 – 12.30pm)
# Board Member Attendance Schedule 2019

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>20 Feb</th>
<th>Mar</th>
<th>9 Apr</th>
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<td>Catherine Abel-Pattinson</td>
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<td>Katrina Bungard</td>
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<td>Dr Ashraf Choudhary</td>
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<td>Kylie Clegg</td>
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<td>Pat Snedden</td>
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# BOARD MEMBERS’ DISCLOSURE OF INTERESTS

26 June 2019

*New items in red italics*

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</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  
                          • *Chairman*, Housing NZ Ltd |
| Dr Ashraf Choudhary    | • Board Member, Otara-Papatoetoe Local Board  
                          • Member, NZ Labour Party  
                          • Chairperson, Advisory Board Pearl of Islands Foundation  
                          • Co-Patron, Bharatiya Samaj Charitable Trust |
| Catherine Abel-Pattinson| • Board Member, Health Promotion Agency  
                          • Board Member, healthAlliance NZ Ltd.  
                          • National Party Policy Committee Northern Region  
                          • Member, NZNO  
                          • Member, Directors Institute  
                          • Co-Chair, National Party Health Policy Committee  
                          • Husband (John Abel-Pattinson):  
                          o *Director, Blackstone Group Ltd*  
                          o *Director, Blackstone Partners Ltd*  
                          o *Director, Blackstone Treasury Ltd*  
                          o *Director, Bspoke Group Ltd*  
                          o *Director, Barclay Management Ltd*  
                          o *Director, AZNAC (JAP) Ltd*  
                          o *Director Chatham Management Ltd*  
                          o *Director, GCA Trustee Ltd*  
                          o *Director, MAFV Ltd*  
                          o *Director, Manaia No. 4 Trustees Ltd*  
                          o *Director, Wolfe No. 1 Ltd*  
                          o *Director, Greenstone Motels Ltd*  
                          o *Director, Silverstone Property Group Ltd*  
                          o *Director, various single purpose property owning companies* |
<table>
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<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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<tr>
<td>Colleen Brown</td>
<td>• Chair, Disability Connect (Auckland Metropolitan Area)</td>
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<td>• Member, Advisory Committee for Disability Programme</td>
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<td>• Manukau Institute of Technology</td>
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<td>• Member, NZ Down Syndrome Association</td>
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<td>• Husband, Determination Referee for Department of Building and Housing</td>
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<td>• Director, Charlie Starling Production Ltd</td>
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<td>• District Representative, Neighbourhood Support NZ Board</td>
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<td>• Chair, Rawiri Residents Association</td>
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<td>• Director and Shareholder, Travers Brown Trustee Limited</td>
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<td>Dianne Glenn</td>
<td>• Member, NZ Institute of Directors</td>
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<td>• Life Member, Business and Professional Women Franklin</td>
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<td>• Member, UN Women Aotearoa/NZ</td>
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<td>• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust</td>
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<td>• Life Member, Ambury Park Centre for Riding Therapy Inc.</td>
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<td>• Member, National Council of Women of New Zealand</td>
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<td>• Justice of the Peace</td>
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<td>• Member, Pacific Women’s Watch (NZ)</td>
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<td>• Member, Auckland Disabled Women’s Group</td>
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<td>• Life Member of Business and Professional Women NZ</td>
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<td>George Ngatai</td>
<td>• Director, Transitioning Out Aotearoa</td>
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<td>• Director, The Whanau Ora Community Clinic</td>
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<td>• Chair, Safer Aotearoa Family Violence Prevention Network</td>
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<td>• Huakina Development Trust (Partnership Clinic)</td>
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<td>• Lotteries Community (Auckland)</td>
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<td>• Board Member, Counties Manukau Rugby League Zone</td>
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<td>• Member, NZ Maori Council</td>
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<td>• Director &amp; Shareholder, BDO Marketing &amp; Business Solutions Limited (TBC)</td>
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<td>• Director &amp; Shareholder, Ngatai Bhana Limited</td>
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<td>• Director &amp; Shareholder, Family Care Limited</td>
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<td>• Member, Restorative Justice Aotearoa</td>
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<tr>
<td>Katrina Bungard</td>
<td>• Chairperson MECOSS – Manukau East Council of Social Services.</td>
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<td>• Deputy Chair Howick Local Board</td>
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<td>• Member of Amputee Society</td>
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<td>• Member of Parafed disability sports</td>
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<td>• Member of NZ National Party</td>
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<td>Member</td>
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</tbody>
</table>
| 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  
                        • Trustee & Beneficiary, Mickyla Trust  
                        • **Trustee & Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies but less than 1% of the shares in those companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, NextMinute Holdings Limited). It also includes a shareholding of less than 1% in Orion Health Holdings Limited. Orion Health has commercial.** |
| 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*  
                        • Member, Health Partners Shareholder Review Group  
                        * subsidiaries of Te Urungi o Ngati Kuri Limited |
<table>
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<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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| 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  
• Member, Workforce Development Early Childhood Education Advisory Committee                                                                 |
| 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 26 June 2019

<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>
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</thead>
<tbody>
<tr>
<td>Mark Gosche</td>
<td>Social Wellbeing Board</td>
<td>Vaka Tautua has a contract with the Social Wellbeing Board.</td>
<td>20 February 2019</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>Margie Apa</td>
<td>Middlemore Foundation</td>
<td>Holds an ex officio role on the Middlemore Foundation.</td>
<td>20 February 2019</td>
<td>That Margie Apa’s specific interest be noted and that she may remain in the room and participate in any discussion but be excluded from any voting, if applicable.</td>
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Minutes of the Meeting of the Counties Manukau District Health Board
Wednesday, 15 May 2019

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
Dianne Glenn
Lyn Murphy
Pat Snedden
George Ngatai
Kylie Clegg
Katrina Bungard
Apulu Reece Autagavaia
Colleen Brown

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

APOLOGIES
Apologies were received and accepted from Margie Apa and Donna Baker.

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

WELCOME
Mr Ngatai opened the meeting with a karakia.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
The Disclosures of Interest were noted with an amendment for Mr Snedden - Member of the Health Partners Shareholder Review Group.

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 9 April 2019

Resolution (Moved: Dianne Glenn/Seconded: Pat Snedden)

That the Minutes of the Board Meeting held on the 9 April 2019 be approved.

Carried

2.2 Action Item Register

Noted.

3 WORKSHOP

3.1 Quality Improvement & Patient Safety, Health Quality & Safety Commission (Dame Alison Paterson, Iwona Stolarek and Dr Mary Seddon)

The Board was taken through a presentation outlining the role of the Commission, the Board’s governance role in health and safety and how to use data to answer the five key quality and safety questions.

A 30-minute educational session on control charts will be scheduled at an upcoming Board meeting.

4. EXECUTIVE REPORTS

4.1 Chief Executive Officer’s Report (Margaret White)

The report was noted and taken as read.

Security – to better understand our shortcomings, Beca Consulting were commissioned to undertake a review of the security controls currently in place and to advise on additional requirements to protect staff and their vehicles. This work is being phased into three phases with Phase 1 due to be completed end-June 2019; Phase 2 (July to mid-October) will deliver additional controls and Phase 3 (still under development) will likely include options for a centralised CCTV monitoring and control stations at MMH and MSC. Phase 1 includes security upgrades at the Western Campus, s-Bend and MSC.

Board Secretary to extend the invitation to the Staff Security Forum on Friday 24 May to the Board.

Ms Jeffs to invite union representatives to attend the fortnightly Security meetings.

Health Targets - health targets remain a concern.

Faster Cancer Treatment (FCT)

Patients are referred onto the FCT pathway by their GP if there is a suspicion of cancer, most will not have cancer but they start off on this pathway until the requisite investigations have been carried out to take them off.

Dr Johnson commented that there has been a sharing of ideas regionally and a lot of work has been undertaken to try and cut time out from the FCT pathway however, there is a resource constraint
which is creating bottlenecks due to increased volumes and as all patients with cancer are using the same resources, this means there are symptomatic cancer patients waiting much longer than they should be.

The Chair advised that the Minister reiterated last week that where there are issues with performance, his expectation is that DHBs will have a comprehensive action plan which will, ultimately, be monitored by the Ministry. From today’s report, there is clearly a deterioration with performance which is largely unchanged from Q2 and remains significantly below the 95% target.

A full report on the FCT programme, including what can be addressed (ie) administrative errors, and what the plans are to improve performance, to be included as part of the CEOs next report to the Board.

Immunisation

It was noted that the new incentives pilot programme will commence in Q4 2018/19 to encourage engagement with Maori whaanau and pepe in the eight month old cohort. This programme will run for one year and will be evaluated. The focus of the pilot is to address inequity in Maori immunisation coverage at eight months.

Measles

Apulu Reece Autagavaia commented on the majority of confirmed cases of measles not being linked, and the three cases in South Auckland.

Extend an invitation to ARPHs to present their Measles Strategy at the next CPHAC meeting, particularly as it pertains to the Pacific community, and what they are doing to counter the ‘anti-vaccine’ campaign.

Social Wellbeing Board – the Chair queried whether there has been a loss of momentum due to the delay in securing revenue for the Social Wellbeing Board. Ms White undertook to look into this and report back to the Board.

Nursing Strategy - the draft Nursing Strategy was launched on 14 May. The DHB strategy is to support healthy communities, healthy people, whaanau and families, and to deliver healthy services. The strategy was created with and for the nursing community of CM Health.

A separate Midwifery workforce strategy will be developed following consultation on the potential role of Clinical Director, Midwifery.

Certification – the Certification team were highly complementary of the DHB as an organisation which is living its values. The DHB received 7 new corrective actions which will support the organisation to be even better and reflect areas that we are already aware of and in most cases, have actions underway already.

Celebrations/Ceremonies – the Chair asked that the Board receive invitations to any celebrations/ceremonies being held by the DHB so Board members can attend, if available.
4.2 Corporate Affairs and Communications Report (Paula Taylor & Parekawhia McLean)
The report was noted and taken as read.

Resolution (Moved: Mark Gosche/Seconded: Apulu Reece Autagavaia)

That the Board:

Receive the Corporate Affairs and Communication Report for the period ending 31 March 2019.

Carried

(Paula Taylor departed at 12.20pm)

4.3 Health and Safety Performance Report (Elizabeth Jeffs)
The report was taken as read.

Staff Wellbeing – Ms Jeffs advised that all issues in relation to fatigue should be logged by staff through Risk Pro and they will also be visible through the Trendcare rostering system (ie) it will be clear when people are doing patterns of work that are likely to result in fatigue. Ms Jeffs also advised that the NZNO have released a Code of Practice which is currently under consultation across the DHBs which includes a Fatigue Safety Management Plan that DHBs can implement and there is also a piece of national work being undertaken around wellbeing in general with one of the first pieces of work being a Wellbeing Strategy which focuses on fatigue.

Spinal Unit – the new security measures that have been implemented at the Otara Spinal Unit to improve staff safety (ie) improved lighting, installation of swipe card access were noted. The Chair was keen to understand whether the staff feel that the measures they requested are working and good enough. Ms Jeffs undertook to check in with the staff at the Spinal Unit and provide feedback in her next Board report.

Middlemore Crescent Development – it will be important to remain engaged and connected with HLC in relation to this development insofar as parking for staff who may park there and safer roadways are concerned.

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

That the Board:

Receive the Health and Safety Report for the period ending 31 March 2019.

Carried
4.4 Finance & Corporate Business Report (Margaret White)
The report was noted and taken as read.

The Cath Lab business case is still with the joint Ministers for final approval and sign-off, and has been for some time. The Chair confirmed that he would bring this up with the Ministry at the strategic meeting on 21 May.

Resolution (Moved: Pat Snedden/Seconded: Mark Gosche)

That the Board:


Carried

5. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Mark Gosche/Seconded: Pat Snedden)

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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<tbody>
<tr>
<td>Public Excluded Minutes of 9 April 2019 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</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 As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<tr>
<td>Event</td>
<td>Details</td>
<td>Section Reference</td>
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<td><strong>Response to Winter Demand 2019</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td><strong>Commercial Activities</strong>&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
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<tr>
<td><strong>2019/20 Annual Planning</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td><strong>Commercial Activities &amp; Negotiations</strong>&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations.</td>
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<tr>
<td><strong>Microbiology Nucleic Acid Extraction Contract</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td><strong>Commercial Negotiations</strong>&lt;br&gt;The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial negotiations.</td>
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<td><strong>Clinical Equipment Services Contracts</strong></td>
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<td>Case</td>
<td>Section of the Official Information Act 1982</td>
<td>Reason for Withholding Information</td>
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<tr>
<td><strong>RISSP Workspace Business Case</strong></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td><strong>Linen &amp; Laundry Contract Extension</strong></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td><strong>Post Implementation Review</strong></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities</td>
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<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.</td>
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<tr>
<td><strong>MH&amp;A Pukekohe &amp; Papakura Refit Project</strong></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities &amp; Negotiations</td>
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<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 and negotiations.</td>
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<td>Section</td>
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<tr>
<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
<td>NZHIH Funding Request</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>[Official Information Act 1982 S9(2)(i)]</td>
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<tr>
<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
<td>Renal Patients not Eligible for Publicly Funded Care</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
<td>Middlemore Clinical Trials Presentation/Research Strategy</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>NZPH&amp;D Act 2000 Schedule 3, S32(a)</td>
<td>Chief Executive’s Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
</tr>
<tr>
<td>[Official Information Act 1982 S9(2)(i)]</td>
<td>Public Interest</td>
<td>The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest.</td>
</tr>
</tbody>
</table>
Carried

The public meeting closed at 12.35pm.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 15 MAY 2019.

__________________________________________
BOARD CHAIR

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

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 May 2019</td>
<td><strong>Health &amp; Safety Performance Report</strong></td>
<td><em>Spinal Unit</em> – the new security measures that have been implemented at the Otara Spinal Unit to improve staff safety (ie) improved lighting, installation of swipe card access were noted. The Chair was keen to understand whether the staff feel that the measures they requested are working and good enough. Ms Jeffs undertook to check in with the staff at the Spinal Unit and provide feedback in her next Board report.</td>
<td>26 June/7 August</td>
<td>Elizabeth Jeffs</td>
<td>Work in progress. A full report will be made available on 7 August.</td>
<td>✓</td>
</tr>
<tr>
<td>15 May 2019</td>
<td><strong>CEO Report</strong></td>
<td>A full report on the FCT programme, including what can be addressed (ie) administrative errors, and what the plans are to improve performance, to be included in the CEO report.</td>
<td>26 June</td>
<td>Margie Apa</td>
<td>Refer Item 3.1 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>15 May 2019</td>
<td><strong>HQSC Workshop</strong></td>
<td>Schedule a 30-minute educational session on control charts.</td>
<td>7 August</td>
<td>Mary Seddon</td>
<td></td>
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<tr>
<td>9 April 2019</td>
<td><strong>Health &amp; Safety Performance Report</strong></td>
<td><em>Aggression &amp; Violence</em> – once there is sufficient data from the Code Orange pilot and other work being undertaken in this area, present a deep dive into this area to the Board.</td>
<td>Date TBC</td>
<td>Elizabeth Jeffs</td>
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<tr>
<td>20 February 2019</td>
<td><strong>Health &amp; Safety Performance Report</strong></td>
<td><em>Aggression &amp; Violence</em> – reporting over the last six-month’s has increased particularly in Mental Health. Ms Abel-Pattinson noted that the new Tiaho Mai facility was designed to reduce aggression and be much safer for staff. Provide a report in six-month’s time on the incident rates in Mental Health because if we do have a facility that has a measurable drop in aggression and violence incidents, then that would be something to share with other facilities.</td>
<td>7 August</td>
<td>Elizabeth Jeffs</td>
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<tr>
<td>DATE</td>
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<tr>
<td>20 February 2019</td>
<td>Presentation</td>
<td>Middlemore Foundation CEO – update to the Board</td>
<td>7 August</td>
<td>Sandra Geange</td>
<td></td>
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<tr>
<td>20 February 2019</td>
<td>HAC Minutes 29.1.19</td>
<td>Tamaki Oranga Service – an independent review is underway. Review to be made available to the Board &amp; HAC when completed.</td>
<td>7 August</td>
<td>Tess Ahern</td>
<td>A draft report has been received and comments have been made on it. An update will be made at the 7 August Board meeting.</td>
<td></td>
</tr>
</tbody>
</table>
Minutes of the
Regional Disability Support Advisory Committee
Held on Thursday, 4 April 2018 at 1.00am
Senior Citizens Room, Fickling Convention Centre, 546 Mount Albert Road, Three Kings, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Co-Chair)
Jo Agnew (Committee Co-Chair)
Catherine Abel-Pattinson (CM Health Board Member)
Dianne Glenn (CM Health Board Member)
Katrina Bungard (CM Health Board Member)
Michelle Atkinson (ADHB Board Member)
Robyn Northey (ADHB Board Member)

ALSO PRESENT

Debbie Holdsworth (Director Funding, WDHB & ADHB)
Samantha Dalwood (Disability Advisor, WDHB)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions, CM Health)
Sue Waters (Chief Health Professions Officer, ADHB)
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.

WELCOME

The Chairs opened the meeting at 1.10pm and welcomed all those present to the meeting.

1. AGENDA ORDER AND TIMING

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

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from Allison Roe, Edward Benson, Gwen Tepania-Palmer, Judy McGregor, Margie Apa, Dana Ralph-Smith and Katrina Bungard for lateness.
2.2 Disclosure of Interests

Ms Tafau will make noted amendments to the Disclosure of Interests.

2.3 Disclosure of Specific Interests

There were no special disclosures in relation to today’s agenda.

2.4 Minutes of the Previous Meeting

Confirmation of the Minutes of the Regional Disability Support Advisory Committee meeting held on 4 April 2019.

Wording change advised by Ms Atkinson and noted by Ms Tafau.

Moved Colleen’s paper into a General Business section added to the end of the Agenda.

Resolution (Moved: Dianne Glenn/Seconded: Michelle Atkinson)

That the minutes of the Regional Disability Support Advisory Committee meeting held on 4 April 2019 be approved.

Carried

2.5 Action Items Regiseter

Currently still waiting for some DOI’s, titles are being amended.

Ms Holdsworth followed up with the MOH who have identified issues with privacy as being a barrier to this information being shared. It was suggested that the Co-Chairs send a letter to the new DDG (Adri Isbister), advising that we have received the letter of expectations.

Action
Ms Holdsworth and Ms Dalwood will draft the letter and send to the Co-Chairs for their approval and signature. The DHBs are interested in a mechanism that would facilitate the sharing of data. The letter should include a timeframe.

Action
Mid-Central Prototyping: Ms Dalwood to provide a link to Ms Tafau to a presentation that Lorna Sullivan has already done. For information purposes for the Committee members.

Katrina Bungard arrived at 1.30pm

Action
Buildings & Services: Audit was taken in 2011 by Auckland, Waitemata have been included in this from the time of their amalgamation. Determine if there has been a similar audit been undertaken by CM Health. Ms Brown to follow up with Margie Apa.

Action
Equity based provision for Maaori & Pacific – debate was held around whether or not this action item should sit with the committee. WDHB/ADHB believes this should sit with MHAC. CM Health will check with their Chairman of the Board to determine his view.
The committee agreed that it was crucial to be able to capture the data that identifies patients as disabled/impaired as this information is only provided on a voluntary basis. There is not coding or capturing of this data in order for a report to be generated.

**Action**
Ms Dalwood will send links to the Maaori & Pacific Disability strategies for dissemination to the committee for their information.

3. **DISCUSSION**

3.1 **Letter of Expectations from the Minister of Health**

Data collection: Information that Taikura Trust holds is the baseline. We know it’s not 100% accurate and that people will still sit under the radar, but this would be a start.

It was determined that a presentation from Taikura Trust on the data that they hold would be beneficial to the committee.

MSD recently held a series of meetings looking at the implications of Accessibility Legislation and what possible framework should be developed to support such legislation.

It is the DHBs responsibility to ensure that their providers have accessible services.

The Committee agreed that it needs to be confident the Implementation Plan is addressing what the community has advised that they need and expect. The work that is being done to improve outcomes for disabled people should be part of meeting the Minister’s expectations.

Health Literacy isn’t about what information people can understand, rather it’s about how organisations provide information in formats the people can understand.

**Action**
ADHB/WDHB will share their Health Literacy policy with CM Health.

DHBs are shifting toward making health literacy a focus when co-designing services, etc. One of the challenges will be assisting front line staff to be able to impart the required information in a meaningful way.

4. **DISCUSSION**

4.1 **NZ Disability Strategy Implementation Plan 2016-2026: Progress Report** (Samantha Dalwood, Disability Advisor, WDHB)

It was agreed that this would be a metro Auckland plan. The progress document reports quarterly – and gives an overview of what that has been done.

The progress report was reviewed with questions presented by the committees.

Each progress report is to be saved into the RDiSAC resource centre.

A suggestion was made that at the top of the paper to state that this is a variance reporting system.
The Regional Disability Advisory Committee:

**Received** this progress report.

**Moved:** Catherine Abel Pattinson/Seconded: Robyn Northey

**Carried**

### 4.2 Proposed Regional Disability Advisory Committee DRAFT Work Plan 2019 (Sanjoy Nand)

Deep dives: can we find out what autism international best practice is, as advised by an expert and then determine where are our DHBs are in relation to this. Three top things we could do better. Focus on Child Autism: transitioning into Adult Health Services.

**Action**

A presentation by Autism NZ at the September meeting is to be organised.

It was agreed that a lot of the issues are at the interface between Government agencies and providers/patients so having MOH, MOE, MSD sitting at the table at each meeting would be of benefit.

Data: first deep dive. What is currently available, what isn’t available? The data that we do have, where does it sit?

#### 5. GENERAL BUSINESS

The question was asked as to whether there is any community representation at this committee? It was suggested that one community representative could be invited from each metro DHB.

**Action**

Community Representation is to be an agenda item for the 6 June 2019 meeting. Consider the rationale for having community representative on the committee.

The meeting concluded at 3.15pm.


Colleen Brown, Committee Co-Chair                      Jo Agnew, Committee Co-Chair
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 10 April 2019 at 9.00am – 12.30pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

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**PART I – Items considered in Public Meeting**

**BOARD MEMBERS PRESENT**

- Colleen Brown (Committee Chair)
- Dr Ashraf Choudhary
- Dianne Glenn
- George Ngatai
- John Wong
- Katrina Bungard
- Dr Lyn Murphy
- Apulu Reece Autagavaia

**ALSO PRESENT**

- Fepulea‘i Margie Apa (Chief Executive)
- Dr Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
- Dr Gary Jackson (Director, Population Health)
- Dr Kate Yang (Business Manager)
- 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.

**WELCOME**

The meeting commenced at 9.00am with a welcome from the Chair, Ms Brown and a prayer from Dr Choudhary.

1. **AGENDA ORDER AND TIMING**

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

2. **GOVERNANCE**

2.1 **Apologies**

Apologies were received and accepted from Elizabeth Powell.
2.2 Register of Interests

The amendments to the Disclosures of Interest were noted by Ms Tafau. There were no amendments to the Disclosure of Specific Interests.

2.3 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 27 February 2019.

Resolution (Moved: Colleen Brown /Seconded: Apulu Reece Autagavaia)

That the minutes of the Community and Public Health Advisory Committee meeting held on 27 February 2019 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Action Items were noted as being on track. Ms Apa advised that it was acceptable to make the immunisations paper available for the Committee's information.

2.5 CPHAC Workplan 2019

The Workplan was noted as being on target.

3. PRESENTATION

3.1 Long Term Conditions Model of Care – Co-design Discovery Phase Report (Lucy Hall, Service Development Manager, Primary Care; Matt Hannant, General Manager Funding & Service Development; Campbell Brebner, Chief Medical Advisory, Primary Care)

Dr Brebner advised that this is an important piece of work, hearing from the community. There is a need to be clear that if we are going to be successful, further investment will be needed and as such is here asking CPHAC to be an advocate for this co-design.

The presentation is to take CPHAC on a journey of the learnings so far from all of the communities that have been engaged with to date.

High performing providers need to begin looking at the structure of their workforce in order to provide equitable care.

CPHAC was interested to know how confident the team are that providers will be on board with this co-design model. The DHB will use their influence in order to work with providers in forging a way forward to achieve the expected outcomes.

CPHAC felt it would be beneficial to have the Maaori/Pacific/Asian experts on board at the outset.

The larger challenge is the way the DHB fund, this will be another area to investigate, in particular for those with Long Term Conditions.

CPHAC would like to see youth and disabled consulted with as well, throughout this process.
A point was raised in regard to the percentage of a GPs day spent seeing people with a short term condition and those with long term conditions. CPHAC was advised that data shows a nurse-led model is a successful way to manage long term conditions.

The team advised that some of the community are still in need of social connectedness in order for them to be aware of what services are out there.

CPHAC acknowledged the team for their work undertaken to date. Mr Ngatai felt that the report, from a Maaori perspective, was doing a good job of capturing voices.

Mr Hannant advised that the GP Transparency Initiative. There is currently a small number of GPs on the site, that have been rated. This has been 4/5 years in the making.

**Action**
Dr Yang to share notes from CPHAC’s special meeting with the South Asian Community for consideration in the co-deisgn work.

**Action**
Mr Hannant will speak with Communications in regard to sharing the GP Transparency Initiative on CM Health’s social media.

### 3.2 CM Health Living Smokefree Service – Action Plan (2018-2020) (Basil Fernandes, Portfolio Manager, Smokefree Living; Sarah Sharpe, Public Health Physician, Population Health)

Living smokefree is critical for families in terms of so many health outcomes; disease, pregnancy, child health.

Recent data collections shows that Counties Manukau is not currently on track to reach the Smokefree 2020 (less than 5% prevalence), in particular for Maaori & Pacific.

Currently there are approximately 55,000 people that smoke in Counties Manukau with the largest group being of the age 25-44 (25,000). Maaori female numbers are sitting at 44% and 30,000 of the 55,000 that smoke are living in quintile 5 areas.

Mr Fernandes advised the committee that the CM Health Smokefree Living team has been recognised as one of the best nationwide. Mr Fernandes said that the team is very appreciative of the support they receive from ELT; backing their work in the community, trialling new initiatives, etc.

The Smokefree Living service is a One Stop Shop, currently receiving approximately 5000 referrals per year. This number has tripled from 1200 in 2013. The team supports Primary, Secondary care and Maternity services.

**Action**
Mr Fernandes to follow up with Elizabeth Jeffs (Director Human Resources) to determine if we can ask staff whether or not they smoke. An anonymous survey was suggested.

Actively working with the Ministry to support Vaping suppliers to supply responsibly. In line with UK research, 11% of people that CM Health support in their service have used vaping and their rate of quit success is higher than for those that don’t using vaping.

Concern was expressed by CPHAC around the fact that currently there were no regulations around opening vaping shops.
Ms Sharp advised that whilst it is better for quitters to vape if they want to, there is harm associated with vaping, but not as harmful as smoking. So the government is taking a risk proportionate approach whereby we look at how we can disrupt the inequities and help people to become smokefree, by using vaping if they wish. This is transformational technology and the most recent evidence shows that those who vape (with nicotine in the vaping liquid), it is more effective than NRT. It is a useful technology for smokers wanting to quit. Ms Sharpe did stress that it is NOT recommended for young people or those wanted to take it up.

Big gap in legislation for vaping. There was a cabinet paper in November 2018 asking for an amendment in the Smokefree environments act this year, to make it illegal to sell to U18. This is being led by Jenny Salesa. Currently vaping and liquids are not governed by law, hence there are issues with product safety. The intention is for the same laws that apply to tobacco to apply to synthetic tobacco and vaping.

Dr Jackson responded to further concerns from CPHAC members, advising that whilst there would still be some risk of cardiac disease, from the nicotine, the elimination of plant-based tobacco would remove the risk of lung cancer.

Living Smokefree is actively working with schools around smokefree education.

Tobacco Free Generation (TFG)
• TFG is a proposed tobacco endgame strategy involving a legislated ban on provision of tobacco to those born from a set date onwards.
• Also used as a concept or approach.
• We are developing a TFG approach in Counties Manukau; key areas are:
  − Smokefree pregnancies;
  − Babies live in/with smokefree homes/whaanau;
  − Young people are supported to be smokefree (i.e. to never start smoking);
  − Young people who smoke are supported to quit;
  − Promote cross-generational smokefree change.

TFG is a very interesting concept. Model shows that this is a pro-equity strategy, especially for Maaori and the under 45 age group. Being used as a concept/movement in the UK/Singapore.

CM Health is developing a TFG approach in CM. Priority on families with children aged 0-4 (as indicated by the key areas above).

CM Health’s message is that vaping is not for youth, or for those that haven’t smoked before and that the primary use is as a quit tool.

Action
CPHAC would like Mr Fernandes and Ms Sharp to return in six months.

4. BRIEFING PAPER

4.1 Metro-Auckland Healthy Weight Action Plan for Children Progress Report (Carmel Ellis, General Manager Integrated Child, Youth & Maternity, Primary Care)

Move the Healthy Weight action plan to next agenda and ask Carmel to attend.
5. INFORMATION PAPERS

Papers were noted.
Ms Brown noted that the Stop Gout book could be reduced further in word content.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: George Ngatai/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 Workshop Session – Mental Health &amp; Addiction NGO Procurement Options</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>
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</table>

Carried

This first part of the meeting concluded at 10.25am.


______________________________________________________________________________________________________________________________________________
Colleen Brown
Committee Chair
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 22 May 2019 at 9.00am – 12.30pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

ALSO PRESENT

Fepulea’i Margie Apa (Chief Executive)
Dr Campbell Brebner (Chief Medical Advisor, Primary Care)
Dr Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Katherine Yang (Executive Advisor to the CE)
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.
Dr Mariam Parwaiz (CM Health Public Health Registrar) attended as a learning experience.

WELCOME

The meeting commenced at 9.00am with a welcome from the Chair, Ms Brown and a prayer from Apulu Reece Autagavaia.

1. AGENDA ORDER AND TIMING

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

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from George Ngatai, Katrina Bungard, Dr Gary Jackson and Elizabeth Powell and Apulu Reece Autagavaia for lateness.
2.2 Register of Interests

The amendments to the Disclosures of Interest were noted by Ms Tafau. There were no amendments to the Disclosure of Specific Interests.

2.3 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 10 April February 2019.

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

That the minutes of the Community and Public Health Advisory Committee meeting held on 10 April 2019 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Action Items were noted as being on track.

2.5 CPHAC Workplan 2019

The Workplan was noted as being on target.

3. BRIEFING PAPERS

3.1 Metro Auckland Healthy Weight Action Plan for Children Progress Report (Carmel Ellis, GM Integrated Child, Youth & Maternity, Primary Care)

Paper was taken as read.

Plan now in its second year. DHBs are delivering different programmes, not all the same. Ms Ellis made a note to advise that the report be amended to read more clearly.

Overall, CM Health is tracking well against the actions.

The Healthy Weight Management for B4SC data shows that for the whaanau involved, BMIs are stabilised for the children. Engagement is solid for the 12 months with the first three months being quite intensive; meal planning and mentoring. Provider continues support post the first three months, but not so intensively.

Each DHB is measured on the number of kids identified as needing intervention. Not all families take up the service when it is offered. The decline of Maaor is on the increase and the reasons for this are being investigated. Analysis of the data is being undertaken with B4SC providers.

The Metro Auckland Clinical Group Forum (MACGF) will be discussing the B4SC programme. The Primary Care response may not be as focused as we would like for overweight children (not the case for obese children), so how this can be changed within Primary Care will be a focus.

CPHAC would like to know if GPs have the necessary information on hand to pass to parents of overweight children. The committee was advised that this is a PHO responsibility, there is a Health Pathway. Whilst the information is to hand and the data shows that this is being
used, however, this is not to say that every GP knows about Health Pathways and is using them.

**Action**

Dr Brebner will raise CPHACs concerns to the next MACGF around overweight children. CM Health CPHAC would appreciate if Dr Brebner could convey to PHOs that Clinical Pathways uptake is important and that all GPs should be using this regularly.

B4SC providers can refer overweight children directly to Otara Health (Healthy Weight provider). Otara Health will advise the GP of the referral.

Ms Ellis and her team are working with GPs to ensure they have the tools and the confidence to have these conversations, even earlier than B4SC. Professional development has been engaged to assist with this training.

Ms Ellis advised CPHAC that the information provided in the report is a Health response. This second Report on Action Plan Indicators for the Metro-Auckland DHB Healthy Weight Action Plan for Children presents an overview of activity during Q1&2. The Action Plan indicators have been developed collaboratively across the region, with consistency in data collection and reporting, where appropriate. The indicators will be reviewed and updated before the next round of reporting; updates will occur annually to ensure actions which have been fully achieved are replaced with new actions, or closed as appropriate. Regular updates to CPHAC will continue. While many actions remain on track, it is important to recognise that broader societal and environmental factors need to be harnessed to shift the population as a whole towards a healthy weight.

The BMI measuring tool has been standardised across the DHBs in secondary care. It is hoped that this tool till filter down into primary care, which will be most beneficial.

95% of CM Health providers and their sub-contractors must have a Healthy Eating Policy. This is written into contracts, so is a signed obligation.

**Action**

Bariatric Surgery for Women of child bearing age – update the notes to reflect that this is not an issue for CM Health.

**Action**

Well Child Review – Ms Ellis will provide a report for Ms Tafau to circulate to the committee via Diligent resource. It has been acknowledged that the B4SC is not working for our communities and in fact, if continued to be followed, will increase inequities.

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

The Community & Public Health Advisory Committee:

Received this update report on the progress CM Health has made against the Metro-Auckland Healthy Weight Action Plan for Children.

Noted that this plan sits alongside the Healthy Auckland Together (HAT) Plan 2015 – 2020.

Carried

3.2 **Addressing Inequity in Maaori Childhood Immunisation Coverage Update** (Katarina Komene, Programme Manager, Maaori Child Health & Dr Mataroria Lyndon & Carmel Ellis, GM Integrated Child, Youth & Maternity, Primary Care)
Paper was taken as read.

The committee were advised that it can take between seven to 14 texts to whaanau to track children that require immunisations. Incentives are showing signs of improving engagement.

1.5 to 2% decrease for CM Health, however, the anti-vaccination campaign has seen the decline rate increase to approx. 3%.

When whaanau do decline, they are followed up with and offered a conversation to ensure the choice they are making is informed.

The vast majority of Māori don’t decline. It is a matter of timing. Improving timeliness is a targeted pilot and this is why the incentive is being offered. These are whaanau that have indicated they do want their children immunised.

Homelessness, if advised, is followed up and the whaanau are provided support.

The incentive pilot is being monitored every three months with an evaluation to be undertaken after 12 months. It is hoped that positive results will see a continuation of the incentive scheme.

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

The Community & Public Health Advisory Committee:

*Noted* the progress made on the initiatives to address the disparities in Māori immunisation coverage.

*Noted* the design process and plan for these initiatives and the next steps for piloting.

*Carried*

4. **UPDATES**

4.1 **Pacific Health Overview**

The provided presentation will be included in the next agenda as an information item.

Dr Schaaf is confident that the team is making a difference for the community, but that improvement is only a small part of what needs to be done as a whole to better improve health outcomes for Pacific.

There is a network of eight to ten providers that are available to provide after-hours care. Dr Schaaf advised that the knowledge that coming to Emergency Care gives fanau comfort that they will be seen, if x-rays are required, it can be done onsite, etc. The fanau will leave the hospital feeling as though they have been cared for.

4.2 **Hospital in the Home Update** (Penny Magud, GM Locality Services & Dr Carl Eagleton, Clinical Director, Medicine)

Numbers to date are small but this has allowed the Pathway to be fully tested. The main population is Mangere/Otara and Manukau with a few in Franklin. 55% are from the high needs population. This work is in support of rising acute care in the community, supporting District Nurses in order to avoid readmission and transition from secondary to primary care.
Dr Eagleton advised that the District Nurses have been great and having a Nurse Practitioner available is most beneficial.

Mr Eagleton provided information around specific cases and the success of the patients being able to be treated in their home. The information provided by the District Nurses to the hospital based clinicians gave confidence that these patients are receiving excellent care.

Heart failure patients are the biggest recipients of Hospital in the Home. This group of patients can frequently readmit due to not seeing their GP in a timely manner, for a variety of reasons. Being able to be seen in their homes eases the burden on hospital based clinicians and eases the anxiety of the patient when they can maintain their health at home and don’t require readmission.

Intelligent support is also being utilised by the hospital. Scales for diabetic patients can Bluetooth results to the clinician.

Ms Tafau to pass on the suggestion to the Secretariat of the Board in regard to Hospital in the Home Patient – provide a patient story to the Board.

Nurses can visit the home more than once per day if the patient requires that level of care. The handover to the GP for high needs patients is extremely important for their continuity of care.

Hospital in the Home provides that layer of clinical support that allows a qualifying patient to be looked after in their home, after an appropriate transition.

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

The Community & Public Health Advisory Committee:

Noted the information provided in this update.

Carried

5. **DISCUSSION**

5.1 **Asian & South Asian Health**

Barriers to access included financial constraints, transport, language and cultural barriers.

The general consensus was that it was the Older People of these communities (recent migrants) who are experiencing the most difficulty in navigating the health system.

**Action**
Create a paper that provides a link to resources and distribute to those we have met with already in order for the information to be disseminated.
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:

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

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<tr>
<td>3.1 Health of Older People – Non Renewal of Day Activity Projects</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

This first part of the meeting concluded at 11.15am.


__________________________
Colleen Brown
Committee Chair
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Thursday, 2 May 2019 at 1.00pm
Kidz First Seminar Room 2, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

PART I – Items Considered in Public Meeting

BOARD MEMBERS PRESENT
Dr Lyn Murphy (Chair)
Catherine Abel-Pattinson (Deputy Chair)
Dr Ashraf Choudhary
Colleen Brown
Dianne Glenn
George Ngatai
Kylie Clegg

ALSO PRESENT
Margie Apa (Chief Executive)
Dr Gloria Johnson (Chief Medical Officer)
Dr Jenny Parr (Chief Nurse and Director of Patient and Whaanau Experience)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Avinesh Anand (Deputy CFO, Provider)
Dr Kate Yang (Executive Advisor, CEO’s Office)
Teresa Opai (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

WELCOME
The tour of Kidz First commenced at 1.25pm. The meeting commenced at 2.15pm. Dr Murphy opened
the meeting by expressing her thanks to Nettie Knetsch for the tour of Kidz First.

APOLOGIES
There were no apologies for this meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS
The following Disclosures of Interest were noted for update:
• Ms Clegg – amend reference to Orion per updated advised to Board.
• Ms Brown – remove reference to Auckland Council Disability Advisory Panel and NZ Strategy and
  Reference Group.
• Ms Abel-Pattinson – add membership of Health Alliance Board.

There were no Specific Interests to note regarding the agenda for this meeting.
1. AGENDA ORDER AND TIMING
   Agenda items were taken in the same order as listed on the agenda.

2. BOARD COMMITTEE MINUTES
2.1 Minutes of the Hospital Advisory Committee 13 March 2019

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

   That the Minutes of the Hospital Advisory Committee meeting held on 13 March 2019 be approved.

   Carried

2.2 Action Items Register – Public
   Noted.

2.3 Hospital Advisory Committee Work Plan
   The report was taken as read.

   The Chair requested that ‘draft’ be removed from the work plan.

   Action: Secretariat to update Work Plan, removing the reference to ‘draft’.

3. PROVIDER ARM PERFORMANCE REPORT
3.1 Executive Summary (Margie Apa)
   The report was noted and taken as read.

3.2 Balanced Scorecard (Margie Apa)
   The report was noted and taken as read.

3.3 Hospital Services Project Portfolio Overview (Margie Apa)
   The report was noted and taken as read.

3.4 Finance Report (Avinesh Anand)
   The report was noted and taken as read.

3.4.1 Non Resident Bad Debt Summary (Avinesh Anand)
   The report was noted and taken as read.

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

   That the Hospital Advisory Committee:

   Note and receive the reports.

   Carried
4. CORPORATE REPORTS

4.1 Patient Experience and Safety Report (Dr David Hughes)
The report was taken as read.

4.1.1 Safety, Experience, Compliance and Measurement Dashboard
The report was taken as read.

4.1.2 National Patient Experience Survey Results
The report was taken as read.

Dr Hughes provided key points:
- Internal inpatient experience survey received 346 responses, mostly from maternity.
- Overall care rating of 86%.
- Still looking at a target for complaint resolution – in discussion with other DHB’s about how they set their targets. Australian standard is 35 working days.
- Patient Experience report released today. CM Health is tracking about the same as the NZ average with no red zones this quarter.

4.1.3 QSM Local Report
The report was taken as read.

Dr Hughes noted that the only red spot is around the timing of antibiotics but there has been a lot of work with the anaesthetists, particularly around hip replacements and the new electronic record used through the operation to more consistently note down the time the operation commenced compared with the time the antibiotics were given.

Dr Parr advised that CM Health has been accepted by the Health Quality and Safety Commission as a pilot site for a new QSM for Consumer Council.

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

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

4.2 Patient Flow – Every Hour Counts Portfolio Report (Dr Mary Seddon)
The report was taken as read.

Dr Seddon provided key points:
- Patient flow pressure continues across the five acute flow working groups - ED, bed utilisation, discharge planning, community services and MRI. MRI has reduced the waiting list during April by around 500.
- Proactive discharge planning needs home-base wards in medicine and a system that can capture bed vacancies. Medical representation at the huddles is important. Workaround in place for bed numbering for TrendCare but this will not work for patient flows. Need IPM upgrade scheduled for end of year.
- Since introducing the requirement to list the name of the multi-drug resistant organism when requesting an Isolation Room Clean (previously called Terminally Clean), usage has reduced.
- Staff have been coping with the demand pressures for 12-18 months.
- Early work with click process shows people are engaged.

Dr Parr advised that recent feedback from nurses indicates they are keen to get flow working but waiting on consultation around medical rostering so it can happen. Nurses expressed that they have a connection with the people at CM Health and feel they are providing value but want more time to do a good job and feel constrained with what they can deliver.

**Resolution** (Moved: Lyn Murphy/Seconded: Dr Choudhary)

*That the Hospital Advisory Committee:*

*Note and receive the report.*

*Carried*

**4.3 Response to Action Item 3.2 January 2019 HAC - Balanced Scorecard (Brad Healey)**

The report was taken as read.

Mr Healey provided key points:
- Rate of presentations to ED from persons aged 75 years or older has increased slightly, and in line with population growth.
- DNA rate overall is higher than ideal, but more concerning in Maaori (double) and Pacific (triple) than the other groups.
- Experiments and trials indicate single biggest influencer to patients attending appointments is having an EN or RN make contact with the patient in advance of the appointment. However, this is labour intensive and creates a resourcing issue.
- Survey being collated on Maaori and Pacific patients. Early themes suggest appointments are not suitable, have multiple appointments and need to link appointments so patient can come once rather than multiple times, affordability (time off work). Transport is not as big an issue as previously thought.

Mr Ngatai noted having people that look and sound like our patients will get a response from our patients, and talking about the relationship rather than the appointment.

**Resolution** (Moved: Lyn Murphy/Seconded: Ms Brown)

*That the Hospital Advisory Committee:*

*Note and receive the report.*

*Carried*

**4.4 Women’s Health – Presentation (Nettie Knetsch, Thelma Thompson, Dr Sarah Tout)**

Ms Knetsch provided a presentation to the meeting. Key points:

- 3% increase in births in hospital with 5% decrease at Primary Birthing Unit.
- Total number of births YTD down 1% from FY17/18.
- Increase in complexity of births reflected in increased Caesarean section, induction of labour, epidurals used, diabetes in pregnancy and transfers to Neonatal Unit.
Primary Birthing unit is used extensively for post natal stay.
Phased 3-stage implementation plan to address capacity and workforce shortages are in place.

4.5 Smokefree Policy Update (Basil Fernandes, Dr Sarah Sharpe, Dr Gary Jackson)
The report was taken as read.

Dr Sharpe, Public Health Physician, advised the Ministry of Health and CM Health's Smokefree Team were proposing a risk proportionate approach. She acknowledged that there is not enough known about the harms of vaping at this point, but there is clear evidence that for those that smoke, it is far better for them to vape. Eleven percent are much more likely to quit successfully with vaping than with a nicotine patch. The DHB is well off target for reaching their Smokefree goals for Māori and Pacific, and vaping could be used to change the trajectory. The Smoke Environment Act does not cover vaping so it is currently legal to supply to under 18's. This is expected to be revised later in the year.

Mr Fernandes advised that the Ministry has strongly recommended the DHB come up with a policy to include vaping as soon as possible.

An extended discussion took place with many of the Committee strongly opposed to the proposed changes to the existing policy.

Views of Committee members included:
- Ms Clegg noted the current policy states 'DHBs could allow vaping in outdoor spaces if they so choose'. The biggest issue is of younger people getting into vaping, so why would the DHB look to change the policy?
- Ms Able-Pattinson advised she was strongly against introducing vaping for a range of clinical reasons. The DHB runs the risk of the public asking why they have allowed vaping and assuming it is endorsing it as being safe. She had read the World Health Organisation does not support vaping.
- Dr Choudhary advised he was totally opposed to vaping.
- Mr Ngatai noted that people are vaping in public spaces and the proposed change to the policy is to create an environment to support patients in their journey. He acknowledged that the Board would need to work with Facilities to create an area that is not visible.
- Ms Glenn did not like vaping but acknowledged it was a tool to get people off cigarettes.
- Ms Brown asked what response we as a Board should give to people vaping on site. Ms Brown asked what are other DHBs were doing. Dr Sharpe responded that all DHB's were working to address this. Vaping was raised at a recent WDHB Board meeting with the Board asking for more information to understand the nuances.
- Dr Murphy asked if vaping was covered under the current Smokefree policy. CM Health policy does prohibit e-cigarettes but does not mention the word vaping. She suggested that any change in the policy is deferred until the DHB receives a clear signal from the Government. Dr Sharpe responded that the view of the Ministry of Health was that vaping was an effective tool for current smokers who wish to switch over, in order to quit smoking.

Ms Apa advised that the context of the policy is to develop two sites in which people can vape, which can be controlled. The DHB is actively engaging with schools as health promoters, and view vaping as a tool to stop smoking. From an inpatient perspective, tools are limited and vaping would be an additional tool. The DHB is not proposing to promote vaping, but to use it as an additional support for smokers trying to quit. Ms Apa suggested to the meeting that the DHB approach this on a trial basis, collect data, and review after a year.
The Committee agreed that this matter be referred to the Board with HAC’s advice minuted, requesting background information about vaping, access to the evidence that informs the decision, and some options.

Resolution: Moved: Colleen Brown/Seconded: Catherine Abel-Pattinson

That the Hospital Advisory Committee:

Refer the proposed changes to the Smokefree policy, including vaping on the hospital grounds, to the full Board for further discussion.

Carried

4.6 Fast Cancer Treatment (Anne-Marie Wilkins, Dr Jon Mathy, Dr Gary Jackson)
Dr Mathy, Ms Wilkins and Dr Jackson provided a presentation to the meeting. Key points:

- CM Health population growing and aging, with 3.6% growth per annum in cancer by 2023.
- Chemotherapy and radiotherapy volumes rising by 7% per annum.
- Diagnostics and surgery is undertaken at Middlemore, with most patients going to Auckland for chemotherapy and all for radiotherapy as per regional agreement.
- CM Health has consistent not met the Faster Cancer Treatment target since June 2018 due to enormous increase in volume, with capacity to meet demand unable to be realised.
- There are several initiatives in place to try to achieve this target again. Goal is to report and guide regional and local strategy to optimise cancer services.
- Future focus is the optimisation of the patient journey, a regionally coordinated model of care and resource requirements.
- Cancer is the biggest killer of the NZ population. Survival is improving overall but not as fast as in Australia.
- Differences between NZ and Australia:
  - Overall survival across every stream where NZ lags behind.
  - NZ behind in screening approach to catch patients at an earlier stage and access to capacity overall. Auckland already at 100% capacity so unable to treat patients in a timely fashion.
  - Access to drugs – too expensive for NZ to fund.
  - Public/Private split where 40-50% have private sector access but in CM Health it is 5-10%.

4.7 Human Resources Report
The report was noted taken as read.

Resolution (Moved: Lynn Murphy/Kylie Clegg)

That the Hospital Advisory Committee:

Note and receive the report.

Carried

4.8 Auckland Regional Public Health Service – Nitrate Levels in Drinking Water
The report was noted and taken as read.
5. INFORMATION PAPERS
5.1 Facilities Service Report (Anton Venter)
The report was noted and taken as read.

5.2 Emergency Department Medicine Integrated Care (Brad Healey)
The report was noted and taken as read.

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

5.4 Central Clinic Services (Ian Dodson)
The report was noted and taken as read.

5.5 Women’s Health and Kidz First (Nettie Knetsch)
The report was noted and taken as read.

5.6 Adult Rehabilitation and Health of Older People (Dana Ralph-Smith)
The report was noted and taken as read.

5.7 Integrated Mental Health and Addictions (Tess Ahern)
The report was noted and taken as read.

5.8 Middlemore Central (Ian Dodson, Dr David Hughes)
The report was noted and taken as read.

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

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

6. GENERAL BUSINESS
6.1 Update on Strike Management (Dr Gloria Johnson)
Overall, pleased with how things have gone to date, helped by a significant proportion of RMO’s (Registrars and House Officers) working through (67% of RMO’s: 80% of Registrars and 44% of House Officers). Unaware of any complaints to date and the general public have been incredibly understanding. The situation has been complicated by the stolen mail, with a very small number of patients turning up for appointments that had been cancelled.

The long term impact will be the need to rebook clinics, with some services running Saturday and/or extended clinics. There will be a potential effect on revenue in relation to the elective surgeries, due to the necessity to delay more complex cases. Main concern is for those patients who have relatively infrequent appointments, ie: yearly appointments, as clinics are already full.

Morale is good as coverage was well managed. Facilitation is scheduled to start next week and two facilitators have been appointed. The key issue seems to be that DHB would like changes to the process around introducing new rostering and how it runs, but the RDA has the right of veto which is seen as a fundamental problem. The Minister is fully informed and is supportive of the DHB’s position.
6.2 **Certification Update (Jenny Parr)**

Comprehensive 4 days of auditing commencing 7 May. One set of evidence for continuous improvement around Fundamentals of Care has been submitted. Controlled documents down from 28% to 16%. Anticipate corrective actions reducing from 13 to 8. For the first time will be including an action around the safe staffing CCDM programme. Because we don’t have TrendCare implemented and don’t have data, we are expecting a corrective action. HAC members have been invited to the welcome session.

The recent success of new Nurse Practitioners - Julena Ardern (Neonatal) and Bobbie Milne (Community Diabetes) were noted. Recently agreed that CNS’s in the Neonatal unit are to become Nurse Practitioners over time, which will grow our NP’s to about 10. Senior medical staff becoming getting interested in the opportunities this presents.

7. **RESOLUTION TO EXCLUDE THE PUBLIC**

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

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

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

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<td>Public Excluded Minutes of 13 March 2019 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>
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<td>Strategy and Infrastructure Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td>Service Coverage for FY19/20 (Price Volume Schedule)</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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Carried

The Public Meeting closed at 4.34pm.

The next meeting of the Hospital Advisory Committee will be held on Wednesday 5 June 2019.

Signed as a true and correct record of Counties Manukau District Health Board’s Hospital Advisory Committee meeting held on 2 May 2019.

Dr Lyn Murphy
Chair

5/6/20
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Thursday, 5 June 2019 at 1.30pm
Spinal Unit, 30 Bairds Road, Papatoetoe, Auckland

PART I – Items Considered in Public Meeting

BOARD MEMBERS PRESENT
Dr Lyn Murphy (Chair)
Dr Ashraf Choudhary
Colleen Brown
Dianne Glenn
George Ngatai
Kylie Clegg

ALSO PRESENT
Dr Gloria Johnson (Chief Medical Officer)
Dr Jenny Parr (Chief Nurse and Director of Patient and Whaanau Experience)
Dr Kate Yang (Executive Advisor, CEO’s Office)
Teresa Opai (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

APOLOGIES
Catherine Abel-Pattinson (Deputy Chair)
Margie Apa (Chief Executive)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Avinesh Anand (Deputy CFO, Provider)

WELCOME
The tour of the Spinal Unit commenced at 1.45pm. The meeting commenced at 2.25pm. Dr Murphy opened the meeting by expressing her thanks to Dana Ralph-Smith for the tour of the Spinal Unit.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS
There were no Disclosures of Interest to note requiring update.

There were no Specific Interests to note regarding the agenda for this meeting.
1. **AGENDA ORDER AND TIMING**
   Agenda items were taken in the same order as listed on the agenda.

2. **BOARD COMMITTEE MINUTES**
   2.1 **Minutes of the Hospital Advisory Committee 2 May 2019**
   Ms Glenn queried item 4.6 Fast Cancer Treatment and Mr Mathy’s suggestion during his presentation that it would be advantageous to apply for trials of specific cancer drugs that would be free for patients undergoing treatment. Dr Johnson clarified that CM Health is proceeding with planning for this. The Middlemore Clinical Trials is the conduit to this and would be dependent on CM Health being able to expand the oncology infusion unit which will in turn depend on the expansion of the Manukau Health Park. This would provide the capacity to undertake additional infusions for clinical trials and CM Health would then be in a position to accept them if they were offered.

   **Resolution** (Moved: Lyn Murphy/Dianne Glenn)
   That the Minutes of the Hospital Advisory Committee meeting held on 2 May 2019 be approved.

   **Carried**

   2.2 **Action Items Register – Public**
   Noted.

   2.3 **Hospital Advisory Committee Work Plan**
   The report was taken as read.

   Ms Murphy suggested a change to the site visit for the 11 July meeting, to instead visit the Emergency Department during the winter season, rather than the scheduled Mental Health unit. Dr Parr suggested that we also bring forward Brad Healey’s deep dive as it is tied to the Emergency Department, and we move the site visit and deep dive for Mental Health out to the 28 August meeting.

   **Action:** Dr Yang to update workplan to reflect above change.

3. **PROVIDER ARM PERFORMANCE REPORT**
   3.1 **Executive Summary (Jenny Parr on behalf of Margie Apa)**
   The report was taken as read.

   Dr Parr provided key points:
   - The hospital is under immense pressure already. The Emergency Department teams are seeing further unprecedented numbers coming through and the pressure is being felt right through the hospital.

   Ms Brown queried the reference to procedures that were deferred due to the strikes and how long it would take to catch up. Dr Johnson advised that the aim was to try to reschedule within 6 weeks ideally. The main concern is that for some patients it is anxiety-provoking to have to wait, but no incidents of patient harm had been noted. An SMO has reviewed the waiting list for cardiac tests and identified those at risk because of the amount of time they were waiting. A decision was made to outsource some of them.
Ms Brown queried the transfer of in-utero twins to Tauranga. Dr Parr advised that there was a comprehensive national network of availability that works to avoid transfers at any time.

Ms Brown queried the number of birthing units in CM Health and whether we should considering rationalising these given the cost of maintenance, or alternatively outsourcing. After discussion it was agreed that a report be presented to the 9 October meeting including details of utilisation, population growth projections and cost comparison across all CM Health birthing units.

**Action:** GM Women’s Health to provide report on birthing units at 9 October meeting.

Ms Brown commented on the clever thinking of the new walk-in screening unit alongside the High Risk Diabetes in Pregnancy clinic and asked that the Chair send a letter of congratulations.

**Action:** Kate Yang on behalf of Chair to write letter of congratulations to unit.

Ms Brown acknowledged the accomplishments of the bowel screening programme and encouraged the need for community champions and to identify the best ways of improving response levels.

Ms Brown commented on the lack of Ophthalmology data in the report for April or May.

Ms Glenn expressed concern at the result vs target of the diagnostic access service. Dr Johnson advised that this is being actively addressed with extra weekend clinics and changes to the way the team was working. There is an ongoing problem with workforce shortage across Auckland.

Ms Clegg acknowledged the positive theatre utilisation results. Dr Johnson advised that whilst the changes that have been made are sustainable, bumping patients from elective to accommodate acutes results in some challenges. Ms Murphy queried how CM Health could accommodate the gender reassignment mentioned in the recent budget. Dr Johnson advised that she believed there would be a process run through the CEO’s, COO’s and CFO’s to cost up the service, determine the capacity required and then submit a proposal should CM Health wish to take this on.

Ms Glenn acknowledged and congratulated the accreditation of the Respiratory Function Laboratory Service and the two 20,000 bed day projects.

Ms Brown noted the $35m set aside in the budget for additional needs for children and expressed her disappointment that this funding was based on population, not needs.

Dr Choudhary queried whether the angiography target result was due to shortage of staff. Dr Johnson confirmed that there was a shortage of technical staff, and despite working extended hours and doing extra clinics, the absence of the second cath lab is a significant issue and CM Health were now looking at outsourcing patients.

Ms Glenn congratulated the cancer treatment team on their performance result.

### 3.2 Balanced Scorecard (Jenny Parr on behalf of Margie Apa)

The report was taken as read.

Dr Parr provided key points:
- Pressure in Emergency Department as discussed earlier in the meeting.
- Discussions at today’s Cancer Steering Group around faster treatment are being referred to the Board.
- Staffing is a problem across a number of areas which was born out in our certification, sometimes caused by volume, sometimes by circumstance.
- Recruitment is challenging. From a nursing perspective, only 400 new graduates are in the pool for the whole of New Zealand. Considerable work is being undertaken via the Director of Nursing national group to take more control and leadership of workforce planning and the Ministry are informed about what nursing needs as a profession.
- CM Health has joined the ADHB and WDHB Maori Alliance Leadership (MALT) team so will benefit from the sharing of initiatives.

3.3 **Hospital Services Project Portfolio Overview (Jenny Parr on behalf of Margie Apa)**
The report was noted and taken as read.

3.4 **Finance Report (Kate Yang on behalf of Avinesh Anand)**
The report was taken as read.

Ms Murphy queried how the DHB was going to meet its financial challenges for FY19/20. Dr Johnson advised the DHB is going to come in with a significantly lower deficit than predicted for FY19/20, mainly due to capital not spent and vacancies not filled. There was some discussion at ARF about the potential approach to reduce the deficit further for FY19/20, but that is a challenge without increasing the clinical risk that we already carry.

Ms Murphy queried whether a discussion had been had regarding which services would be cut if we decided to do this. Dr Johnson advised that discussion had not taken place, and that some referrals were already being turned away because they are not acute or urgent and not in areas which are currently focused on by the Government. Dr Parr advised that all services not funded by Vote Health funding throughout the entire organisation had been reviewed. Hospital services are already stretched, Community services are under resourced already, and the only way to save money would be to perhaps outsource some services.

Ms Glenn queried the forecast to year end deficit for FY18/19 which is favourable against budget. Dr Johnson advised that is due to capital not spent and vacancies not filled. In regards to having higher thresholds for outpatient FSA’s and of not seeing certain patients, the risk of holding is that their clinical situation may become acute, which is a very real concern voiced by clinicians. Dr Johnson explained the P1-3 grading system. She noted that P3 FSA’s for urogynaecology have not been offered as the DHB is short of capacity. These particular thresholds are determined by the DHB, not regionally.

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

That the Hospital Advisory Committee:

Note and receive the reports.

**Carried**

4. **CORPORATE REPORTS**

4.1 **Patient Experience and Safety Report (Dr David Hughes)**
The report was taken as read.
4.1.1 Safety, Experience, Compliance and Measurement Dashboard
The report was taken as read.

Dr Hughes provided key points:
- Inpatient experience survey is the highest number of survey respondents in a month.
- Cases acknowledged within five working days sits at 99% vs 70% in January.

Ms Glenn queried the six adverse events reported. Dr Hughes advised that the pressure injuries did not all occur in the one month, but rather was a look back in the incident management system being reviewed at the present time.

4.1.2 Safety, Experience, Compliance and Measurement Dashboard Variance Report
The report was taken as read.

4.1.3 Inpatient Experience Snapshot Report
The report was taken as read.

Dr Hughes provided key points:
- Ratings show that overall we are much better at coordinating care within the hospital.

Ms Brown expressed concern about the after discharge care level. Dr Hughes advised the integration activities are all geared toward helping people get better coordinated care post discharge and is focussed on ensuring the transition happens smoothly.

Dr Parr noted that quick care coordination in midwifery is an inherent problem for the profession due to the variety of perspectives. These particular questions are things that are problematic in the national survey, they were in the annual plan last year and have been chosen to be the focus of Fundamentals of Care, so this falls to Charge Nurses to look at these questions locally and to undertake improvement locally.

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

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

4.2 Patient Flow – Every Hour Counts Portfolio Report (Dr Mary Seddon)
The report was taken as read.

Dr Seddon provided key points:
- Better information is now available about the pressures that the Emergency Department (ED) is under, both with complexity and numbers. Good mitigation currently going on in ED particularly around multi-disciplinary team huddles, resulting in improved team culture.
- No longer looking to relocate the hand patients but to manage them in a more timely manner.
- Project for optimising access to community services has Occupational Therapy waiting list down to 48 in Otara and Mangere, and there is no longer an inequity in waiting times across the region.
- Utilisation of MRI building 58 is 98%, with waiting lists down to 870 from 1303 patients due to weekend lists and late lists and optimising staffing. Aiming to reduce to 300 in the next couple of months.
• A full report of the Booking and Scheduling of Services Review is with Ms Apa. Current process is no longer satisfying either the staff who work there or the patients who visit, so there is a real momentum for change.

Ms Murphy queried the decision to leave hand patients where they are. Dr Seddon advised that the Discharge Lounge, day surgery, TATU area and plastics ward were considered but none of these options could accommodate the numbers or provide a room for examination. Instead, the process of care was reviewed and the bigger issue was the wait to be seen. Dr Johnson is reviewing whether a Charge Nurse Specialist could be the first point of call with these patients, making it a nurse-led process.

Ms Glenn queried the numbering of beds trial in ward 8. Dr Seddon advised the manual process is showing some promise, with reduced cleaning times. Discussions are being held with the CIO about other options to number beds. This is not a quick fix and will remain an issue until the regional upgrade to the patient management system.

Ms Clegg queried the siloed approach to prevent blockages of ED patients and the strategies involved. Dr Seddon advised some of planned changes to Middlemore Central will make it more obvious where patients are waiting and integrated whiteboards would provide visibility of pressure points. It has also been suggested that senior ward nurses rotate through ED during the shift so they get a better understanding of the challenges faced in ED.

Dr Parr noted that having a central group of people with a view across the entire hospital gives better perspective. In the interim, have made some changes to improve the situation.

Dr Yang suggested that rather than doing a medical deep dive in conjunction with the ED visit as discussed earlier, a deep dive for ED is undertaken instead, moving the medical deep dive to later in the year.

**Action:** Dr Yang to update workplan.

Dr Parr noted that interviews have just concluded for the Clinical Director and General Manager roles, and consultation for the Clinical Nurse Director will commence in the next couple of weeks. The plan was for these to be in place by the start of July but this may depend on when the Manager can start.

Ms Glenn queried the decreasing patient bed movements by not returning outliers on other medical wards to a home ward. Dr Seddon advised there are four home wards, any patient admitted to any home ward remains in that home ward. Outliers elsewhere will need to move if they are going to stay more than one night. Infectious Diseases are particularly worried if a patient has been tested for a resistant bug and the result is not returned before the move. If outlying in an inappropriate ward they will move.

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

**That the Hospital Advisory Committee:**

**Note and receive the report.**

**Carried**
4.3 CM Health Child Healthy Weight Evaluation Update
The report was noted and taken as read.

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

That the Hospital Advisory Committee:

Note and receive the report.

Carried

Mr Ngati excused himself from the meeting for 10 mins to take a phone call.

4.4 Hospital in the Home (Penny Magud, Kylie Star, Professor Harry Rea, Anna Mastrovich)
The report was taken as read.

Ms Magud provided key points:
- Hospital in the Home (HITH) as a pathway was introduced last June and since then 91 patients have been on that pathway, with the vast majority from Manukau, Otara and Mangere.
- Numbers have been lower than originally anticipated. Dedicated medical staff are starting in August/September. Nurse Practitioners are wanting to ensure they can interact with the hospital so the SMO’s and the hospital gain more confidence in the community staff in managing complex cases.
- The patient remains as an inpatient in a virtual ward. The patient has visual continuity on eVitals which can be uploaded in the community and published in real time for SMO review in a ward round. Families feel supported by having a senior clinician or nurse come in and support them. Average length of time working with a patient is 5.5 days. Escalation plans are in place.
- Professor Rea visits homes with Nurse Practitioners within 12-24 hours of discharge.
- A particular focus of the two new SMO’s coming on board would be to work through the medical assessment unit, identifying patients suitable for transition to HITH and manage accountability for that patient through to handover to the GP.
- Over the past 2 years there has been an increase from 250 patients per month across the whole district to 500-600 patients per month that need to be seen within the first 24 hours.
- HITH service a maximum 3-4 per patients per day per NP, with the vast majority of patients coming from the wards rather than ED/MAU.
- In order for ED patients to go to HITH without first being admitted would require a dedicated role within ED and MAU, operating 7 days per week and with overall visibility.
- Next steps for HITH is to ensure NP’s are able to have greater flexibility to work alongside the team, to ensure newly rotated doctors are skilled in being able to identify potential patients for HITH, working through ED and MAU to turn people around.

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

That the Hospital Advisory Committee:

Note and receive the report.

Carried
4.5 Corrective Action Update (Dr Jenny Parr)
The report was taken as read.

Dr Parr provided key points:
- Certification review overall was very pleasing and shows a continuous trajectory of improvement.
- The review was hugely complimentary of staff and the work we are doing.
- The hospital is experiencing extreme pressure on multiple fronts and services yet still doing a really good job of running the hospital in a way that meets the required standards.
- Thirteen corrective actions were received and are currently being validated with teams.
- Two continuous improvements recommendations were made for management infection of CRO outbreak and Fundamentals of Care programme.

Dr Parr explained that a Certification Audit involves auditors coming on site for a full audit, going to various departments. Eighteen months later a Surveillance Audit is conducted, specifically looking at the Corrective Action to see how many they can close.

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

That the Hospital Advisory Committee:

Note and receive the report.

Carried

4.6 ARHOP Deep Dive – Presentation (Dana Ralph-Smith)
Ms Ralph-Smith provided a presentation to the meeting. Key points:

- ARHOP services, professional groups, locations and services were outlined.
- Spinal rehabilitation remains the lowest length of stay throughout New Zealand and Australian facilities.
- Key challenges are patient volumes, patient complexity, workforce and facilities.
- Strategies are in place to overcome both short term and longer term challenges.
- Regular benchmarking is provided via Australian Rehab Outcome Centre. Ten years of data indicates we are keeping functional gains going, length of stay down and getting patients back to their homes. Struggling with housing, particularly in Auckland, but otherwise continue to benchmark well.

5. INFORMATION PAPERS
5.1 Facilities Service Report (Anton Venter)
The report was noted and taken as read.

5.2 Emergency Department Medicine Integrated Care (Brad Healey)
The report was noted and taken as read.

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

5.4 Central Clinic Services (Ian Dodson)
The report was noted and taken as read.
5.5 Women’s Health and Kidz First (Nettie Knetsch)
The report was noted and taken as read.

5.6 Adult Rehabilitation and Health of Older People (Dana Ralph-Smith)
The report was noted and taken as read.

5.7 Integrated Mental Health and Addictions (Tess Ahern)
The report was noted and taken as read.

5.8 Middlemore Central (Ian Dodson, Dr David Hughes)
The report was noted and taken as read.

Resolution (Moved: Lyn Murphy/Seconded: Colleen Brown)
That the Hospital Advisory Committee:

Note and receive the reports.
Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC

Due to an error with the Diligent upload, the Committee was unable to view the agenda and supporting documents that had been uploaded for the Public Excluded meeting. Therefore, the Resolution to Exclude the Public was not tabled and the Minutes of the 02 May Public Excluded meeting will be carried over to the 17 July meeting for approval.

The Public Meeting closed at 4.30 pm.

The next meeting of the Hospital Advisory Committee will be held on Wednesday 17 July 2019.

Signed as a true and correct record of Counties Manukau District Health Board’s Hospital Advisory Committee meeting held on 5 June 2019.

__________________________________________  __________________________
Dr Lyn Murphy                                      Date
Chair
Recommendation

It is recommended that the Board:

Receive the Chief Executive’s Report for the period 16th May – 26th June.

Prepared and submitted by: Margie Apa, Chief Executive Officer

Introduction

This report covers the period from 16 May – 26 June 2019.

News and Events

World Smokefree Day

On May 31, various activities around Middlemore Hospital were set up to celebrate World Smokefree Day. Along with a variety of resources were made available for patients and staff to refer themselves or those they work with to the Living Smokefree Service. A Carbon Monoxide (Smokerlyser) Testing Station was set up in the reception area of Middlemore Hospital for people to test themselves.

A competition was launched to see who could refer the highest number of referrals to the Living Smokefree Service. The team, ward or Manukau Super Clinic module which has referred the most during 13 May to 13 June will receive healthy treats for morning or afternoon tea. The winners will be announced on the 3rd week of June.

Free Nicotine Replacement Therapy (NRT) is available to CM Health staff, contractors, discharged patients, patient visitors/ whaanau and volunteers. The "Free NRT Voucher" can be accessed through the Living Smokefree Service, Haumanu Pharmacy (on the Middlemore Hospital Campus), trained Smokefree champions within Middlemore Hospital and security staff.
Some of our Smokefree practitioners, Rachel Tapa and Saini Semisi, promoting Smokefree Day activities

World Smokefree Day activities out and about the community, pictured above Apulu Reece Autagavaia

**Flu Vaccinations**

More than 62% of staff have already been vaccinated and we are continuing to encourage all staff members to receive their vaccine, with peer vaccinators throughout the organisation as well as vaccination stations at Middlemore Hospital and at the Occupational Health office. CM Health has sufficient stock to continue staff immunisation.
**Samoan Language Week**

We celebrated Samoan Language Week (27 May – 2 June). This year’s theme was ‘Alofa atu nei. Alofa mai taeao – Kindness given. Kindness gained’.

Staff were encouraged to greet Samoan patients appropriately and try using the language with Samoan speaking patients and fanau, through a presentation on Samoan language and optional two-hour Samoan language classes. During the classes, participants had the opportunity to practise applying our translated organisation values when working and applying care for patients and fanau, practise how to greet and approach patients and family respectfully, taught a simple conversation to build rapport and an effective working relationship with fanau, and worked on relevant words and short phrases from participants to increase connection with patients and fanau in their respective roles.

![Participants from the Samoan language workshop](image)

**Engagement with Auckland Council**

A successful workshop was held this month with members of the Auckland Council Planning Committee. This was also attended by representatives from southern Local Boards. The workshop was arranged so that CM Health could hear about Council plans, particularly around growth, in the southern part of the Auckland region. Both Council and CM Health have identified the need for both organisations to be aware of each other’s plans as they impact on the same areas and people.

The workshop also enabled CM Health to talk to the Council about the issues the DHB faces as a result of the make-up of our communities. For some of the members at the meeting, it was the first time they had
seen evidence of these. For example, CM Health is home to 200,000 people living in poverty. That is bigger than the whole of some DHBs.

Auckland Council and CM Health have agreed that it is important that our growth is aligned with the growth of the region to ensure the health needs of the growing population can be met. Parekawhia McLean and Dr Gary Jackson will meet with Council’s senior management to further discussions at an operational level, with the aim of building a collaborative relationship on issues of mutual interest. It has been agreed that CM Health will also provide similar briefings to Local Boards in the southern area.

Security update
On 24 May we held a Staff Safety Forum at Middlemore Hospital, led by NZ Police. The forum provided staff with an opportunity to ask questions about the measures they can take to ensure their personal safety and the safety of their property.

We had over 200 staff attend the forum, which was filmed and is now available on our intranet. Additional forums at other locations are planned.

The presentation by the Police was delivered in an informative and often entertaining manner. The messages were very clear:

• This is our place and we need to make sure we own it
• Interact with people; show you are taking note of what is happening in the hospital and surrounding area
• Be vigilant; don’t walk around looking at your phone – instead check who is around and report anything that is suspicious
• Train yourself to be observant – if you see something that doesn’t look right, make sure you can give an accurate description if required
• Don’t leave valuables in your vehicle
• Ensure our buildings are clean and welcoming, inside and out – this shows we take pride in our place

Meetings are being held each fortnight to overview the activities taking place to improve our security measures. For example, in February this year, staff requested 500 security escorts to carpark and transport. In March, this increased to 1000 and in April, CM Health provided 3750 security escorts. We are continuing to provide security escorts to over 3000 staff each month.
Police have increased the frequency of patrolling around Middlemore Hospital, in particular around times that shifts are changing. They are also calling into the hospital more, providing a visual presence. The increase in security staff, hours of coverage and visibility of police has already led to a reduction in car thefts from hot spots around the hospital.

Phase one of our capital works programme to improve security infrastructure such as improved lighting, fencing and additional cameras is on track for completion at the end of July, and we are working on Phase two concurrently. Pictures below show Western Campus carpark.

![Above: Well-lit Western Campus Carpark at night](image)

We are currently scoping the carpark lighting requirements at Manukau SuperClinic so that we can go to tender, and have started alarm installation at Bairds Road. A workshop is being held to look at our requirements for a security monitoring centre at Middlemore Hospital.

We are also part of a stakeholder group including NZTA, Auckland Transport, Auckland Council, ACC and Secure Parking looking at what changes can be made, including around the Middlemore Train station. Further security improvements are expected to be announced in due course.

Furthermore, CM Health has initiated an independent assessment of our security system, as requested by the Board. We have been in discussions with an expert in this field who has conducted similar exercises for other DHBs. A formal proposal from him is currently being assessed.

**Measles**

Over the past few weeks there has been a significant increase in the number of measles cases notified in the Counties Manukau area. While there are a number of household clusters, there have also been sporadic cases not linked to a known source. Many of these are in our Pacific community.

The graphic below shows the total number of confirmed cases of measles this year. It represents an increasing number in CMDHB. There is a higher than usual hospitalisation rate.
Auckland Regional Public Health Service (ARPHS) has called for greater vigilance around measles as many of the cases have attended after-hours and general medical clinics, often on a number of occasions, before they knew they were contagious.

They have also brought forward the age that babies in the Auckland region can be vaccinated, from 15 months to 12 months. The change has been made immediately as the number of cases of measles was becoming more prevalent in babies and young children. General Practitioners have been asked by ARPHS to recall anyone under 5 years (and 12 months or older) without MMR1 and to provide opportunistic screening for anyone 1-50 who has not had MMR1.

Although CM Health has had some presentations at Middlemore hospital, we are encouraging people who think they may have, or have been exposed to, measles to contact their GP in the first instance. Representatives from CM Health have spoken on Radio NZ, Radio Tarana and PMN 531 to raise awareness of this highly contagious virus and to also encourage people to get vaccinated. Videos have also been produced in English, Samoan and Tongan for our social media channels, and we also have access to videos produced by Waitemata DHB.

Deep Dive #1 - Community Stroke Rehabilitation

At the Regional Governance Group last week, I learned that we have seen a fantastic reduction in inpatient stroke rehabilitation from a high of 32% to 16% over the last 2 years which has helped reduce our overall regional rates. This is due to the timely access to community rehabilitation, in which CM Health has one of the most developed programmes in the region. I have asked Dana Ralph-Smith, GM ARHOP, Nick Henzell, Service Manager for Stroke Services and Dr Geoff Green - Geriatrician, Stroke Lead to introduce the Community Stroke Rehabilitation services below.

Stroke: The situation at Counties Manukau Health

Stroke is the 3rd most common cause of death in non-Maori women and 4th most common cause of death in Maori women and non-Maori men. (Ministry of Health, Ngaa mana hauora tuutohu: Health status indicators. Major causes of death) In New Zealand, stroke incidence is more common in Maori and Pacific Island populations, who also tend to have more severe strokes than individuals of other ethnicities. Additionally, roughly 20% of all stroke patients end up in long term institutional care.

At Counties Manukau Health (CM Health), the number of people presenting acutely to Middlemore Hospital with stroke annually has continued to increase overtime, from 875 in CY2016 to over 922 in CY2018. However, due to developments in acute treatments, including interventions such as clot retrieval
and thrombolysis, the proportion of these patients who require inpatient rehabilitation has dropped, declining from 36% in CY2016 to 16% in CY2018. This has significantly contributed to the overall decrease seen across the Northern Region.

More recent Regional developments, such as the hyper-acute pathway for patients who suffer a stroke after-hours (who are diverted via ambulance to Auckland City Hospital for 24/7 intervention services), have meant patients experience less complications following their acute stroke, and can be cared for in community settings without the need for inpatient rehabilitation. This is a testament to the great work that the CM Health team have been doing, and reflects the strong connections that CM Health has with other DHBs in the metro-Auckland region who are experiencing similar increasing demands on their acute stroke services.

Consequently, the stroke patients that are now being seen in inpatient rehabilitation are more complex and require extensive periods of intensive rehabilitation therapy which continues on discharge into the community as appropriate. With facilities that are no longer fit for purpose, increasing patient complexity and constant acute demand pressures, the stroke rehabilitation service has continued to provide quality services across the continuum of care, extending from the acute stroke ward, to the inpatient rehabilitation ward, and finally into the community via a robust Community Stroke Rehabilitation (CSR) programme. The development of this community service overtime has resulted in a large proportion of acute stroke patients (30-35%) being referred to Community Stroke Rehabilitation, often following inpatient rehabilitation but also directly post-acute. As such the importance of this service has grown, and will be the focus of this paper.

**Why is rehabilitation important after a stroke?**

Rehabilitation services are a critical part of the continuum of health care services for people who are seeking to regain or maintain their life roles and their quality of life after a personal illness, injury or other physically debilitating medical emergency such as a stroke.

Due to the significant physical disability that a stroke causes, a patient is required to readjust to their condition in order to work towards independence. This is achieved through a team with intensive therapy, rehabilitation medicine input, changes in lifestyle, and new supportive equipment, with the patient and their whanau. For a stroke patient, specialised rehabilitation is required to regain a similar level of function as to what the patient had prior to the stroke. This can be carried out in both hospital and home settings. Rehabilitation can reduce institutionalisation rates, improve quality of life and reduce recurrent strokes.

**Why is rehabilitation done at home compared to on-going rehabilitation in a hospital setting?**

While rehabilitation within a hospital setting may consist of more intensive rehabilitation therapy and support in an environment that is specifically designed to deliver a model of care for these patient cohorts, rehabilitation at home can be an equally beneficial option for patients and reduces the risks associated with prolonged hospital stays. Evidence is that community treatment is at least as effective as inpatient treatment, preferred by patients, reduces inpatient length of stay and is cost saving compared to inpatient rehabilitation.

Part of the future direction of rehabilitation is a focus on community settings whereby patients are supported to regain their independence and quality of life following their illness or injury at their own home; this also makes for a smoother transition back to the community.

Over the last two years there has been a decline in acute stroke patients being transferred to inpatient rehabilitation at CM Health and conversely an increase in patients having their rehabilitation at home with the Community Stroke Rehabilitation service. This may be due to a robust and well established Community Stroke Rehabilitation service but may also reflect an overall proportion of milder strokes due to advancement in acute stroke interventions such as thrombolysis and clot retrieval.
What do we offer in the Community Stroke Rehabilitation (CSR) service?

Community Stroke Rehabilitation is an important facet of the CM Health stroke service, and operates under two models with an interdisciplinary team providing goal focussed rehabilitation. The team consists of physiotherapists, occupational therapists, speech Language therapists, dieticians, social workers, rehab therapy assistants and most recently a psychologist. Medical input is provided from Dr Geoff Green.

The high Intensity model this is for new stroke patients and who are medically stable. Patients suitable for this model have functional disability from their stroke which would have otherwise required inpatient rehabilitation. These patients have been deemed safe enough (with family or support) to have their rehabilitation within their own home. Patients are also able to participate in a high intensive programme.

The low intensity model is for stroke patients who have had a stroke onset within 2 years and who are medically stable. There is a functional disability which requires rehabilitation from a stroke specialist interdisciplinary team. Patients are able to participate in rehabilitation, are able to set goals and perform self-directed rehabilitation.

How is Community Stroke Rehabilitation at Counties Manukau Health different to other DHBs?

CM Health first established a Community Stroke Rehabilitation team in 2005 which was strengthened to include early supported discharge (ESD) in 2013. The New Zealand stroke guidelines currently consider ESD to be best practise for stroke patients, and in 2013 during an ESD pilot the service achieved a 17 day reduction in average length of stay for stroke patients on the programme. Having both a low intensity and high intensity (early supported discharge) model delivered by the same interdisciplinary team is different to other DHB’s within NZ. Counties Manukau Community Stroke Rehabilitation service accepts all suitable adult patients, and has the most patients in the Northern Region.

Community Stroke Rehabilitation was the first, and one of only two DHB stroke services in NZ who are collecting ambulatory outcome measures and submitting this data to the Australasian Rehabilitation
Outcome Centre (AROC). The service is using AROC reporting as a learning tool to drive quality improvement. As other DHB’s start to collect ambulatory outcome measures, the AROC reporting will also be able to be used for benchmarking.

**Benefits to the patient**

- Reduced risk associated with prolonged hospital stays
- Goal directed and patient/whanau focused treatment. Provides an opportunity for family to support the patient on their rehab journey
- Rehabilitation within a familiar environment (at home). Allows the patient to learn skills in the same place they will use them

**Key Performance Indicators**

CM Health stroke rehabilitation services are monitored by the Ministry of Health via two Key performance indicators:

- 80% of acute stroke patients are transferred to inpatient rehabilitation within 7 days. Current 12 month average: 56%
- 60% of acute stroke patients referred for community stroke rehabilitation services are seen by a member of the community team within 7 days of hospital discharge. Current 12 month average: 48%

We are failing to consistently meet these targets primarily due to the increasing complexity of the patient cohort at Counties Manukau Health, with the majority of stroke rehabilitation episodes being high-complexity patients who require more acute treatment prior to being ready for rehabilitation and during rehabilitation may require medical gases, single rooms and more space and specialised patient moving and handing equipment. However, many improvements in the services have occurred over the last 18 months:

- Short-term rehab now in operation on the acute stroke ward,
- Community Stroke Rehabilitation team engage patient prior to discharge via an in-reach model, and
- Community data is now being collected for AROC benchmarking.

Quality improvement is at the forefront of the minds of the team with all service initiatives aimed at better supporting the patient to achieve their rehabilitation goals.

**The Stroke (Acute + Rehabilitation) Team Leaders at Counties Manukau Health**

Edward Wong    Clinical Head, Acute Stroke CM Health  
Cynthia Bennett   Clinical Head, Rehabilitation CM Health  
Geoff Green     Geriatrician, Stroke Lead CM Health  
Kamna Devi     CNM, Acute stroke ward  
Raewyn Maguire CNM, General Rehabilitation Ward  
Jo-Anne Michaels Mulder   Section Head, Community Stroke Rehabilitation  
Pauline Owens Stroke CNS  
Amy Yeo Stroke CNS  
Thomas Cherian Stroke CNS  
Nick Henzell Service Manager, Stroke Services CM Health
Deep Dive #2 - Impact of Body Size on Service Delivery

CM Health has the largest number of those morbidly obese (body mass index $\geq 40$) of all District Health Boards in New Zealand at 36,000 adults. This is about 8000 higher than expected for our population age, socioeconomic deprivation, and ethnicity. This number is nearly twice as many such people as the next highest District Health Board. Some of the downstream consequences of our population body size are that service delivery takes longer, is more complex, and is prone of complications. I have asked Mr Matt Tomlinson, Clinical Head of Department of Orthopaedic and Michelle McCallum-Jones, Orthopaedic Service Manager to comment on the impact of obesity in Orthopaedic services.

Orthopaedic Service at Counties Manukau Health

CM Health Orthopaedic department provides paediatric and adult secondary and tertiary services including hip and knee joint replacement and revision surgery, foot and ankle, shoulder, spinal, pelvic and lower limb arthroscopic surgeries. Spinal cord impairment (SCI) and traumatic mangled limb services are provided as part of national trauma destinations guidelines and the department provides adult musculoskeletal tumour services as one of two national centres. The department works in partnership with the Plastic department providing services for Hand orthopaedic surgery and the mangled limb service. Provision of care for the Pacific region is an integral part of the service with both elective and trauma patients being treated here. In addition an annual outreach clinic is provided to Niue. An annual average of 8000 inpatients are treated, 60% acute and 40% elective and approximately 28,000 outpatient visits occur with 6000 of those being new First Specialist Appointments (FSA).

Body Mass Index

BMI stands for body mass index and is a way for us to measure overweightness. BMI of 20-25 is considered normal range, 25-30 is overweight, 30-35 obese, over 35 is morbidly obese and more than 40 is super obesity.

Based on BMI data collected since September 2018, 30% of orthopaedic discharges were of patients who were categorised as overweight, a further 49 % obese or super obese. This does not include patients that may have transferred to another speciality such as Plastics for ongoing treatments prior to discharge.

Obesity affects the musculoskeletal system in many ways by putting more pressure on joints, ligaments and tendons. Obese patients are more prone to chronic joint issues including arthritis and wear and tear on hips, knees ankles and feet in particular, as well as being more prone to acute injury due to additional pressures placed on the bones and joints.
Looking after increasing numbers of obese patients is having a major impact on our ability to provide services to our patients in Orthopaedics in a number of different ways, from assessment of patients to definitive care and beyond.

**Referral and Assessment**

At the time of initial referral or assessment we see mobility and transport issues in gaining access to our services. An example is of a tertiary referral patient from Hawkes Bay DHB with a deteriorating arthritic spinal condition, who was airlifted in his lazy boy chair to Middlemore for specialist treatment. In the outpatient clinic setting seating of the obese patient is limited to multiple seats joined with no arm rests between each seat, these being limited in the clinic space and causing displacement of other patients to the central foyer of the SuperClinic. Seating within the individual clinic rooms is also limited with most obese patients having to sit on the plinth rather than a chair.

There are practical difficulties during physical assessment and diagnostic work up of the obese patient. Tissues are more difficult to palpate – which is what clinicians do when they examine using their hands - due to the overhanging pannus and depth of tissue particularly for such things as deep infections and axial problems in the spine or pelvis where physical examination is less rewarding.

It is challenging to find solutions to standard treatment options including casting and bracing of injuries due to the size of available products and ability to make adjustments safely. Non weight bearing following lower limb injury is often not possible and leads to longer LOS, increased mobility aids such as wheelchairs and difficult discharge solutions for the home environment.

**Radiology Imaging**

While machinery plays an important part of the diagnostics there are physical limitations. Radiological diagnostics of CT and MRI are provided by models that are some of the largest on the market. The aperture on CT in the main CT suite is 2 cm smaller than the biggest on the market and the table is at its max at 307kgs. Current MRI models do not come any bigger at this time. The patient’s girth becomes a challenging factor as well as their weight. In many super obese patients these diagnostic aids are unusable, potentially leading to compromised patient care and outcomes.

**Ward based care challenges**

Due to the overall physical size of the high BMI patient nurses do not have the size or strength to provide safe manual handling for turning and transfers for personal, pressure area and wound care interventions as there is significant risk to the staff and the patient. Hoisting of high BMI patients out of bed requires up to 5 staff and additional and alternative staffing resources have been utilised with Orderlies now a routine part of the ward based team, particularly for the spinal cord impaired (SCI) patients requiring care at 3-4 hour intervals day and night. These patients are frequently unable to turn themselves in bed. Occupational Health incidents highlight staff injuries directly related to caring for the obese patient. Additional resources are required for transporting the patient around the hospital for ongoing diagnostics or procedures where the need for two orderlies can be required.

Studies show overweight and obese patients have a higher level of disease activity, pain level, fatigue score, functional disability and spinal mobility impairment. Postoperative wound problems and wound infection are much more common in these patients and the incidence of prosthetic joint infection is much greater, sometimes leading to the requirement of revision surgery, prolonged intravenous antibiotics and greatly increased hospital and outpatient costs.
Theatre

Theatre list planning has additional complexities that include timing both for the impact on theatre utilisation with the need for specialised Anaesthetists and HDU/ICU bed availability. Surgical theatre time is estimated to be extended by about 1 hour each for the obese patient.

The obese patient will most likely have other conditions that affect them, or “comorbidities”, that include diabetes, ischemic heart disease and asthma so more time is required for anaesthesia as intravenous access can be extremely difficult and techniques such as spinal or epidural anaesthesia are a problem. Extra-long epidural needles have had to be purchased. If requiring intubation, ventilation can be difficult because of the patient’s chest size and weight.

Challenges and increased risk occur in the operating theatre during surgery associated with the prolonged open wound, longer reach through fat layers and larger wounds. There is a need for extra skilled assistance, commonly another surgeon, instead of an additional nurse as surgical instruments are often barely long enough for the surgeon to perform the surgery. Additional instruments have been purchased that includes longer drill bits and guide wires.

Radiology imaging is poorer quality due to the depth of the tissue and specialised radiology equipment such as the O Arm, a 3d scanner, cannot always be used because of difficulty fitting larger patients inside it. New operating table specifications are now required to have the capability to take up to 300 kg, the previous 220kg limit now regularly exceeded with surgeons speaking of previous tables appearing to be bending during surgery.

Infection Rates

A recent study led by Orthopaedic Surgeon Professor Rocco Pitto on the “Effect of malnutrition on post op infection rates” looked at patients with a total hip procedure between October 2014 and August 2016. It found that for the high BMI patient the incidence of prosthetic joint infection is 5 times greater, sometimes leading to the requirement of revision surgery, prolonged intravenous antibiotics and greatly increased hospital and outpatient costs.

A recent patient journey of a 50 year old male with high BMI and a spinal cord injury highlights the difficulties that we face with MMH being asked to take over his care that included spinal rehabilitation and a large pressure area which prevented him following the expected rehabilitation pathway to the Auckland Spinal Rehabilitation Unit. His complex cares have needed additional staffing 3-4 hourly throughout the 248 days of his inpatient stay, whereas the normal sized patient’s stay would have been considerably shorter. Now unable to return home for many months until housing modifications are completed, 19 private
hospital residential care facilities have been approached with only one agreeing eventually to accept him for ongoing care. The extra consumption of our precious resources has been enormous.

MMH is dealing with increasing numbers of high BMI patients with particularly challenging needs for care coordination as a result of their large size, comorbidities and poorer surgical outcomes. The extra personnel, equipment and time involved in caring for them places a significant additional burden on our already stretched resources.
Our People

*International Nurses Day*


*International Midwifery Day*

We also celebrated International Midwives Day on the 5 May 2019.

*Nursing and Midwifery Symposium 2019*

In lieu of the annual Nursing and Midwifery Awards ceremony, we held a Nursing & Midwifery Symposium on 14 May. This was very well attended. We had three keynote speakers and 16 poster presentations; and a number of staff presented their work on the day. The calibre of work across the organisation has very high and many attendees commented on how much they enjoyed hearing new research from colleagues. Presentations from the sessions were made available to all staff on our internal website.

Our tertiary institution partners presented preceptor awards and scholarships, as well as awards for presentations across the continuum of care from Primary Care to Hospital. I was delighted to see Esmé Green attended in person. Esmé is a retired Registered Nurse, who was Middlemore Hospitals’ first Trainee Nurse in 1947. She spoke passionately about the development of profession of nursing and her ongoing commitment to CM Health.

Kate Henderson and Carissa Kaveney, recipients of Esmé Green Scholarships
Wanted Down Under: TV Programme

Staff nurse Michelle Nicholson-Burr was filmed explaining the benefits of working as a nurse in New Zealand and particularly Counties Manukau Health for a BBC programme ‘Wanted Down Under’. This has a wide reach as it is sold globally.
Performance and Outcomes Priorities

Performance Summary – Quarter 3 2018/19

<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Final results</th>
<th>Achievement Quarter 3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Departments</td>
<td>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</td>
<td>NOT ACHIEVED</td>
</tr>
<tr>
<td>Previous results:</td>
<td></td>
<td>Trending: ➔ (minimal/no change)</td>
</tr>
<tr>
<td>Q4 2017/18: 91% (Maaori: 90%, Pacific: 90%)</td>
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<tr>
<td>Q1 2018/19: 84% (Maaori: 84%, Pacific: 83%)</td>
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<tr>
<td>Q2 2018/19: 87% (Maaori: 86%, Pacific: 87%)</td>
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<tr>
<td>March 2019 (Q3 result): 86% total population (Maaori: 85%, Pacific: 86%) (target 95%)</td>
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</tbody>
</table>

Performance is largely unchanged from quarter 2 and remains significantly below the 95% target.

Barriers to achievement of the target: Increased volumes, resource constraints, lack of inpatient capacity (hospital occupancy)

A review of Emergency Department resources is underway as part of Winter Plan and following a benchmarking exercise of provider (or clinical staffing) resources. Acute presentations are increasing in volume and complexity. In combination with more patients is the lack of inpatient capacity resulting in overcrowding of the ED.

Activity underway to address these barriers and improve performance:

- Every Hour Counts: ‘ED flow’ is one of seven quality improvement programmes included in the Every Hour Counts portfolio. Inpatient capacity is currently one of the barriers to achieving the ED target. Currently medical and surgical wards aim to get 30% of patients to the discharge lounge by 11am although results are variable. A home-based ward model of care in acute medicine began in December 2018 with the aim of
improving flow to inpatient wards. Under this model purposefully collocated patients are cared for by a team of doctors, nurses and allied health staff based on the ward, rather than by different teams who move around the hospital with the objective of creating geographical efficiencies and avoiding “safari ward rounds”. Progress on this model, however, has been hampered by high hospital occupancy resulting in constrained ability to relocate patients to create efficiencies.

- **The Emergency Q pilot:** The Emergency Q pilot began in September 2018. Emergency Q is a digital information system designed to help patients make informed choices about the most appropriate care for their condition. Emergency Q aims to alleviate demand pressure on the ED through encouraging eligible patients to attend alternative urgent care providers. Between September 2018 and March 2019, 1,689 (20%) eligible patients chose to use Emergency Q and attend a local A&M clinic for free. Analysis of the full trial results has not yet been completed but positive effects observed and feedback from patients has been positive. Initial feedback from ED staff is that the pilot has made a big impact to our waiting and triage area for both staff and patients and reduced staff abuse due to wait times. An extension for the pilot to continue for a further six months over the winter period has been approved which will provide us with a full year of data. The effectiveness, including cost effectiveness, of the service is currently being evaluated with an interim evaluation report due to be released in June and a final evaluation, covering a full year of utilisation data through to September 2019, to be completed later this year.

- **Resourcing:** Recruitment of Care Capacity Demand Management (CCDM) FTE has been approved by the DHB and the Ministry of Health and is currently underway.

- **ED Trigger Tool:** A trigger tool has been established and work is currently underway with IT to provide a transparent view of the trigger tool and code response to ED capacity. The trigger tool aims to identify early when ED is not coping and enable an escalation plan to be developed to cope with the demand.

### Elective Surgery*  
**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).**

**Previous Results:**  
- **Q4 2017/18:** 101.5%  
- **Q1 2018/19:** 102.1%  
- **Q2 2018/19:** 100.4%

**Trending:** ➔ (minimal/no change)
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Final results</th>
<th>Achievement Quarter 3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 3 (YTD result): For the first time in the 2018/19 year, performance against this measure has dropped below target. Against the year to date total planned volumes of 15,448 ESD, actual delivery was 15,159. There was a negative variance of 289 or 98.1% of planned.</td>
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<tr>
<td><strong>Barriers to achievement of the target:</strong></td>
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<tr>
<td>• <strong>Industrial action</strong> by resident medical officer (RMO) staff</td>
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<td>• <strong>High acute volumes</strong> causing cancellation of elective theatre lists;</td>
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<tr>
<td>• <strong>Staff shortages</strong> (particularly anaesthetists); and</td>
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<tr>
<td>• <strong>Increasingly tight private sector capacity</strong> making access to additional operating capacity and outsourcing difficult.</td>
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<tr>
<td>CM Health remains committed to further improving the elective delivery for Q4 to meet end of year targets.</td>
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<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>
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<tr>
<td><strong>Previous Results:</strong></td>
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<td><strong>Trending:</strong> 🗑 (downward trend)</td>
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<tr>
<td>Q4 2017/18: 93%</td>
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<tr>
<td>Q1 2018/19: 89%</td>
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<td>Q2 2018/19: 85%</td>
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<tr>
<td>March 2019 (Q3, six-month result): 76% (target 90%)</td>
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<td><img src="https://via.placeholder.com/150" alt="Graph" /></td>
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<tr>
<td>CM Health’s performance against the 62-day Faster Cancer Treatment (FCT) target is trending down with a result of 76% in Q3 against a target of 90%. Note that performance did improve in the month of March (to 81% for a single month result). Between October 2018 and March 2019 only 140 of the 185 eligible patients between received their first cancer treatment within 62 days of being referred with a high suspicion of cancer. Performance has declined since 2017/18, during which CM Health achieved the 62-day target in all quarters.</td>
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</table>
### Performance measure (previous Health Targets)

#### Final results

#### Achievement Quarter 3 2018/19

<table>
<thead>
<tr>
<th>Barriers to achievement of the target:</th>
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<tbody>
<tr>
<td>The key reasons for breaching the target can be grouped into four categories:</td>
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<tr>
<td>• patient factors (e.g. patient choosing to reschedule or delay appointments),</td>
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<tr>
<td>• clinical factors (e.g. priority of other health matters over cancer),</td>
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<tr>
<td>• capacity factors (e.g. lack of diagnostic procedural capacity, oncology provider FTE, theatre capacity, regional radiation oncology capacity), and</td>
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<tr>
<td>• system factors (such as administrative errors).</td>
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</tbody>
</table>

Capacity constraints are by far the largest cause of breach. Four key tumour streams - gynaecology, lower gastrointestinal (GI), lung and head and neck - have been identified as contributing to more than 50% of the total 62 day patient volume and 80% of the capacity breaches (36/45).

Specific barriers affecting performance include:

- **Volumes** - volumes entering the 62 day pathway for gynaecology and head and neck tumour streams have more than doubled compared to same date range in the previous year. For gynaecology, the volumes increases in the past 6 months are due to a change in grading practices to bring CM Health in line with the region against the FCT business rules. CM Health is the lowest performing DHB in the region for gynaecology.

- **Increased lower gastrointestinal (GI) volumes and competing demands** – both 62 day and 31 day lower GI patients access the same surgical services and resource. With the National Bowel Screening Pilot now in place at CM Health, 31 day volumes are increasing (bowel screening patients are 31 day patients) which in turn places increased pressure and competing demands on outpatient clinics and theatre lists.

These competing demands can lead to prioritisation issues where clinical need can be at odds with achieving the target, in instances where 62 day patients are prioritised ahead of 31 days patients in order to meet the FCT target. A key focus for the cancer services is to ensure that regardless of a how a patient has presented to the cancer pathway, they are prioritised according to need. Performance against the 62 day target may be negatively impacted as a result.

- **Regional Radiation Oncology Capacity Constraint** - Capacity constraints in ADHB radiation oncology continue to create additional delays for patients requiring radiation treatment regardless of when they are referred to this service.

- **Stretched Cancer Nurse Coordinator (CNC)**
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
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<th>Achievement Quarter 3 2018/19</th>
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<tbody>
<tr>
<td>resource – The CNC role is pivotal in navigating patients from entering cancer pathways until they are either excluded or reach cancer treatment. The CNC is responsible for expediting and escalating appointments to ensure this happens in a timely manner.</td>
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<tr>
<td><strong>Activity underway to address these barriers and improve performance:</strong></td>
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<tr>
<td>• Gynaecology tumour stream: The FCT team is currently working with regional colleagues to review and compare pathways at other Metro Auckland DHBs to try and understand key differences and potential for improvement to CM Health processes.</td>
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<tr>
<td>• Regional capacity constraint: Advice from ADHB on options to turnaround radiation oncology wait times is in progress under the governance of the Regional Cancer Board.</td>
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<tr>
<td>• Maintaining focus on the 62-day target: The FCT team is working hard with all tumour streams to ensure that the 62-day target is kept front of mind regardless of its relative deprioritisation by the MOH.</td>
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<tr>
<td>• Diagnostics: Improvements in MRI wait times are expected to flow into FCT.</td>
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<thead>
<tr>
<th>Immunisation</th>
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<tbody>
<tr>
<td>95% of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Maaori and Pacific population groups).</td>
</tr>
<tr>
<td><strong>Previous Results:</strong></td>
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<tr>
<td>Q4 2017/18: 93% (Maaori: 84%, Pacific: 94%, Asian: 98%)</td>
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<tr>
<td>Q1 2018/19: 93% (Maaori: 85%, Pacific: 95%, Asian: 98%)</td>
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<tr>
<td>Q2 2018/19: 93% (Maaori: 83%, Pacific: 94%, Asian: 99%)</td>
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<tr>
<td>March 2019 (Q3 result): 92% total population (Maaori: 83%, Pacific: 95%) (target 95%)</td>
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<tr>
<th>Target</th>
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<tr>
<td>NOT ACHIEVED</td>
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<tr>
<td>Trending: ➔ (minimal/no change)</td>
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</table>

The total coverage at eight months has dropped by 1% from last quarter. Maaori coverage remains unchanged while Pacific has increased slightly (1%).
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
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<th>Achievement Quarter 3 2018/19</th>
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</thead>
<tbody>
<tr>
<td>Barriers to achievement of the target:</td>
<td></td>
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<tr>
<td>• Lower immunisation rate for OIS over the holiday period - The mobility of families during the holiday season resulted in the Outreach Immunisation Service (OIS) immunising fewer babies. More families declined OIS appointments due to other commitments, not wanting to upset children over the holiday season and not being home. Over January, February and early March the Outreach Immunisation Team (OIS) were often required to visit the same home numerous times. Of Maaori whaanau referred to the OIS, 7% (19) were non-responders who did not engage with the OIS even after many visits.</td>
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<tr>
<td>• Increased declines - More families were declining immunisations during quarter 3 with the decline rate increasing to 3.2% (from 2.7% in quarters one and two). Some families spoke of their fears regarding the Samoan babies who have died in Samoa, others wanted to do further research into immunisation and some did not want to be contacted.</td>
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<tr>
<td>• Homelessness and transiency - Issues of homelessness and transiency continue to be a challenge. For example the OIS team had difficulty contacting families who were originally living in motels but had then moved on without a known forwarding address (“gone no address”). From the referrals of Maaori babies received by OIS for the quarter 5% (14) were “gone no address”.</td>
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<tr>
<td>Activity underway to address these barriers and improve performance:</td>
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<tr>
<td>• Maaori pepe prioritised - OIS prioritise Maaori pepe for home visits and if not engaging or available in the week a Saturday visit is attempted. The team working with Maaori families will stay engaged with them from start to finish, building relationships and supporting their needs.</td>
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<tr>
<td>• Saturday clinics - Maaori babies who have missed the opportunity of an OIS visit will continued to be offered the service as well as an invitation to the Saturday clinic. The Immunisation Nurse Leader is to collaborate with other stakeholders and Maaori service providers in the community to establish a case review type forum where families can be supported through existing relationships, for example with Well Child providers.</td>
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<tr>
<td>• New incentives programme - A pilot will start next quarter utilising incentives to encourage engagement with Maaori whaanau and pepe in the eight month old cohort for 2018/2019. This will last a year and will be evaluated. The focus of the pilot is to address inequity in Maaori immunisation coverage at eight months.</td>
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<tr>
<td>Performance measure (previous Health Targets)</td>
<td>Final results</td>
<td>Achievement Quarter 3 2018/19</td>
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<td>---------------------------------------------</td>
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<tr>
<td><strong>Raising Healthy Kids</strong></td>
<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>ACHIEVED</td>
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<tr>
<td></td>
<td>Previous Results:</td>
<td>Trending: ➔</td>
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<tr>
<td></td>
<td>Q4 2017/18: 100%</td>
<td>(minimal/no change)</td>
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<td></td>
<td>Q1 2018/19: 100%</td>
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<td></td>
<td>Q2 2018/19: 100%</td>
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<tr>
<td></td>
<td>March 2019 (six-month result): 100% total population (Maaori: 98%, Pacific: 100%) (target 95%)</td>
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<tr>
<td><strong>Tobacco</strong></td>
<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>NOT ACHIEVED</td>
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<tr>
<td></td>
<td>Previous Results:</td>
<td>Trending: ➔</td>
</tr>
<tr>
<td></td>
<td>Q4 2017/18: 92% (Maaori: 91%, Pacific: 92%)</td>
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<td>Q2 2018/19: 89% (Maaori: 88%, Pacific: 89%)</td>
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<tr>
<td></td>
<td>March 2019: 89% total population (Maaori: 88%, Pacific: 89%; Asian: 92%) (target 90%)</td>
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</tbody>
</table>

CM Health has narrowly missed the 90% target again in quarter 3 with no improvement in performance since quarter 1. However we believe that, as in previous years, performance will increase to meet the target before the end of the financial year.

**Barriers to achievement of the target:**
Quarters 2 and 3 are always challenging with many different priorities competing for practice time/attention. There are challenges around ensuring general practices maintain focus on the target, particularly given uncertainty around the National Health Targets based on public comments from the Minister. We continue to push the importance of this activity with our PHOs and practices. We are concerned to note that performance for Maaori continues to be lower than other ethnicities and did not
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>reach the target.</td>
<td></td>
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<tr>
<td><strong>Activity underway to address these barriers and improve performance:</strong></td>
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<tr>
<td>There are multiple activities underway to support achievement of the target, including the following:</td>
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<tr>
<td>• <strong>Active clinical leadership/clinical champions:</strong> An on-going area of focus has been on improving ways in which PHOs can provide ABC to patients who are transient and do not have up to date contact details. The Smokefree Advisor –primary care have been working with PHOs to discuss strategies such as appointment scanning, improved coding systems, ensuring opportunities are not missed if the patient attends the practice with a family member.</td>
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<tr>
<td>• <strong>Active, dedicated management to support ABC activities in General Practice:</strong> All PHOs have committed staff responsible for ensuring this health target is achieved. Most practices have an identified Smokefree target champion who leads practice activity and ensures the practice is aware of their performance and activities that are needed to either reach the target or maintain the current level of performance. Although for most practices this activity is now part of BAU and sustained throughout the year, these staff are used to sustain momentum towards the end of each quarter and year. Most PHOs have continued providing extra resource (FTE) to practices to offer evening/weekend (moonlight) calling for brief advice. PHOs have noted that although this is very effective it is very resource intensive. However it has proven effective for practices that were struggling to reach target, and has led to the significant increase seen over the last quarter for some PHOs. We will continue to work with our PHOs and practices to ensure that this activity is seen as year-round and is sustainable.</td>
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<table>
<thead>
<tr>
<th>Maternity</th>
<th>90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking</th>
<th>ACHIEVED</th>
</tr>
</thead>
</table>
| Previous Results:  | Q4 2017/18: 92% (Maaori: 94%, Pacific: not reported)  
Q1 2018/19: 92% (Maaori: 93%, Pacific: not reported)  
Q2 2018/19: 96% (Maaori: 98%, Pacific: not reported)  
March 2019: 94% total population (Maaori: 99%, Pacific: not reported) | **Trending:** ➔  
(minimal/no change) |
<table>
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<th>Achievement Quarter 3 2018/19</th>
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<tbody>
<tr>
<td>Achieved: Results indicate the target was met in Quarter 3 2018/19.</td>
<td><img src="image" alt="Graph" /></td>
<td><img src="image" alt="Graph" /></td>
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<tr>
<td>Not Achieved: Results indicate the target was not met in Quarter 3 2018/19.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Performance against the Elective Surgery target is reported one month in arrears.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>** 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 31 March-31 May 2019.
Prepared and submitted by Donna Baker, General Manager Communications and Engagement and Parekawhia Mclean, Director Strategy and Infrastructure.

Purpose This paper provides an update on Corporate Affairs and Communications activity for the period 31 March - 31 May 2019.

External Communications

Proactive Media

A number of positive stories were promoted through media releases and the CM Health website. These included hosting a visit by the BBC for filming for TV show Wanted Down Under, proactively managing reactive media on mail theft, staff safety and resident doctor’s strike. In May 2019 we promoted website stories on Health Science Academies, community initiatives delivering free flu vaccination and an interview with CM Health specialist Dr Mataroria Lyndon about his work and attending one of the most prestigious Universities in the world.

Mail Theft

Communications drafted a media statement following the theft of a large amount of CMDHB mail from the DHB contractor’s East Tamaki distribution centre, in the lead up to the resident medical officer strike. The statement provided information on the number of appointment letters and letters to patients that had to be re-printed and sent. Communications also facilitated interviews with a number of media outlets.

Baby removed from Middlemore Hospital

Communications supported police and managed CM Health’s response to media following removal of a baby, by his mother, from the hospital whilst requiring medical attention. Police issued an initial statement to locate the baby, and Communications drafted a statement responding to follow up media queries.

Resident Medical Officer Strike

Communications proactively released a media statement about CM Health preparation for a week long junior doctors’ strike and facilitated targeted media interviews.

Facilities

Communications worked with CM Facilities to manage a proactive opportunity with Stuff journalist Hannah Martin and photographer, providing an update on current work programme at Scott building and other building programmes. This resulted in a balanced story on Stuff.

Diabetes
Communications facilitated RNZ journalist, Guyon Espiner on a visit to speak with a senior specialist about diabetes as part of a story about funding. He interviewed patients as part of the visit. The interview was featured in a story on RNZ.

Influenza deaths

We received and managed a significant number of queries from media relating to two influenza deaths at CM Health. A short statement was prepared.

Proactive Releases and Website Stories

April 2019
- Nod for baby friendly approach to breastfeeding
- Counties Manukau welcomes funding boost for Tiaho Mai (MR)
- Enticing new nurses to Counties Manukau key to campaign
- Counties Manukau works to close gaps in cancer treatment
- Expo connects Pacific Social Services
- Heavyweight support for Jammies in June
- New Tiaho Mai service gets thumbs up from staff and users
- Wanted Down Under – BBC visits CM Health
- Intensive care patients cheered by visits from four legged friends
- CM Health re-sending appointment letters following mail theft (MR)
- Reducing the use of blood for better patient outcomes
- Plans in place for junior doctors strike (MR)

May 2019
- Facilitation best chance of settling RMO dispute
- Health Science Academies focus for Fit for Purpose Camp
- Reading App takes off at CM Health
- Community Initiative delivers free flu vaccination to elderly
- Nurses present tools of the trade
- Fisher&Paykel present CM Health with 12 myAirvo units
- A touch of Ivy League at CM Health
- Former smoker urges people to quit now

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.

April has been a significantly quieter period compared to the same time in 2018, however there have been a number of repeat requests from media that have been managed via OIA and media team related to progress on Facility matters over the last year.

There has been a focus on matters in Women’s Health services (staffing, clinical prioritisation and complaints), as well as Union requests for information related to bargaining, the cost/ impact of RMO industrial action and employee entitlements.

May has seen a number of OIA requests sent to DHBs triggered by, and linked to, Government announcements including the Mental Health Inquiry, and additional funding for transgender services. Requests related to the impact of the ongoing RMO strikes on costs and services continued. While media
OIA requests have reduced, the ones received are complex and relate to areas/topics where there can be significant data/information limitations, requiring collation and interpretation.

The Ministry of Health has advised DHBs that the Speaker of the House has recently issued a ruling to all Ministers, advising they have responsibility for answering written parliamentary questions on operational matters that relate to their portfolio. MoH has clarified how this ruling applies to DHBs, and has been advised by their Chief Legal Advisor that MoH will need to seek information from DHBs in order to answer some written questions.

The timeframes for answering written parliamentary questions are much tighter than for OIA requests (typically 48 hours/2 working days), with limited time for review. MoH estimate between 1-5 percent (20-100) of the 2,000 questions that they receive each year are likely to require information from DHBs. This will be in addition to Ministerial and Ministry requests for information, currently managed via the CEO Office. DHBs have been asked to advise MoH of a centralised point at each DHB for future Parliamentary questions to be sent to.

More information on the OIA process and a form to submit requests is available:

Copies of recent OIA releases on common topics are also now on the website.
Routine Sector Communications

Connect+

Internal Communications put the finishing touches on the Connect+ June magazine. The magazine was published on 4 June, and is available online and in the public domain through our Connect+ stands. In this issue:

- Respiratory Function Lab Receives Accreditation
- Wanted Down Under
- Nursing & Midwifery Awards 2019
- Achieving Health Equity
- And more....

Internal Communications

Facilities Master Plan

During April, internal communications interviewed key facilities staff around a number of significant projects associated with the 10-year Facilities Master Plan. The main focus has been on the relocation of the histopathology lab, the new chiller that is being installed to support new areas like MRI, Acute Mental Health Unit and Ko Awatea; and the specialised rehab centre. These will be published during the next period. The team continues to await sign off of the 10 year Master Plan Strategy and it is hoped this will be completed during the period also.

Scott Reclad

Internal communications has continued to support the Scott project. A review of the master planning pages on the intranet (Paanui) is being undertaken and will include a newly developed section on the Scott Building. All collateral has been added and a notice put into the Daily Dose advising where staff can access information on this project. Wording has been approved for a shortened version of the multicultural translations about the Scott building reclad. The video produced for staff drop in sessions is now also showing on the screen in main reception.

Brand Guidelines

Internal communications has undertaken a full review of our brand guidelines. Once approved, a communications exercise will be undertaken through our Daily Dose and other channels to ensure staff are aware of this resource and the importance of maintaining our brand.

CEO Awards (local heroes)

During April, internal communications met with the Director Human Resources and made a number of changes to the plan to simplify and streamline the process. This is currently with HR for progressing with the CEO.

Staff Forum

Work is underway to prepare for the two staff forums scheduled at Botany SuperClinic and Middlemore Hospital. During this period, promotional collateral was developed and scheduled across internal channels. Internal communications also worked with the CEO’s office to coordinate the events, including developing an agenda for both events and securing speakers.
Staff Safety Forum

The team organised a highly successful staff forum on 24 May, where two members of CM Police delivered a lively presentation on keeping safe. Attendance was exceptionally high and staff participated by asking a number of questions. A video of the session is on Paanui, and staff have been advised of this through our Daily Dose. Plans are now being made for similar staff forums to take place at Manukau SuperClinic, Pukekohe Hospital and the Spinal Centre. Internal communications are continuing to work with CM Police as part of an on-going campaign to increase their presence across CM Health.

This will include:

- Short videos on key tips for staff
- Safety tips for the wards
- Drop in/pop up police desk
- Coffee with a Cop
- Police bus that will visit other CM Health locations

Team Counties Blogs

During April, the following Team Counties blogs were published:

- Meet The Team: Ngaa Raukohekohe (new Adult Mental Health team at Pukekohe hospital).
- Meet the team: Mentoring group helps students gain the confidence they need to achieve their goals.

Flu Campaign

Internal communications continued to attend the fortnightly flu steering group meetings. Promotion through internal channels continued via the Daily Dose, Paanui, and posters. Internal communications provided promotional support for roving vaccination clinics during this time. It was announced at the recent steering group meeting that an inpatient vaccination programme would commence Monday 10 June. Collateral from the National campaign is likely to be used for patient facing communication.

International Nurses Day

Internal communications continued to support International Nurses Day (12 May) and International Midwives Day (5 May). A series of displays were held in the main foyer between 11am to 1pm to showcase the great work happening in the different service areas. Internal communications supported the Nursing & Midwifery Symposium held on 14 May; this included scripting and videoing award sponsors; and sourcing/photographing images to support the Nursing Strategy, which also formed part of the day.

Care Capacity Demand Management (CCDM)

We are continuing to support the CCDM programme on branding and design of a bi-monthly newsletter.

Insulin Safety Week

Internal communications worked with the Insulin Safety team on promotional material to support Insulin Safety Week. Promotional material was shared via all relevant internal channels.

Pink Shirt Day

Internal communications worked with Organisational Development to support Pink Shirt Day activities across the organisation. Promotional material was shared and communicated via internal channels and social media channels during and following the activities.
Samoan Language Week

Talofa! Samoan Language Week was celebrated from Sunday 26 May to Saturday 1 June. This year’s theme was ‘Lalaga le si’osi’omaga mo se lumana’i manuia’ - ‘Weave an environment for a better future’. The Pacific Health team held two drop-in sessions to showcase the Samoan language. We have agreed on a process for the promotion of future language week celebrations.

Other Campaigns supported by Internal Comms through the month of May

- NZ Sign Language Week
- CMDHB Hand Hygiene Day (Flash Mob at Reception)
- CMDHB Audit Certification Week
- Privacy Week
- Ward 21 Opens to provide a combination of services for Women’s Health
- Mental Health Addictions Information about Vacancies and Services Set Up Main Entrance

The Design Team

Below are a few examples of collateral our design team has produced for our various CMDHB Business groups.

Stakeholders & Communities

Measles Outbreak
We are utilising radio and our social media channels to encourage people to get vaccinated, particularly people who have not received any MMR vaccinations.

Proactive Stories

- **Chaplains:** We are currently profiling the work of our chaplains – the first story on Paanui was about the commissioning of reverends Garey Clark and Tauilili Talaivao and the following one about Kaumaatua Ropata George
- **Patient Blood Management:** We released an article in our internal and external webpages about the implementation of a patient blood management programme that has reduced the use of blood resulting in better patient outcomes as well as cost savings.
Winter/Flu Campaign

- We attended the Manurewa Community Network meeting and the Korean Positive Ageing Trust, delivering flu collateral/resources and promoting the flu campaign.
- Supporting community stakeholders, Asian Health Gain Advisor Kitty Ko and Life Pharmacy Pakuranga’s flu vaccination clinics which were targeted to people aged over 65 from the Asian community. There were 14 clinics; more than 350 people received their free flu vaccines at temples, activity centres, Justice of Peace meetings, churches and community centres.
- The Primary Care Team organised an Influenza Immunisation Working Group to bring together all departments that are involved with administrating/promoting flu immunisation in the hospital and community. We presented the communications plan on how we are supporting these departments in promoting flu immunisation to their specific community groups.
- Promoted the Emergency Q App on social media to help alleviate pressure on our ED.

Advertising & Media

- Radio and print advertising across Mai FM, Radio Tarana, PMN 531, Samoan Times and the Chinese Herald to support flu vaccination started in May and will run until the end of June.
- Radio interview spots on Tarana and PMN 531: Primary Care Programme Manager Kate Dowson went on PMN 531 on 23 May to talk about winter wellness, immunisation, and Emergency Q.
- Immunisation Nurse Leader Claudelle Pillay was on Radio Tarana on 22 May to talk about immunisation with a focus on flu vaccination.

Smokefree Day

- Promoted the free access to Nicotine Replacement Therapy to our staff.
- Supported the Living Smokefree team in the lead up to World Smokefree Day with internal promotion of the day (posters, Daily Dose and Paanui articles).
- Published a Smokefree article on our external page, a social media video and post about the Smokefree stand on the day, and signage in areas where people are still smoking outside the hospital.

Matariki

We have worked with Kaumaatua Te Teira Rawiri to produce resources for Matariki including posters, screensavers and social media tiles. Comms is providing support to the project team in the planning of activities.

Alcohol Harm Minimisation

We continue to support the AHM team as follows:
- Supported the presentation and promotion of a 360° Empathy Tool to CMH staff working with young people with addiction issues and hazardous drinking behaviours.
- Produced two pieces of design collateral for the alcohol harm minimisation team – a guide for staff on Alcohol ABC and an infographic containing alcohol harm statistics specific to CM Health.
- Comms is working with the AHM team and external agency Currative on refreshing John McMenamin’s Alcohol ABC training videos for CM Health and Secondary Care settings. The current focus is on scripting the videos.
Bowel Screening

We are running advertising in the local newspapers and regionally promoting the programme through radio and print advertising. This will be concentrated in June and July. We are working on refreshing/updating the collateral to better reflect our population by replacing generic images with photos of our local people. We are co-ordinating a proactive media release on a patient’s screening journey, with a call to action to get people to do the test.

Women’s Health

- We attended the Baby Friendly Hospital Initiative celebrations at all three birthing units, photos and story shared throughout internal and external channels.
- Maternity Assessment Clinic (MAC) opening: promoted throughout our internal channels, CM Health Facebook page, and Instagram to promote the services at MAC.
- Birthing Units, a communications plan is being prepared to promote the birthing units to coincide with Matariki.

Recruitment

- Maaori Workforce – Allied Health: A video has been completed with physio Jessica Penney to promote Allied Health careers, as well as Maaori staff. This video will be released across our internal channels, social media channels, and Allied Health/physio networking channels. The video will also be used as a promotional tool when speaking with secondary and tertiary students.
- Pacific Health Sciences Academy and Project WAT: We are supporting the team to develop a promotional communications plan highlighting the successes of the programme and raising awareness among Pacific parents and high school students of both programmes and the benefits and supports provided to students.
- Midwifery Recruitment: Supporting the team to craft compelling content to attract midwives to come and work at CM Health; supporting the production of a recruitment video for midwifery vacancies

Digital Channels

Website (www.countiesmanukau.health.nz) In April we saw traffic change on our website: a larger distribution of activity across time of day, and an increase in traffic vs. last period. This can be attributed to increased media releases. Through May we saw more traffic on our website in the evening. This could be people looking for our services after hours as winter demand increases.

Audience Growth Metrics (May 2019)

![Figure 1 Web Site Data Metrics from Google Analytics](image)
Audience Growth Metrics (April 2019)

Social Media
The majority of our content in April was recruitment-focused and not celebratory, which is a favourite amongst the audience on this channel.

May was a solid period for Facebook following the merger of The Healthy Together Facebook Page into the CM Health Facebook Page; our busiest yet with 55 posts. It’s great to see posts such as the Emergency Q post perform as well as this demonstrates that our Healthy Together audience is still engaged with us after the merge. It is also positive to see stronger-than-usual audience growth as a lost was forecast as a result of merging the two Pages.

For this report, statistics from the Healthy Together Page have been excluded as nothing of value can be derived from them. Change metrics have also been adjusted to account for the exclusion of these statistics. We have also included Instagram metrics in this report.

A content plan has been developed for Instagram, which we re-introduced at the end of April.

<table>
<thead>
<tr>
<th></th>
<th>Total Followers</th>
<th>Follower increase</th>
<th>Messages Sent</th>
<th>Impression s</th>
<th>Impressions per Post</th>
<th>Engagements (incl. post clicks)</th>
<th>Engagements per Post</th>
<th>Post Clicks</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2019 CM Health Facebook</td>
<td>16,743</td>
<td>+0.72%</td>
<td>55</td>
<td>200,638</td>
<td>3,647</td>
<td>23,812</td>
<td>432</td>
<td>18,649</td>
</tr>
<tr>
<td>April 2019 CM Health Facebook</td>
<td>8,787</td>
<td>+1.24%</td>
<td>15</td>
<td>78,461</td>
<td>5,230</td>
<td>5,766</td>
<td>384</td>
<td>4,064</td>
</tr>
<tr>
<td>May 2019 CM Health Twitter</td>
<td>2,687</td>
<td>+0.64%</td>
<td>20</td>
<td>20,991</td>
<td>1,049</td>
<td>75</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>April 2019 CM Health Twitter</td>
<td>2,670</td>
<td>--</td>
<td>8</td>
<td>12,628</td>
<td>1,578</td>
<td>31</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>May 2019 CM Health LinkedIn</td>
<td>7,001</td>
<td>+1.71%</td>
<td>8</td>
<td>17,289</td>
<td>2,161</td>
<td>1,465</td>
<td>183</td>
<td>1,124</td>
</tr>
<tr>
<td>April 2019 CM Health LinkedIn</td>
<td>6,898</td>
<td>+1.71%</td>
<td>6</td>
<td>11,109</td>
<td>1,851</td>
<td>325</td>
<td>54</td>
<td>226</td>
</tr>
<tr>
<td>May 2019 CM Health Instagram</td>
<td>512</td>
<td>--</td>
<td>21</td>
<td>9,800</td>
<td>466</td>
<td>703</td>
<td>33</td>
<td>191</td>
</tr>
</tbody>
</table>
## CM Health Facebook

### April 2019 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>Counties Manukau District Health Board has full contingency plans in place ahead of planned industrial action by some junior doctors from 8am Monday, 29 April to 8am Saturday, 4 May. We will provide urgent and acute care during the strike, and ensure…</td>
<td>661</td>
<td>3</td>
<td>8.34%</td>
<td>7,928</td>
<td></td>
</tr>
<tr>
<td>Join the team! Counties Manukau Health in Auckland, New Zealand is currently seeking applications from exceptional Radiographers with experience in all medical imaging modalities. Permanent, fixed term and casual…</td>
<td>670</td>
<td>8</td>
<td>7.35%</td>
<td>9,113</td>
<td></td>
</tr>
<tr>
<td>Are you or someone you know looking for a radiography role where you can make a difference? We've got several great opportunities! For more information, contact Amy Varcoe + 64 9 259 3640. #JoinTheTeam</td>
<td>1,018</td>
<td>17</td>
<td>6.43%</td>
<td>15,810</td>
<td></td>
</tr>
</tbody>
</table>

### May 2019 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>Our Emergency Department is experiencing high demand. If your condition is not an emergency, did you know that you could go to your local Accident and Medical clinic where waiting times are usually significantly shorter?</td>
<td>508</td>
<td>8</td>
<td>14.10%</td>
<td>20,462</td>
<td></td>
</tr>
<tr>
<td>Nursing &amp; Midwifery Symposium 2019 photo album</td>
<td>500</td>
<td>1</td>
<td>48.44%</td>
<td>5,917</td>
<td></td>
</tr>
<tr>
<td>Are you, or someone you know interested in working in Mental Health &amp; Addictions? Come along and join us to find out more information about our vacancies and services…</td>
<td>401</td>
<td>17</td>
<td>14.62%</td>
<td>13,158</td>
<td></td>
</tr>
</tbody>
</table>

## CM Health LinkedIn

April was a good period for LinkedIn as we found a good balance of posts about workplace culture and recruitment – which resulted in a jump for both reach and engagement metrics. This type of content continues to perform well on our LinkedIn channel. Through May, LinkedIn performance was good as we see our engagement rise. Posts celebrating the donation of 12 MyAirvo machines from Fisher & Paykel Healthcare and our Mental Health & Addictions recruitment ad performed very well, and were the standout reason for the increase in engagement.
CM Health LinkedIn April 2019 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 been a year and a half since Nelsan first walked through our doors with a vision of what could be. Between volunteering in the Ophthalmology and ACC departments, her knowledge on processes increased, as did her...</td>
<td>150</td>
<td>0</td>
<td>3.87%</td>
<td>3,871</td>
</tr>
<tr>
<td></td>
<td>Are you or someone you know looking for a radiography role where you can make a difference? We’ve got several great opportunities! For more information...</td>
<td>59</td>
<td>1</td>
<td>3.49%</td>
<td>1,692</td>
</tr>
<tr>
<td></td>
<td>Are you ready for an exciting role within our Cancer Service? Here’s your opportunity to join a fantastic team and make a difference to our patient’s...</td>
<td>41</td>
<td>0</td>
<td>3.31%</td>
<td>1,237</td>
</tr>
</tbody>
</table>

CM Health LinkedIn May 2019 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>CM Health has received a donation of 12 MyAirvo machines and consumables from Fisher &amp; Paykel Healthcare to keep our vulnerable patients with COPD out of hospital. #healthytogether #peoplehelpingpeople #healthtech</td>
<td>212</td>
<td>4</td>
<td>12.51%</td>
<td>8,841</td>
</tr>
<tr>
<td></td>
<td>Are you, or someone you know interested in working in Mental Health &amp; Addictions? Come along and join us to find out more information about our vacancies and services. We will be set up in the main entrance...</td>
<td>32</td>
<td>1</td>
<td>5.40%</td>
<td>2,279</td>
</tr>
<tr>
<td></td>
<td>Are you seeking a role that will offer you the flexibility that you need? Join us as a part time Physiotherapist at Home Health Care in Franklin. We are establishing innovative ways of working in the community and need an experienced Physiotherapist...</td>
<td>10</td>
<td>0</td>
<td>3.47%</td>
<td>1,153</td>
</tr>
</tbody>
</table>

CM Health Instagram

The metrics we see on Instagram are good in comparison to the size of our audience, and our engagement rate (9-10%) sits well above the industry average (3%). As Instagram is a channel driven by positivity, it’s not surprising to see posts celebrating our staff were our top performers. Instagram is the only channel that gives a clear indication of reach split (followers reached vs. non-followers reached), so this is something we will closely monitor. As of May, 16% of our post viewers were not following us.

<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>Last Sunday was World Hand Hygiene Day - spreading awareness of good hand hygiene for patient safety. Our Infection Control team and the Renal team put on a great performance highlighting the importance of washing our ringaringa...</td>
<td>46</td>
<td>0</td>
<td>9.16%</td>
<td>502</td>
</tr>
<tr>
<td></td>
<td>In recognition of International Nurses Day (12 May) and International Midwives Day (5 May) a series of displays will be held in the main foyer area of Middlemore Hospital this week between 11am to 1pm daily...</td>
<td>68</td>
<td>2</td>
<td>9.74%</td>
<td>698</td>
</tr>
<tr>
<td></td>
<td>CM Health has received a donation of 12 MyAirvo machines and consumables from @fphcare to keep our vulnerable patients with COPD out of hospital #peoplehelpingpeople #healthytogether #healthtech</td>
<td>59</td>
<td>0</td>
<td>9.39%</td>
<td>628</td>
</tr>
</tbody>
</table>

CM Health Twitter

In April we did not see much change in Twitter. However, positive content around the Middlemore Foundation and free Mental Health workshops performed well and we saw a boost in reach. Through May we saw a large increase in per-post engagement which can be credited to popular conversations such as Pink Shirt Day and NZ Sign Language week. This is something we will aim to replicate in the future.
### April

<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>CW Health</td>
<td>@ministryv</td>
<td>1,308</td>
<td>8</td>
<td>0.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CW Health</td>
<td>@ministryv</td>
<td>1,115</td>
<td>15</td>
<td>1.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CW Health</td>
<td>@ministryv</td>
<td>904</td>
<td>1</td>
<td>0.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CW Health</td>
<td>@ministryv</td>
<td>8</td>
<td>0</td>
<td>0.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### May

<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</td>
<td>@ministryv</td>
<td>4,423</td>
<td>2</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@ministryv</td>
<td>1,437</td>
<td>1</td>
<td>2.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@ministryv</td>
<td>1,016</td>
<td>10</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@ministryv</td>
<td>902</td>
<td>24</td>
<td>3.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: The table shows the top 4 tweets for each month based on impressions.*
Social Listening

Peaks:
- Mid-April: Baby taken from MMH (then found)

Figure 12 Social volume, sentiment and sources
Figure 13 Social reach and hours
Figure 14 social influence, topics and weekdays
Social Listening

Peaks:
- Mid-May: Galbraith building to be scrapped
Figure 13 Social reach and hours
Figure 14 social influence, topics and weekdays
News/Media Listening
Peaks

- **April 2:**
  - Multiple car crashes
  - Reports of ‘extreme fire risk’
- **April 15-16:** Baby taken from MMH and then found
- **April 26-27:**
  - DHB to re-send letters after mail stolen
  - Person critically injured in house fire
  - Person shot in Harley-Davidson store in ‘gang-related’ incident taken to MMH

![Figure 15 social volume, sentiment and sources](image-url)
Figure 16 hours and reach
Figure 17 influence, topics, and weekdays
News/Media Listening

Peaks

- Mid-May: Man in critical condition with suspected gunshot wound.
- Late-May: Two flu deaths
Figure 16: Hours and reach

05/01/2019 to 05/30/2019 (News)

Reach (News)

- AutoNewspaperAdmin: 94.9M
- https://www.nzherald.co.nz/news/article... (94.9M)
- MSN New Zealand: 44.7M
- That's despite the Counties Manukau Dis...
- Dan Satherley, Ela: 44.7M
- Nearly 2000 people were seen at Middle...
- MSN New Zealand: 44.7M
- That was the motivation to get this study...
- MSN New Zealand: 44.7M
- The number of premature babies at Midd...
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 May 2019.


Glossary for Monthly Performance Scorecard and Report

<table>
<thead>
<tr>
<th>Lost time incidents</th>
<th>Any injury claim resulting in lost time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost time injury Frequency Rate</td>
<td>No of lost time injuries per million hours worked.</td>
</tr>
<tr>
<td>LTIFR (Lost Time Injury Frequency Rate)</td>
<td>(Number of Lost Time Injuries / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td>Injury Severity Rate</td>
<td>Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked.</td>
</tr>
<tr>
<td>LTISR (Lost Time Injury Severity Rate)</td>
<td>(Number of Lost Hours / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td>Notifiable Injury/illness</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.</td>
</tr>
<tr>
<td></td>
<td>(b) any admission to hospital for immediate treatment</td>
</tr>
<tr>
<td></td>
<td>(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance</td>
</tr>
<tr>
<td></td>
<td>(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.</td>
</tr>
<tr>
<td></td>
<td>(e) any other injury/illness declared by regulations to be notifiable.</td>
</tr>
<tr>
<td>Notifiable Incident</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 capsize; or any other incident declared by regulations to be a notifiable incident.</td>
</tr>
<tr>
<td>Notifiable Event</td>
<td>Death of a person, notifiable injury or illness or a notifiable incident.</td>
</tr>
<tr>
<td>Pre-Employment</td>
<td>Health screening for new employees.</td>
</tr>
<tr>
<td>Worker</td>
<td>An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer.</td>
</tr>
<tr>
<td>Reasonably Practicable</td>
<td>Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk.</td>
</tr>
</tbody>
</table>
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 and WorkSafe notification:**
  There were no notifiable events in April or May 2019.

- **2019 Staff Influenza Vaccination Programme**
  The soft launch commenced in April 2019.
  60% of the CMDHB staff received flu vaccinations and the programme is continuing in the service areas through the 137 peer vaccinators and supplemented with the OHN team.

- **H&S Induction training**
  - E-learning module development underway expected roll out in July. Designed to replace the Welcome Day generic session.
  - Induction H&S currently delivered via pre-commencement online module and supported in service with the H&S induction handbook.

- **Incident Reporting in May:**
  May incidents decreased from 100 in April to 98. Of the 98, 20 related to aggression and violence
incidents and 22 the ‘other category’ with a continued trend of staff either hitting into stationery objects or insect bites. Remainder of incidents are spread across the remaining incident types, with a an increase in BBFE incidents of 18 compared to 13 in April, moving and handling incidents remained unchanged at 15 and a slight increase in slips, trips, falls incidents of 10 compared to 7 in April 2019.

Current Issues Update

• Actions following ACC AEP Audit (November 2018):
  a. Worker Participation – Worker Engagement Participation and Representation (WEPR) Agreement (based on Canterbury agreement) draft negotiated with unions at meeting on 29 April and the unions are currently signing the agreement with all parties expected to have signed by June.
  b. Worker Participation – Draft Framework and Policy to be updated following H&S Strategy/Vision work completed and incorporated into the draft documents.
  c. H&S Representative function to update on new initiatives including overview of WEPR Agreement, new in service inspection tool and ‘R U OK’ session.
## Health and Safety Performance Scorecard

### Lagging Indicators

<table>
<thead>
<tr>
<th>Number of Reported Incidents</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>98</td>
<td>-</td>
</tr>
<tr>
<td>Contractors</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Visitor</td>
<td>3</td>
<td>-</td>
</tr>
</tbody>
</table>

Number of injury claims | 25 | <35 | **Green** |
Lost time incidents     | 1   | <5  | **Green** |
Lost time injury frequency rate | 13.8 | <10 | **Red** |
Cost of Injury claims    | $2,219 | -   | **Green** |
Lost time injury severity rate | 397.8 | <630 | **Green** |

### Predominant Incident Profile

- Aggression and Violence: 20
- Moving and Handling: 15
- BBFE: 18
- Slips/ Trips/ Falls: 10

### Leading Indicators

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&amp;S Representative training completed</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Pre employment health screening completed</td>
<td>99%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target or better</td>
<td>Achieved</td>
</tr>
<tr>
<td>95-99.9% 0.1-5% away from target</td>
<td>Substantially achieved</td>
</tr>
<tr>
<td>90-94.9% 5.1-10% away from target*</td>
<td>Not achieved, but progress made</td>
</tr>
<tr>
<td>&lt;90% &gt;10% away from target**</td>
<td>Not achieved</td>
</tr>
</tbody>
</table>

### Indicators in Red

- **LTIFR**
  - 12 month rolling average figure remains above the target at 13.8 (vs target of 10) and slightly lower than April figure of 14.8.

### Indicators in Blue

- **H&S Representative training completed**
  - 16 candidates attended the H&S Representative training session in May 2019.

- **Pre-employment health screening completed**
  - 77 of the 78 new starters had full clearance prior to their start date with the one remaining candidate on restricted duties until full clearance obtained.
LTIFR

The LTIFR rolling average figure of 13.8 a slight decrease on the March figure of 14.7 contrasting with the low February figure. The February individual monthly variance is due to the bulk loading of costs that represent lost time for previous months which should be averaged out across a longer period. The rolling average figure remains reasonably constant.

Discussions and action by WellNZ in backdating the correct LTI figure to appropriate months still to be completed to represent the monthly totals more accurately. The 12 month rolling figure continues to be a more accurate gauge of performance rather than individual month results.

Severity still remains lower during the December to April 2019 period than the October to November peak in 2018.
Injury Claim Data

<table>
<thead>
<tr>
<th>Number of lost days for month</th>
<th>$ total for month</th>
<th>$ total for month</th>
<th>$ total cover cost for month</th>
<th>Total $ cost for month</th>
</tr>
</thead>
<tbody>
<tr>
<td>133.90</td>
<td>21,181.21</td>
<td>10,217.21</td>
<td>14,684.42</td>
<td>46,082.84</td>
</tr>
</tbody>
</table>

Key Health and Safety Risks

CM Health Key H&S risks management update, including key initiatives to reduce/manage risk.

**Key**

- **Green**: Risk is well managed – all significant actions complete
- **Blue**: Risk is well managed - some minor actions to be completed
- **Yellow**: Risk is being managed and has some significant actions underway
- **Red**: Risk is being managed and has some significant actions yet to progress

**Risk: Occupational Health & Safety - Aggression and Violence**

*(Emergency Department, Mental Health, Community Mental Health)*

**Previous Report Action**

- In response to the two staff members who were assaulted in Orakau Road following their night shift, the following action has been taken:
  - Multi-agency forum created to discuss a collaborative approach toward violence, aggression and other social issues and recommendations on best approach to identify and respond to them collectively.
  - Security presence has been boosted at Middlemore hospital and the car parking areas with increased patrolling by security officers supported by the local police force. In addition to:
    - More perimeter fencing for Western Campus
    - Additional lighting
    - Further cameras

**Current Action**

- 3 incidents in April within Tiaho Mai were reviewed by Service Manager and actions to change placement of staff workstations within the open client area will reduce the opportunity for further incidents.
- An incident occurred in May which appears to be similar.
## Risk: Hazardous Substances and New Organisms (HSNO)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • A chemical spill in an equipment cleaning area prompted the checking of spill kit stock and SDS sheets. The spill was contained with no injuries.  
• Hazardous Goods Advisor produced an action plan to ensure emergency items are inspected frequently.  
• Implementation of emergency item inspections across the organization, with spill kits contents inspected as part of the bi-monthly audit. | • Refer to the Facilities report for details.                                  |

## Risk: Contractor Management

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • Policy and procedure developed, stakeholder feedback incorporated. Awaiting approval to publish for organizational use and implementation.  
• Safe365 software reviewed by H&S team following ADHB implementation for management of their Contractors. F&E reviewing the Safe365 option as part of their Contractor Management implementation. | • F&E have taken over the management of Contractor Management and currently recruiting a Contract Manager.  
• Health Alliance and the Auckland DHBs are setting up a regular safety meeting. |

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • A review of other DHBs non-clinical manual handling activities and of evidence based research on the most effective ways to control risks has been undertaken.  
• Application made for ACC Workplace Injury Prevention Grant, 2019 submitted. If approved will work with external organization to produce an e-learning interactive module to identify and manage the non-clinical manual handling risks. | • ACC Workplace Injury Prevention Grant application unsuccessful, awaiting feedback on this decision.  
• Analysis underway of options to develop programme for 2020 delivery and will consider ACC feedback in this. |

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • Research review being undertaken by Occupational Health Nurse and H&S to identify initiatives to reduce incidents.  
• Reviewing other DHB’s injury rates and initiatives to benchmark CMH results. | • Report being prepared by Business Analyst to understand if there are key trends associated with the BBFE’s with report in July/August Board report.  
• BBFE reported total incidents increased from 13 the total of in April to 18 in May 2019. |

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
</table>
- Discussion with non-clinical teams regarding seasonal risks (wet floors) to be aware of increased risk of slips, trips and falls.
- The increase in the Management/Administration team slips, trips and falls incidents has resulted in a review of root cause to help reduce incidents.
- Environmental factors contributed to falls, such as wet surfaces.
- Reported total incidents increased from 7 the total of in April to 10 in May 2019.

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot Leadership H&amp;S module to be delivered in April by EMA facilitator utilizing the ADHB module. Review on effectiveness and possible implementation.</td>
<td>H&amp;S Leadership module delivered by EMA facilitator received positive feedback with 2 further sessions booked for July and October cohorts.</td>
</tr>
<tr>
<td>E-module induction video under development with OD team and expected to be delivered at end of May.</td>
<td>H&amp;S Representative training session completed with 16 staff trained. All cohort passed the NZQA unit standard at first attempt.</td>
</tr>
<tr>
<td></td>
<td>Further work on E-module induction video with initial module launch expected in June/July.</td>
</tr>
</tbody>
</table>

### Risk: Wellbeing – 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>Wellness page on Paanui has been renamed as Wellbeing and resources have been updated on management of fatigue.</td>
<td>Flu campaign – 60% of staff have been vaccinated which is 4,384 people.</td>
</tr>
<tr>
<td>A Wellbeing guide under production in collaboration with ADHB and will be launched to H&amp;S reps at their Hub on 23 May 2019.</td>
<td>All Independent Vaccinators and Peer vaccinators in place and delivering flu vaccinations.</td>
</tr>
<tr>
<td>An abridged version of ‘R U OK?’ programme being trialled with the aim of training additional facilitators and offering to teams across the DHB.</td>
<td>Increase in measles vaccinations and enquiries relating to outbreak of measles cases both presenting at ED and in the community. Information communicated to staff via Daily Dose and OHN team.</td>
</tr>
<tr>
<td>Flu campaign to commence in April 2019.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of incidents related to work related dermatitis with recommendations on how to manage and avoid issues by OHN/OHP team.</td>
<td>Guidance and advice have been provided on various environmental issues.</td>
</tr>
<tr>
<td>Ergonomic review of work service work areas following Manager Referrals have been conducted to improve work environment and reduce potential for injuries in the Discharge lounge; Laboratories and Histology services following their move to new premises.</td>
<td></td>
</tr>
</tbody>
</table>
## Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Documents have been prepared and are with the unions for negotiation.</td>
<td>• Signatures from participating Union Organisers being received.</td>
</tr>
<tr>
<td>• Following the 29 April union negotiation meeting the documentation will be socialized with the GM’s/Service Managers and presented to the ELT H&amp;S Committee at 4 June meeting.</td>
<td>• Worker Participation Agreement Document, once signed, will be reviewed by the GM’s/Service Managers then presented to the Executive H&amp;S Committee when finalized.</td>
</tr>
<tr>
<td></td>
<td>• Work in progress to provide tools for successful implementation and ongoing promotion of worker participation.</td>
</tr>
</tbody>
</table>
Reported Incidents

Rolling year-on-year monthly comparison:

Previous 13 months – 114.2
Current 13 months – 123.7

May monthly figures year on year appear to fluctuate with a high in May 2018. Overall the average has increased which represents the increased reporting on A&V, M&H and BBFE incidents.

Key Observations:

- **Aggression and Violence (20):** Highest reported incident category. Slight decrease from April figure of 33. EMIC had the highest reported incidents. ED continuing capture of incidents within the Code Orange initiative with higher risk incidents being reported within Riskpro.
- **Other (22):** Increased from April figure of 21. Causation profile:
  - Hitting stationary/falling/moving object: 8
  - Laceration/cut/tear: 4
  - Bite/scratch by animal/insect/spider: 3
  - Burn/scratch: 1
  - Crushed/pushed/stepped on: 1
  - Lighting/glare: 1
  - Property damage/vandalism: 1
  - Safety policy violation: 1
  - Trapped between/by moving object: 1
  - Unauthorised access/trespass: 1
- **BBFE (18):** Remains in top three incident rates. Significant increase from the April figure of 13. OHN investigating trend/causation through follow up with services and individuals. Highest incidents continue to occur within SAP service reviewing causation factors to identify areas for improvement.
- **Moving and Handling (15):** Remained unchanged from April figure of 15.
- **Slip/Trip/Fall (10):** Slight increase from April figure of 7.
Aggression and Violence

Rolling year-on-year monthly comparison:
Previous 13 months – 27.2
Current 13 months – 29.2

- 13 Month rolling average figure higher than previous 13 months and continues to be consistently higher due to increase in reporting and awareness.
- ED tracking ‘Code Orange’ trial working with Security Services to better control elevated behaviour.
- EMIC & MH continue to represent highest reported figures with initiatives identified between services, security and H&S to raise awareness and address immediate issues.
- Causation profile:
  - Assault – physical: 11
  - Behaviour – aggressive/threatening: 6
  - Assault – verbal/gesture: 1
  - Assault – sexual: 1
  - Behaviour – inappropriate: 1

BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly comparison:
Previous 13 months – 23.5
Current 13 months – 26

- BBFE incidents significantly lower than last 25 months of reporting: 25 (2017) and 34 (2018).
- SAP service continues to have the highest number of incidents with follow up discussions happening with the service. Inattention/distraction highest cause of incidents.
- OHSS tracking trends and following up with services to reduce reoccurrence.
- Causation profile:
  - Inattention/distraction: 5
  - Patient condition/acts of others: 3
  - Improper work techniques: 2
  - Other: 2
  - Policy/Safety rule violation: 2
  - PPE not used: 2
  - Incorrect equipment: 1
  - Job factor: 1
Moving and Handling

Rolling year-on-year monthly comparison:
Previous 13 months – 21.5
Current 13 months – 22

- Consistent reduction in reported incidents compared to May 2018 figure of 27.
- MMC services slightly higher than other services, but overall total result low for May period.
- H&S team working with non-clinical teams to review M&H training requirements.

Causation profile:
- Action/behaviour of employee or patient/affiliate: 7
- Lifting/carrying/load size/job factors: 4
- Awkward position/posture: 2
- Human factors: 2

Slips, Trips and Falls

Rolling year-on-year monthly comparison:
Previous 13 months – 13.8
Current 13 months – 12.5

- Consistent reduction in reported incidents compared to May 2018 figure of 18.
- EMIC services have the highest incidents at 3.

Causation profile:
- Surface – slippery/wet: 3
- Slipped/tripped/stumbled: 3
- Action/behaviour of employee/awkward posture/position: 2
- Awkward posture/position: 1
- Equipment malfunction/faulty: 1
Reported Incidents Summarised by Workforce and Division

Occupational Health Service Update

Case and Claims Management:

Injury Management claims managed as high risk through WellNZ or low risk through Injury Case Manager at CMH.

Total claims for the April period at 215 and May period at 289 is up from 191 as reported in March 2019. The ratio of accepted and pending remains the same at approximately 40% indicating more than half of the claims are more complex to assess and may require referral to OHP for confirmation.

ACC Audit reviewed CMH and WellNZ Case Management and confirmed that our claim processing and management is aligned with ACC tertiary accreditation guidelines.

Noted that the declined cases have increased to 11 in April and 15 in May with 1 noted in March 2019.

Vaccinations:

Vaccinations administered as part of the pre-employment screening and staff influenza vaccination programme has resulted in full utilization of OHN clinics.

Education/information programme on Measles immunity via Daily Dose and OHN support resulted in increase in MMR vaccinations and proactive immunity testing. This initiative in response to the increase in Measles in New Zealand and cases presenting in EMIC.

Flu vaccinations have been given at time of other immunization/pre-employment screening. Staff Influenza Vaccination Programme officially launched in mid-April with both Peer Vaccinators and OHN administering.
Clinic Appointments:

OHP appointments are high, with full clinics delivering services to:
- Staff returning from injury (RTW/Fitness to work) together with ergonomic evaluations in service.
- Increase in referrals/complexity of cases resulting in longer close out periods.
- OHN clinics are full with PEHS vaccinations; increase in MMR vaccinations and flu vaccinations due to launch of Staff Influenza Vaccination Programme.

Staff non-attendance at clinic appointments has decreased although still high at 12% of total appointments. OHN follow up phone calls to identify key reasons for DNA with illness being a contributing factor.
Summary of Employee Assistance Programme Usage at Counties Manukau DHB – 1/5/18 to 30/4/19
Provided by EAPworks

Consideration is advised of:
- Comparison of usage with other DHBs and other general users to see if our demographics are reflective of others.
- Review of communications about this service.

**Work/Personal Split**

The overall total number of employees who sought help through the Employee Assistance Programme (EAP) during the previous 12 months was 404, made up of 118 employees identifying work related issues as their primary presenting issue and 286 as non-work issues.
Ethnicity Categories

In the year to date the most frequent users of the service within each demographic category has been identified as:

The Ethnicity category **European** representing **51%** of the total identified usage.

Occupational Categories
The occupational category Clinical representing 69% of the total identified usage.
Gender Categories

The gender category **Female** representing **88%** of the total identified.

Age Categories

The Age category **31 ~ 50 yrs.** representing **53%** of the total identified usage.
Information Paper
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 5 June 2019.

Submitted by: Margaret White – Chief Financial Officer

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>AMHU</td>
<td>Acute Mental Health Unit</td>
</tr>
<tr>
<td>ARC</td>
<td>Age Residential Care</td>
</tr>
<tr>
<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
</tr>
<tr>
<td>BOY</td>
<td>Balance of Year</td>
</tr>
<tr>
<td>COC</td>
<td>Cause of Change</td>
</tr>
<tr>
<td>CCDM</td>
<td>Care Capacity Demand Management</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CIC</td>
<td>Capital Investment Committee</td>
</tr>
<tr>
<td>CIO</td>
<td>Chief Information Officer</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community &amp; Public Health Advisory Committee</td>
</tr>
<tr>
<td>CTU</td>
<td>Council of Trade Union</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>FPIM</td>
<td>Finance Procurement &amp; Information Management</td>
</tr>
<tr>
<td>FSA</td>
<td>First Specialist Appointment</td>
</tr>
<tr>
<td>HOP</td>
<td>Health of Older People</td>
</tr>
<tr>
<td>ICR</td>
<td>Investment Confidence Rating</td>
</tr>
<tr>
<td>ICT</td>
<td>Information &amp; Communication Technology</td>
</tr>
<tr>
<td>IDF</td>
<td>Inter District Flows</td>
</tr>
<tr>
<td>LSL</td>
<td>Long Service Leave</td>
</tr>
<tr>
<td>MBIE</td>
<td>Ministry of Business, Innovation &amp;</td>
</tr>
<tr>
<td>MECA</td>
<td>Multi-Employer Collective Agreement</td>
</tr>
<tr>
<td>MERAS</td>
<td>New Zealand College of Midwives</td>
</tr>
<tr>
<td>MMCT</td>
<td>Middlemore Clinical Trials</td>
</tr>
<tr>
<td>MMF</td>
<td>Middlemore Foundation</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NZHPL</td>
<td>New Zealand Health Partnerships Limited</td>
</tr>
<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
</tr>
<tr>
<td>PAYE</td>
<td>Pay As You Earn</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>PSA</td>
<td>The New Zealand Public Service Association</td>
</tr>
<tr>
<td>PVS</td>
<td>Price Volume Schedule</td>
</tr>
<tr>
<td>RISSP</td>
<td>Regional Information Systems Strategic Plan</td>
</tr>
<tr>
<td>SABR</td>
<td>Stereo Ablative Radiotherapy</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>

Purpose

The purpose of this paper is to provide the Board members with an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 5 June 2019.

1.0 30 April Financial Result and Key financial updates

CM Health produced a $752k favourable result against budget for April 2019, YTD $7.1M favourable (refer Table 1 below).

The YTD result is primarily driven by upsides for ACC levy, reduced finance charges (namely interest and depreciation) associated with delay in capital spend, and the impact of vacancies (Management & Admin positions held vacant and the impact of delay to recruit to clinical roles), part offset by delayed savings, under delivery of Electives (workforce and impact of industrial action) and additional costs for SMO cover during industrial action.

As at 30 April the Full Year forecast was $44.8m deficit. This has subsequently improved to $43.206m following confirmation with the MOH regarding forecast Elective delivery.
| Table 1: Statement of Performance by Operating Arm for the period ended 30 April 2019 |
|---------------------------------|---------------------------------|---------------------------------|
| Net Result                      | April 2019                      | Full Year                       |
|                                 | Month                           | YTD                             |                             |
|                                 | Act $000 | Bud $000 | Var $000 | Act $000 | Bud $000 | Var $000 | Bud $000 | Forecast at 30 April 2019 $000 |
|                                 | $000   | $000   | $000   | $000   | $000   | $000   | $000   | $000               |
| Hospital Provider               | (2,443) | (2,771) | 329    | 2,085  | (8,045) | 10,130 | (11,457) | 426                |
| Integrated Care                 | (2,670) | (2,726) | 57     | (27,067) | (27,154) | 87     | (32,590) | (32,802)           |
| Provider                        | (5,113) | (5,498) | 385    | (24,982) | (35,199) | 10,217 | (44,047) | (32,376)           |
| Funder                          | (458)   | (770)   | 311    | (12,012) | (7,817) | (4,194) | (9,357) | (15,222)           |
| Governance                       | 45     | (11)    | 56     | 1,040  | (78)   | 1,119  | (91)   | 2,792              |
| Surplus / (deficit)             | (5,526) | (6,278) | 752    | (35,953) | (43,094) | 7,141  | (53,495) | (44,806)           |

**Provider**

Hospital Provider Position is $329k favourable (YTD $10.130m favourable) to budget. The key drivers remain reduced costs (vs. budget) associated with overall volumes lower than contract (refer table 2), the favourable impact of management and admin vacancies held and delay to recruit clinical roles (refer table 3), together with additional revenue from ACC and Tahitian burns.

Integrated care is on Budget YTD.

**Funder**

The Funder Arm is $311k favourable (YTD $4.194m unfavourable) to budget. The YTD result primarily reflects additional IDF outflows together with delays to secure savings plan revenue initiatives, greater than Budget PHO & Laboratory volumes all offset by Mental and HOP underspends. The favourable month result includes Mental Health underspend claw back from the Provider Arm.

**Governance**

Governance Arm is $56k favourable (YTD $1.119k favourable) to budget driven by a combination of vacancies and gains on sale of assets. These gains are partly offset by unbudgeted costs including savings plan, consulting of $155k, Crown Monitor costs of $30k, NRA fees $265k unfavourable YTD and Board approved legal fees $174k.

**2018/19 Savings Plan**

While many projects are progressing well, the savings programme is well behind target due to a number of factors; namely a significant reduction in the forecast savings attributed to length of stay reductions and bed closures in the Every Hour Counts / Patient Flow portfolios, an inability to achieve any additional revenue in relation to MOH funding reviews, and delay to deliver on a selection of other projects. The latest savings forecast has been taken into account in the consolidated DHB forecast to 30 June 2019 and has been offset by other factors. Services are now working to reset balance of year expectations and confirm opportunities for 2019/20.

**Volume Summary**

Month and YTD acute volumes remain on trend reflecting higher acute demand. April acute volumes are slightly higher to trend indicating the start of Winter. Reduced elective volumes reflect acute pressure across the system, ongoing staff shortages and RDA industrial action. Outsourcing is underway to mitigate under delivery to contract.
Table 2: Volumes for the period ended 30 April 2019

<table>
<thead>
<tr>
<th>Performance vs Contract</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td>General Medicine Inpatients</td>
<td>1,379</td>
<td>1,262</td>
</tr>
<tr>
<td>General Surgery Inpatients</td>
<td>863</td>
<td>808</td>
</tr>
<tr>
<td>Orthopaedic Inpatients</td>
<td>682</td>
<td>634</td>
</tr>
<tr>
<td>Emergency Medical Services Inpatients</td>
<td>390</td>
<td>388</td>
</tr>
<tr>
<td>Paediatric Medicine Inpatients</td>
<td>225</td>
<td>188</td>
</tr>
<tr>
<td>Plastic &amp; Burns - Inpatients</td>
<td>445</td>
<td>474</td>
</tr>
<tr>
<td>Cardiology – Inpatients</td>
<td>264</td>
<td>263</td>
</tr>
<tr>
<td>Respiratory – Inpatients</td>
<td>95</td>
<td>187</td>
</tr>
<tr>
<td>Gynaecology Inpatients</td>
<td>123</td>
<td>148</td>
</tr>
<tr>
<td>Gastroenterology - Inpatients</td>
<td>90</td>
<td>87</td>
</tr>
<tr>
<td>Secondary Neonatal</td>
<td>263</td>
<td>320</td>
</tr>
<tr>
<td>Maternity Inpatients</td>
<td>685</td>
<td>633</td>
</tr>
<tr>
<td>All Others</td>
<td>365</td>
<td>321</td>
</tr>
<tr>
<td><strong>Sub-total ACUTE WIES</strong></td>
<td>5,869</td>
<td>5,711</td>
</tr>
<tr>
<td>Orthopaedic Inpatients</td>
<td>319</td>
<td>428</td>
</tr>
<tr>
<td>General Surgery Inpatients</td>
<td>296</td>
<td>332</td>
</tr>
<tr>
<td>Plastic &amp; Burns - Inpatients</td>
<td>195</td>
<td>244</td>
</tr>
<tr>
<td>Gynaecology Inpatients</td>
<td>78</td>
<td>114</td>
</tr>
<tr>
<td>ORL Inpatients</td>
<td>88</td>
<td>116</td>
</tr>
<tr>
<td>Ophthalmology Inpatients</td>
<td>111</td>
<td>132</td>
</tr>
<tr>
<td>Skin lesions</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Cardiology – Inpatients</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Urology – Inpatients</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td>All Others</td>
<td>19</td>
<td>24</td>
</tr>
<tr>
<td><strong>Sub-total Elective WIES</strong></td>
<td>1,165</td>
<td>1,425</td>
</tr>
<tr>
<td><strong>Total WIES</strong></td>
<td>7,034</td>
<td>7,197</td>
</tr>
<tr>
<td>ED Presentations</td>
<td>9,486</td>
<td>9,529</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance vs Last Year</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This Year</td>
<td>Last Year</td>
</tr>
<tr>
<td>Acute WIES</td>
<td>5,869</td>
<td>5,897</td>
</tr>
<tr>
<td>Elective WIES</td>
<td>1,165</td>
<td>1,425</td>
</tr>
<tr>
<td>Acute Discharges</td>
<td>7,308</td>
<td>7,185</td>
</tr>
<tr>
<td>Elective Discharges</td>
<td>1,142</td>
<td>1,376</td>
</tr>
<tr>
<td>Births</td>
<td>662</td>
<td>653</td>
</tr>
<tr>
<td>ED Discharges</td>
<td>9,486</td>
<td>9,340</td>
</tr>
<tr>
<td>FSA Volumes</td>
<td>3,740</td>
<td>4,109</td>
</tr>
<tr>
<td>FU Volumes</td>
<td>9,658</td>
<td>10,145</td>
</tr>
</tbody>
</table>

Note that procedural volumes are not included in the above chart

**FTE**

April YTD FTE reflect vacancies driven by continued delays to recruit FTE in clinical areas, part offset by outsourcing and the impact of the April FTE nursing movement due to an accrued stat days credits provision for Easter, unbudgeted FTE for approved initiatives (Funded CCDM, E-Vitals, E-Prescribing) and a lower uptake of annual leave against expectation. The Management and Admin vacancy reflects deliberate hold on positions and/or rolling vacancies.
The full Financial Variance Report for the period ended 30 April 2019 is presented in Appendix 1 of this report.
Appendix 1 – Financial Report for the period ended 30 April 2019

YTD 30 April 2019 the consolidated result is $7.141m favourable to budget.

Table 4: Statement of Revenue and Expenditure for the period ended 30 April 2019

<table>
<thead>
<tr>
<th>Net Result</th>
<th>April 2019</th>
<th>Full Year Budget</th>
<th>Forecast as at 30 April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Year to Date</td>
<td>Bud Var</td>
</tr>
<tr>
<td></td>
<td>Act Bud Var</td>
<td>Act Bud Var</td>
<td>Bud Var</td>
</tr>
<tr>
<td></td>
<td>$000 $000 $000</td>
<td>$000 $000 $000</td>
<td>$000 $000 $000</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>139,408 140,816 (1,408)</td>
<td>1,409,275 1,408,578 697</td>
<td>1,690,239 1,691,618</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>3,576 2,963 613</td>
<td>36,028 29,770 6,259</td>
<td>35,706 44,713</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>142,984 143,779 (795)</td>
<td>1,445,303 1,438,347 6,956</td>
<td>1,725,945 1,736,331</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>58,150 58,747 597</td>
<td>552,232 568,805 16,574</td>
<td>683,283 664,598</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,164 998 (166)</td>
<td>17,382 9,199 (7,463)</td>
<td>11,913 20,846</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>5,806 6,016 210</td>
<td>61,773 58,294 (3,479)</td>
<td>70,194 75,191</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>60,832 61,076 244</td>
<td>618,701 610,877 (7,825)</td>
<td>733,028 743,059</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>10,301 10,160 (141)</td>
<td>102,692 103,152 459</td>
<td>124,564 124,657</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>6,226 6,790 564</td>
<td>67,246 67,690 444</td>
<td>81,211 79,756</td>
</tr>
<tr>
<td>Operating Expenditure</td>
<td>142,478 143,786 1,308</td>
<td>1,420,026 1,418,736 (1,290)</td>
<td>1,704,192 1,708,107</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>506 (8) 513</td>
<td>25,277 19,611 5,666</td>
<td>21,753 28,224</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,941 3,163 222</td>
<td>30,322 31,629 1,307</td>
<td>37,955 36,206</td>
</tr>
<tr>
<td>Interest</td>
<td>- - -</td>
<td>- - -</td>
<td>- - -</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>3,091 3,108 17</td>
<td>30,908 31,077 169</td>
<td>37,292 36,824</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(5,526) (6,278) 752</td>
<td>(35,953) (43,094) 7,141</td>
<td>(53,495) (44,806)</td>
</tr>
</tbody>
</table>

Commentary on Major Variances:

**Crown Revenue**

April 2019 month was $1.408m unfavourable to budget (YTD $697k favourable), reflecting the following:
- Delay to secure savings plan revenue initiatives $445k unfavourable (YTD $4.4m unfavourable);
- Mental Health and Health of Older People unbudgeted pay equity $397k favourable (YTD $4.0m favourable) with matching additional costs in provider payments;
- IDF inflows adjustment to contract YTD $1.5m favourable;
- Additional ACC arrears revenue YTD $644k favourable
- Additional MECA funding YTD $1.2m favourable;
- HWNZ training costs, invoiced ahead of plan $106k favourable (YTD $621k favourable);
- Breast screen revenue adjustment $78k unfavourable (YTD $430k unfavourable); and
- Bowel screening volumes variance to contract $32k unfavourable (YTD $593k unfavourable).
Crown Revenue - Elective Programme

- Anaesthetic Consultant shortfalls, Day of Surgery cancellations and the impact of the RDA strikes have resulted in underdelivery predominantly in General surgery, ENT services, Gynaecology and Ophthalmology. As at 30 April 2019 the MOH elective programme is tracking 4.8% (1,041 WIES) behind contract, reflecting an adverse position of $1.7m for the month (YTD $5.3m unfavourable).
- A level of additional outsourcing has been approved to meet the MOH elective discharge target to mitigate the introduction of capped volumes for skin lesion activity.
- The DHB is working with the MOH regarding the recognition of additional ambulatory volumes.

Other Revenue

April 2019 month was $613k favourable to budget (YTD $6.259m favourable), reflecting the following:
- Favourable timing of Pacific contract revenue (offset by cost) $26k favourable (YTD $1.6m favourable);
- Retail pharmacy sales $36k unfavourable (YTD $703k favourable), reflecting growth in sales (offset by COGs);
- Tahitian burns additional billing $62k unfavourable (YTD $1.163m favourable), reflecting higher demand in 2019;
- Interest received $103k favourable (YTD $880k favourable) due to better than Budget cash position;
- Research grants received from MMCT YTD $544k favourable;
- Bad debts recovered $402k favourable; and
- Child and Youth donations from MMF YTD 935k favourable.

Personnel and Outsourced Personnel

Net personnel costs for April are $431k favourable (YTD $9.111m favourable), reflecting the continued vacancies across the services (delay to recruit and services holding non clinical admin vacancies where appropriate) and the impact of industrial action has resulted in FTE and dollar costs under budget, with partial offsets in YTD unrealised savings and outsourced personnel.

Internal and external bureau has been used to cover existing vacancies and annual leave during the year. Clinical bureau engagement is driven mainly by demand in General Medicine, additional theatre sessions in Orthopaedic and Plastic Surgery as well as specials and watches required in the Burns Unit.

Actual FTE’s including outsourced were 75 FTE favourable YTD.

The April YTD result also includes the following adjustments:
- SMO Claims for four RDA strikes $2.147m unfavourable;
- The ongoing cost impact of the ETU MECA for Support Staff, now settled, being $1.4m unfavourable;
- Accrue stat days credits provision $671k unfavourable;
- Accrual for LSL and Gatruities in line with expected year end actuarial valuation $2.0m unfavourable;
- Release of ACC Levy provision following confirmation of ACC employer status $2.827m YTD favourable; and
- Favourable release of residual balances of settled MECA’s (PSA AH, PSA Nursing, ETU & NZNO) of $2.66m.

Outsourced services

Outsourced Services were $210k favourable (YTD $3.479m unfavourable) driven by the following:
- Pacific contract costs higher than budget, offset by revenue, $10k favourable (YTD $1.393m unfavourable);
• An agreed overspend in Surgical services to meet the MOH Elective contract, $142k favourable (YTD $1.15m unfavourable); and
• An increased YTD MRI outsourcing due to staff shortages and delayed implementation of new machines, $159k unfavourable (YTD $1.221m unfavourable). Note that additional MRI outsourcing of $1.6m has been included in the forecast result.

Provider Payments
April was $244k favourable to budget (YTD $7.825m unfavourable), reflecting the following:
• IDF wash up provisioning greater than budget, primarily ADHB $500k unfavourable (YTD $8.8m unfavourable);
• Mental Health unbudgeted pay equity $397k (YTD $4.0m unfavourable), offset by revenue;
• Maori Health savings target shortfall $64k unfavourable (YTD $564k unfavourable), and the remaining balance being partly offset by additional revenue;
• offset by Mental Health & HOP underspends $900k favourable (YTD $6.3m favourable.)

Clinical supplies
April was $141k unfavourable (YTD $459k favourable) reflecting the following:
• Demand driven volume related reduced spend, in part due to the RDA strikes and outsourcing of clinical procedures have contributed to the favourable variance in clinical supplies, largely in cancer drugs, renal fluids, bloods, diagnostics, shunts & stents as well as prostheses; and
• Unrealised savings in Provider of $294k month (YTD $2.8m unfavourable) and unbudgeted costs associated with additional Tahitian Burns patients offset by lower clinical equipment leasing costs $59k favourable (YTD $961k favourable).

Infrastructure costs
April was $564k favourable to budget (YTD $444k favourable), reflecting the following:
• Cost of goods sold increase due to higher pharmacy sales (offset by revenue) $40k (YTD $729k);
• Offset by gain on sale of land in August 2018 (YTD $377k) that was not accounted for in 2017/18; and
• Unrealised Provider Arm savings $185k unfavourable (YTD $1.4m), related to Lambie Drive property leases, infrastructure costs attributed to bed closures and environmental sustainability.
<table>
<thead>
<tr>
<th></th>
<th>Act $ 000</th>
<th>Budget $ 000</th>
<th>Var $ 000</th>
<th>Mar-19 $ 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>47,812</td>
<td>(11,779)</td>
<td>59,591</td>
<td>36,994</td>
<td>10,818</td>
</tr>
<tr>
<td>Trust</td>
<td>2,843</td>
<td>833</td>
<td>2,010</td>
<td>2,840</td>
<td>3</td>
</tr>
<tr>
<td>Prepayments</td>
<td>1,745</td>
<td>637</td>
<td>1,108</td>
<td>1,692</td>
<td>53</td>
</tr>
<tr>
<td>Debtors</td>
<td>54,951</td>
<td>57,694</td>
<td>(2,743)</td>
<td>50,085</td>
<td>4,866</td>
</tr>
<tr>
<td>Inventory</td>
<td>8,113</td>
<td>8,465</td>
<td>(352)</td>
<td>8,605</td>
<td>(492)</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>120,792</td>
<td>61,178</td>
<td>59,614</td>
<td>105,544</td>
<td>15,248</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>676,268</td>
<td>686,386</td>
<td>(10,118)</td>
<td>638,077</td>
<td>38,191</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>4,162</td>
<td>-</td>
</tr>
<tr>
<td>Information Software</td>
<td>662</td>
<td>693</td>
<td>(31)</td>
<td>662</td>
<td>-</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>2,557</td>
<td>4,850</td>
<td>(2,293)</td>
<td>2,645</td>
<td>(88)</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>897,893</td>
<td>910,351</td>
<td>(12,458)</td>
<td>859,790</td>
<td>38,103</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(207,374)</td>
<td>(213,013)</td>
<td>5,639</td>
<td>(204,523)</td>
<td>(2,851)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>690,519</td>
<td>697,338</td>
<td>(6,819)</td>
<td>655,267</td>
<td>35,252</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>46,942</td>
<td>55,261</td>
<td>(8,319)</td>
<td>83,870</td>
<td>(36,928)</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>737,461</td>
<td>752,599</td>
<td>(15,138)</td>
<td>739,137</td>
<td>(1,676)</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>46,445</td>
<td>56,912</td>
<td>(10,467)</td>
<td>46,445</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>904,698</td>
<td>870,689</td>
<td>34,009</td>
<td>891,126</td>
<td>13,572</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>118,593</td>
<td>94,840</td>
<td>23,753</td>
<td>106,126</td>
<td>12,467</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>11,481</td>
<td>6,429</td>
<td>5,052</td>
<td>11,473</td>
<td>8</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>17,599</td>
<td>23,073</td>
<td>(5,474)</td>
<td>18,567</td>
<td>(968)</td>
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<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>21,955</td>
<td>14,275</td>
<td>7,680</td>
<td>17,604</td>
<td>4,351</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>118,700</td>
<td>109,999</td>
<td>8,701</td>
<td>115,423</td>
<td>3,277</td>
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<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>288,328</td>
<td>248,616</td>
<td>39,712</td>
<td>269,193</td>
<td>19,135</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(167,536)</td>
<td>(187,438)</td>
<td>19,902</td>
<td>(163,649)</td>
<td>(3,887)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>616,370</td>
<td>622,073</td>
<td>(5,703)</td>
<td>621,933</td>
<td>(5,563)</td>
</tr>
</tbody>
</table>
### Commentary on Major Variances:

- **Closing bank was $59.591 m favourable to budget.** Net cash flows from operations (revenue, expenses and payroll) were $4.385m favourable to budget. (refer cash flow variance explanation for further details).

- **Debtors were $2.743m lower than Budget as a result of improved collections and timing differences.**

- **Net Fixed Assets and Investment in Associates are $25.605m 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 are still in progress).**

- **Creditors are $23.753m favourable to Budget due to timing differences in Accounts Payable.**

- **Income In Advance was higher than Budget by $5.052m largely due to recovery of a bond for the AMHU Project now transferred from Accrued Creditors, and timing of revenue received.**

- **Employee entitlements were $8.701m greater than budget mainly reflecting timing of payroll accruals including $2m accrual ahead of the year end actuarial valuations for Long Service Leave and Gratuities.**

- **The favourable working capital variance to Budget of $19.902m is mostly attributable to the timing matters detailed above.**

- **Crown equity variance of $14.806m reflects the delay in commencing Stage 2 of AMHU, resulting in less than forecast drawdowns in our equity injection funding.**
### Table 7: Statement of Cash flow for the period ended 30 April 2019

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th></th>
<th></th>
<th></th>
<th>YTD</th>
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<th></th>
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<tr>
<td></td>
<td>Act $ 000</td>
<td>Budget $ 000</td>
<td>Var $ 000</td>
<td>Act $ 000</td>
<td>Budget $ 000</td>
<td>Var $ 000</td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from Operating activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>134,540</td>
<td>140,579</td>
<td>(6,039)</td>
<td>1,145,772</td>
<td>1,407,333</td>
<td>8,439</td>
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<tr>
<td>Other</td>
<td>3,422</td>
<td>2,837</td>
<td>585</td>
<td>34,591</td>
<td>29,199</td>
<td>5,392</td>
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<tr>
<td>Cash was applied to:</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(75,491)</td>
<td>(78,442)</td>
<td>2,951</td>
<td>(861,409)</td>
<td>(865,777)</td>
<td>4,368</td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>(50,521)</td>
<td>(57,409)</td>
<td>6,888</td>
<td>(534,249)</td>
<td>(561,936)</td>
<td>27,687</td>
<td></td>
</tr>
<tr>
<td>Capital charge</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(18,545)</td>
<td>101</td>
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<tr>
<td><strong>Net cash from Operations</strong></td>
<td>11,950</td>
<td>7,565</td>
<td>4,385</td>
<td>36,160</td>
<td>(9,827)</td>
<td>45,987</td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from Investing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(1,265)</td>
<td>(4,723)</td>
<td>3,458</td>
<td>(22,741)</td>
<td>(49,203)</td>
<td>26,462</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>(100)</td>
<td>100</td>
<td>(447)</td>
<td>(3,173)</td>
<td>2,726</td>
<td></td>
</tr>
<tr>
<td>Interest rec.</td>
<td>161</td>
<td>58</td>
<td>103</td>
<td>1,463</td>
<td>583</td>
<td>880</td>
<td></td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>(37)</td>
<td>-</td>
<td>(37)</td>
<td>(9)</td>
<td>1,978</td>
<td>(1,987)</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(1,141)</td>
<td>(4,765)</td>
<td>3,624</td>
<td>(21,734)</td>
<td>(49,815)</td>
<td>28,081</td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from Financing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>12</td>
<td>-</td>
<td>12</td>
<td>356</td>
<td>-</td>
<td>356</td>
<td></td>
</tr>
<tr>
<td>Crown Equity funding/other reserves</td>
<td>-</td>
<td>4,121</td>
<td>(4,121)</td>
<td>1,779</td>
<td>16,580</td>
<td>(14,801)</td>
<td></td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td>12</td>
<td>4,121</td>
<td>(4,109)</td>
<td>2,135</td>
<td>16,580</td>
<td>(14,445)</td>
<td></td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>10,821</td>
<td>6,921</td>
<td>3,900</td>
<td>16,561</td>
<td>(43,062)</td>
<td>59,623</td>
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</tr>
<tr>
<td><strong>Opening cash</strong></td>
<td>39,842</td>
<td>(18,692)</td>
<td>58,534</td>
<td>34,102</td>
<td>31,291</td>
<td>2,811</td>
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</tr>
<tr>
<td><strong>Closing cash</strong></td>
<td>50,663</td>
<td>(11,771)</td>
<td>62,434</td>
<td>50,663</td>
<td>(11,771)</td>
<td>62,434</td>
<td></td>
</tr>
<tr>
<td><strong>Reconciliation Summary</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Surplus/(Deficit)</strong></td>
<td>(5,526)</td>
<td>(6,277)</td>
<td>750</td>
<td>(35,953)</td>
<td>(43,092)</td>
<td>7,140</td>
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<tr>
<td>Add/(Less) non-cash items</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,942</td>
<td>3,164</td>
<td>(222)</td>
<td>30,329</td>
<td>31,630</td>
<td>(1,301)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2,584)</td>
<td>(3,113)</td>
<td>528</td>
<td>(5,624)</td>
<td>(11,462)</td>
<td>5,839</td>
<td></td>
</tr>
<tr>
<td><strong>Add/(Less) items Classified as Investing or Financing activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on Disposal</td>
<td>(12)</td>
<td>-</td>
<td>(12)</td>
<td>(882)</td>
<td>-</td>
<td>(882)</td>
<td></td>
</tr>
<tr>
<td><strong>Add/(Less) Movements in Financial Position items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors and Other Receivables</td>
<td>4,919</td>
<td>(296)</td>
<td>5,215</td>
<td>(391)</td>
<td>(1,827)</td>
<td>1,436</td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>(492)</td>
<td>75</td>
<td>(567)</td>
<td>(414)</td>
<td>62</td>
<td>(476)</td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>(9,534)</td>
<td>10,899</td>
<td>(20,432)</td>
<td>(7,320)</td>
<td>3,400</td>
<td>(10,721)</td>
<td></td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>19,653</td>
<td>-</td>
<td>19,653</td>
<td>50,791</td>
<td>-</td>
<td>50,791</td>
<td></td>
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<tr>
<td></td>
<td>14,546</td>
<td>10,678</td>
<td>3,869</td>
<td>42,666</td>
<td>1,635</td>
<td>41,030</td>
<td></td>
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<tr>
<td><strong>Net Cash flow from Operations</strong></td>
<td>11,950</td>
<td>7,565</td>
<td>4,385</td>
<td>36,160</td>
<td>(9,827)</td>
<td>45,987</td>
<td></td>
</tr>
</tbody>
</table>
Commentary on Major Variances for the month:

- Cash-flow from Crown Revenue is $6.039m favourable to budget, reflecting variances noted under table 7 above.

- Payments to suppliers were $2.951m lower than budget mainly as a result of variations to the planned timing of supplier payments in the budget.

- Employee Payments were $6.888m favourable to budget representing the timing of the payment of payroll accruals and vacancies.

- Fixed Assets $3.458m favourable to budget representing the delayed timing of capital spend for major capital projects.

- Crown Equity funding was unfavourable to Budget by $4.121m as no equity injection was required given the slower capital spend on the Acute Mental Health Unit and the Scott building re-clad projects.
Counties Manukau District Health Board
1st Draft 2019/20 Northern Region Service Plan

Recommendation

It is recommended that the Board:

Receive the first draft Regional Service Plan for review and endorsement.

Note this paper was endorsed by the Executive Leadership Team on 4 June to go forward to the Board.

Note that the Northern Region Service Plan is being drafted by the NRA to meet the requirements outlined in MoH guidance.

Note that the attached document is a ‘work in progress’ draft, required to be shared with the Ministry to enable early comment upon the content of our Region’s plan.

Note that further changes are expected to this plan and any feedback from this meeting will be used to influence further versions of the Regional Plan.

Note that, in line with the Regional Governance Manual as previously agreed, delegations for Regional Service plan sign-off to Board Chairs already exist. This will permit the regional plan to be presented to the MoH as a signed-off and finalised document within the current 21 June 2019 target timeframe.

Note that the final Regional Plan will be provided back to each of the Northern Region Boards, for information, once agreed by the DHB Board Chairs via the Regional Governance Group forum.

Approve and reconfirm that delegation of authority for final sign-off of the Regional Service Plan be given to the Regional Governance Group comprising our Region’s DHB Chairs.

Prepared and submitted by: Prepared By: Tony Phemister Portfolio Manager NRA and approved by Peter Huskinson CEO NRA

Glossary

CEO - Chief Executive Officer
CMO - Chief Medical Officer
MoH - Ministry of Health
NRA - Northern Regional Alliance
NRLTHP - Northern Region Long Term Health Plan
NRLTIP - Northern Region Long Term Investment Plan
NRSP - Northern Region Service Plan
OPF - Operating Policy Framework

Executive Summary

This paper’s purpose is to inform the Board on progress made developing the Northern Region Service Plan (NRSP) for 2019/20, to provide an opportunity for Board review and feedback on this first draft and to seek endorsement for this early ‘work in progress’ version which is to be shared with the Ministry of Health before the end of May 2019. Any feedback from the Board will be used to develop subsequent drafts. This first draft has been reviewed by the CEOs and CMOs prior to submission.
Introduction/Background

The NRSP is collated by the Northern Regional Alliance (NRA) on behalf of the four northern region DHBs. It is developed to demonstrate that regional planned work is consistent with the Ministry of Health (MoH) 2019/20 Annual Planning Guidelines, and to provide national assurance that as a Region, we are progressing actions that meet the national expectations for 2019/20. This first draft NRSP 2019/20 outlines work that will be progressed via regional mechanisms across our DHBs over the coming year.

This NRSP highlights only a subset of the total health plan work that will be progressed within the Northern Region during 2019/20. Our broader Northern Region health planning work includes work to: deliver upon our Northern Region Long Term Investment Plan (NRLTIP) Jan 2018; strengthen our health service design and implementation work; strengthen the regional ‘enabler’ functions of capital, workforce and IS/IT planning. Elements of our wider agenda of regional work have been noted in this NRSP where it is helpful to demonstrate the strong alignment with the national work areas of interest. This NRSP leverages upon the work that our Region has previously undertaken within the NRLTIP process, and builds on the successes and lessons learned over the last year.

The NRSP approach has been taken in order to ensure that the Minister and MoH requirements for Regional Service Plans do not detract or shift resource from the Northern Region Long Term Health Planning work that is a priority for our Region. The approach minimises the potential requirement for additional regional work by demonstrating the alignment between what we have already planned, and have in-train, and the nationally identified areas of focus and expectations for regional service planning work.

The NRSP draft will be submitted to the Ministry of Health as an ‘early draft’, to enable early MoH review and feedback on the content of the Regional plan. The plan signals that our Region remains committed to the intent of not trying to address every challenge in our region but rather to focus on priority areas to address sustainability (clinical and financial) and address inequalities.

This year the Regional Service Plan continues to place a particular emphasis upon actions to:

- Set strategic direction and to implement change reflecting the priorities established in the long term planning work initiated under the NRLTIP, Jan 2018
- Address the national work requirements of the NZ health regions as communicated by the Ministry of Health.

Our Region is committed to making strong progress with regard to these areas, notwithstanding the fact that they present significant challenges. The regional emphasis on quality and safety, as well as equity, is woven through all the regional plan work-streams.

Progress to Date

This first draft NRSP should be considered a ‘work in progress’ recognising that there are still elements that require further work and clarification, in ongoing consultation with stakeholders within our Region; and with the MoH.

This first draft of the NRSP has been reviewed at the Regional Executive Forum held on the 17th May. At that meeting our four DHB CEOs and CMOs have:

- Agreed the first draft NRSP for submission to the Ministry of Health as ‘work in progress’
- Noted that further work is required to develop the Plan, the implementation plans, targets and milestones for each workstream and the alignment of this Plan with DHBs’ Annual Plans.

This work is to be completed prior to submission of the final draft of the NRSP.
Timelines and Regional Sign-Off

At this point in time the regional planning process is working to a 21 June 2019 final draft submission deadline. The Ministry has indicated that the indicated final draft submission date of 21 June may be extended to reflect the national budget process, but this is not yet confirmed.

To meet the 21 June 2019 deadline the Final Draft NRSP 2019/20 is currently planned to be taken via the Regional Executive Forum to the Regional Governance Group for DHB Chair sign-off. This is in accordance with the Regional Governance Manual, previously agreed by DHB Boards, which notes Boards’ delegation of the Regional Service Plan sign off to the Regional Governance Group comprising District Health Board Chairs. This sign off process will permit the Northern Region Service Plan to be presented to the MoH as a finalised document within the indicated 21 June target timeframe.

The signed-off Final Regional Plan will be provided back to each of the Northern Region Boards, for information, in parallel with, or following the submission of the Final NRSP to the MoH, as Board meeting schedules permit.

Conclusion

We are committed to working regionally and locally to deliver the goals and initiatives indicated in this draft Plan. We understand the benefits from working collaboratively within our Region. Our collective efforts can realise better outcomes if we make the best use of our resources. The collegial approach demonstrated by our senior clinicians and managers ensures strong leadership in meeting our strategic goals.

We look forward to feedback on this first draft, while the NRA continues to refine the NRSP 2019/20 to ensure it meets expectations and enables our Region to achieve real gains in the coming year.

Appendix

1. Northern Region Service Plan – Implementation Element 19/20
The Northern Region Service Plan
Implementation Element 2019/20

Long Term Plan Year 2

DRAFT 1.1
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1. Overview

The Northern Region Service Plan further expands the region’s substantive commitment to region-wide collaboration

In 2018 the Minister of Health approved the northern region’s long term investment plan, which is the cornerstone of the long term plans for each DHB to meet the region’s unique fast growing population needs and complexity in a way that is sustainable for our finances, our workforce, and for clinical practice.

The year 2019/20 represents the second year of the health blueprint set out in that plan and builds on the progress delivered in 2018/19. The arrangements for taking forward the key reforms to every sector of care have been thoroughly refreshed and reflect a move, from strategic design, to the specification, detailed design, commissioning and monitoring of changes to build a high performing health system that realises our long term vision. The 2019/20 plan will continue to respond to significant changes in the Iwi partnership arrangements to impact on the totality of our healthcare reform programme.

The strategic planning agenda for the year ahead includes delivering on the four 18 month deep dive focus projects that were initiated in 2019/20, and progressing the implementation of those deep dives that have already reported their recommendations.

The underlying demand and capacity model has an agreed maintenance schedule for all key variables to respond to: significant change; refreshed national and regional data availability; updating for the capital approvals status of our proposals; and the latest assessment of delivery timelines. The update of the model which will be concluded later this year.

Our regional service plan also reflects a full commitment to excel in the five service areas that are recognised, nationally, as common priorities for all four regions:

- Building on the strong data and digital portfolio that is set out in our long term investment plan.
- Providing clarity on five high impact workforce initiatives, which form one part of a wider deep dive focus on workforce being undertaken across our region.
- Continuing to build on and expand our ambitions to eliminate hepatitis C as a major public health concern ahead of 2030 in line with international commitments.
- Incorporating into our region's well established cardiovascular services and stroke services clinical networks the assurance we are delivering on the 7 national priorities.
- Taking forward our collaborative work on healthy aging, both through our population and public health deep dive, and through cross project initiatives aimed to ‘bend the curve’ and moderate demand for care through extending healthy life expectancy. This collaborative work will place a continued focus on prevention and earlier intervention to reduce the future burden of disease.

The New Zealand government’s planning priorities are reflected in our region either in the work programme of a well-established network, or a dedicated deep dive focus. These work areas draw together experts and stakeholders to pursue in more detail the direction of travel set out in the northern region long term investment plan.

Our strategic development and regional plans for 2019/20 compliment work being undertaken at DHB levels. Support of strong fiscal management, and improved supply side productivity and efficiency is a key test of our implementation work-streams.

In many cases the northern region delivers outstanding services, sometimes in challenging circumstances. We have a highly committed workforce that continually strives to deliver high quality care. The northern region is committed to the New Zealand triple aim. We are focussed on ensuring that the capacity and capability of our regional health delivery system is ready to meet demand. We will do this in a manner that maximises value from available resources; working to improve the health and equity of our populations and the quality, safety and experience of care delivered to individuals and whānau.
Our plans for 2019/20 reflect our increasing conviction from all the regional work we have undertaken; we can no longer think, and operate, primarily within the confines of DHB boundaries. We must integrate and share resources, assets and services in order to provide the very best services to the people living in our region. To continue to deliver on the triple aim, we are making a step change in how we think about, and provide, healthcare in the northern region. A **whole of system approach is the key concept driving change.**

Having worked together to develop a shared approach to strategic planning for our future needs, we now need to ensure that the same joined-up-thinking and approaches translate into the detailed design and specifications of services, and the delivery of changes in how we invest in, deliver, monitor and evaluate clinical care. We have established new regional implementation governance to progress this approach.

Many of our focus areas will require greater integration across the community-hospital interface. We will drive clearer delineation between services at our major hospitals, local hospitals and those sites with elective surgery focus. A shift toward providing greater access in primary and community settings, and ensuring diagnostic services are fit for purpose has emerged as a strong goal in our long term planning. We are also working on ways to provide greater capability for people to self-care and better manage long term conditions.

We are still progressing strategy and implementation initiatives through defined portfolio and programme mechanisms. In 2019/20 the long term health planning **portfolio** of work will be progressed under five programmes of work:

- Health Service Design
- Health Service Implementation
- Facilities and Infrastructure
- Capital Process Improvement
- Information Systems

2. **Introduction**

In this 2019/20 northern region service plan we set the expectations for the financial/planning year that are required to meet our legislative, national and regional expectations to deliver an effective, safe and efficient healthcare system. This plan represents the key items we will work on regionally to improve health outcomes and reduce inequities for the 1.87 million people living in the northern region.

Our strategic direction aligns with other regional and national strategic directions, these include:

1. The New Zealand healthcare triple aim
2. The New Zealand Health Strategy
3. The Northern Region Long Term Investment Plan 2018
4. Other contextual plans, such as: the NZ Disability Strategy, DHB Strategic and Annual plans, Māori health plans, and the Healthy Ageing Strategy.

This plan details areas of focus where the region:

- Particularly wants to see improvement in current service arrangements, and we believe that working regionally will enable this to happen.
- Wishes to improve financial, clinical or service sustainability.
- Has identified important initiatives that it makes sense to progress once, in a collaborative and consistent manner rather than independently by each DHB.
- Believes collaborative work as a regional health system will make a real difference in:
  - Health status and health equity for our populations
  - Patient and whānau experience of care and the quality, safety and outcomes of care
  - Our ability to meet the needs of our growing aging and changing population in a clinically and financially sustainable way

This action plan details our priority objectives, actions, timelines and accountabilities. It has been designed to provide a structured mechanism for our DHBs to document the regional collaboration efforts and to align service and capacity planning in a deliberate way.
The initiatives identified in this plan are primarily concerned with either:

- Further clarifying the Region’s strategic direction of travel or future models of care including ensuring mainstream services become more responsive to the needs and aspirations of Māori in order to improve health outcomes for Māori
- Delivering explicit outcomes, according to the schedule of changes that we need to make to meet future demands and to improve our services, or
- Driving process improvements through measurement, reporting and activity monitoring

3. Te Tiriti o Waitangi - Progressing our commitments together

The northern region DHBs recognise and respect Te Tiriti o Waitangi a key founding document for New Zealand. As Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi, it provides a framework for Māori development, health and wellbeing in the region.

The New Zealand Public Health and Disability Act 2000 also outlines DHB requirements to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

The region commits to ensuring this RSP is taken forward in line with the legislative obligations of DHBs as Treaty partners and DHB obligations for improving outcomes and achieving health equity for Māori. Te Tiriti o Waitangi provide us with a conceptual and consistent framework for Māori health gain across the health sector and the articles of Te Tiriti provide four domains under which Māori health priorities for the Northern region DHBs can be established, monitored and developed. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

**Article 1** – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the Northern region DHBs’ provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequalities. It provides for active partnerships with mana whenua at a governance level.

**Article 2** – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB’s individual and collective activities across the region.

**Article 3** – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

**Article 4** – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Our DHBs commit to realize their Tiriti obligation to honour the beliefs, values & aspirations of Māori patients & whānau, staff and wider communities across all activities.

Recently two Iwi Partnership Boards (Northern for Northland, Waitematā and Auckland DHBs and a Southern partnership incorporating Counties Manukau & Waikato DHBs) have been established. These Te Tiriti o Waitangi based partnerships have been established in recognition of the mana and authority of both Māori and the Crown. The articles of Te Tiriti focus these partnerships on governance and decision making in health that achieves rangatiratanga/self-determination and health equity for Māori. Each partner also recognises the knowledge, aspirations and resources that they collectively bring to fulfil joint purpose and goals.

It is anticipated that these regional partnership boards will build upon existing local partnerships and joint work between DHBs and iwi (mana whenua and mataawaka) by providing a platform for coordinated efforts to achieve intergenerational wellbeing for whānau Māori in the Northern region. Our regional plans represent a snapshot which we anticipate will be further shaped as we take forward these new arrangements, with the origination of priority areas of focus, as well as approaches to implementation of change, informed by our partnerships.
4. Progressing Equity in the health of our communities

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. Improving health outcomes for Māori and Pacific peoples and making measurable progress towards achieving equity of health outcomes and reducing the equity gap is expected to underpin regional activity.

This expectation is commensurate with the DHBs legislative obligations in the NZ Public Health and Disability Act 2000 which requires DHBs “to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders”.

We have a focus on complementing the plans taking place in each DHB that address equity gaps wherever they occur for any subpopulations not well served by existing universal health services. Reducing gaps in health outcomes between different groups based on ethnicity, deprivation, age, gender, disability and location informs our priorities and the way we implement change:

Key examples of work underway include:
- Development of an equity model for our regional cancer services
- Newly initiated work in community and primary care
- Enhanced regional workforce initiatives with a particular focus on supporting the capacity and capability of our Māori and Pacific workforce including ensuring opportunities for these groups to partner with us in developing and implementing plans to achieve health equity for our population.

4.1 Māori Health

Māori health equity and accelerating Māori health gain is a priority for this plan and the region is committed to working collaboratively with the Māori health teams and the iwi partnership boards to achieve this.

In addition to the guidance provided by mana whenua, our Māori workforce and our Māori patients and whānau, our equity approaches for improving Māori health will be guided by He Korowai Oranga, Māori Health Strategy, the Equity of Health Care for Māori Framework, and the Whānau Ora Health Impact Assessment.

He Korowai Oranga has an overarching goal of pae ora, which translates to healthy futures for Māori.

*Figure 1: He Korowai Oranga*
Pae ora consists of wai ora (healthy environments), whānau ora (healthy families) and mauri ora (healthy individuals). Pae ora encourages everyone in the health and disability sector to work collaboratively, and to work across sectors to achieve a wider vision of good health for everybody.

The four pathways of the original He Korowai Oranga framework continue to tell us how to implement the strategy. These pathways are:

- Supporting whānau, hapū, iwi and community development
- Supporting Māori participation at all levels of the health and disability sector
- Ensuring effective health service delivery
- Working across sectors

Equity of Health Care for Māori: A framework guides health practitioners, health organisations and the health system to achieve equitable health care for Māori. There are three actions that support the framework.

- Leadership: by championing the provision of high quality health care that delivers equitable health outcomes for Māori
- Knowledge: by developing a knowledge base about ways to effectively deliver and monitor high quality health care for Māori
- Commitment: to providing high quality healthcare that meets the healthcare needs and aspirations of Māori

4.2 Pacific Health

The Region is committed to working collaboratively with the Pacific Health teams to accelerate Pacific Health gain. Our approach to improving Pacific health is guided by A’la Mo’ui: Pathways to Pacific Health and Wellbeing which is the Government's national plan for improving health outcomes for Pacific peoples, families and communities.

A’la Mo’ui has four priority outcome areas:

- Systems and services meet the needs of Pacific peoples
- More services are delivered locally in the community and in primary care
- Pacific peoples are better supported to be healthy
- Pacific peoples experience improved broader determinants of health

Figure 2: A’la Mo’ui
4.3 Asian and Middle Eastern, Latin American and African (MELAA) Health

The Region is committed to achieving health equity for Asian, Middle Eastern, Latin American and African (MELAA) groups. This will be done by working collaboratively with the Asian & MELAA Health teams and supporting the implementation of the Auckland Metro Area Asian & MELAA Health Plans which aim to increase health gain in targeted Asian & MELAA populations where health inequalities impact on their health status. The region resources disability service and support needs for refugees and migrants in the Auckland region, provides sustainable health interpreting services to the primary health sector, provides cultural and linguistically diverse (CALD) training programmes for the primary and secondary health and disability workforce, and ensures mental health services are responsive to refugee and migrant groups.

4.4 Health for Other High Needs Populations

The region recognises that the social gradient in health impacts all communities, with socioeconomic deprivation a cross-cutting dimension. Our Long Term Investment Plan commitment to progressively change the balance of our investment into prevention and earlier intervention will make greatest gains in communities where social determinants create a greater burden of ill health. Our approach to regional planning considers the health equity impact on these populations by planning services to provide access relative to health need, and by moving towards establishing as standard sub-population based monitoring arrangements that allow us to baseline and track the impact over time of new care models as we implement them.

5. Strategic Position of the Northern Region

Our Long Term Investment Planning work helped us to identify the key issues for the region. We know that Health status is 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. We know that health services are not sufficiently centred on the patient and their whānau, and in certain areas the quality, safety and outcomes of care are not optimal. We also know that the needs of a rapidly growing, ageing and changing population cannot be met in a clinically or financially sustainable way with our current capacity and models of care.

5.1 Our Strategic Challenges & Responses reflect the Long Term Investment Plan

With one in five deaths each year from causes amenable to healthcare, disproportionately affecting our Māori, Pacific, and high deprivation populations, the imperative to reduce the 1,800 excess deaths each year whilst living within financial means of around $8 per person per year for the region is a central challenge we have set out in our long term plans.

Therefore, our major investments will be jointly planned to deliver maximum health gain for the populations we serve, with those at greatest need benefiting most. We continue to work at balancing capital across the themes of fix, future proof and accelerate. Developing our workforce and IT/IS capabilities is essential for helping us to achieve our goals.

As a region we are being led by the four DHBs to a more integrated, collaborative health system. We will plan community, primary, secondary and tertiary services for our region as a single population, optimise health outcomes, and engage people in their health and wellbeing. Together we aim to extend and balance service delivery across all settings, locations and times.

Our strategic framework focuses on improving and optimising to the best of our ability, the following:

- Health outcomes and equity
- Patient experience
- Quality, safety and effectiveness
- Efficiency and productivity
- Resource investment

Our work has identified some key ways to approach the issues we must address:

- **Balancing care** across settings
- Invest in **population health** approaches
- Work **intersectorally** on the social determinants of health
- More integrated primary, community and social care system to **prevent and manage long-term conditions**
- Targeted **proactive care**
- Investing in intermediate and home based **care for non-acute patients**
• Maximise **wellbeing** and ability to **self-care**
• Better networking an **integrated care system around the patient**
• Engaging our population in **co-design** of services
• Improving **communication and collaboration** with technology
• **Standardising** care pathways
• Working with **tertiary education partners** to better prepare work ready graduates
• Develop more meaningful and accurate **measures for outcomes and patient experiences**
• Improve **asset tracking** and the **measurement of asset utilisation**

Across the region our plans anticipate that all decision makers will be able to depict how their work will deliver on the strategies and help to address the key health issues our population faces.

### 5.2 Our Linkages to achieve Impact

#### Whole of System Implementation

Reflective of the diverse range of partners responsible for the region’s health there is a reasonably complex array of organisations involved in the implementation of the initiatives highlighted in the regional plan. In some instances one organisation will lead an initiative, and others will contribute and participate to support the lead. In a number of instances all organisations will have shared accountability for delivery and performance.

Our CEOs and clinical leaders are at the forefront of our programme, demonstrating visible personal leadership and commitment to realising the regional strategy. Each CEO has taken a lead role on different aspects of the regional plan. Clinical governance is provided by the CMOs who provide networks with support and leadership, and are the key link between networks and other senior management.

Clinical leaders are appointed to lead the priority networks and are the key people on point for their services. The leaders work in partnership with the multidisciplinary members of the network to identify and progress specific initiatives. Clinical membership on networks typically comprises doctors, nurses and allied health from across the primary and secondary sector, and the non-governmental sector.

Much of the successes of regional working over the past years can be attributed to our senior executive commitment and our clinical leaders. As in previous years, they will continue to be instrumental in creating a trusting and collegial regional culture and promoting leading practice and innovation in clinical care.

This regional plan should be read alongside each northern region DHB’s strategic intentions, as the region pursues an approach with some planning and implementation at both regional and local level, as appropriate to specific services and populations.

[Diagram: Collaboratively Planned Regional / Metro, Collaboratively Implemented & Funded, DHB x 4 Planned at Local Level, DHB x 4 Implemented & Funded]

Appendix 1 sets out in further detail the specific roles for District Health Boards, Clinical Networks, The Northern Region Alliance (NRA), Health Alliance, Primary Care Alliances, Other Social Sector Agencies, Aged Residential Care, The Non-Governmental Organisation (NGO) sector, and National entities in the development and implementation of our plans.
5.3 Funding Mechanisms to Deliver the Northern Region’s Programmes

The NRA manages the operational budget for supporting the delivery of the health service design, health service implementation, and regional capital and workforce components of the regional plan. The Northern region DHBs fund the NRA for this regional service on a population based funding formula (PBFF) basis.

The work to progress the IS/IT priorities is the responsibility of hA. hA is funded by the DHBs to the level determined by the depreciation associated with the DHB assets that have been transferred from DHBs to hA books. Additional funding may be agreed from DHBs as part of the annual IS/IT planning and budgeting cycle dependent upon priorities and requirements associated with annual IS/IT development plans.

Additional resources are contributed to the delivery of the regional plan by many Northern region entities and individuals across the continuum of care. This contribution is usually in the form of time participating in workshops and regional meetings and also includes development or review of workstream deliverables. The cost of this time is met by those organisations and individuals.

The regional priorities and work plans are developed and endorsed by regional clinical networks, regional work groups, the executive sponsor, and DHB Boards. The Regional Governance Group provides oversight and the governance for this process is delivered by both the NRA and hA. The resource requirements are identified in parallel with the finalisation of the regional plans:

- The NRA undertakes a budgeting process under the governance of the NRA Board
- HealthAlliance undertakes a budgeting process under the governance of the hA Board

Regional activity that needs capital funding follows the guidance of the Capital Investment Committee. Individual DHB funding requirements are identified as part of a business case process and capital approvals follow local DHB, regional capital committee, and national approval processes and comply with national investment approval guidelines.

The service budgets for existing services or those subject to change through the region’s planning and implementation sit primarily within each DHB, considered through the regional governance set out in section 9.

6. Progressing the Northern Region’s Priorities

[DN: Sections need further drafting to respond to MoH guidance “For each area of focus identified in the implementation section of the plan specifically, are supporting financial, clinical and service sustainability”]

The population growth, changing demographics and wide differences between our populations mean that our health services need to adapt and develop new service delivery models to best meet the local population needs. We need to:

- Reduce disparities so that there is equity in health outcomes across all population groups
- Focus on health conditions associated with high need and health disparity, improving the patient journey through the health system and addressing issues relating to improving patient outcomes
- Focus on prevention and management of long-term conditions to reduce the burden of cancer, heart disease and other avoidable long-term conditions
- Develop a healthcare system that is integrated across the continuum, including service delivery, and data and information flow between and across secondary, primary, community and other services
- Provide patient-centred care and care closer to home where patients, whānau and communities are at the centre of the health system and actively engaged as partners in their own care
- Continue to focus on quality of care and patient safety
- Plan for financial sustainability given the growth and increasing demand on services.

Through this plan we will work collaboratively to focus on service improvement opportunities that:

- Improve outcomes and accelerate health gain across all population groups
- Optimise patient experience
- Optimise quality safety and effectiveness
- Optimise efficiency and productivity
- Ensure investment in ‘fit for purpose’ infrastructure
Following are the Northern region agreed priorities for delivery in 2019/20. Each area describes its key objectives and annual action plan with an indication of which quarter the deliverable is planned to be completed. We monitor performance against the target timeline through the quarterly reporting mechanism and take action when required to modify schedules or resolve issues to bring overall plans back on-track. We communicate status, risks and issues regularly through our steering groups and portfolio management structures.

[DN: Content to be developed if needed for: Collective Improvement Programme & Regional decision support, Quality improvement as an enabler including through DHB agencies (e.g. i3/Ko Awatea)]

Building on the approach set out in 2018/19, the priority pathways and services involve firstly taking forward towards implementation over the next year and beyond our deep dive health service design recommendations relating to Regionally Integrated Cancer Services, Elective Care, Radiology Asset Management, and Frailty. Secondly, our plans involve completing the second tranche of deep dives in five further areas, to set strategic direction in Public and Population Health, Community Services & Primary Care, Laboratory services, Mental Health & Addiction and in Workforce.

These major areas of work are complemented by our work to progress our Information Systems Service Plan and Capital Plans, and supplemented by the work of our Clinical Networks contributing to our priorities for Cardiovascular Services, Stroke, Child Health, and Trauma, and our Regional Hepatitis C service network.

To reflect the structure of MoH guidance about national priorities on workforce, data & digital and healthy ageing, our regions plans relating to the workforce deep dive, ISSP and frailty are detailed in section 7.

6.1 Progressing our First Tranche of Deep Dives to Implement Strategic Direction

The deep dives for Cancer and Elective Services have been remitted to be taken forward through a new regional health services implementation steering group to translate the recommendations into detailed co-designed specialty pathways reflected in service specifications with, for the first time, a systematic commitment to collaboratively procuring, funding and monitoring at a regional level wherever this will achieve our commitment to services consistently operating across boundaries.

6.1.1 Regional Integrated Cancer Services (Deep Dive #1.1)

The region has established an Integrated Cancer Service (NRICS) aligned to tumour streams to ensure that all patients in the Region receive the same standard of care regardless of where they present. This direction of travel for cancer services indicates that, in the short to medium term, as a region we will:

- Develop a single cancer service delivered in a managed clinical network model with a lead provider/s for each tumour stream who will be accountable for the delivery of the tumour stream through the accreditation of providers across the pathway
- Ensure that patients will be at the centre of all we do, and we will engage proactively with them in the design and delivery of their care
- Ensure robust approaches are in place to support the prevention and screening of cancer
- Increase the local delivery of the high volume / low complexity elements of a tumour stream pathway and oncology within each DHB, and deliver infusion services in a number of primary and community care settings
- Invest in radiotherapy capacity in locations other than the Auckland City Hospital campus when step increases in capacity are required
- Ensure we have ready access to data and information to inform our decision making in a service where personalised medicine will increasingly become the norm, and to inform research that will enable evidence based decision making to achieve best outcomes for our population.
- Plan our service delivery around tumour streams with each having a lead provider
- Develop agreed standards of care and pathways and over the next 5-10 years, the region will progressively adopt these standards
- Invest in ameliorating risk factors and increasing screening and prevention
- Further develop our palliative care services.

In 2018/19, the first year of implementing the long term investment/health plan, we have established governance arrangements for both the Regional Cancer Board (NRICS) and an Implementation Oversight Group for Head and Neck Cancer.
As a result all patients are treated through a multidisciplinary meeting supported by videoconference where needed; all services are working to common standards, and DHB recruitment for head and neck cancer consultant workforce is considered on a regional basis.

The region’s priorities and key actions for cancer services work in 2019/20 are set out in the table below.

### Northern Region Long Term Health Planning

<table>
<thead>
<tr>
<th>Design</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Head and Neck Cancer Tumour stream:</strong></td>
<td>Q1</td>
</tr>
<tr>
<td>o Finalise accreditation process and support the implementation and monitoring of accreditation</td>
<td></td>
</tr>
<tr>
<td>o Progress review of Head and Neck Cancer standards and QPI’s.</td>
<td></td>
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<tr>
<td>o Develop Head and Neck PROMS and trail regionally with a view to promote nationally long term</td>
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</tr>
<tr>
<td>o Develop co-design processes to be used across all tumour streams from e-referral to survivorship plans</td>
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</tr>
<tr>
<td><strong>Develop plan for next tumour streams or services that are to be reviewed (dependent on outcome of the Cancer Equity project)</strong></td>
<td></td>
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<tr>
<td><strong>Local Infusion Planning</strong></td>
<td></td>
</tr>
<tr>
<td>o Support next steps of local delivery of medical oncology planning and implementation and aim to achieve 5% of local delivery</td>
<td></td>
</tr>
<tr>
<td><strong>We will have completed plans to site radiotherapy outside Auckland to deliver care closer to patients</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Implementation</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition Head and Neck Review to BAU:</strong></td>
<td>Q1</td>
</tr>
<tr>
<td>o Finalise regional recruitment process, monitor and evaluate</td>
<td></td>
</tr>
<tr>
<td>o Finalise funding priorities to enable enhance patient care and experience [DN: REF paper underway to prioritise initial $900k to fund CNs, oral health, etc. Jo Brown on subgroup ]</td>
<td></td>
</tr>
<tr>
<td><strong>Co-Design:</strong></td>
<td></td>
</tr>
<tr>
<td>o Embed revised co-design processes for Head and Neck Cancer and develop the process into current workstreams, monitoring and evaluation through patient surveys</td>
<td></td>
</tr>
<tr>
<td><strong>Implementation of the equity model and action plan</strong></td>
<td></td>
</tr>
<tr>
<td>o Implement key actions and accompanying changes as per the agreed plan and timeline. This will include coordination with other regional activities as required.</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Enabler</th>
<th>Target Completion Date</th>
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</thead>
<tbody>
<tr>
<td><strong>Develop business case for ISSP support for PROMS platform</strong></td>
<td>Q1</td>
</tr>
<tr>
<td><strong>Review requirements and linkages with national CHIS work programme</strong></td>
<td></td>
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</tbody>
</table>

### Ministry of Health mandated (equitable outcomes action focus areas)

<table>
<thead>
<tr>
<th>Developing the Northern Region Cancer Equity Model</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop and implement an approach for analysing regional data that identifies key areas of inequity in cancer and supports prioritisation of actions. This includes consideration of the following:</strong></td>
<td>Q1</td>
</tr>
<tr>
<td>o Key principles</td>
<td></td>
</tr>
<tr>
<td>o Groups such as ethnicity, gender, socio-economic status, location</td>
<td></td>
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<tr>
<td>o Outcome (e.g., mortality, survival)</td>
<td></td>
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<tr>
<td>o Patient experience</td>
<td></td>
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<tr>
<td>o Potential for improvement/amenability</td>
<td></td>
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<tr>
<td>o Areas of the cancer pathway (e.g., prevention, primary care, early detection, treatment)</td>
<td></td>
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<tr>
<td>o Tumour stream</td>
<td></td>
</tr>
<tr>
<td><strong>Elicit peer review of data analysis methodology</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Organise and prepare multi-stakeholder workshop to ensure regional agreement and confirmation of equity priorities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Development and confirmation of equity model including action plan (this will take multiple quarters)</strong></td>
<td></td>
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</tbody>
</table>
Northern region Long Term Health Planning

- Use the key priorities agreed for the region to develop more detailed overview for each area that reflects:
  - Completed data analysis for each priority area
  - Summary reviews of the related evidence-base
  - Existing work underway to improve cancer care across the region as well as any related efforts to further develop equity understanding in DHBs and regional health workforce
- Identify range of potential actions/interventions that can be implemented via the Northern region Cancer Network to address equity priority areas.
- Develop an accompanying view of required change efforts that shows how these efforts might be coordinated to ensure quick implementation and/or increase the impact of our work.
- Engage key stakeholders in discussion and review of the equity model and action plan
- Seek review and sign-off of plan by the Northern region Integrated Cancer Board including confirmation of timeframes for implementation and scale of change
- Complete Undertaking scoping work to determine where changes are most needed to ensure equitable outcomes for patient with cancer
- Developing detailed pathway map(s) to identify cancer equity ‘hotspots,’ with reference to existing work and synthesis of key evidence and data
- As-is Assessment and gap analysis about the pathway(s) and the extent to which it supports self, family/whānau-directed care and provides what patients need.
- Engagement of and discussion with key stakeholders/ key representatives from each stage of the pathway i.e., Māori, clinicians and consumers
- Using the information obtained to develop revised pathway(s) using a co-design process with key stakeholders including patients, family and whānau
- Confirmation of appropriate learnings and consolidation of information into an equity model with recommendations for specific activities/plans/work programme.

Contracted work (MoH or other externally funded)

- Reports directly to the National Screening Unit. EGGNZ’s detailed schedule of activity is provided to the NSU in the quarterly report. The aim of the agreement with the MoH is for EGGNZ to continue as the clinical oversight group providing support and to ensure on-going sustainable endoscopy quality improvement.
- As per our contract, our schedule of activity includes:
  1. Develop a sustainable sector funding model for EGGNZ
  2. Provide the Ministry of Health with:
     - Advice on endoscopy/colonoscopy;
     - Advice on how to accredit colonoscopy units based on the NZGRS system for screening; and
     - Advice on the functions and priorities of NEQIP
  3. Provide clinical advice and guidance to NEQIP
     - Including advice on the functions & priorities of NEQIP
     - To promote and embed NZGRS into NZ publically funded endoscopy units

Operational Process Improvement work initiated/monitored by Clinical Network

The network team also provides Secretariat support for the Bowel and Gynaecology Oncology Tumour streams, national cancer staging project and Bowel Cancer QI project.
6.1.2 Elective Care without Boundaries (Deep Dive #1.2)

Our Electives Deep Dive identified a number of opportunities to deliver better health outcomes for our population and to support the provision of high quality, patient centred and accessible services. The direction of travel for Elective Service developments in the region continues to be to:

- Treat metro Auckland as a single catchment area for elective services with adapted Northland specific elements of care appropriate for its more dispersed geography.
- Separate elective and acute activity as far as reasonably possible, invest in specialised facilities to support this separation where economically feasible and co-locate where required.
- Organise the surgical element of elective pathways around four broad tiers of elective provision as follows:
  - Short stay surgery
  - Procedure specific units
  - Complex surgery for complex patients
  - Specialist services
- Shift specialist services to be delivered by one provider where there is evidence that this will improve outcomes, or there are economy of scale benefits.
- Progress towards a consistent approach to electives/planned procedures across the region including:
  - Standardise clinical and non-clinical systems and processes
  - Determine appropriate standardised intervention rates for key procedures
  - Apply common referral and triage processes
  - Use consistent prioritisation tools across services
- Apply minimum quality standards across providers.
- Develop a planned and long term relationship with the private sector.

The regional objectives for 2019/20 build on work undertaken this year for vascular, ophthalmology & elective musculoskeletal services, whilst reflecting a move to a six step collaborative planning and funding methodology, reflecting the end to end pathway from referral to discharge for both surgical and medical elective activity. Projects are planned for typically an 18 month cycle to incorporate time for procurement and informing planning and funding budget cycles.

The electives programme will progress in parallel two pipelines of work, a sustainability track will deliver on our future care models for services where addressing duplicated overhead or workforce and service pressures are important for clinical and financial sustainability, or where new pathways can free up resource through more efficient and productive pathways as part of our commitment to ‘bending the curve’ for sustainable growth as set out in the Long Term Plan. A health gain and equity track will deliver on future care models for services where step-changes in performance will make a strong contribution to more effectively managing and reducing the burden of ill health, and addressing the levels of and differences in mortality and morbidity amenable to health.

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Complete Register of Regional Model of Care Projects</td>
<td>Q1 Q2 Q3 Q4</td>
</tr>
<tr>
<td>• Align project approaches to meet six step methodology</td>
<td></td>
</tr>
<tr>
<td>• Conclude prioritisation of implementation pipeline programme</td>
<td></td>
</tr>
<tr>
<td>o Sustainability Track (from Vascular, Dermatology, Gynaecology, Endoscopy, Spinal, Bariatric Services)</td>
<td></td>
</tr>
<tr>
<td>o Equity &amp; Health Gain Track (TBC)</td>
<td></td>
</tr>
<tr>
<td>• Sign-Off detailed brief and approach for each project</td>
<td></td>
</tr>
<tr>
<td>• Assign Virtual Project Team from DHB and NRA with clinical lead &amp; sponsor</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> Progress Elective Pathway Sustainability Track</td>
<td></td>
</tr>
<tr>
<td>• Evaluate multi-site provision models (lead provider / multi-site provider) to inform specifications:  [DN: Subject to Steering group view ]</td>
<td></td>
</tr>
<tr>
<td>o Vascular Services</td>
<td></td>
</tr>
<tr>
<td>o Interventional Radiology</td>
<td></td>
</tr>
<tr>
<td>o Urology</td>
<td></td>
</tr>
<tr>
<td>o Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Action Points</td>
<td>Target Completion Date</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>3. Elective Pathway Sustainability Track - First Pipeline Speciality [DN: To be confirmed]</td>
<td>Q1 X Q2 X Q3 X Q4 X</td>
</tr>
<tr>
<td>• Draw together strategic needs assessment (SNA) for the sub populations relevant to the specialty to inform patient centric requirements</td>
<td></td>
</tr>
<tr>
<td>• Review current services and pathways, against the SNA and LTIP deep dive – gap analysis of where to focus change</td>
<td></td>
</tr>
<tr>
<td>• Undertake End to end whole-of-service co-design as needed to realise the opportunities for integration, improvement, &amp; equity</td>
<td></td>
</tr>
<tr>
<td>• Development of Output-based specifications to provide clarity on the pattern of care, standards, and outcomes</td>
<td></td>
</tr>
<tr>
<td>• Set out Procurement plan collaboratively from providers to the region through a single ongoing point of accountability</td>
<td></td>
</tr>
<tr>
<td>• Establishing ongoing monitoring arrangements collectively to monitor demand, utilisation, performance and outcomes</td>
<td></td>
</tr>
<tr>
<td>4. Elective Health &amp; Equity Gain Track - First Pipeline Speciality [DN: To be confirmed]</td>
<td>Q1 X Q2 X Q3 X Q4 X</td>
</tr>
<tr>
<td>• Draw together strategic needs assessment (SNA) for the sub populations relevant to the specialty to inform patient centric requirements</td>
<td></td>
</tr>
<tr>
<td>• Review current services and pathways, against the SNA and LTIP deep dive – gap analysis of where to focus change</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>• Development of Output-based specifications to provide clarity on the pattern of care, standards, and outcomes</td>
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</tr>
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<td>• Set out Procurement plan collaboratively from providers to the region through a single ongoing point of accountability</td>
<td></td>
</tr>
<tr>
<td>• Establishing ongoing monitoring arrangements collectively to monitor demand, utilisation, performance and outcomes</td>
<td></td>
</tr>
</tbody>
</table>

6.1.3 Regionally Optimised Radiology Assets

Long Term Objectives

The Radiology Deep Dive set out our Region’s direction of travel for service developments. In the short to medium term, as a Region we will:

- Focus on radiology asset management to ensure a service that is fit for purpose as a key enabler for other clinical services. This requires that we:
  - Improve our understanding of the drivers of future demand and technological advancement of imaging services, specifically in Computed Tomography, Magnetic Resonance Imaging and Positron Emitting Tomography-CT.
  - Deliver on:
    - Replacement and upgrading of equipment at end of life
    - Ensuring appropriate regional radiology resources to meet
      - Demand from population growth
      - Advancements in radiology imaging utilisation in screening and treatment, such as bowel and hyper-acute stroke services
  - Explore alternative models of equipment investment to defer capital expenditure whilst maintaining service levels to meet the growing demand.
- Support the work with training institutes and regulatory authorities to ensure a skilled and supported workforce is available to deliver the service.
- Support the development of an investment plan for Radiology Information systems that will ensure a future proofed region wide image archiving and reporting capability.
The Region’s priorities and key actions for 2019/20 for radiology are set out in the table below. It is anticipated the work programme will also respond to requirements arising from the elective pathway implementation projects including the role of greater diagnostic support to primary care pre-referral pathways.

Radiology 2019/20 Action Plan

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1. Support development of facilities and equipment to meet current and future demand:</td>
<td>X</td>
</tr>
<tr>
<td>• Ensure asset plans and business cases are informed by updated demand projections and advances in treatment modalities and protocols</td>
<td></td>
</tr>
<tr>
<td>• Progress business cases for additional facilities and equipment in all modalities</td>
<td></td>
</tr>
<tr>
<td>2. Workforce</td>
<td>X</td>
</tr>
<tr>
<td>• Ensure workforce planning is informed by updated demand projections and advances in treatment modalities and protocols and considered in all business cases for facilities and equipment</td>
<td></td>
</tr>
<tr>
<td>• Support recruitment and retention of identified vulnerable workforces with ongoing review of vacancies and coordinated planning of training, recruitment processes, retention incentives and workforce wellbeing initiatives</td>
<td></td>
</tr>
<tr>
<td>3. Radiology Information systems</td>
<td>X</td>
</tr>
<tr>
<td>• Support implementation of PACSLink across DHBs and private providers</td>
<td></td>
</tr>
<tr>
<td>• Support implementation of RIS/PACS upgrade</td>
<td></td>
</tr>
</tbody>
</table>

6.2 Completing our Second Tranche of Deep Dives to set strategic direction

Our second tranche of deep dives for the most part are expected to have recommendations considered, prioritized and endorsed in Quarter one of the 2019/20 financial year. This section anticipates next steps for some deep dives but will be subject to further refinement once the findings are signed off. Our key focus in early 2019/20 is to ensure these extensive projects address the critical issues identified in moving from current patterns of care to a sector specific application of the future care model set out in our long term plan.

6.2.1 Public and Population Health (Deep Dive #2.1)

Our deep dive recommendations are expected in Q1 of 2019/20. They reflect the following key emerging findings and priorities:

We are a large, fast growing and diverse region with areas of significant socioeconomic deprivation.
- Approximately 562,000 extra people are expected to be living in the Region in the next 20 years.

There are significant inequities and ill health linked to ethnicity and deprivation particularly for Māori and Pacific.

A significant burden of ill health is potentially avoidable.
- On average 1,800 potentially amenable deaths occur each year in the Region and more than two thirds (69%) of the gap in life expectancy for Māori and more than half (55%) of the gap for Pacific is preventable or amenable.

A small number of risk factors significantly contribute to health loss.
- 5 conditions (including neuropsychiatric, cancer, CVD and MSK) account for 76% of health loss.
- More than a third (38%) of all health loss is attributable to modifiable risk factors.
- The leading risk factors are: diet; BMI; tobacco; high blood pressure; and high blood glucose.
- These risk factors are not mutually exclusive and there is overlap between some risk factors such as diet and BMI.
Population health is a key area identified in the LTIP to improve health, reduce inequities and mitigate demand for beds.

There is a strong economic case for investing in public health interventions.
- A recent systematic review estimated that the mean return on investment (ROI) from public health interventions was 14.3 to every single unit of currency invested. There is limited provision of many of these interventions in the Region currently.

There are opportunities to improve our prevention and early detection services.
Key opportunities include: Health protection, Child and maternal health, Tobacco control, Obesity, Reducing alcohol related harm, mental health promotion.

Recommendations from the regional work will be structured around three themes:

1. **Strengthening the Infrastructure to Deliver Core Public Health Functions** - doing the basics well and ensuring that core functions (particularly those provided by public health units) are robust and sustainable
2. **Developing / strengthening a Public Health / Prevention System** – reorienting the system to a focus on prevention and determinants of health.
3. **Investing in Priority Areas** that will deliver shorter term gains (3-5 years) in equity and health outcome. Potential areas of focus in this area include Obesity, Alcohol, Tobacco, Early years, and Mental health promotion

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1. A strong resilient public health infrastructure across the region</td>
<td>Specifics to be informed by final DD recommendations</td>
</tr>
<tr>
<td>2. Reorienting the system to focus on prevention and determinants of health</td>
<td>Specifics to be informed by final DD recommendations</td>
</tr>
<tr>
<td>3. Producing business case compliant phased multi-year investments for enhanced returns scaled to need to commission interventions in key risk factors</td>
<td>Obesity Case</td>
</tr>
</tbody>
</table>

**6.2.2 Community Services and Primary Care (Deep Dive #2.2)**

Primary and community services are the first point of contact for most people seeking health care. When it is working well, primary and community services coordinates care across the system, reduces demand on health services overall, and helps keep people well. At the same time primary and community services are facing very significant challenges: to improve outcomes and reduce inequities; meet changing patient expectations and rising demand; and deliver a modern, high performing and sustainable service.

The Primary and Community Care Deep Dive is being undertaken to address these challenges. The purpose of the Deep Dive is to set out the broad strategic direction for Primary and Community Care services in order to inform investment decisions. Equity is the key focus of the deep dive. It is intended to consider the transformation required to help address inequities in access, quality, and outcomes; particularly for Māori and Pacific populations.
The objectives of the Deep Dive are to:
- Set out the broad **strategic direction** for primary and community care services over the next 10-15 years with a particular focus on addressing inequities in access, quality, and outcomes
- Identify the **system redesign** required to achieve this strategic direction
- Develop a high level **action plan** for the work required to progress agreed recommendations for improvements.

This Deep Dive was started in 2018/19. Phase 2 of the deep dive setting out the strategic direction is planned to be completed by the end of June 2019 and Phase 3 outlining the system redesign required planned to be completed by the end of 2019. We will take account of and input into the Ministers Review of the New Zealand Health and Disability Sector as this develops.

The Region’s priorities and key actions for regional primary and community care work in 2019/20 are set out in the table below.

**Primary & Community Care 2018/19 Action Plan**

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1. Confirm and Refine Approach</td>
<td></td>
</tr>
<tr>
<td>• Confirm relevance of phase 3</td>
<td>X</td>
</tr>
<tr>
<td>• Develop and agree system redesign approach</td>
<td>X</td>
</tr>
<tr>
<td>2. System Redesign</td>
<td></td>
</tr>
<tr>
<td>• Distil key change requirements from future state work</td>
<td>X</td>
</tr>
<tr>
<td>• Review and collate evidence re areas of service redesign</td>
<td>X</td>
</tr>
<tr>
<td>• Organise and prepare for multi stakeholder workshops</td>
<td>X</td>
</tr>
<tr>
<td>• Hold workshops</td>
<td>X</td>
</tr>
<tr>
<td>• Use outputs from workshops to identify system redesign options</td>
<td>X</td>
</tr>
<tr>
<td>3. Options Development and Selection</td>
<td></td>
</tr>
<tr>
<td>• Identify options to address barriers to change</td>
<td>X</td>
</tr>
<tr>
<td>• Assess options</td>
<td>X</td>
</tr>
<tr>
<td>• Select preferred option</td>
<td>X</td>
</tr>
<tr>
<td>• Detail preferred option</td>
<td>X</td>
</tr>
<tr>
<td>4. Strategic Implementation Plan</td>
<td></td>
</tr>
<tr>
<td>• Develop strategic implementation plan for preferred option</td>
<td>X</td>
</tr>
</tbody>
</table>

**6.2.3 Regional Networked Community & Acute Laboratory Services (Deep Dive #2.3)**

The 2017 Northern Region Laboratory Services external review broadly found quality lab services being delivered in the region, with notable opportunities to harmonise, modernise, and prepare for the future. The recommendations centred on the themes of establishing a regional service, delivering greater consistency across the region, and aligning development and investment.

Following on from the review a Deep Dive programme of work commenced in 2018/19. We have convened a regional oversight group that is leading an extensive programme of work across the areas of regional labs framework, assets and facilities, workforce, IS/IT and change management. The region has also concluded renegotiation of a long term community laboratory services contract which is strategically aligned to the regional transformation programme. The contract is making a substantial contribution to financial sustainability for DHBs over the next eight years.
We have a vision of a high performing, regional laboratory and pathology network delivering equity of access to diagnostics where patients' whānau are fully involved to enable best care. We want to deliver the best staff experience and strive to be leaders in innovation and research. The agreed strategic goals for laboratory services are to:

1. Work together across the region through effective leadership, management and collaboration frameworks
2. Optimise investment decisions through regional planning to ensure an effective, sustainable and innovative regional network
3. Harmonise our laboratory systems to enable safer, equitable and more efficient care
4. Ensure a resilient, well trained and engaged laboratory workforce, fit for future opportunities

Our focus this year is to continue the extensive regional programme of work underway. This Programme is led by a regional governance group that reports to the regional Health Service Design Authority who are overseeing the process to govern resources freed up from the efficiencies delivered, ensuring they are wisely invested in further transformation of services to reduce the need for external capital by the region through an internal indicative business case process.

For 2019/20 this area will continue to have a mix of strategy development and implementation work which impacts the resourcing level and skill mix needed to deliver the variety of elements in the Programme plan. This year we will also focus on increasing the time and resources we invest in engagement, communications, and change management within DHBs laboratory teams.

**Long Term Objectives**

We are continuing the work required to set out the broad strategic direction for laboratory services over the next 10-15 years within the context of a 25 year horizon. We have clarified our strategic goals, and completed initial analysis and regional recommendations in the areas of ‘network framework’, assets and investment planning, workforce, and information systems and technology.

We have identified some areas that still require a thorough analysis in order to fill in gaps in the strategic direction for laboratories:
- Sites and capacity/capabilities required to support growth, service model changes, and potential new hospital sites
- Point of Care Testing – hospital and community
- Digital Pathology
- Laboratory needs assessment to support national and regional genomics direction
- Planning to become leaders in innovation and research

We will plan Health Service Design initiatives on these topics over the coming years to fully round out the strategic thinking in this space, based on their relative urgency/priority as assessed in the IBC review process.

**Annual Objectives**

The laboratory services work plan emphasises those areas where we know there are benefits to be gained from harmonising and working more closely together across DHB and community/public organisational boundaries.

The region’s objectives for 2019/20 are to:
- Establish a regional governance and management ‘framework’ designed to strengthen regional working
- Implement coordination of asset and investment planning practices across the region
- Complete a workforce plan in partnership with our laboratory workforce
- Extend the rollout of electronic lab tests ordering in both community and hospital settings
- Harmonise our provider index and results visibility in both community and hospital settings
- Agree a programme of work for the next 3-5 years to deliver the vision and goals
The region’s action plan for the year is set out below.

### Laboratory Services 2019/20 Action Plan

<table>
<thead>
<tr>
<th>Action Points - NEW</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1 Strategy and Programme activities</td>
<td></td>
</tr>
<tr>
<td>• Complete indicative / programme level business case</td>
<td>X</td>
</tr>
<tr>
<td>• Indicative business case regional review and approvals processes</td>
<td></td>
</tr>
<tr>
<td>• Deliver a report to Health Service Design Authority with recommendations for the sites/facilities, capacity and capability required for laboratory services to support regional growth and service changes</td>
<td></td>
</tr>
<tr>
<td>• Deliver a Regional Digital Pathology assessment and recommendations</td>
<td></td>
</tr>
<tr>
<td>2 Establishing a Regional Service</td>
<td></td>
</tr>
<tr>
<td>• Laboratory Service Implementation Oversight Group (LSIOG) delivers governance and advisory functions to the Health Service Design Authority</td>
<td>X</td>
</tr>
<tr>
<td>• Complete Framework proposal regional review and approvals processes</td>
<td></td>
</tr>
<tr>
<td>• Create a detailed Framework implementation plan</td>
<td>X</td>
</tr>
<tr>
<td>• Implement those elements of the Framework scheduled for 2019/20</td>
<td>X</td>
</tr>
<tr>
<td>3 Asset and Procurement Planning</td>
<td></td>
</tr>
<tr>
<td>• Complete options analysis for consolidated assets register</td>
<td>X</td>
</tr>
<tr>
<td>• Implement regional laboratory assets oversight functions as defined and agreed in the Framework proposal</td>
<td></td>
</tr>
<tr>
<td>• Refine the quality of capacity and utilisation measures</td>
<td></td>
</tr>
<tr>
<td>• Deliver business case for consolidated assets register investment</td>
<td></td>
</tr>
<tr>
<td>• Regional review and approvals processes of assets register business case</td>
<td></td>
</tr>
<tr>
<td>4 IS Planning and Delivery</td>
<td></td>
</tr>
<tr>
<td>• Develop electronic ordering regional strategy</td>
<td>X</td>
</tr>
<tr>
<td>• Establish regional LIS vendor management function</td>
<td>X</td>
</tr>
<tr>
<td>• Establish regional labs IS collaboration forum</td>
<td></td>
</tr>
<tr>
<td>• Initiate electronic ordering alignment project</td>
<td></td>
</tr>
<tr>
<td>• Initiate Service Provider Index (SPI/Dr. Dictionary) alignment project</td>
<td>X</td>
</tr>
<tr>
<td>• Initiate HL7 integration project</td>
<td></td>
</tr>
<tr>
<td>5 Workforce</td>
<td></td>
</tr>
<tr>
<td>• Onboard additional resources to support programme related change management and communications work across DHBs lab teams</td>
<td>X</td>
</tr>
<tr>
<td>• Deliver a regional laboratories workforce plan</td>
<td></td>
</tr>
<tr>
<td>• LSIOG to prioritise recommendations from the plan and report to HSDA</td>
<td></td>
</tr>
<tr>
<td>• Complete scoping/costing work and a labs workforce project plan</td>
<td></td>
</tr>
<tr>
<td>• Begin implementation</td>
<td></td>
</tr>
</tbody>
</table>

### 6.2.4 Mental Health and Addiction (Deep Dive #2.5)

Mental Health and Addiction services remain a priority within the Northern region. Whilst wider action awaits the government’s national response to the He Ara Oranga; the National mental health inquiry, the Northern region elected to undertake a deep dive focusing on High users of inpatient services and a review of Consult Liaison Psychiatry services.

The Consult-Liaison psychiatry Model of care has been finalised, and is being submitted to the Regional Executive forum in June. A key recommendation is the addition of Addiction Specialists to Consult Liaison teams across the region.
The High user deep dive is a significant project which has included analysis of inpatient use of 10,500 people from 2012 to 2017, a stocktake of current rehabilitation centric services in the region and identification of strategies to reduce excessive use of acute inpatient bed days. The first draft has been completed, and consultation is currently occurring. Significant work will need to be undertaken to progress the recommendations subject to approval by the Regional Executive Forum.

Work is also underway to develop a Model of care for withdrawal management from Alcohol and other Drugs with draft developed for consultation by the end of May. This will be incorporated into the wider focus on Addiction Services planned for 2019/20.

The Key objectives of the Mental Health and Addiction Services Network for 2019/20 are to:
- Develop services that best meet the needs of people who are high users of inpatient services with a focus on assertive rehabilitation at an earlier stage of their journey
- To review models of care to enhance access and choice for people requiring mental health and addiction services (addiction and child and youth).
- To ensure models of care incorporate a focus on equitable access to services and equitable outcomes.
- To determine future strategies required to meet the needs of an aging population requiring mental health and addiction expertise during their journey.

The Region’s indicative priorities and key actions for 2019/2020 are set out in the table below. The priorities will be reviewed once the National response to He Ara Oranga has been announced to ensure they are appropriate and aligned.

**Mental Health and Addictions 2019/2020 Action Plan**

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1 High Users</td>
<td></td>
</tr>
<tr>
<td>• Progress implementation plan to progress approved recommendations in relation to the Rehabilitation Continuum of care to best meet the needs of high users of inpatient services.</td>
<td></td>
</tr>
<tr>
<td>2 Addiction</td>
<td></td>
</tr>
<tr>
<td>• To undertake stocktake and review Model of Care for Addiction Services in the Northern region to best meet the needs of the population including women, Māori, Pacific, Older People, criminal justice clients and LGBTIQ communities. Work undertaken on the SACAT and Managed withdrawal from Alcohol and Drug services in 2018/19 will be integrated into the wider Model of care.</td>
<td></td>
</tr>
<tr>
<td>• The development of a regional action plan to respond to incidents of significant harm caused by synthetic cannabis</td>
<td></td>
</tr>
<tr>
<td>3 Youth Forensics</td>
<td></td>
</tr>
<tr>
<td>• Finalise and implement revised Model of Care for Youth Forensics to accommodate 17 year olds being processed through Youth Court from 1st of July, once confirmation received of funding package.</td>
<td></td>
</tr>
<tr>
<td>4 Child and Youth</td>
<td></td>
</tr>
<tr>
<td>• Undertake stocktake of services currently available within the region to meet the needs of Child and youth requiring mental health and/or AOD intervention, including crisis response, to inform future service developments.</td>
<td></td>
</tr>
<tr>
<td>5 Older People</td>
<td></td>
</tr>
<tr>
<td>• To undertake a stocktake of current services and Models of care (Mental Health and Addictions) operating in the Northern region including gaps and challenges to inform services required in future to meet the demands of an aging population.</td>
<td></td>
</tr>
<tr>
<td>6 Perinatal Infant Maternal Mental Health</td>
<td></td>
</tr>
<tr>
<td>• Undertake research project to identify barriers and strategies that could be implemented to enhance access of Pacific Island mothers to PIMH services.</td>
<td></td>
</tr>
</tbody>
</table>
### 7. Action Points

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NGO Services</strong></td>
<td></td>
</tr>
<tr>
<td>• To undertake stocktake of the peer support workforce in the Northern region and to determine strategies required to meet the increased demand for this workforce over the next five years</td>
<td>Q4 X</td>
</tr>
<tr>
<td>• To undertake a review of reporting requirements across the region with the aim of reducing the burden of reporting by consolidating and streamlining reporting requirements.</td>
<td></td>
</tr>
<tr>
<td>• 3 workshops held with NGO services to enhance capability and capacity in relation to PRIMHD reporting.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient services</strong></td>
<td></td>
</tr>
<tr>
<td>• Development of strategy including identification of implications to progress open wards in acute inpatient facilities.</td>
<td></td>
</tr>
<tr>
<td>• Collect barriers to discharge from acute inpatient units to inform system level strategies needed to prevent discharge delays.</td>
<td></td>
</tr>
</tbody>
</table>

### 7. Northern Region Priorities Addressing National Requirements of Regions

The national requirements for all regions are already embedded into key work streams for the northern region either as deep dives and enablers to implement our long term plan or from the work of well-established regional clinical networks.

#### 7.1 Data and Digital – Our Integrated Strategic Services Plan

The Northern region Information Systems Strategic Plan (ISSP) and Regional Roadmap provide the direction for the Regional ICT Investment Portfolio. Version 1 of the ISSP was developed in FY17/18 and Version 2 and Roadmap were updated and approved at regional governance and DHB board levels in FY18/19. The ISSP and Roadmap were presented to MOH and Treasury and are well understood by key stakeholders. Significant capital and operating investment will be required to achieve the outcomes defined in the ISSP.

The purpose of the ISSP is to provide direction for ICT investment required both to maintain current services and address risk within our environment and to enable the changes required under the Northern region Long-Term Investment Plan, also approved in FY18/19. Information Systems and Technology are key enablers to help the Northern region deliver to our plan and to achieve our vision of an integrated, patient centred health system.

The ISSP addresses four Investment Portfolios which are discussed in more detail in subsequent sections. These are:
- Strengthen and modernise our ICT Foundations
- Become experts at Interoperability and Data-sharing
- Simplify and harmonise our complex layers of applications
- Work effectively together as a capable region

Progress has been made in each of these areas over the last 12 months and these portfolios direct the investments we will be making over the coming years.

The ISSP provides a clear set of principles to inform the region’s direction and investments. These are well aligned to the Ministry of Health guidelines for FY19/20 planning:
- Standards-based integrated systems;
- Regional and national implementations where possible;
- All of Government initiatives for Cloud based solutions and “as a Service” offerings as first options
Two significant changes have occurred in the last 12 months that provide a solid foundation for delivery of the Northern region ISSP. These are:

- Establishment of the new regional governance structure, including new regional governance for IS strategy, design and delivery in line with the ISSP Programme Charter which was also approved by all DHB boards and other regional groups.
- Completion of a 10 year ‘Affordability Review’ of investments required over the next 3-4 years to implement the first phase of the Northern region ISSP. This review focused on both the capital investment required for initiatives but also the implications for operating expenditure of the transition towards ‘as a service’ models of consumption and delivery.

Each of these is discussed in more detail below, prior to presentation of ICT investment plan aligned to the Northern region’s Investment Portfolios.

**Northern region IS Governance**

The scope of the ISSP Programme and the associated delivery approach has been derived based on a number of key principles, as follows:

- **One Consolidated & Aligned Plan** – With the exception of minor projects, all initiatives will be planned, coordinated and delivered as a single coordinated plan, i.e. covering Run, Change and Transformational initiatives. This will facilitate alignment of organisational impacts, the allocation of key resources, and the identification and mitigation of key dependency risks.

- **One Consolidated Funding Plan** – the demand for funding will be identified in a single coordinated budget, i.e. covering Run, Change and Transformational initiatives. This will facilitate a unified and portfolio-based view of all demand for capital funding, and the required sources of funds, covering internal depreciation-based funding, C-share-based funding, and external centrally allocated Government funding.

- **One Consolidated Benefits Realisation Plan** – with the exception of minor projects, the benefits and capabilities associated with the ISSP will be identified and managed in a single coordinated plan.

- **One Consolidated Architecture** – with the exception of minor stand-alone projects, all initiatives will be designed in compliance with a single set of architectural principles and reference architectures. This will ensure a common approach to business processes, data management, technical architectures, communication architectures, and application architectures, which will ensure that the Regional objectives related to extensibility, reliability, and interoperability, are satisfied.

- **One Governance Framework** – all governance and management forums will be aligned. This will ensure a common approach across the Region covering the essentials of portfolio, programme and project management, and will contribute to effective decision management.

As part of the implementation of the Northern region’s new governance structure, a new regional IS Governance structure was implemented. The structure is shown in Figure 3.

Key aspects of the design of the governance structure are the separation of strategy, design and investment planning (the ISSP Design Authority) from delivery (the ISSP Delivery PSG). Recognising the scope and complexity of whole of sector information systems, a number of Design Councils have also been established. These include:

- Health Services Design Council – to provide an end to end clinical and operational and service user view of how the systems come together
- Regional Data Design Authority – to provide strategic direction and oversight to data governance and management in the region, including the use of standards
- Regional Architecture Group – to provide direction and oversight of the region’s consolidated architecture and technology choices
- Regional Privacy Group – to provide oversight of the design and application of privacy policy and governance of privacy matters
- Regional Information Security Forum – led by the region’s Chief Information Security Officer to provide direction and oversight of information security matters.
This structure directly aligns to and supports the Ministry of Health’s guidelines with respect to delivery of regional, integrated, standards-based systems. All projects must validate their designs through these Design Councils to ensure:

- The technology used is consistent with the Northern region’s agreed architectural principles, including ‘All of Government’ initiatives for Cloud based solutions and “as a Service” offerings as first options
- Agreed standards are implemented and any variations are approved, documented and understood
- Systems can and do integrate to facilitate safety and user experience
- Central investments prioritise regional implementations

A key focus for the Health System Design Council and the Regional Data Design Authority over the FY19/20 will be refinement of the ‘core, common and unique classification to help investment prioritisation, standards application and system integration efforts further.

Financial Plan and Affordability

The transition to ‘as a Service’ consumption models has a significant impact on IS Affordability under the current funding arrangements. This became particularly apparent during the board approvals process for the Infrastructure as a Service business case and prompted the region to pause all investments and undertake a review of IS affordability for the Northern region over a 10 year timeframe.

This process was challenging on many levels and required the Northern region to rethink many aspects of the way it funds and is funded for IS as well reconsider the scope and timing of core initiatives. The outcome of the review is still being finalised through the regional IS governance process but a final recommendation is in the endorsement and approval process. This recommendation presents a plan that is considered affordable from a capital and operating perspective over the next 10 years and achieves an acceptable balance between strategic objectives and risk mitigation.

The Northern region ICT Investment Portfolio presented below is the recommended ‘best affordable’ plan. Quarterly reports will be submitted on progress against the plan. A summary of the plan is shown in the figure below:

Approximately 90% of the FY19/20 Northern region central capital fund is allocated to projects that are ‘in flight’.

[DN: Put individual initiatives into a separate appendix?]
Modernise and Strengthen our ICT Foundations

The following initiatives have been prioritised in FY19/20 in this Investment Portfolio:

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Phase as at Q4 FY18/19</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure as a Service (IaaS)</td>
<td>Feasibility &amp; Service Establishment</td>
<td>Implementing robust Infrastructure Services for the Northern region based on the All-of-Government IT Services Catalogue. The scope of the project includes Service Establishment, and the transition over a number of years of the services contained within the 4 DHB IT facilities into new resilient data centres, which will be provided by Spark/Revera.</td>
</tr>
<tr>
<td>PABX replacement</td>
<td>Feasibility &amp; Business Case</td>
<td>This project will establish a regional unified communications platform and migrate/retire the 6 largest/oldest/highest risk PABXs (accounting for approx. 52% of all Northern region call volume).</td>
</tr>
<tr>
<td>Workspace : Windows 10 Upgrade / Office 365</td>
<td>Feasibility &amp; Business Case</td>
<td>The scope of this project includes upgrading Windows 7 to Windows 10, implementing an upgraded e-mail exchange and SharePoint solution, and implementing a new workspace environment, which will facilitate a mobile capability, for the Northern region. This initiative will facilitate significant productivity efficiencies for all affected staff.</td>
</tr>
<tr>
<td>Regional Network Hubroom Upgrades</td>
<td>Solution Delivery</td>
<td>This project will upgrade certain high-priority network hub rooms.</td>
</tr>
<tr>
<td>SAN storage switch upgrade</td>
<td>Solution Delivery</td>
<td>This project will replace and enhance the capacity of existing IT storage equipment.</td>
</tr>
<tr>
<td>Digital Acceleration – Public Cloud Enablement</td>
<td>Feasibility</td>
<td>[DN: To be completed]</td>
</tr>
<tr>
<td>Cybersecurity</td>
<td>Feasibility</td>
<td>[DN: To be completed]</td>
</tr>
<tr>
<td>Identity and Access Management (IAM)</td>
<td>Feasibility</td>
<td>The scope of this initiative includes the provision of an identity and access management solution for the Northern region, which will allow staff and patients to securely and efficiently access the northern regions data using a trusted digital identity. The Design phase for this project will be completed as part of the RCCC project funded via CIC. Build and initial implementation will be through the Cardiac Rehabilitation Enablement project (if funded). A regional IAM capability is fundamental to data sharing and regional integrated systems.</td>
</tr>
</tbody>
</table>

Become Experts at Data Sharing and Interoperability

The following initiatives have been prioritised in FY19/20 in this Investment Portfolio:

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Phase</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>JCAPS Replacement (IEP)</td>
<td>Solution Delivery</td>
<td>The IEP Project will complete the migration of existing key enterprise application interfaces from a dated an un-supported application (i.e. JCAPS) to a new fit-for-purpose Enterprise Application Integration solution (i.e. Mule soft). This project will also create standard Application Programming Interfaces (APIs) for common interfaces that will be available for re-use by other applications.</td>
</tr>
</tbody>
</table>
**Interoperability & Data Sharing**

**Health Information Platform (HIP)**

**Feasibility**

The objective of the HIP project is to provide the capability to improve data sharing across the Northern region for point of care and analytics. The HIP Project will leverage the IEP platform and augment the existing Test Safe application to provide the basis for access to federated data accessible by users across the Northern region system. THE HIP solution will be delivered progressively over a number of years. The Design phase for this project will be completed as part of the RCCC project funded via CIC. Build and initial implementation will be through the Cardiac Rehabilitation Enablement project (if funded). A regional HIP capability is fundamental to data sharing and regional integrated systems.

**Aspire**

**Feasibility**

[DN: To be completed]

---

**Simplify, Harmonise and Rationalise our Applications**

The following initiatives have been prioritised in FY19/20 in this Investment Portfolio:

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Phase</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Administration replacement Programme (HARP) – expected to be funded by CIC</td>
<td>Feasibility</td>
<td>This project will replace the existing ADHB hospital administration systems (primarily CMS, PHS, PIMS Theatre). This project will significantly enhance the capability of the systems used for hospital administration and will; in addition, facilitate rationalisation, standardising and consolidation of the associated applications within ADHB with the potential for reuse across the region.</td>
</tr>
<tr>
<td>Regional Community Collaboration Care (RCCC) – expected to be funded by CIC</td>
<td>Feasibility</td>
<td>This project will replace the existing Jade-based Community Care system used by community and mental health services within NDHB, and will in addition provide a new Regional Community Collaboration Care solution for the Northern region. Design for this solution will incorporate the Design phases for the IAM and HIP projects.</td>
</tr>
<tr>
<td>Concerto – CPU8 Upgrade (NDHB &amp; ADHB)</td>
<td>Solution Delivery</td>
<td>The Clinical Portal Upgrade will provide a single instance of Clinical Portal 8 capable across all four Northern DHBs, therefore improving availability of relevant patient data to clinicians. The Clinical Portal solution will provide a consistent look and feel across the region, be highly resilient and reliable and operational costs will be reduced due to convergence, collaboration and standardization.</td>
</tr>
<tr>
<td>National Oracle Solution/ FIPM</td>
<td>Feasibility and Business Case</td>
<td>Implementation of the FPIM project will improve the region’s capability to manage its supply chain supporting operating theatres and other time critical services.</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Enablement – – expected to be funded by CIC</td>
<td>Feasibility and Business Case</td>
<td>This project will implement the minimum viable set of the core identity/ access management and data sharing building blocks to enable model of care change designed to ‘bend the demand curve’. These building blocks, used in conjunction with shared care planning capability from the RCCC project will enable the region-wide implementation of the national Cardiac Rehabilitation guidelines that should reduce readmissions and release bed capacity for 6-12 beds.</td>
</tr>
<tr>
<td>Secure Communications</td>
<td>Feasibility</td>
<td>This project will define and implement a suite of communications solutions that securely enable a range of communications use cases between clinicians individually and in groups, including critical communications, messaging and task management.</td>
</tr>
<tr>
<td>Applications feasibility studies</td>
<td>Initiate</td>
<td>Several feasibility studies will be undertaken to inform future investment strategies based on the defined Regional Roadmap. These include Radiology, e-Orders/ e-Ask, Core Hospital Clinical Solutions (EMR) and the Regional Self-care Portal strategy.</td>
</tr>
</tbody>
</table>
**Work Effectively as a Capable Region**

The following initiatives have been prioritised in FY19/20 in this Investment Portfolio:

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Phase</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISSP and Regional Roadmap</td>
<td>In flight</td>
<td>The Regional Roadmap will be updated in Q1 FY19/20 with input from additional domains and revisions of existing domains based on projects under way.</td>
</tr>
<tr>
<td>What else do we want to call out? i.e. development of data standards/ maturing the governance and financial modelling, new operating models…?</td>
<td></td>
<td>[DN: To be completed]</td>
</tr>
</tbody>
</table>

**7.2 Workforce (Deep Dive #2.4)**

The workforce deep dive will deliver a range of recommendations and high level actions mapping out what needs to be achieved to build a sustainable workforce in support of the Northern Region Long Term Plan’s strategic direction.

The objectives are to:

- Set the broad strategic direction for workforce development over the next 10-15 years with a particular focus on addressing the prospective workforce gaps and creating a workforce ‘fit for the future’.
- Identify the system and work redesign required to achieve this strategic direction.
- Develop a high level plan for the key changes and actions required in the next 5 years towards achieving this strategic direction.

In the 2018/19 year the workforce deep dive specifically focused across equity and enabler areas. In particular we examined our current state and developed a view on the challenges and opportunities to best meet our future direction. As a result we have agreed a range of strategies that strengthen existing initiatives which we will continue with and also sets in place new strategies to prepare us better for the future. These include:

- Building our Māori workforce and our Pacific workforce – bringing to the fore the strengths and cultural richness they bring to the care we deliver to our patients.
- Valuing our workforce and build our organisational culture to reflect and include a workforce representative of our diverse population and which values and demonstrates indigenous intelligence; Mātauranga Hauora.
- Growing our workforce to meet the massive scale of growth we are already presented with including how we optimise our economic / employment footprint to benefit the communities we serve.
- Preparing our workforce for the digital future which is with us now, and ensuring we #leave no one behind.
- Rethinking and shifting the industrial landscape and employment relations practice to support increased flexible work options and fairness across occupational groups.
- Optimising our learning models and career pathways to include our entire workforce.

The workforce deep dive will continue into the 2019-20 year as the scope expands to include workforce supply and additional occupational groups. The workforce development initiatives for the 2019-20 year are set out below. They prioritise cultural competence across our entire workforce, support the DHBs’ annual plan activities and reflect key strategies from the workforce deep dive to date.
## Workforce 2019/20 Action Plan

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1 Strengthen cultural competency across the workforce:</td>
<td></td>
</tr>
<tr>
<td>• Foster and develop organisational cultures that are mana enhancing and support Māori kaupapa and voices</td>
<td>X</td>
</tr>
<tr>
<td>• Realise cultural competence for all staff, in particular re-educating our existing workforce to develop cultural competence</td>
<td>X</td>
</tr>
<tr>
<td>• Recruitment and selection processes will include cultural competency criteria</td>
<td></td>
</tr>
<tr>
<td>• Cultural competency is included in induction and orientation programmes for all new employees</td>
<td></td>
</tr>
<tr>
<td>• Measure the impact of cultural competency in patient experience surveys</td>
<td></td>
</tr>
<tr>
<td>Grow the capacity and capability of our Māori and Pacific Workforce:</td>
<td></td>
</tr>
<tr>
<td>• Increase the size of our Māori and Pacific workforces to reflect the communities we serve by 2025</td>
<td>X</td>
</tr>
<tr>
<td>• Improve our data quality and intelligence</td>
<td>X</td>
</tr>
<tr>
<td>• Focus on implementing recruitment processes, retention strategies and development opportunities to increase and sustain our Māori and Pacific workforces</td>
<td>X</td>
</tr>
<tr>
<td>• Identify and prioritise potential Māori and Pacific employees for leadership development and create accelerated pathway opportunities to targeted senior level leadership roles.</td>
<td></td>
</tr>
<tr>
<td>2 Continue the workforce deep dive to set the broad strategic direction for workforce development in the next five years and longer term (next 10-15 years) in support of the long term health planning for the region.</td>
<td>X</td>
</tr>
<tr>
<td>• Scope, resource and mobilise key areas of focus</td>
<td>X</td>
</tr>
<tr>
<td>• Develop view re challenges and opportunities across key workforce groups - nursing, Kaiāwhina, midwifery</td>
<td></td>
</tr>
<tr>
<td>• Identify range of innovations/ initiatives to best meet future models of care</td>
<td></td>
</tr>
<tr>
<td>• Develop options, consider, agree and resource priorities for 5 year timeframe</td>
<td></td>
</tr>
<tr>
<td>3 Develop the regional graduate management development programme using Māori health gain approach in readiness for 2020/21 commencement.</td>
<td>X</td>
</tr>
<tr>
<td>• Resolve gap in National HW funding for programme [DN: Originally dependent upon Health Workforce funding which has been withdrawn ]</td>
<td>X</td>
</tr>
<tr>
<td>• Set up programme advisory and resourcing</td>
<td></td>
</tr>
<tr>
<td>• Complete programme design</td>
<td></td>
</tr>
<tr>
<td>• Design programme communications and collateral</td>
<td></td>
</tr>
<tr>
<td>4 Formalise partnerships with education providers to actively collaborate and share collective regional goals to better prepare, grow and develop our workforce.</td>
<td>X</td>
</tr>
<tr>
<td>• Establish formal partnership(s) with agreed terms of reference</td>
<td></td>
</tr>
<tr>
<td>• Establish principles to guide scope and approach to collaboration</td>
<td>X</td>
</tr>
<tr>
<td>• Develop initial agreed priorities</td>
<td></td>
</tr>
<tr>
<td>5 Create a joint regional quantitative analytics function to inform immediate and medium term recruitment and training supply needs.</td>
<td>X</td>
</tr>
<tr>
<td>• Set up regional workforce analytics advisory</td>
<td>X</td>
</tr>
<tr>
<td>• Develop regional work programme</td>
<td></td>
</tr>
<tr>
<td>• Deliver on agreed priorities</td>
<td></td>
</tr>
<tr>
<td>6 Implement agreed plans to support a sustainable cardiac physiologist workforce.</td>
<td>X</td>
</tr>
<tr>
<td>• Establish current state and action plan</td>
<td></td>
</tr>
<tr>
<td>• Implement actions</td>
<td></td>
</tr>
</tbody>
</table>
7.3 Regional Hepatitis C Services

Long Term Objectives

The Hepatitis C Steering group work plan places emphasis upon progressing three key health themes:
- To implement integrated hepatitis C assessment and treatment services across community, primary and secondary care services in the region.
- To increase hepatitis C treatment uptake and primary care prescribing.
- To diagnose those undiagnosed and lost to follow up.

Annual Objectives

The Region's objectives for 2019/20 are to:
- Raise awareness of, and provide education on the hepatitis C virus (HCV), its risk factors, and management/treatment options to the general public, Primary Healthcare teams, and specifically to NGOs and service providers for whom the targeted at risk population are already known in the Northern region.
- Provide targeted testing of patients most at risk for HCV exposure through point of care and/or community based laboratory services.
- Enhance the delivery of an integrated hepatitis C service through community based HCV testing and care including liver health assessment through the AST to Platelet Ratio (APRI) and/or liver elastography scans to support the right care in the right place at the right time.
- Collaborate across primary and secondary care to support people with allied services such as community alcohol and drug services, needle exchange, and other social agencies best placed to support HCV treatment and ongoing management.
- Detection, management and treatment of HCV will focus on the six ‘at risk’ populations including those who have ever injected drugs; ever received a tattoo or body piercing using unsterile equipment; had a blood transfusion before 1992; ever lived or received medical treatment in a high-risk country; ever been in prison or have been born to a mother with hepatitis C.
- Better understand the cascade of care across demographic measures to ensure equity of access to diagnosis and management/treatment, and ensuring no one is left behind in achieving cure from HCV.

2019/20 Action Points

Receive and consolidate quarterly reports from the Northern regions DHBs which detail progress and opportunities across the regions;
- Community Alcohol and Drug Service
- Needle exchange
- Corrections Department facilities
- Primary care and other community providers
- Secondary services

Work with the Northern regions Correctional Facilities Health Team to implement a HCV service with the goal of micro-elimination within this vulnerable and at risk population.

Establish ‘line of sight’ reporting through the Regional Data Sharing HealthSafe programme to allow meaningful analysis and reporting on key demographics to ensure equity of access, diagnosis, and treatment.
### National Project: Hepatitis C 2019/20 Action Plan

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progress key existing HCV initiatives</strong></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>- Education and awareness in the general public on HCV and its risk factors</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Education and awareness across key stakeholders to facilitate HCV diagnosis and treatment for at risk communities</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Support and enhance the delivery of HCV services through primary care undertaking the Laboratory look-back review of identified patients.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service development</th>
<th>X</th>
<th>X</th>
<th>Process Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Undertake a micro-elimination project with the Northern region Corrections Department at Wiri Men’s prison</td>
<td>X</td>
<td>X</td>
<td>Process Improvement</td>
</tr>
<tr>
<td>- Gain line of sight on the cascade of care for key demographics to ensure equity of access and treatment for cure.</td>
<td>X</td>
<td>X</td>
<td>Process Improvement</td>
</tr>
</tbody>
</table>

### 7.4 Regional Cardiovascular Network

#### Long Term Objectives

Improve access to cardiac services which will help our population to live longer, healthier and more independent lives. The Northern region’s Cardiac Clinical Network has identified the following issues with CVD management in the Northern region:

- There is variation in both access and timeliness of access to core cardiology assessment, investigation and management across the primary-secondary continuum.
- Variations in CVD outcomes by socio-economic status and ethnicity have been identified and our ongoing goal will be to work toward ensuring these groups meet accepted intervention rates and health outcomes.

The regional objectives for 2019/20 are to:

- Continue to support implementation of better cardiovascular models of care to meet demand and to improve the quality of care delivered across the continuum of care
- Community Cardiac Arrest project
  - Increase use of bystander cardiopulmonary resuscitation (CPR) working with the Community Cardiac Arrest National Working group
  - Progress access to Public Access defibrillators (PADs), focusing on the Hokianga region which has a high Māori population and placement of PADs in maraes is to be considered in consultation with local iwi.
  - Work to increase competence in CPR within the general population
  - Increase public awareness of sudden cardiac death incidents and how to prevent them
- Support DHBs in the implementation, use and audit of the updated accelerated chest pain pathways
- Focus on heart failure; including continuing to improve access to Echo, to address issues in the Echo workforce.

The key focus in 2019/20 will be to:

1. Compile, monitor and ensure ongoing achievement of regional KPI’s
   - Ensure current measures agreed for Cardiology, Cardiothoracic, Heart Failure, and Community Cardiac Arrest, across the Region, continues to be closely monitored to ensure targets are achieved, improvements are agreed and progressed, and appropriate capacity is available
   - Apply an equity lens across high risk populations to identify and reduce CVD related health disparities
2. Progress two key projects to a successful conclusion:
   o Community Cardiac Arrest project:
     Look to reduce amenable mortality by working to provide increased access to Public Access Defibrillators (PADs) throughout the northern region focusing, in the first instance, on the Hokianga district.
   o Develop a database for collection of Cardiac Rehabilitation programme data with the intent of progressing this to effective reporting and measurement of patient health outcomes along with increased participation in such programmes.

Cardiovascular Services 2019/20 Action Plan

Provide periodic reports relating to the following regional service measures. Agree and progress improvement actions required for maintaining regional achievement of standing KPIs in the following areas:

- Cardiology Health Targets
- Cardiothoracic Health Targets
- Intervention Rates for Cardiology and Cardiac surgery
- Medication adherence reports (CVD Risk Management)
- Waiting list management targets
- Access to Echo

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1 Pathways</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2 Community Cardiac Arrest project</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3 Electrophysiology (EP)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4 ECG Transmission by Ambulance Process</td>
<td>X</td>
</tr>
<tr>
<td>5 ECHO</td>
<td>X</td>
</tr>
</tbody>
</table>

The Northern Region Service Plan - Implementation Element 2019/20
Long Term Plan Year 2
### 7.5 Regional Stroke Network

The priorities for stroke services across the northern region build on the following achievements in 2018/19:

- The region implemented the second phase of the hyperacute stroke pathway. This extended afterhours ambulance diversions to Auckland City Hospital's Hyperacute Stroke Unit to all people domiciled in the metro-Auckland areas (only West Auckland domiciled for Phase 1).
- The region developed the Auckland and Northland Out-of-Hospital Acute Stroke Destination Policy in conjunction with St John and the National Stroke Network, which guides decision making for clinical personnel in out-of-hospital settings (ambulance service and primary care personnel).
- The region is meeting the national thrombolysis target rate of 10% and timeliness of access to thrombolysis is on par with the national median door-to-needle times (60 – 61 minutes).\(^1\)
- Three out of the four DHBs now have 24/7 access to CT perfusion imaging which is key to quick identification of suitable candidates for percutaneous stroke intervention (clot retrieval).
- More than 220 people have received PSI via the Northern Region service in the last 12 months to April 2019, with median onset-to-groin times better than the national median (within 3.5 hours for metro-Auckland and within 4.5 hours for Northland).
- Over 140 DHB staff attended the annual Regional Stroke Study Day hosted by Auckland DHB in October 2018.

### Long Term Objectives

The Long Term Objectives of the Northern Region Stroke Network are to:

- Continue developing and implementing consistent protocols, incorporating advances in care and streamlining pathways for people who have experienced stroke.
- Strengthen collaboration between community, primary, secondary and tertiary stroke services.
- Review ways to strengthen stroke prevention initiatives, public awareness, in-hospital, and community rehabilitation stroke services.
- Align access to stroke services and models of care across the region, consistent with national guidelines.
- Identify the impact of stroke and the barriers to stroke services for Māori and other ethnic groups in order to instigate actions to address inequalities.
- Identify the impact of stroke and the barriers to stroke services for people living in areas of limited geographic access in order to instigate actions to address inequalities.

### Annual Objectives

The Region’s objectives for 2019/20 are to:

- Implement a regional strategy for the management of stroke risk in patients with non-valvular atrial fibrillation.
- Ensure continued improvement in access to stroke treatment for patients presenting within the hyperacute stage of stroke.

\(^1\) National Thrombolysis Register REDcap reports, Q1 and Q2, 2018/19
- Incorporate advances in care by building on existing services – expanding use of CT Perfusion guided decision making.
- Advocate for a national telestroke service to provide cross cover and improve outcomes for stroke patients who are not able to be transported to a regional hyperacute stroke centre within stipulated treatment timeframes.
- Maintain timely access to acute inpatient stroke services.
- Improve timely access to rehabilitation services, with a focus on access for under 65 year olds.
- Benchmark acute stroke services against National Stroke Network standards for acute stroke units.
- Improve data collection for community rehabilitation services to support service development and clinical practice.
- Further develop stroke leadership and collaboration.
- Plan for a sustainable, adaptive and informed stroke workforce.

### Stroke 2019/20 Action Plan

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Stroke Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>Management of Non-Valvular Atrial Fibrillation for people at risk of stroke</td>
<td></td>
</tr>
<tr>
<td>- Develop Case for Change and seek approvals to implement a regional plan for management of NVAF in people at risk of stroke</td>
<td>X X X X</td>
</tr>
<tr>
<td>FAST Campaign</td>
<td></td>
</tr>
<tr>
<td>- Support regional engagement with the national FAST campaign and Stroke Awareness Week (October 2019)</td>
<td>X</td>
</tr>
<tr>
<td><strong>2 Acute Stroke Service Development</strong></td>
<td></td>
</tr>
<tr>
<td>Regional Hyperacute Stroke and PSI Pathway Implementation</td>
<td></td>
</tr>
<tr>
<td>- Conclude Phase 2 (Q1 - Aug 2019) and evaluate delivery for quality (safe, timely, efficiency effectiveness, equity, patient -centeredness) and value</td>
<td>X X</td>
</tr>
<tr>
<td>- Implement recommendations for the next phase of service development</td>
<td>X X X X</td>
</tr>
<tr>
<td>Telesroke</td>
<td></td>
</tr>
<tr>
<td>- Advocate for a national telestroke service.</td>
<td>X</td>
</tr>
<tr>
<td>- Analysis of demand assumptions for telestroke services in the region (smaller hospitals, self-presenters, PASTA –yes)</td>
<td>X X X X</td>
</tr>
<tr>
<td><strong>3 Stroke Rehabilitation</strong></td>
<td></td>
</tr>
<tr>
<td>- Establish a regional stroke rehabilitation sub-group to support implementation of the national stroke rehabilitation strategy.</td>
<td>X X</td>
</tr>
<tr>
<td>- Ensure timeliness of access to inpatient and community stroke rehabilitation for all ages and ethnicities, with a focus on improving equity of access for &lt;65 years olds</td>
<td>X X X X</td>
</tr>
<tr>
<td>- Develop community stroke rehabilitation reporting to support improvement of service delivery and access to community rehabilitation. The regional focus will be on:</td>
<td>X X X X</td>
</tr>
<tr>
<td>- Supporting shared learning from AROC community rehabilitation data</td>
<td></td>
</tr>
<tr>
<td>- Regional reporting of the MoH community stroke rehabilitation indicator by ethnicity</td>
<td></td>
</tr>
<tr>
<td><strong>4 Quality Improvement</strong></td>
<td></td>
</tr>
<tr>
<td>- All DHBs to have completed trial certification using the national accreditation framework for acute stroke units</td>
<td>X</td>
</tr>
<tr>
<td><strong>5 Clinical Leadership Development and Regional Collaboration</strong></td>
<td></td>
</tr>
<tr>
<td>- Quarterly Regional Stroke Network education sessions</td>
<td>X X X X</td>
</tr>
<tr>
<td>- Annual Regional Stroke Study Day</td>
<td>X X X X</td>
</tr>
</tbody>
</table>
7.6 Healthy Ageing - Frailty (Deep Dive #1.4)

Phase two of the Frail and Elderly Deep Dive will develop work-streams which align with business and investment objectives of the Northern regional investment logic mapping under the long-term investment plan. A current state analysis due to be carried out in Q4 2018/19, this will inform the implementation programme of work.

The aim is to establish new and effective models of care which maximise productivity and support consistency between the DHBs in a regional approach where appropriate. In the short to medium term, as a Region we will look to:

- Target areas of variation and identify models of care changes that drive an appropriate length of stay in Acute hospital care
- Improve on existing community models of delivery post discharge which improve the probability of a safe return to home.
- Implement fresh approaches for common presentations such as fragility fractures and dementia.
- Work alongside primary care to develop preventative strategies and enhance areas such as minimisation of polypharmacy.
- Partner with various community providers in Home Based Care to provide a wider range of options that enhance the wellbeing of Frail Older Adults.
- Alliance with relevant Social Sector Services to enhance the investment in longer term solutions for the psychosocial determinants of Healthy Ageing and a more compassionate and inclusive community.
- Clarify inter-regional and inter-DHB variation, identify areas of strength and weaknesses throughout the Region and establish the evidence to display this variation and to support any improvements proposed under the work plan.
- Prioritise initiatives based on opportunity for gain and identify lead entities to progress improvement initiatives on behalf of the region.
- Reinforce and adapt the advisory and working groups necessary to complete the implementation program action points.
- Share outcomes and lessons learnt from lead work and support the adaption and adoption in other DHBs.

The Region’s priorities and key actions for 2019/20 are set out in the table below.

<table>
<thead>
<tr>
<th>Frail Elderly 2019/20 Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action Points</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>1 Implementation programme of work</td>
</tr>
<tr>
<td>• Established working groups (4/5) for identified priority areas are underway in each DHB/regionally</td>
</tr>
<tr>
<td>• Areas for change/improvement are agreed with lead entities</td>
</tr>
<tr>
<td>• Cross boundary allocation is in full operation</td>
</tr>
<tr>
<td>• Report on key lessons or changes achieved in priority areas</td>
</tr>
<tr>
<td>2 Dementia Pathways <strong>[DN: Possible MOH Mandate]</strong></td>
</tr>
<tr>
<td>• Coordinate a regional stocktake of dementia services and related activity</td>
</tr>
<tr>
<td>• Design template for regional stocktake</td>
</tr>
<tr>
<td>• Gather information on current state</td>
</tr>
<tr>
<td>• Compile feedback and identify areas for improvement</td>
</tr>
</tbody>
</table>
8. Northern Regional Networks for additional services

Two further regional clinical networks programmes are set out below. Whilst neither is the subject of deep dive focus for the long term plan, and are not identified as national requirements for all regions, the work undertaken by these networks has been prioritised by the region for continued resource. Our continued investment in Child health recognises the strong links to the early years priorities within our population and public health deep dive. Our renewed investment in Major Trauma reflects the need to further embed networked service provision into current practice building on the previous work programme that has delivered major improvements in trauma care.

8.1 Child Health Network

Plans for 2019/20 build on a range of achievements delivered in 2018/19

- **Equity:**
  - The Healthy Weight Working Group developed an infographic for socialising that children's height/weight/BMI be measured regularly in GP practices. This is available as a resource on the Auckland Regional HealthPathway. Posters have been circulated to all PHO’s, Urgent Care Practices and DHB Child Health services.

- **Knowing every child:**
  - The National Child Health Information Platform (NCHIP) Project has moved into development and delivery stage following negotiations with the vendor and the workplan being established.

- **Informing families:**
  - A guide for health professionals has been agreed regionally to enable health professionals to work with families, raise awareness, and promote oral health and healthy weight consistently across the Northern Region. Messages are age appropriate and designed to be used in conversation with the community.

- **Enabling clinical teams:**
  - A northern region neonatal system quality improvement project is underway. The action plan has been agreed. A Neonatal Cot Escalation Plan provides an escalation pathway to coordinate neonatal cot management ensuring all options for neonatal cots are explored before transfer out of region occurs. An expanded daily report for out of area neonates has been implemented providing visibility of babies to their home units.
  - A Northern Region Head Injury and Concussion in Children pathway was developed for primary care in 2016. ACC has implemented the funding for a Sport Concussion Assessment Tool (SCAT5) nationally commencing 1 December 2018 following a positive ACE screen (see head injury pathway).

- **Advocating for the child:**
  - The Northern Region 6 week infant check working group agreed the actions and responsibilities relating to the six week postnatal check. The recommendations have been sent to the Ministry of Health to inform the Well Child Tamariki Ora Review.

Long Term Objectives

The Regional Child Health Plan aligns with the Child and Youth Well-being Strategy and contributes to the vision that “New Zealand is the best place in the world for children and young people”\(^2\).

The Child Health work plan places emphasis upon progressing five, well-established, child health themes:

- **Equity:** Our projects aim to eliminate differences in health that are ‘not only avoidable but unfair and unjust’ (MoH definition, 2019)
- **Knowing every child:** enhancing systems of enrolment for effective engagement with universal healthcare
- **Informing families:** using consistent health promoting messages regionally
- **Enabling clinical teams:** to deliver health care to those with highest need through supporting models of care and evidence-based approaches
- **Advocating for the child:** through coordinated regional approach and active intersectoral relationships.

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## Child Health 2019/20 Action Plan

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td><strong>1 Improve equity:</strong></td>
<td></td>
</tr>
<tr>
<td>• We will use co-design to strengthen Māori and Pacific participation.</td>
<td></td>
</tr>
<tr>
<td>• We will segment child health information focusing on Māori and Pacific ethnicity and deprivation quintile to inform action plans and project design.</td>
<td></td>
</tr>
<tr>
<td>• We will engage with key stakeholders (e.g. Auckland Regional Public Health Service) to:</td>
<td></td>
</tr>
<tr>
<td>o Agree key messages for mothers and babies including promoting immunisation and smoking cessation in pregnancy, particularly for Māori</td>
<td></td>
</tr>
<tr>
<td>o Improve uptake of the NZ Immunisation Schedule for migrant children now living in New Zealand (e.g. Pacific children receiving vaccination for mumps)</td>
<td></td>
</tr>
<tr>
<td>o Learn from effective models of care where health improvements for Māori demonstrate improved outcomes</td>
<td></td>
</tr>
<tr>
<td>• We will deliver oral health/healthy weight messages to the health workforce and other sectors where children are at higher risk of poor outcomes. For example those attending low decile schools.</td>
<td>X</td>
</tr>
<tr>
<td><strong>2 Know every child better:</strong></td>
<td></td>
</tr>
<tr>
<td>• We will support the NCHIP information system to ‘Go Live’ in three districts across the region by contributing to regional communications, supporting change management and engaging with stakeholders.</td>
<td></td>
</tr>
<tr>
<td><strong>3 Help inform families:</strong></td>
<td></td>
</tr>
<tr>
<td>• We will provide whānau who have babies in Northern Region neonatal units information about clinical management and time course; supporting them to have realistic expectations about the transfer of infants when required to manage either regional capacity or to be as close to home as possible</td>
<td>X</td>
</tr>
<tr>
<td>o All neonatal units in the northern region will agree the documentation to be discussed with the families about anticipated length of stay, and the neonatal unit processes for transfer required for appropriate care or to the hospital of domicile</td>
<td>X</td>
</tr>
<tr>
<td>Action Points</td>
<td>Target Completion Date</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td><strong>Enable clinical teams:</strong></td>
<td>Q1</td>
</tr>
<tr>
<td>- We will agree the process to coordinate regional transfer of babies in neonatal units across districts and includes appropriate repatriation</td>
<td></td>
</tr>
<tr>
<td>o A KPI dashboard is reported monthly to give the visibility of the neonates from districts outside of domicile</td>
<td></td>
</tr>
<tr>
<td>o Criteria for transfer between neonatal units is developed and published on neonatal internal websites.</td>
<td></td>
</tr>
<tr>
<td>- We will identify strategies and prevent morbidity associated with chronic cough for children under 2 years of age through the design for regional implementation (strong equity focus).</td>
<td>X</td>
</tr>
<tr>
<td>This will include:</td>
<td></td>
</tr>
<tr>
<td>o Establishing a regional working group</td>
<td>X</td>
</tr>
<tr>
<td>o Providing the working group with the related epidemiology for children admitted to hospital with chronic cough in the northern region</td>
<td></td>
</tr>
<tr>
<td>o Defining the scope of the project and have the workplan endorsed by the CHSG</td>
<td>X</td>
</tr>
<tr>
<td>o Publishing the pathway for a regionally consistent prevention model for children under two years of age with chronic cough</td>
<td></td>
</tr>
<tr>
<td>- We will continue to progress the work that has been completed within subspecialty paediatrics to identify a number of areas where there is an opportunity to deliver care closer to home and/or in home DHB within the region.</td>
<td>X</td>
</tr>
<tr>
<td>o Continue to develop these opportunities as workforce capacity and capability and facilities allow.</td>
<td></td>
</tr>
<tr>
<td>- We will ensure neonatal and maternity services are integrated to respond quickly to urgent clinical need and cope with peaks and troughs in demand.</td>
<td>X</td>
</tr>
<tr>
<td>Actions include:</td>
<td></td>
</tr>
<tr>
<td>o A standardised template is developed for reporting to the Regional Neonatal Leadership Group</td>
<td></td>
</tr>
<tr>
<td>o Quarterly updates on developments with maternity and neonatal units are received by the Regional Neonatal Leadership Group.</td>
<td>X</td>
</tr>
<tr>
<td><strong>Advocate for the child:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td></td>
</tr>
<tr>
<td>- We will align Northern Region child health work to the emerging Child and Youth Wellbeing Strategy, other relevant government reviews, and Northern Region Long Term Health Plan.</td>
<td>X</td>
</tr>
<tr>
<td>o The Child Health Steering Group is provided with all reviews as they are communicated nationally</td>
<td></td>
</tr>
<tr>
<td>- We will provide evidence based technical advice about direction of travel for the northern region child health, ensuring an equity lens</td>
<td></td>
</tr>
<tr>
<td>o A technical working group will be established</td>
<td></td>
</tr>
<tr>
<td>o Areas for regional priority in the ‘early years’ will be based on evidence. Regional workplan timeframes are agreed by CHSG</td>
<td></td>
</tr>
<tr>
<td>- We will improve service integration with infant mental health services</td>
<td></td>
</tr>
<tr>
<td>o Establishing regional network relationships and agree the approach to improve service alignment</td>
<td></td>
</tr>
<tr>
<td>- We will scope the health/education interface in ECE, primary and secondary schools and increase opportunities for joint working</td>
<td>X</td>
</tr>
<tr>
<td>o Deliver a report about existing regional health/education interface models for joint working with children in education settings</td>
<td></td>
</tr>
<tr>
<td>o Identify perceived gaps</td>
<td></td>
</tr>
<tr>
<td>o Identify inequities relating to school readiness including the perception and acceptance of ‘normal’ in communities.</td>
<td></td>
</tr>
</tbody>
</table>
Monitor progress:

The regional Child Health Plan aims to add benefit through a regional approach. When regional projects close, the responsibility for implementation moves to the districts. The regional role becomes monitoring. The Child Health Network will provide, and/or receive, periodic reports relating to the following regional service measures. Agree and progress improvement actions required for maintaining regional achievement of standing KPIs in the following areas:

- Immunisation rates
- Rheumatic Fever
- Oral Health
- Sudden Unexpected Death in Infants (SUDI)
- Skin infection

8.2 Major Trauma Network

The Major Trauma network moved to operating as a ‘light touch’ network in 2018/19. The appointment of a new clinical lead with additional project management and analytical support from the NRA is designed to provide the network with an opportunity to progress further improvements at greater pace and scale in 2019/20.

The overarching purpose for the network is to drive clinical collaboration across services involved in the end to end patient pathway for major trauma to deliver clear and consistent & equitable outcomes for the region in improving mortality, morbidity, and effective and efficient use of resources for patients.

The draft work priorities for the network are set out below,

[DN: Network are reviewing draft in parallel with REF]

<table>
<thead>
<tr>
<th>Action Points</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
</tr>
<tr>
<td>1. Recruit to the new network leadership team</td>
<td></td>
</tr>
<tr>
<td>• Lead, project management and analytics resource appointed</td>
<td></td>
</tr>
<tr>
<td>2. Royal Australasian College of Surgeons National review</td>
<td></td>
</tr>
<tr>
<td>• Identify relevant recommendations which can be implemented in the Region.</td>
<td></td>
</tr>
<tr>
<td>• Develop implementation plans for the identified key actions</td>
<td></td>
</tr>
<tr>
<td>3. Severe Trauma and Moderate Brain Injury</td>
<td></td>
</tr>
<tr>
<td>• Analyse sTBI and moderate brain injuries, &amp; develop packages of care for moderate brain injuries for regional deployment</td>
<td></td>
</tr>
<tr>
<td>4. Training Education and Research</td>
<td></td>
</tr>
<tr>
<td>• Develop education modules for inpatient ward trauma nurses</td>
<td></td>
</tr>
<tr>
<td>• Scope a research project to identify patient outcome measures for long-term trauma outcomes aligned to wider regional PROMs approach</td>
<td></td>
</tr>
<tr>
<td>5. Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>• Develop rehab pathways for bilateral non-weight bearing fractures, PTSD and long-term pain management</td>
<td></td>
</tr>
<tr>
<td>6. Future Arrangements</td>
<td></td>
</tr>
<tr>
<td>• Consider international practice in operational provider networks and how these will be reflected in the arrangements for major trauma in the region</td>
<td></td>
</tr>
</tbody>
</table>
Embedding Quality and Safety in Services

The Northern region previously supported a Regional Patient Safety Network (RPSN) with secretariat/project management support provided by Northern Regional Alliance resource. In previous regional service plans, the work of this group was represented in a ‘Quality’ section. During 2018, the NRA Board, in collaboration with the Regional Executives Forum took a decision to cease secretariat support for the coordination of the RPSN, ensuring DHB structures remain the locus for clinical governance of quality and safety. The DHBs have agreed that:

- quarterly teleconferences will occur between DHB representative members and the Health Quality and Safety Commission (HQSC) in order to maintain a forum for raising patient safety and quality issues requiring a consistent approach in the northern region
- the HQSC could present through the Metro Auckland Clinical Governance Forum on a regular basis to keep patient safety and quality issues at the forefront
- the Regional Deteriorating Patient Programme Implementation Group would continue with support from the chair’s office

[DN: Check positioning with CMO Sponsor & REF]

9. Regional Leadership and Governance

Delivery of the initiatives outlined in this regional plan requires strong governance and the participation of a wide range of stakeholders and organisations. We will continue to work with our DHBs, healthAlliance, primary care Alliance Partners, primary care and community representatives who participate in our clinical networks and other regional workgroups to ensure alignment of plans and actions.

The Region is committed to this plan. Delivery requires strong leadership and confidence across all sectors and regional agencies. The Region’s leading clinicians have prioritised those initiatives where significant gains can be made, and which are feasible to achieve and measure.

The level of commitment shown to this plan from the four DHBs and our primary care and community partners gives us confidence that we can embed the changes required across all levels of our health system. To realise our goals we will continue to develop new and established relationships particularly across primary, community and hospital services. Our aim is to achieve a level of integration which is both meaningful and productive.

At a regional level, we will be measuring our performance and monitoring progress against the activities that have been committed to as part of this plan.

Two key governance groups oversee all clinical and business services activities:

- **Regional Governance Group (RGG)** - Membership comprises DHBs Chairs, with Chief Executive Officers (CEOs) and Chief Medical Officers (CMOs) attending in an ex officio capacity and others by invitation. The Regional Governance Group:
  - Provides a collective regional forum to address, monitor and influence current and long term planning of regional health services and capital planning
  - Shapes thinking on the regional direction, particularly in relation to long-term planning of regional health services
  - Identifies any issues impacting on the ability of the Region to efficiently deliver health services to the Northern region population
  - Agrees annual and longer term strategic priorities and the Regional Service Plan
  - Approves regional strategy and ensures alignment with the New Zealand Health Strategy 2016
  - Monitors progress and performance against regional plans
  - Deliberates as a collective group and drives a regional collaboration agenda
  - Acts as an escalation point for regional issues that cannot be resolved in other groups
  - Periodically reviews the effectiveness of the regional working framework and the establishment or disestablishment of regional groups.

RGG is a steward for regional decision making. It operates within Board delegations to Chairs and as such the RGG has no formal delegations. It is the guardian of the ‘regional direction of travel’ and ensures that progress is made against the actions. RGG holds the Regional Executives Forum to account for delivery.
• **Regional Executives Forum** – Membership includes the CEOs, CMOs and Chief Financial Officers (CFOs) from each DHB, with the expectation being that the CFOs will attend quarterly with all papers copied to them. The Regional Executives Forum provides active leadership and operational oversight to all regional activities. Specifically, the group:
  o Provides leadership for the regional agenda, ensuring that sound advice is provided to the Regional Governance Group to inform discussions and recommendations in regard to regional strategy
  o Is accountable to the Regional Governance Group for the development of and delivery of the regional plan/s that are aligned with the New Zealand Health Strategy 2016
  o Monitors performance against plans and service level agreements
  o Considers risks to the Region’s operations, strategies and plans
  o Addresses operational and other issues that are within the delegations of individual members of the group
  o Ensures there are appropriate regional groups and networks to support effective regional collaboration and strategy implementation and monitors the effectiveness of regional groups.

The Regional Executives Forum is accountable to the Regional Governance Group. In addition each member is accountable to their Board and management and shall inform their own organisation of the activities of the Regional Executives Forum that may be significant for their DHB.

The prioritised programme of work mapped out in the Regional Service Plan builds on a strong history of regional collaboration over the last decade. It is only by working together across all care settings that we will be able to address the challenges of the future.

9.1 Regional Governance and Decision Making

Building upon the findings of our 2018 Northern region Long Term Investment Plan, we have continued a series of area ‘deep dives’ to further develop a shared understanding of the current state, risks and opportunities for various services, conditions and settings.

We are updating our Long Term Health Planning collateral and processes, including establishing updated Governance structures with clearer mandates to either develop or implement the regional ‘direction of travel’. We believe the time and consideration put into the form and membership of these structures across the Region’s four DHBs, HealthAlliance, and the Northern regional Alliance will position us very well for the future.

The modified Governance and Oversight structure comprises:

• **Executive Sponsors** – Responsible for Portfolio Alignment, Communications and Stakeholder Engagement. This group was agreed as the exec leads from each of the programmes of work, complimented by exec officio members as may be required for subject matter expertise

• **Health Service Design Authority** – responsible for oversight of the Region’s Health Services Plan work and the various Deep Dive projects work. This group was expected to reflect the membership of the NRLTIP#1 steering group:
  o Complemented: with additional individuals to reflect that NRLTIP#1 was primarily a Hospital investment piece of work and on-going and subsequent health planning thinking would need to take a broader perspective
  o Reduced: by expertise that would be more appropriately focussed upon the capital investment work

• **Health Service Implementation Steering Group** – responsible for developing, specifying and procuring specialty level services on a metro wide or region wide basis that reflect the new models of care produced by the Health Service Design Authority.

• **ISSP Design Authority** – responsible for governing and controlling design components associated with the programme to deliver the future state services and business processes associated with the new models developed by the Health Service Design Authority and Implementation Steering Group, and maintaining the ISSP Roadmaps which guide priorities and sequencing of change.

• **ISSP Delivery Programme Steering Group** – which is accountable for delivery of the suite of sub programmes and projects in the ISSP to meet clinical and operational service requirements, realise
intended benefits, and deliver the programme of change to time, and to budget.

- **Regional Capital Investment Design Authority** – responsible for:
  - Fulfilling the functions and expectations of the Regional Capital Committee with regard to business case approvals
  - Driving Capital planning system process improvements
  - Oversight of Facilities, Infrastructure and Clinical Equipment planning and delivery, ensuring quality assurance and control of the planning process and capacity and capability to implement and deliver the approved works

Figure 3: Northern region Governance and Oversight Structure

The Northern Region Health Plan is intended to improve health outcomes and reduce inequalities for the 1.87 million people living in the Northern region. It places emphasis upon selected actions that will be progressed in a joined up manner across the four District Health Boards (DHBs) in our Region. These are actions that it makes sense to progress once, in a collaborative and consistent manner, rather than independently by each DHB.

The Northern Region Health Plan has been developed under our regional governance structure, with significant contributions from our clinical networks, clinical governance groups and other regional workgroups. It represents the thinking of clinicians and managers from both our hospital and community settings. This plan is founded upon working together as a region to provide health care that makes best use of available resources, and improves access to services.

See sections 1 and 2.5 which detail the regional organisations/groups roles and responsibilities which support our regional decision making processes.
9.2 Line of Sight

Our strategic planning framework ensures we align actions across national, regional and local environments. The structure of our regional Portfolios, Programmes and Projects is frequently assessed to ensure direct alignment with our strategic objectives. Executive, management and clinical engagement in regional work prioritisation ensures close connections between the regional and DHB annual planning processes.

Alignment is further supported by how we engage with each other as a region:

- Regional networks being led by senior clinicians from the four DHBs
- Involvement of planning and funding managers, and hospital, primary and community clinicians in each of the clinical networks and major programmes of work who contribute to both local and regional planning
- Focused planning discussions in the networks regarding regional and local priorities for action
- Identification of any potential Information Systems (IS), workforce, capital or operational impacts that may result from regional actions
- Consideration of all applicable local, regional and national plans and strategies to ensure that planned activities are informed and have a measurable outcomes focus
- Engagement of senior executive leadership across the four DHBs
Appendix 1: Our Linkages and Partnerships in more detail

- **District Health Boards (DHBs)**
  DHBs take the lead on assessing the health needs of populations and funding services to meet these needs. They deliver predominantly hospital and community specialist services. DHBs sponsor the governance groups and, in partnership with the signatories of this plan, provide oversight of performance against the priority goals and achieving improvements in patient outcomes.

  DHBs have responsibility and accountability for integration and the performance of primary care in their districts. This is expected to be achieved by continuing to build local partnerships through collaboration and forming alliance agreements. Other DHB activities include:
  - Active participation of clinicians and managers in networks and the delivery of DHB and regional priorities
  - Supporting the development of and investing in locality care partnerships/networks, Integrated Family Health Centres and neighbourhood healthcare homes
  - Aligning funding to the Regional Plan and DHB priorities
  - Supporting primary care partners and the Whānau Ora providers.

- **Clinical Networks**
  The focus of clinical networks is collaborative planning and monitoring across levels of care and organisations. Networks are the key mechanism to drive:
  - The strategic direction and prioritised initiatives across primary, community and hospital care
  - Performance targets and adjusting resources and work plans to improve health outcomes and patient experience for the population
  - Engagement with primary, community and secondary care providers and the users of services

- **The Northern Regional Alliance (NRA)**
  NRA works in conjunction with the four northern DHBs to achieve the Minister’s and region’s priorities and to support the effective implementation of policy directions and objectives. In particular, the NRA will support the four Northern DHBs in areas where there is benefit from working regionally. The NRA leads the delivery of the long term health service planning and implementation activities.

  The NRA also supports links with the Health Workforce New Zealand (HWNZ) and Health Quality and Safety Commission (HQSC) to ensure that the regional and national priorities are aligned.

  Increasingly NRA will focus its resources around supporting the prioritised areas for regional working. The key drivers for NRA engagement are:
  - Nationally mandated that we engage regionally/can demonstrate regional support
  - Regionally consistent view of information is required
  - Activity impacts multiple DHBs/services/portfolios
  - Increase consistency/reduce variation
  - Reduce duplication/cost and improve efficiency/effectiveness
  - Economies of scale/effective use of scarce resource
  - Engagement of wide range of stakeholders required
  - “Independent facilitation/co-ordination” of process required
  - Capacity and technical capability available to support timely delivery of key activities
  - Leverage regional knowledge and “infrastructure”/linkages

- **HealthAlliance New Zealand (hA)**
  healthAlliance is the regional business services agency for the four DHBs. The key service activities are finance (transactional processing), procurement, supply chain, information services, and Regional Internal Audit Services. The activities of this organisation are governed by the healthAlliance New Zealand Board which comprises seven directors including one representative from each DHB and two independent directors. healthAlliance leads the delivery of the business services, including Information Systems Strategic Plan (ISSP).

- **Alliance Partnerships in Primary Care**
  Primary care providers are critical to the delivery of the regional ‘direction of travel’. PHOs are a key mechanism to drive changes to clinical practice associated with delivering a greater breadth of services locally. They will likely have a stronger focus on planned care for high-needs populations to prevent acute and unplanned admissions, and supporting older and frail people to live independently.
The seven Auckland PHOs have five key areas of focus:

- System outcomes to design and implement optimal performance based on the use of System Level Measures (SLM’s) to drive clinically led quality improvement
- New models of care that optimise self-directed care at home and in the community
- Developing fit for purpose practice models that deliver proactive patient centred care
- Information infrastructure to enable integrated and self-directed care
- Governance to drive and sustain the change agenda, the next step is to develop a single Alliance Leadership Team (ALT) for metro Auckland.

- **Other Social Sector Agencies**
  Linkages with other social agencies are important in the delivery of this plan, particularly with regard to Child Health. The health outcome for many of the children in the care of health services depends on addressing the upstream determinants of health. Children with, or at risk of, rheumatic fever and respiratory conditions will receive preferential access to housing services to address structural and functional overcrowding and to enable warmer houses. Initiatives often involve collaboration with agencies such as Oranga Tamariki - Ministry for Children, education providers, and Te Manatū Whakahiato Ora - Ministry of Social Development to deliver whole of system care to the most vulnerable children and their families.

- **Aged Residential Care**
  Aged Related Residential Care (ARRC) comprises a number of operators who provide residential care for our elderly. Cooperation and collaboration with the range of ARRC providers is important in the implementation of activities to reduce acute presentations from residential care and increase advanced care planning activities, and to improve the safety of patients from falls and pressure injuries.

- **Non-Governmental Organisation (NGO) sector**
  This sector is very important to many aspects of the regional strategic direction, particularly Healthy Ageing, Mental Health and Addictions, Cancer, and Child Health. In each of these areas linkages exist or are being strengthened to share information and align activities. These relationships are important to ensure consistent messages are being provided, regardless of where our population seeks help.

**National Entities**

The Northern region actively contributes to a number of national organisations and forums with a strong focus on ensuring alignment with national strategies and developments to achieve integration across all of our networks and activities. In particular:

- The Northern region workforce and training hub drives workforce development in the region with close alignment to the direction of Health Workforce New Zealand.
- The regional informatics work is guided by the national IT strategy and the direction of the Digital Advisory Board to maintain alignment between national and regional priorities.
- Clinical networks contribute to national specialty groups and forums to ensure alignment between regional and national direction.
- The Northern region Patient Safety Network focuses on improving patient safety and quality of care and implementing regional and national initiatives by working in collaboration with the Health Quality and Safety Commission (HQSC).
Recommendation

It is recommended that the Board:

Receive this report which outlines proposed changes to the CM Health Smokefree Policy.

Approve the proposal for a dedicated vaping area within the Mental Health campus at Middlemore Hospital.

Approve the proposal for at least one other vaping area on Middlemore Hospital grounds.

Prepared and submitted by: Basil Fernandes (Portfolio Manager, Smokefree), Sarah Sharpe (Public Health Physician, Population Health), and Summer Hawke (Manager Population Health Programmes), on behalf of Gary Jackson (Director, Population Health).

Purpose

The purpose of this paper is to seek Board approval of proposed changes to the Smokefree Policy, which is part of the CM Health Living Smokefree Service’s proposed approach to supporting people who choose to use vaping (i.e. e-cigarettes) to quit smoking, as part of our wider work to equitably reduce smoking in the CM Health population.

Executive Summary

Smokefree work continues to be a key population health priority for CM Health. Although smoking prevalence is reducing, stark ethnic inequities remain, and current actions are not enough to achieve the Smokefree 2025 goal (5% or less smoking prevalence across all groups), which current estimations predict will be missed by a large margin for Māori and Pacific Peoples.

This paper presents an overview of proposed changes to the CM Health Smokefree Policy, which would allow for vaping in designated outside areas within the CM Health grounds. This would align with the Ministry of Health advice to DHBs to support people who choose to use a vaping product to stop smoking. Background on the issue and our rationale for the proposed changes are presented. Some options for designated vaping areas are outlined, for consideration by the Board. Particular attention is given to an option for mental health clients, who have a very high smoking prevalence, and need sustained support to quit, and to help address our duty of care for these people when they are inpatients. An evidence brief on the benefits and harms associated with vaping is included in the Discussion section.

Background

Smoking is the second highest preventable risk factor for premature death and morbidity in New Zealand, with Māori and Pacific Peoples disproportionately affected. The life expectancy gap in CM is currently 9.3 years and 7 years between Māori and Pacific Peoples, respectively, and those of New Zealand European/Other ethnicities. Large contributions to this gap are from the potentially preventable long-term health conditions cardiovascular disease, diabetes, respiratory disease and cancers. Smoking cessation (alongside reducing obesity, poor nutrition, and alcohol use, and improving physical activity) is critically important for prevention of these diseases and reducing the life expectancy gap, as well as other important conditions and inequities (e.g. pregnancy outcomes, infant
and child health). Therefore, in CM Health, smokefree work continues to be a key population health priority.

Although smoking prevalence is reducing, stark ethnic inequities remain, and current actions are not enough to achieve the Smokefree 2025 goal (5% or less smoking prevalence across all groups), which current estimations predict will be missed by a large margin for Māori and Pacific Peoples. As well as strengthening our ‘business as usual’ smoking cessation services and support, we need to champion innovative approaches for smoking cessation and harm reduction. This includes supporting people who choose to use vaping products to help their quitting.

The use of vaping products to help quitting by people who smoke is growing at a rapid rate and provides a potential opportunity to dramatically reduce smoking prevalence rates and reduce inequities. The Ministry of Health position statement on vaping (see Appendix 1) states that, while vaping products are not completely harmless, they are much less harmful than smoking tobacco (i.e. for those who are addicted to smoking tobacco). Smokers switching to vaping products are highly likely to reduce the risks to their health and those around them. In the ‘Key Messages’ section of the Position Statement, the Ministry of Health states that:

- Vaping products are intended for smokers only;
- The evidence is growing that vaping can help people to quit smoking;
- There is no evidence that vaping products are undermining the long-term decline in cigarette smoking among adults and youth; and
- Despite some experimentation with vaping products among people who have never smoked, vaping products are attracting very few people who have never smoked into regular vaping, including young people.

The Ministry of Health has provided guidance to Smoking Cessation Services stating that services must: become ‘vaping friendly’, provide accurate information to people about vaping, and support people who choose to use a vaping product to stop smoking. Advice from the Ministry of Health states that “smokefree policies should be updated to include vaping and other products that are not smoked (e.g. heat not burn). Updated smokefree policies should reflect that there are no legal restrictions on vaping in smokefree areas and that, whilst vaping in indoor spaces may be inappropriate, DHBs could allow vaping in outdoor spaces if they so choose.”

The Ministry of Health and Health Promotion Agency have launched a New Zealand-specific Vaping Facts website: https://vapingfacts.health.nz, which provides key facts about vaping, information on vaping versus smoking, and information on vaping to quit smoking. The website states that it is for people who are looking to quit smoking and those who support them, as well as anyone interested in the role of vaping in New Zealand as a way to quit.

Information on e-cigarette use by clients of the Living Smokefree Service (Jan 2017-June 2018) shows that 11% of clients were reported as using e-cigarettes; there were no differences by ethnicity. The Service reports higher quit rates among those who vape (77% quit rate) compared with those who do not vape (62% quit rate). The Living Smokefree Service has a plan in place to support people who choose to vape to quit smoking. This includes:

- Upskilling the Living Smokefree Service staff and other healthcare professionals so as to be able to provide appropriate advice and support to clients/patients regarding use of e-cigarettes (and including concurrent use of smoking cessation medications and e-cigarettes);
- Developing information for clients and providing support including group-based therapy for people who use e-cigarettes;
- Engaging with responsible vape vendors, sharing Living Smokefree Service information and encouraging referrals for stop smoking support; and strengthening the capture of data about e-cigarette use by clients.

\[1\] Note that the Government is intending to amend the Smokefree Environments Act 1990 to address vaping.
In addition, we recommend making changes to the CM Health Smokefree Policy to enable the provision of support to Middlemore Hospital inpatients who choose to vape to quit smoking. Note that mental health clients are a priority group for smokefree work. Approximately 80% of Tiaho Mai inpatients smoke. Access to vaping as a tool for harm minimisation and quitting smoking has high levels of support from Tiaho Mai inpatients and staff, and would help to address our duty of care for our mental health inpatients.

The experiences of staff in CM Health Living Smokefree Service support the need for the health system to do more to enable clients/patients who smoke to use vaping as a cessation tool, if they choose. Staff report that a number of clients have stopped smoking recently using vaping (i.e. 52 clients in the last quarter, with 30 being Maaori or Pacific people). Most of these clients have said that traditional methods of treatment, such as nicotine replacement therapy and prescription medicines, haven’t worked for them. Vaping has provided an easier transition from smoking because vaping devices are easy to use, involve a hand-to-mouth motion, have flavour, deliver nicotine quickly to ease cravings, and are easier to titrate down to eventually stop vaping. Also, many clients feel that vaping offers an effective option which is much less expensive than smoking. Insights from clients and staff are described in Appendix 2.

Other DHBs are also working to progress updates to their smokefree policies. Mid Central DHB has approved vaping in the courtyard of Ward 21, the Mental Health Service Unit. They intend to add a new vapourless product ‘JAC Vapour – Clear Steam Vapourless E-liquid for E-Cigarettes’ to their Hospital Pharmacy list and to provide this to mental health inpatients to wish to vape to quit smoking.

Proposal
It is proposed that the following changes are made to update the CM Health Smokefree Policy to be in line with Ministry of Health guidance, and to allow for designated vaping areas within the grounds of Middlemore Hospital. This would be reviewed after one year. See Appendix 3 for the entire policy with track changes.

CM Health policy current wording (page 2): “E- Cigarettes are not to be used on Counties Manukau Health premises in line with Ministry of Health Advice On E- Cigarettes”.

Revised wording: “Counties Manukau Health seeks to balance the objectives of 1) supporting people who smoke who choose to vape for smoking cessation or harm reduction and 2) protecting people, particularly children and young people, from any potential risks associated with vaping. People who choose to vape to quit smoking may do so only in designated outside areas within the Counties Manukau Health grounds, as determined by the Executive Leadership Team. This includes e-cigarettes and other products that are not smoked (e.g. ‘heat not burn’ products).

Advice and support regarding the use of vaping products for smoking cessation and harm reduction is available from the Living Smokefree Service.”

Designated Vaping Areas
Following consultation with the Executive Leadership Team, Tiaho Mai management team, the Facilities manager, and the Security manager, we propose two options for designated vaping areas:

- **Option 1**: One vaping area only, in a discreet area at the rear of Tiaho Mai, only for Tiaho Mai inpatients, whaanau, and visitors.
- **Option 2**: A vaping area at Tiaho Mai as indicated in Option 1 plus an area in the Middlemore Hospital grounds public area, which is proposed to be at the northern side of the pedestrian crossing opposite Edmund Hillary Building.

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1 Based on audits for March and April of Tiaho Mai inpatient notes.
Discussion: Benefits and harms of vaping

There is an emerging body of literature about the benefits and harms of vaping. There are two recent, substantial evidence reviews, one by Public Health England (2018) and one by the US National Academies of Sciences, Engineering, and Medicine (NASEM, 2018). Both reviews reach conclusions that: vaping can benefit people who smoke who can switch from smoking to vaping; vaping is not risk free; vaping is not recommended for young people or non-smokers; and more research is needed. However, there are often differing views between the US and the UK on the risks of using vaping to help quitting, which are picked up by the NZ media. NZ in general, through the MoH, is taking a position consistent with the UK views and our work is aligned with the MoH in this area.

A key question to be considered is whether vaping helps people to quit smoking. One of the first Randomised Controlled Trials (RCTs) to address this question was conducted in New Zealand (Bullen et al. 2013) and found vaping, with or without nicotine, was modestly effective at helping smokers to quit. Another early RCT (Caponnetto et al. 2013) in smokers not intending to quit found that the use of e-cigarettes, with or without nicotine, decreased cigarette consumption and helped with smoking cessation without causing significant side-effects. Since then a number of systematic reviews have been conducted; seven of these have included meta-analyses and have produced different results (two found a positive effect of vaping on smoking cessation, four were inconclusive, and one was negative). One of these systematic reviews was a Cochrane Collaboration Review (2016) which investigated whether electronic cigarettes help people stop smoking, and whether they are safe to use for this purpose. This review concluded that there is evidence that using an electronic cigarette containing nicotine increases the chances of stopping smoking in the long term compared to using an electronic cigarette without nicotine. The review could not determine if electronic cigarettes were better than nicotine patches, because the number of participants in the study was too small. No serious adverse events related to electronic cigarette use were detected.

Vaping product technology is evolving rapidly and the products used in the early studies are now obsolete. The most recent RCT published (Hajek et al. 2019) evaluated the 1-year efficacy of second generation e-cigarettes (refillable) as compared with nicotine replacement therapy, when provided to adults seeking help to quit smoking and combined with face-to face behavioural support. This was a
large trial in 886 participants conducted in the stop-smoking service setting across three sites in London, Leicester, and East Sussex, England. Vaping was found to be significantly more effective for smoking cessation than nicotine replacement therapy (both products were accompanied by behavioural support). The 1-year abstinence rate was 18.0% in the vaping group and 9.9% in the nicotine-replacement group (Relative Risk 1.83; Confidence Interval 1.30-2.58; p<0.001).

Another key question to be considered is whether vaping is safe (both for the user and bystanders). Vaping products are electrical devices that produce a vapour (rather than smoke) by heating a liquid (containing vegetable glycerine, propylene glycol, colours/flavours, +/- nicotine) which the user inhales. Vapour lacks the cigarette smoke toxins which cause most of the harm associated with tobacco smoking (including cancers, cardiovascular disease, and respiratory disease) and therefore vaping has a substantially lower risk than smoking. However, there are a range of chemical constituents and toxicants which may be present in vapour (e.g. aldehydes, volatile organic compounds, phenolic compounds, flavours, solvent carriers). Although these appear to be present at levels considered to be a negligible or low risk to health, the long-term effects are not yet known. Reports of poisonings from the vaping liquids and explosions/fires associated with the electronic devices are rare. Product labelling and quality control of vaping liquids are of concern and these product safety issues are currently being addressed by the Government.

Another question to consider is whether vaping leads to an increase in smoking prevalence in young people. There has been a great deal of concern and commentary about a potential risk that experimentation with vaping by young people may lead to regular vaping and to smoking. This is referred to as a ‘gateway effect’. Currently, there is no evidence of a causal link between vaping and smoking. Despite some experimentation with vaping among people who have never smoked, vaping is attracting very few young people who have never smoked into regular e-cigarette use, including in New Zealand. However this does need to be closely monitored over time and it is important that New Zealand implements the proposed regulatory controls (including making it illegal to sell vaping products to people aged <18 years).

The Ministry of Health’s position on vaping (see Appendix 1) is in line with international evidence and expert opinion. The Ministry of Health considers vaping has the potential to contribute to achieving the Smokefree 2025 goal and to significantly disrupting the significant inequities in smoking prevalence that are present. The Ministry’s Position Statement states “the potential of vaping products to help improve public health depends on the extent to which they can act as a route out of smoking for New Zealand’s 550,000 daily smokers, without providing a route into smoking for children and non-smokers.” The intention of the Ministry of Health and Government is to take a balanced approach which supports people who smoke to switch to significantly less harmful products whilst also protecting children and young people from any potential risks.

Appendices

1: Ministry of Health Position Statement on Vaping (attached separately)
2: Vaping: Youth & youth workers, clients, and staff insights (attached separately)
3: Current CM Health Smokefree Policy with proposed changes indicated (attached separately)
References

8. Stephens WE. Comparing the cancer potencies of emissions from vapourised nicotine products including e-cigarettes with those of tobacco smoke. Tob Control 2018; 27: 10-17
24 April 2019

To: DHB Chief Executives

Kia ora koutou katoa

**Vaping in the context of Smokefree 2025 – a national position statement from the Ministry of Health**

Thank you for the opportunity to meet with you at the recent Chief Executive’s meeting on 11 April to discuss vaping in the context of Smokefree 2025. At the meeting you requested a national position statement on vaping from the Ministry of Health. The national position statement and key messages are provided below. This information is also available on the Ministry of Health’s website.

**National Position Statement on vaping**

In 2011, the Government set a goal for Smokefree 2025. The goal aims to reduce smoking prevalence to minimal levels.

The Ministry of Health considers vaping products have the potential to make a contribution to the Smokefree 2025 goal and could disrupt the significant inequities that are present.

The potential of vaping products to help improve public health depends on the extent to which they can act as a route out of smoking for New Zealand’s 550,000 daily smokers, without providing a route into smoking for children and non-smokers.

The Ministry of Health encourages smokers who want to use vaping products to quit smoking to seek the support of local stop smoking services. Local stop smoking services provide smokers with the best chance of quitting successfully and must support smokers who want to quit with the help of vaping products.

Expert opinion is that vaping products are much less harmful than smoking tobacco but not completely harmless. A range of toxicants have been found in vapour including some cancer causing agents but, in general, at levels much lower than found in cigarette smoke or at levels that are unlikely to cause harm. Smokers switching to vaping products are highly likely to reduce the risks to their health and those around them.

When used as intended, vaping products pose no risk of nicotine poisoning to users, but vaping liquids should be in child resistant packaging. Vaping products release negligible levels of nicotine and other toxicants into ambient air with no identified health risks to bystanders.

Currently there are no mandatory product safety requirements specifically for vaping products in New Zealand, however generic product safety standards apply.

The Ministry of Health will continue to monitor the uptake of vaping products, their health impact at individual and population levels, including long term effects and their effectiveness for smoking cessation as products, evidence and technologies develop.

The Ministry of Health will also continue to meet its obligations under Article 5.3 of the WHO Framework Convention on Tobacco Control to protect public health policy from commercial and other vested interests of the tobacco industry.
Key messages

- The best thing smokers can do for their health is to quit smoking for good.
- Vaping products are intended for smokers only.
- The Ministry considers vaping products could disrupt inequities and contribute to Smokefree 2025.
- The evidence on vaping products indicates they carry much less risk than smoking cigarettes but are not risk free.
- Evidence is growing that vaping can help people to quit smoking.
- Stop smoking services must support smokers who choose to use vaping products to quit.
- There is no international evidence that vaping products are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it.
- Despite some experimentation with vaping products among never smokers, vaping products are attracting very few people who have never smoked into regular vaping, including young people.
- When used as intended, vaping products pose no risk of nicotine poisoning to users, but vaping liquids should be in child resistant packaging.
- The Ministry of Health is identifying safety standards for vaping products in New Zealand. In the meantime, vapers should buy their products from a reputable source, such as a specialist retailer.

If you have any questions or require further information about this letter, please contact Jane Chambers (Manager Tobacco Control) at jane_chambers@moh.govt.nz.

Yours sincerely

[Signature]

Deborah Woodley
Deputy Director-General
Population Health and Prevention
Vaping – Insights from youth & youth workers, clients, and staff

Insights from youth and youth workers in Papakura, Manurewa, Papatoetoe, and Takanini

“Not many youth vape, they are not able to buy them because they are expensive, can’t access them because of the age barrier. They are not real ciggies, don’t taste the same, no buzz from vaping.”

(Feedback given during a focus group on vaping, run by a Living Smokefree Service Health Promoter, with 10 students and a teacher at an Alternative Education provider in Papakura.)

“From my experience of working with our rangatahi, only a small amount of them currently vape or own a vaping device. The initial start-up cost for acquiring a vape and accompanying liquids is a barrier. Spending $40-$80 on purchasing vapes is unrealistic.”

(Insights from a youth worker from a local Drug and Alcohol Harm Minimisation Programme working with Alternative Education providers and high schools in Papatoetoe and Manurewa.)

“We have seen vapes but haven’t tried them, they are expensive, we can’t access them because of our age, and we know very little about vapes.”

(Feedback from 29 Students (aged 14-16 years), from two education providers in Manurewa and Takanini, when they were asked what they know about vaping.)

Insights from clients of the Living Smokefree Service

Patrick McManus

Patrick McManus first approached the CMH Living Smokefree Service Quit Bus in December 2018 at the RI International – Recovery In Action Christmas Party. He told the Smokefree Advisor that he “was sick and tired of being sick and tired.” As part of his recovery, he wanted to be free of cigarettes as he had been smoking for nearly five decades. As a child, he would smoke his grandparent’s cigarette butts.

He had used Nicotine Replacement Therapy (patches and lozenges) in the past and was keen to try them again. However it just wasn’t enough to help him kick the habit for good.

“I was interested in trying an e-cigarette and mentioned this to the Smokefree Specialists. They were supportive of my choice and showed me the different options available, talked to me about the safety of e-cigarettes as a stop smoking tool and that I should aim to stop using an e-cigarette as well as I didn’t want to replace one addiction with another. To support me the specialists welcomed me to attend drop-in clinics as regularly as I wanted. I was able to attend drop-in clinics in the community at venues where I frequented such as at the RI International and at Middlemore Hospital Western Campus which was on my way home and very convenient for

1 All people who have provided insights in this document have given their informed consent for their insights to be described and shared.
me. Attending the clinics was essential to my recovery and smokefree journey. I received regular support from the Smokefree team and their encouragement kept me motivated to become smokefree and blow low Carbon Monoxide readings. I have been using an e-cigarette for a few months now and am currently five consecutive weeks smokefree. Eventually I plan to stop using e-cigarettes as well.”

Patrick is currently undertaking Peer Employment Training and aims to enrol onto Mental Health and Addictions Level 4 to become a Peer Support Specialist. He is also keen on becoming a Smokefree Community Champion. The Living Smokefree team wish him all the best with his recovery journey and he will always be welcome at the Living Smokefree Service.

Losa
Losa is a 37 year old Tongan, Niuean woman from Mangere who was smoking between 1-9 cigarettes a day. She would smoke her first cigarette within the first hour after waking up. She is living with six other smokers. They all decided to quit smoking in a GBT (group based treatment) setting facilitated in their home. She is now smokefree at four weeks and said “6mg nicotine vape helped a lot with my cravings. No withdrawal symptoms or concerns. Happy to have a Smokefree home and family!”

Tamara Teo
Tamara Teo is a 27 year old Maori woman from Otahuhu referred from Kidz First ward as her daughter was seen in the ED department with bronchiolitis. She has been smoking on and off for more than 10 years. She quit ‘cold turkey’, for two years, but then relapsed. She tried NRT, found mouth spray and gum helpful, but had some issues with patches. Eventually she purchased a nicotine vape and used it every day when needed. She reached four weeks smokefree and identified benefits such as “no more smokers cough, more time with kids, feeling determined!” and “feeling good for not smoking for so long!”

Toni Robinson and Joey Herbert
Toni Robinson is a 30 year old Mum of four, who smoked for nearly 20 years and tried to stop smoking cold turkey multiple times. While visiting the Otara Whanau Medical Centre for her sick baby, Toni spoke with a Smokefree Specialist who happened to be onsite promoting the CO monitor (smokerlyser) pop up and smokefree resource station. Through their conversation the Smokefree Specialist enrolled Toni with the Postnatal Incentives programme and organised home visits for Toni for on-going support. Toni mentioned that her children’s health is her main motivation for giving quitting another go. She initially started using lozenges and the Quickmist mouthspray but felt that they weren’t strong enough for her cravings. Her Smokefree Specialist provided information and safe practice on vaping on request. Toni eventually bought herself a nicotine vape and was able to become smokefree. She says that “I feel awesome, vapes are doing its job, no issues with cravings and withdrawals now”. Toni shares that “Since vaping I feel like I’m not being judged as Mum smoking cigarettes.”

Toni’s partner is Joey Herbert, a 37 year old Maori man from Otara. Joey was enrolled with the Whaanau incentives programme and joined Toni for the Smokefree Specialist’s visits at home. He smoked for 20 years and tried to quit many times before. Joey decided to give quitting another serious go for his health, his whaanau and to be a support person for Toni. Although he used Nicotine patches and the Quickmist mouthspray to begin with, he decided to invest in a nicotine vape to help with his strong cravings. The combination of nicotine replacement therapy, vaping and support helped Joey with his cravings and allowed him to make necessary changes to his lifestyle (getting rid of his ashtray, avoided being where his friends would smoke, drinking more water) to
make this quit attempt a successful one. Joey shares, “Since vaping, I've saved $470 a week from not smoking cigarettes which goes towards food and my family.”

**Insights from staff and management at Tiaho Mai**

“Patients who smoke who are detained within mental health in-patients wards suffer severe withdrawal symptoms within the first few days, this can easily escalate in aggressive behaviours due to being denied smoking and will often place themselves, other patients and staff at risk of harm. Some of them express that NRT is often ineffective to suppress symptoms.”

“We have received a number of requests from patients and mental health staff that CM Health should consider allowing a vaping area for the mental health unit.”
Policy: Smokefree

Purpose

The purpose of this policy is to outline Counties Manukau Health’s expectations regarding:

- The health and safety of all individuals within Counties Manukau Health premises and environments;
- Compliance with the Smoke-free Environments Act 1990 and Amendments 2003 and the Health & Safety in Employment Act (HSEA) 1992 and Amendments 2002; and
- Reduction in smoking rates among staff and the community, in accordance with the New Zealand Government goal for a Smokefree Aotearoa 2025 and Counties Manukau Health’s commitment to a Smokefree Counties Manukau by 2025.

Counties Manukau Health is required to ensure that no person smokes at any time in the workplace. As part of its wider role in promoting health and wellbeing, Counties Manukau Health has a responsibility to encourage and support patients and staff not to smoke.

Scope

This policy is applicable to all Counties Manukau Health employees, patients and whaanau, visitors, volunteers, contractors and all others accessing Counties Manukau Health grounds and facilities. It applies to all buildings, grounds and vehicles owned or occupied by Counties Manukau Health, including business and social venues.

Policy

Counties Manukau Health buildings, sites, grounds, offices and vehicles are completely smokefree. Staff cannot smoke on site or where services to patients are being provided off-site (e.g. home visits, community based clinics) or wherever staff are representing Counties Manukau Health.

Smokefree Environment

All Counties Manukau Health sites are smokefree. No smoking or vaping is permitted by anyone inside Counties Manukau Health buildings, vehicles and offices, including in any buildings leased by Counties Manukau Health.

Staff, patients and whaanau, and visitors may NOT smoke in external areas on any site owned by Counties Manukau Health or controlled by them under a lease arrangement. They must leave the site if they wish to smoke. On-site includes boundary fences, gardens and entrances to sites.

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<td>Approved by:</td>
<td>Smokefree Committee</td>
<td>Date First Issued:</td>
<td>20/09/2007</td>
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</tbody>
</table>
Smokefree Policy

At the point of employment and during orientation, staff will be informed of the smokefree policy and support programmes offered to assist staff who smoke. Staff who wish to smoke off-site should not be identifiable as Counties Manukau Health staff by their uniforms or name tags, or any other form of identification.

Tobacco Products

**NO** tobacco products may be sold on any Counties Manukau Health premises. No staff member or volunteer will accept gifts or donations of tobacco products from organisations or charities. Staff may not purchase tobacco products on behalf of patients or supply tobacco products including oral tobacco, to patients.

**Supporting People Who Smoke Who Choose to Use Vaping Products**

E-Cigarettes are not to be used on Counties Manukau Health premises in line with Ministry of Health Advice On E-Cigarettes.

Counties Manukau Health seeks to balance the objectives of 1) supporting people who smoke who choose to vape for smoking cessation or harm reduction and 2) protecting people, particularly children and young people, from any potential risks associated with vaping.

People who choose to vape to quit smoking may do so only in designated outside areas within of the Counties Manukau Health grounds, as determined by the Executive Leadership Team. This includes e-cigarettes and other products that are not smoked (e.g. ‘heat not burn’ products).

Advice and support regarding the use of vaping products for smoking cessation and harm reduction is available from the Living Smokefree Service.

Smokefree Mental Health Services

Mental Health Services also seek to maintain and promote a smokefree environment at all times within Tiaho Mai, in accordance with this policy. This is more fully described in the Smokefree Tiaho Mai Procedure.

Staff Support

Staff are encouraged to attend the ‘Smokefree Best Practice’ training offered through the Learning and Development Unit to assist them to support all patients who are smokers during hospitalisation, as well as whaanau and visitors where appropriate.

Counties Manukau Health is a significant employer within the Counties Manukau community, and as a leader in the drive to achieve a Smokefree Counties Manukau by 2025, the organisation actively encourages a smokefree workforce, and prioritises smokefree support for staff.

For staff who smoke:
Nicotine Replacement Therapy (NRT) quit cards are provided by the Living Smokefree Service in order to help staff manage nicotine dependence while working at Counties Manukau Health or to make a Quit attempt. NRT is heavily subsidised with a quit card. Also, free NRT is made available through Living Smokefree Service.

For staff who want to quit smoking:

- Stop smoking support is offered by the Living Smokefree Service and the Occupational Health and Safety Service. This service is free to Counties Manukau Health staff. Staff are able to receive this help in work time subject to reasonable operational / staffing requirements.

The Living Smokefree Service will endeavour to explore new and innovative opportunities to assist staff to manage their smoking during work hours, to reduce their smoking and/or to stop wherever possible. The Living Smokefree Service can be contacted via Southnet, by emailing smokefree@middlemore.co.nz or by phoning extension 6094 (0800 569 568).

### Staff Non-Compliance

For breaches of the Smokefree Policy, managers will discuss and address non-compliance with their staff member(s) and may do so in accordance with the CMDHB Code of Conduct and the Discipline and Dismissal Policy. This process will be supported by the relevant Human Resource Manager.

Where Security and/or other staff observe staff breaching the Smokefree Policy, they may reasonably remind the staff member of the organisation’s policy, and request the name and area of work of the staff member. This information may be reported to the staff members’ supervising manager. Refusal to cooperate with this process may be considered non-compliance with the Code of Conduct and treated appropriately.

### Clinical Staff and Patient Care

Staff who are responsible for patient care are also encouraged to ensure the Smokefree Policy is discussed with patients on admission to hospital or presentation to clinics. Clinical staff are to identify people patients who smoke and advise patients of appropriate alternatives and support during their hospitalisation such as nicotine replacement therapy (NRT) and referral to the inpatient smoking cessation specialist and/or community cessation provider as appropriate.

Although staff cannot force a patient / client to stop smoking outside, staff should not actively facilitate or assist patients / clients to smoke on the hospital grounds and not escort any patient/client for the purpose of smoking) but should instead offer support and NRT. Where the primary concern is for patient safety this should be handled as such but without promoting smoking as a solution.

The Living Smokefree Service can provide guidance for staff and management on broaching this issue.

### Patient Support

<table>
<thead>
<tr>
<th>Document ID:</th>
<th>A1052991</th>
<th>CMH Revision No:</th>
<th>4.0</th>
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<tbody>
<tr>
<td>Service:</td>
<td>Smokefree</td>
<td>Last Review Date:</td>
<td>12/02/2011 30/03/2016</td>
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<tr>
<td>Document Owner:</td>
<td>Programme Manager - Smokefree</td>
<td>Next Review Date:</td>
<td>12/02/2012 14/04/2019</td>
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</table>
Smokefree Policy

Counties Manukau Health offers support for those patients who wish to quit smoking including:

- Inpatients from all Counties Manukau Health hospitals
- Outpatients who have been referred from a Counties Manukau Health hospital or clinic

Such patients can be referred to the Living Smokefree Service on the Smokefree webpages via Southnet, by emailing smokefree@middlemore.co.nz, or on extension 6094 (0800 569 568). People referred to the Living Smokefree Service will be offered subsidised medication, support during their hospital admission as required, and follow up treatment post discharge. Alternatively, patients may be referred to the patient’s GP or other services in the PHO and the Quitline (0800 778 778) (national service).

Patients who require support for temporary abstinence of nicotine while hospitalised will be offered NRT, which will be charted on the patient’s medication chart as part of their patient care management plan. See the Management of Nicotine Dependence Guideline and the accompanying Management of the Nicotine Dependent Patient Flowchart.

Patient and Visitor Non-Compliance

Security Staff will inform and assist with the enforcement of the Counties Manukau Health Smokefree Policy. However, it is the responsibility of all staff to inform other staff, patients and visitors who are found to be smoking on-site that Counties Manukau Health is smokefree at all times.

For the purposes of clarity, the Counties Manukau Health property boundary along Hospital Road includes up to the railway station, which includes the grass banks beside the railway line, and the Western Campus staff car park within the fence line along Orakau Road. The railway station, under responsibility of Auckland Transport, is also completely smokefree.

Support for Visitors

Parents of children who are admitted to Kidz First can be offered NRT for the duration of the child’s / children’s hospitalisation. All other visitors can be directed to local or regional services, or to the Quitline. For further information on these services contact the Living Smokefree Service.

Living Smokefree Service General Enquiries – ext 6094 or 0800 569 568

Health Promotion and Education

Health promotion is a strong focus of the Counties Manukau Health vision. As well as promoting smokefree throughout Counties Manukau Health, the Living Smokefree Service will provide appropriate smokefree promotion within the community to inform them of the Smokefree Policy. Information on the Living Smokefree Service and community-based smokefree services will be made available by all Counties Manukau Health services for patients, staff and all others who may benefit from it.
Staff Exposure to Second-Hand Smoke

Staff who are exposed to second hand smoke whilst on duty are encouraged to complete an incident form and may report any concerns or issues regarding second hand smoking to the Living Smokefree Service who will follow through in accordance with Incident Process and Resolution Policy and Procedures.

Occupational exposure to second-hand smoke (SHS) is a proven health hazard and staff are entitled to take steps to minimise their exposure, in line with the existing Community/Home-based Visiting Policy. Staff may reasonably request that patients do not smoke whilst receiving care in their own or residential care premises. If staff cannot resolve this issue with clients themselves, they should seek support or advice from their line manager.

Complaints

Staff concerns relating to staff or others smoking or vaping can be documented on the Incidents Form and processed in accordance with Incident Process and Resolution Policy and Procedures.

Complaints about smoking or vaping from patients and / or visitors can be made to the Complaints Line on 277-1667 or extension 3667, or can be in writing or electronically (either by letter, in a happy/unhappy form, or via the Counties Manukau Health website).

Smokefree Systems

Counties Manukau Health is committed to a ‘whole of systems’ approach to Smokefree, and to ensuring that:

- Smoke-exposed patients are identified and offered NRT to manage their addiction;
- All front-line health staff are offered training in effective brief interventions for smoking cessation;
- Patients who are smokers receive frequent and brief interventions for smoking cessation; and
- A smoking cessation service is available to support patients and staff.
Definitions

Terms and abbreviations used in this document are described below:

<table>
<thead>
<tr>
<th>Term/Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>NRT</td>
<td>Nicotine Replacement Therapy</td>
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</table>
| Quit Card         | Exchange card for subsidised NRT  
|                   | 1 quit card = 12 weeks of NRT  
|                   | (can include up to 3 products)  
|                   | Cost: $5 per product (as of 01/01/13) |

Associated Documents

Other documents relevant to this guideline are listed below:

### NZ Legislation
- Smokefree Environments Act (1990) and Amendments (2003)

### NZ Standards
The New Zealand Guidelines for Helping People to Stop Smoking (MOH, 2014)  
<table>
<thead>
<tr>
<th>Organisational Policies, Procedures, Protocols or Guidelines</th>
<th>Nicotine replacement therapy - Standing Order</th>
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<tbody>
<tr>
<td></td>
<td>Standing Orders for Nicotine Replacement Therapy Workbook (Available at Ko Awatea Learn)</td>
</tr>
<tr>
<td></td>
<td>Management of Nicotine Dependence in Patients Who Smoke - Guideline</td>
</tr>
<tr>
<td></td>
<td>Smokefree Tiaho Mai - Procedure</td>
</tr>
<tr>
<td></td>
<td>Discipline and Dismissal Policy <a href="http://cmdhbdocuments/docsdir/opendocument.aspx?id=A5704">Link</a></td>
</tr>
</tbody>
</table>
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:

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 15 May 2019 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, Hospital Advisory Committee &amp; 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>
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<td>hA Class Share Issue</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>
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<tr>
<td>19/20 Proposed Capital Plan</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [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 and negotiations. [Official Information Act 1982 S9(2)(i)]</td>
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<tr>
<td>Category</td>
<td>Description</td>
<td>Confidentiality of Advice by Officials</td>
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<td>Risk Management Report &amp; Draft Risk Management Policy</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>The disclosure of the 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.</td>
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<td>PET CT Supply Agreement</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>Holiday’s Act</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>Options for the Future of NZHIH</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>Research Strategy</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<tr>
<td>Chief Executive’s Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<tr>
<td></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<tr>
<td><strong>Public Interest</strong></td>
<td>The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest.</td>
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<tr>
<td></td>
<td>[Official Information Act 1982 S9(2)(ba)(ii)]</td>
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