MEETING OF THE BOARD
20 February 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
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)
8.00 – 8.30am  Vakatautua – Day Socialisation Programmes
8.30 – 9.00am  Board only session

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 – 12 December 2018
9.20 – 9.25am  2.2 Action Items Register
9.25 – 9.30am  2.3 Draft Minutes Hospital Advisory Committee – 29 January 2019 (Lyn Murphy)

3. PRESENTATION
9.30 – 10.00am  3.1 Middlemore Foundation (Sandra Geange)

Morning Tea Break (10.00– 10.15am)

4. EXECUTIVE REPORTS
10.15 – 10.25am  4.1 Chief Executive Officer’s Report (including Patient Story) (Margie Apa)
10.25 – 10.35am  4.2 Corporate Affairs and Communications Report (Donna Baker)
10.35 – 10.45am  4.3 Health and Safety Performance Report (Elizabeth Jeffs)
10.45 – 10.55am  4.4 Finance & Corporate Business Report (Margaret White)

5. INFORMATION PAPERS
10.55 – 11.05am  5.1 Hospital in the Home Update (Penny Magud)
11.05 – 11.25am  5.2 External Signage Review (Parekawhia McLean)
11.25 – 11.35am  5.3 Quarterly Workforce Report (Elizabeth Jeffs)
11.35 – 11.45am  5.4 2019/20 Annual Plan Overview & Timeline (Alanna Soupen)
11.45 – 12.00pm  5.5 Addressing the Equity Gap in Maaori Childhood Immunisation (Aroha Haggie)

6. RESOLUTION TO EXCLUDE THE PUBLIC
123-125

Lunch Break (12.00 – 12.30pm)
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**Counties Manukau District Health Board**

20 February 2019
# BOARD MEMBERS’ DISCLOSURE OF INTERESTS

**20 February 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  
• Deputy Chair & Board Member, Housing NZ |
| Dr Ashraf Choudhary | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Catherine Abel-Pattinson | • Board Member, Health Promotion Agency  
• National Party Policy Committee Northern Region  
• Member, NZNO  
• Member, Directors Institute  
• Husband (John Abel-Pattinson), Director, Blackstone Group Ltd  
• Husband, Director, Blackstone Partners Ltd  
• Husband, Director, Bspoke Ltd  
• Husband, Director, 540 Great South Ltd  
• Husband, Director, Barclay Suites  
• Husband, Director, various single purpose property owning companies  
• Co-Chair, National Party Health Policy Committee |
| Colleen Brown | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group  
• District Representative, Neighbourhood Support NZ Board  
• Chair, Rawiri Residents Association  
• Director and Shareholder, Travers Brown Trustee Limited |
<table>
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<tr>
<th><strong>Dianne Glenn</strong></th>
<th><strong>George Ngatai</strong></th>
<th><strong>Katrina Bungard</strong></th>
<th><strong>Kylie Clegg</strong></th>
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</table>
| • Member, NZ Institute of Directors  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Member, National Council of Women of New Zealand  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group  
• Life Member of Business and Professional Women NZ | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Huakina Development Trust (Partnership Clinic)  
• Community Organisation Grants Scheme (Auckland)  
• Lotteries Community (Auckland)  
• Board Member, Counties Manukau Rugby League Zone  
• Member, NZ Maori Council  
• Director & Shareholder, BDO Marketing & Business Solutions Limited (TBC)  
• Director & Shareholder, Ngatai Bhana Limited  
• Director & Shareholder, Family Care Limited | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed disability sports  
• Member of NZ National Party | • Deputy Chair, Waitemata District Health Board  
• Trustee (ex officio) - Well Foundation (charity supporting Waitemata District Health Board)  
• Director, Auckland Transport  
• Director, Sport New Zealand  
• Director, High Performance Sport New Zealand Limited  
• Trustee & Beneficiary, Mickyla Trust  
• *Trustee & Beneficiary, M&K Investments Limited (includes an interest in a takeover bid for Orion shares which may result in M&K Investments Limited holding a share of less than 1% in Orion Health Group). Orion Health Group has commercial contracts with healthAlliance and may have commercial contracts with Counties Manukau District Health Board.* |
| Dr Lyn Murphy                                      | • Director and Shareholder, Bizness Synergy Training Ltd  
|                                                 | • Director and Shareholder, Synergex Holdings Ltd  
|                                                 | • Trustee, Synergex Trust  
|                                                 | • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
|                                                 | • Member, New Zealand Association of Clinical Research (NZACRes)  
|                                                 | • Senior Lecturer, AUT University School of Inter professional Health Studies  
|                                                 | • Member, Public Health Association of New Zealand  
| Pat Snedden                                      | • Chair, Auckland District Health Board  
|                                                 | • Chair, The Big Idea Charitable Trust  
|                                                 | • Director, Te Urungi o Ngati Kuri Ltd  
|                                                 | • Chair, National Science Challenge – E Tipu E Rea  
|                                                 | • Chair, Manaiakalani Education Trust  
|                                                 | • Director, Ports of Auckland (and subsidiaries)  
|                                                 | • Trustee, Emerge Aotearoa Trust (and subsidiaries)  
|                                                 | • Director & Shareholder, Snedden Publishing & Management Consultants Ltd  
|                                                 | • Director & Shareholder, Ayers Contracting Services Ltd  
|                                                 | • Director & Shareholder, Data Publishing Ltd  
|                                                 | • Director, Ngati Kuri tourism Ltd*  
|                                                 | • Director, Te Paki Ltd*  
|                                                 | • Director, Waimarama Orchards Ltd*  
|                                                 | • Director, Wharekapua Ltd*  
|                                                 | * subsdiaries of Te Urungi o Ngati Kuri Limited  
| Reece Autagavaia                                 | • Member, Pacific Lawyers’ Association  
|                                                 | • Member, Labour Party  
|                                                 | • Trustee, Epiphany Pacific Trust  
|                                                 | • Trustee, The Good The Bad Trust  
|                                                 | • Member, Otara-Papatoetoe Local Board  
|                                                 | • Member, District Licensing Committee of Auckland Council  
|                                                 | • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation  
|                                                 | • 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 20 February 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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Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 12 December 2018

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

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT
- Mark Gosche (Board Chair)
- Ashraf Choudhary
- Catherine Abel-Pattinson
- Colleen Brown
- Dianne Glenn
- Kylie Clegg
- Lyn Murphy
- Pat Snedden
- George Ngatai
- Apulu Reece Autagavaia

ALSO PRESENT
- Margie Apa (Chief Executive)
- Gloria Johnson (Chief Medical Officer)
- Margaret White (Chief Financial Officer)
- Jenny Parr (Chief Nurse and Director Patient & Whaanau Experience)
- Dinah Nicholas (Board Secretary)
- Ken Whelan (Crown Monitor)
- Donna Baker (GM Communications & Engagement)
- Gary Jackson (Director Population Health)

APOLOGIES
- Apologies were received and accepted from Katrina Bungard.

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

WELCOME
The Chair welcomed everyone to the meeting acknowledging Colleen Brown’s recent Attitude Hall of Fame award and congratulated Jenny Parr who was awarded her Doctorate in Health Science on 11 December.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
- The Disclosures of Interest were noted with the following addition for Apulu Reece Autagavaia - Member Workforce Development Early Childhood Education Advisory Committee.

- 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 31 October 2018

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

That the Minutes of the Board Meeting held on the 31 October 2018 be approved.

Carried

2.2 Action Item Register
Noted.

2.3 Minutes Community & Public Health Advisory Committee – 26 September & 7 November 2018
The minutes were taken as read.

Before School Checks – are these still fit for purpose.

The Board asked that either Dr Tuohy, or someone from the MoH, along with Amanda Malu, Plunket be invited to attend the 3 April Board meeting next year to follow up the discussion on the Before School Checks as that should coincide with the release of the scope of the Well Child review.

2.4 Minutes Hospital Advisory Committee – 29 August & 7 November 2018
The minutes were taken as read.

Anaesthetist Shortage – the Board would like to receive a report on the effects of the Anaesthetist shortage on the broader services at the 20 February Board meeting.

3 PRESENTATION
3.1 Auckland Primary Care Leaders Group
The Board was taken through a presentation from the Auckland Primary Care Leaders Group (APCLG) by representatives from Alliance Health+, East Health, National Hauora Coalition, Procare, Comprehensive Care and East Tamaki Healthcare.

Highlights:
- The 6 metro-Auckland PHOs service 1.6m patients in 360 practices.
- The Health Safe database is now in place which will be key to enabling the free flow of data sharing between the PHOs and the DHB.
- The PPC programme has a lot of value but needs to be reframed around equity.
- GP fees - the PHOs encourage providers to utilise the programmes that are available that will reduce the cost for the patient.

The Chair thanked the representatives from APCLG for attending the meeting today.
4 EXECUTIVE REPORTS

4.1 Chief Executive’s Report (Margie Apa)

The report was taken as read.

*Patient Story* - the Board heard Raymond’s story on nocturnal dialysis.

*Buildings* – buildings featured heavily in November with the opening of Tiaho Mai, the turning of the sod for the new Dental Facility at MSC and the Prime Minister’s announcement of an additional $80m investment for capital works at MMH and MSC which is giving staff confidence of the future of the organisation.

*People* - staff wellbeing has been a big message and whilst strike notices are potentially disruptive to patients, they also have an impact on relationships with frontline staff. Bullying and harassment, which is often a symptom of burnout, is also being dealt with very seriously by the Executive Leadership Team.

The Board asked that letters of congratulations be sent to Dr Joanna Sinclair who was awarded the Ray Hader Award for Pastoral Care for 2018 and the Surgery Team who won an award at the Health Round Table in Melbourne recently.

*Targets* – there is a bit of work still to do in ED. The target got down to 88% in October but slipped back in November to 85%. The complexity of patients presenting seems to be greater which results in pressures on beds and being able to manage length of stay. Every effort is being put into trying to get to the target as quickly as possible but in a sustained way and the Acute Flow work currently underway should assist with that.

*Immunisation* – the team are going to test a constrained financial incentive next year to try and get a lift in the Maori baby coverage. It has worked well engaging Maori in other areas such as Smokefree.

**Resolution** (Moved: George Ngatai/Seconded: Kylie Clegg)

*That the Board:*

Receive the Chief Executive’s Report.

*Carried*

4.2 Corporate Affairs and Communications Report (Donna Baker)

The report was taken as read.

Working is underway to finalise dates next year for the Board meeting with Auckland Council.

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

*That the Board:*


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

Carried

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

ACC Accreditation - ACC accreditation is now completed and the DHB has retained its tertiary level status which has significant financial benefit for the DHB. A plan of actions for 2019 will be brought back through the Board in the New Year.

Incident Reporting – incident reporting generally is under-reported. There is work underway to make the Incident Reporting form quicker and easier to complete for non-clinical incidents.

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

That the Board:

Receive the Health and Safety Report.

Carried

5 PERFORMANCE REPORTS

5.1 NRLTIP Portfolio of Work (Gloria Johnson)
The paper was taken as read.

This paper sought agreement to changes to the oversight and delivery arrangements for progressing the NRLTIP. The changes are refinements to the oversight and delivery arrangements published in the NRLTIP, agreed by the four Northern Region Boards in February to March 2018, and as detailed in the NRLTIP released by the Prime Minister and Minister of Health on Friday 19th October 2018. The oversight changes are required to better:
  o Align subject matter expertise and oversight to NRLTIP specific programmes and areas of work;
  o Clarify the relationships between programmes of work; in particular which programmes ‘set direction’ or define ‘output and process expectations’.

The Board asked that Dr Johnson provide feedback to the NRLTIP Steering Group that equity needs to be more explicit and integrated into everything in the Plan.

Resolution (Moved: Pat Snedden/Seconded: Catherine Abel-Pattinson)

That the Board:

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

Note the Northern Region Long Term Investment Plan, agreed by Boards in February and March 2018, has now been formally released.
Note this paper was endorsed by the Audit Risk & Finance Committee on 21 November to go forward to the Board.

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

Carried

5.2 Regional ISSP (Stuart Bloomfield & Andrew Brant)
The paper was taken as read.

It was noted that the Executive Leadership Team support the RISSP and Roadmap as presented, however are not satisfied that the changes to the RISSP governance will provide the appropriate assurance, scrutiny and oversight of monitoring to ensure it is aligned with the Regional Service Plan as intended.

Resolution (Moved: Pat Snedden/Seconded: George Ngatai)

That the Board:

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

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

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

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

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

Approve the Regional Information Systems Strategic Plan (ISSP) version 2, Regional Road maps version 1, and programme delivery charter with associated proposed regional IS governance arrangements.

Agree that in light of the new governance arrangements, a review of the composition of hA Board will be undertaken by 30 June 2019.

Carried
5.3 MRI Finance Overspend (Ian Dodson)

The paper was taken as read.

There is a forecast overspend of $233k upon completion of the Harley Gray MRI project. This is a 2.9% variance on the total budget of $8,032,573. The cost escalation was signalled to the Asset & Capital Committee throughout the project and is being escalated to the Board now as per s3.5 of the Delegated Financial Authority Policy, as the total costs are likely to exceed the agreed budget by over 2%.

The three key overarching reasons for the cost overruns are; extended procurement process, key equipment exclusions and architectural and professional services design. Overall the key cost overruns can mostly be traced back to the planning and design phases with key equipment and building design elements having been missed or excluded. In addition, the construction contingency of 5% was lean, this was applied by the QS as this was an internal fit-out rather than a green field build.

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

That the Board:

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

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

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

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

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

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

Carried

5.4 HR Workforce Ethnicity & SAPS Report (Elizabeth Jeffs)

The paper was taken as read.

The Board requested a quarterly update on how the DHB is tracking with increasing the numbers of Māori and Pacific staff across our workforce broken down by workforce group and a review of the August 2018 workplace incidents for SAPS.
Ms Jeffs confirmed that there is work underway looking into the lack of Māori & Pacific Dieticians across the Northern region.

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

That the Board:

Receive the Workforce Ethnicity & SAPS reports.

**Carried**

5.5 **Finance & Corporate Business Report** (Margaret White)

The paper was taken as read.

**Resolution** (Moved: Mark Gosche/Seconded: George Ngatai)

That the Board

Receive the Finance & Corporate Business Report.

**Carried**

5.6 **Establishment of Executive Committee of the Board** (Mark Gosche)

The paper was taken as read.

**Resolution** (Moved: Apulu Reece Autagavaia/Seconded: Lyn Murphy)

That the Board:

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

Agreed membership of the Executive Committee will comprise the Board Chair, Dianne Glenn and George Ngatai.

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

Note that all decisions made by the Executive Committee will be reported back to the Board at its meeting on 20 February 2019.

Agree that the Executive Committee be dissolved as at 20 February 2019.

**Carried**
7. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution** (Moved: Lyn Murphy/Seconded: ApuluReece Autagavaia)

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

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

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

<table>
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<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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| Risk Workshop                            | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confidentiality of Advice Tendered by Officials  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials.  
[Official Information Act 1982 S9(2)(f)(iv)] |
| Public Excluded Minutes of 31 October and Actions | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confirmation of Minutes  
As per the resolution from the public section of the minutes, as per the NZPH&D Act. |
| Public Excluded Minutes of the Audit Risk & Finance Committee and Community & Public Health Advisory Committee | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confirmation of Minutes  
As per the resolution from the public section of the minutes, as per the NZPH&D Act. |
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<th>Details</th>
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<td>NOS Risk Mitigation Strategic Assessment</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities</td>
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<tr>
<td>ePA Phase 2 Business Case</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities</td>
</tr>
<tr>
<td>Specialised Rehabilitation Centre IBC Scope &amp; Options/Concept Design Request</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities</td>
</tr>
<tr>
<td>Expansion of Gastro Procedural Capacity</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>Commercial Activities</td>
</tr>
<tr>
<td>Event Description</td>
<td>Reason for Withholding</td>
<td>Acts Referring to Reason for Withholding</td>
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<tr>
<td><strong>Manurewa High School</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>[Official Information Act 1982 S9(2)(i)]&lt;sup&gt;[NZPH&amp;D Act 2000 Schedule 3, S32(a)]&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Regional Primary Acute Care Service</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>
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</tr>
<tr>
<td><strong>Microsoft G2018 Licence Renewal – Ratification of Circular Resolution</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>
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</tr>
<tr>
<td><strong>CEO Update</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>
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</tr>
</tbody>
</table>

**Commercial Negotiations**

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.

**Commercial Activities & Negotiations**

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.

**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.

**Public Interest**

The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Relevant Act(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Mental Health Phase II Procurement &amp; Funding</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)] [Official Information Act 1982 S9(2)(ba)(ii)]</td>
</tr>
<tr>
<td>Primary &amp; Community Contracted Services</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)] [Official Information Act 1982 S9(2)(i) &amp; (j)]</td>
</tr>
<tr>
<td>Long Term Conditions Model of Care Update</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)] [Official Information Act 1982 S9(2)(i) &amp; (j)]</td>
</tr>
</tbody>
</table>

**Carried**

The public meeting closed at 11.55am.
<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>12 December 2018</td>
<td>HAC Minutes 7.11.2018</td>
<td>Anaesthetist Shortage – the Board would like to receive a report on the effects of the shortage on the broader services.</td>
<td>20 February</td>
<td>Margie Apa/Mary Burr</td>
<td>Refer Item 4.1 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>12 December 2018</td>
<td>CPHAC Minutes 26.9.2018</td>
<td>Before School Checks – the Board asked that either Dr Tuohy, or a representative from the MoH, and Amanda Malu, Plunket be invited to attend the 3 April Board meeting to follow up the discussion on B4SC as that should coincide with the release of the scope of the Well Child review.</td>
<td>9 April</td>
<td>Margie Apa/Carmel Ellis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 October 2018</td>
<td>CPHAC Minutes 15.8.2018</td>
<td>Hospital in the Home update</td>
<td>20 February</td>
<td>Margie Apa</td>
<td>Refer Item 5.1 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>19 September 2018</td>
<td>CEO Report</td>
<td>Māori Immunisation – come back to the Board with some fresh ideas for a different approach to target these families.</td>
<td>20 February</td>
<td>Aroha Haggie/Carmel Ellis</td>
<td>Refer Item 5.5 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>31 January 2018</td>
<td>Provider Arm Performance Report</td>
<td>Middlemore Foundation - CE of MMF to provide an overview of how the Foundation supports the hospital and to discuss their new strategy and structure. A copy of the MMF Constitution to be provided at this time.</td>
<td>20 February</td>
<td>Margie Apa</td>
<td>Refer Item 3.1 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>6 December 2017</td>
<td>Health and Safety Report</td>
<td>Way Finding – the Board asked that a review of the Middlemore campus is undertaken by a traffic/transport management expert.</td>
<td>20 February</td>
<td>Pauline Hanna</td>
<td>Refer Item 5.2 on today’s agenda.</td>
<td>✓</td>
</tr>
</tbody>
</table>
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Tuesday, 29 January 2019 at 1.00pm
Ko Awatea, Room 105, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

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

ALSO PRESENT
Margie Apa (Chief Executive)
Dr Gloria Johnson (Chief Medical Officer)
Avinesh Anand (Deputy CFO, Provider)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Kate Yang (Business Manager, Service Leadership Team)
Rebecca Ellis (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
A member of the media was present for the Public section of this meeting.

WELCOME
The meeting commenced at 1.00pm. Dr Murphy welcomed the Committee and in particular the new members of the Committee.

APOLOGIES
Dr Ashraf Choudhary

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

2. **CONFIRMATION OF MINUTES**

   2.1 Confirmation of the Public Minutes of the Hospital Advisory Committee meeting held on 7 November 2018.

   Resolution: (Moved: Dianne Glenn / Seconded: Catherine Abel-Pattinson)
   
   That the minutes of the Hospital Advisory Committee meeting held on 7 November 2018 be approved.
   
   Carried.

   2.2 **Action Items Register – Public**

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

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

3. **PROVIDER ARM PERFORMANCE REPORT**

   3.1 **Executive Summary (Margie Apa)**

   The report was taken as read.

   Ms Apa provided key highlights:
   - November report provides an overview of the financial position and key themes. We have not generated enough savings that are required. It was discussed at the Audit Risk & Finance Committee to review other areas and consider other opportunities to assist with savings and our financial position.
   - The Emergency Department (ED) has seen higher numbers than previous years and the hospital continues to be busy.
   - A review of Tamaki Oranga services is underway by independent reviewers. The Mental Health Unit is a 20 – 30 bed facility for long term rehabilitation. Average length of stay for patients is 1 – 2 years; the facility caters for patients with high complex needs.
     **Action: Review of the facility to be circulated to the Committee once completed.**
   - Ophthalmology triage continues to be under pressure, looking at an acuity tool to assist with reviewing the most urgent cases first. Further clinics being considered to assist with workload. The team is to report back with costings for these further clinics.
   - Neonatal care – mothers with gestational diabetes remains highest in the country. No obesity box to check. Working on coding issues but some considerable time before it is used at this stage.

   Resolution: (Moved: Dianne Glenn / Seconded: George Ngatai)
   
   Receive the report.
   
   Carried.
3.1.1 Complex Conditions Improvement Programme (Mary Seddon)
The report was taken as read.

The report provides an update on the work being done and the number of projects that are currently underway. Some of the work is tied into the acute patient flow programme or has been transferred to the CIO portfolio, such as the Orion Acute Care Plan. Reporting on these projects will be reflected in future dashboards and updates will be brought to the Committee in due course.

Resolution: (Moved: Kylie Clegg / Seconded: Dianne Glenn)
Note and receive the report.
Carried.

3.1.2 2018-19 Hospital Services Work Plan
The report was taken as read.

3.1.3 2019 Hospital Advisory Committee (HAC) Work Plan
The report was taken as read.

The HAC Work Plan is a DRAFT framework for future meetings and is provided to the Committee for their review and comment.

Apart from the usual operational reports, included within the work plan are a number of site visits to various locations around the Middlemore Campus including off site locations and a number of deep dives through each of the service areas they represent.

The Committee commented that Youth Mental Health could be a potential area to include within the deep dives as there is a growing need for families, particularly those families with Autistic children and how to provide for them. Other deep dives to review in addition to those included in the DRAFT Work Plan were those groups with disabilities and a deep dive into provider savings.

Resolution: (Moved: Dianne Glenn / Seconded: Colleen Brown)
Note and receive the report.
Carried.

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

Key indicators show the hospital has been busy. ED length of stay is an area of focus to understand the acute flow across the hospital, for example; what areas are the road blocks in terms of getting patients into beds and the overall occupancy rates. Issues remain to be volumes year on year, Annual Leave accrual and the challenges with strike actions. There has also been a large variation seen in numbers due to the mild flu season.

The Committee commented that ED presentations by Elderly (75+ year olds) had a large variance for the month of October 2018.
**Action:** Provide the Committee with a breakdown of figures on aged demographics for ED presentations.

The ED care app has now been working for three months; statistics are yet to be released. Ms Apa suggested that Tele health could be a good option if it fits the model of specialist care.

The Committee questioned ‘Did Not Attend’ (DNAs). This is currently a focus of ambulatory services.

**Action:** Provide a review on the costs associated with those that do not turn up for their appointments (DNA) and what ethnicity was predominantly not turning up.

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

The report was taken as read.

November financials are $5.96m favourable YTD with the Provider Arm being $1.5m year to date. There have also been some additional costs added for MRI volume and electives in December 2018.

### 3.4 Update on Summer Work Plan – verbal update (Ian Dodson)

Overall summer has been a different flow than the winter plan, with the focus being on resources and the short weeks. A formal review will be completed once winter starts.

Hospital occupancy rates have been similar to last year and this is largely driven by surgical volumes but tracking well and close to forecast. Some bed closures in Ward 2 did not go ahead due to summer occupancy rates. All elective closures went well with no incidents or accidents.

Strike actions have taken a large amount of focus and planning.

The Chair questioned whether there was more demand over the Christmas period. Mr Dodson advised that on Christmas and Boxing Day a reduction is seen but this increases after that and becomes quite busy with usual flow.

### 3.5 Cx Bladder update (Sue Shipperlee / Mark Moores)

The report was taken as read.

Ms Shipperlee provided key highlights:

- A total of 197 had been contacted so far to end September 2018 with 132 who have participated. Of the 132 tested, 72 have been discharged back to their GP, with 48 having been investigated further. 17 of those patients have been discharged and 14 require further intensive treatment.

- Very pleased with the results of the testing so far and this has lead to a reduction in wait times. There has been a range of ethnicities; although more Asian cultures have been seen rather than Maaori or Pacific peoples.
Resolution: (Moved: Colleen Brown / Seconded: George Ngatai) 
Receive the report. 
Carried.

3.6 Women’s Health – Proposed use of Ward 21 (Nettie Knetsch)
The report was taken as read.

Ms Knetsch provided key highlights:
- With the current rise in acuity of pregnant women, the current workforce and facility does not have the capacity to meet the needs of the community and does not meet either local or national guidelines. The re-opening of Ward 21 provides a solution for a number of issues such as Neonatal and Postnatal Capacity, Gynaec Capacity and to provide immediate demand relief.
- Currently there are three primary birthing units which are operated by CM Health being Papakura / Botany and Pukekohe. A women can chose where she gives birth and this is usually influenced by others.
- In an environment of fewer midwives there are several influencing factors which both ADHB and WDHB struggle with as we do with primary care birthing units. Women are encouraged to go to these units or are transferred within 48 hours of giving birth. There are a number of complexities such as women who have caesarean sections, women presenting with high co-morbidities and women birthing extra large or very small babies.
- It is proposed to re-open Ward 21 for antenatal care which will provide a further 24 beds with six beds dedicated to gynaecology care. This would enable the current maternity floor to become primarily a postnatal ward with some dedicated transitional care for both neonates and their mothers. The proposed Ward would solve quite a number of capacity issues for CM Health.
- The Chair advised her concern with regard to both the Mangere Birthing Unit and the additional funding to undertake the implementation of Ward 21. Ms Apa advised that we would need to meet formerly with the provider to ensure a transparent process. With regard to Ward 21, this will essentially create more bed space and capacity for us. Costs are currently being worked through. The facility would be a permanent facility, not a temporary facility.
- The Chair advised that the Committee agreed in principle to the re-opening of Ward 21; however costings were yet to come.

Resolution: (Moved: Dianne Glenn / Seconded: Colleen Brown) 
Note and receive the report. 
Carried.
4. CORPORATE REPORTS

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

The report was taken as read.

4.1.1 CM Health: An Excellent Experience – September 2018

*Action:* The Committee requested a letter of congratulations be sent to Jackie Danes (People Development Consultant) for her contribution towards the success of the Step Up Programme at Counties Manukau Health. Ms Danes was awarded the Skills Highway Champion Workplace Support Mentor Award for 2018.

4.2 Patient Experience & Safety Report (David Hughes)

The reports were taken as read.

Dr Hughes advised that the reports provided to the Committee reflect old data and are now out of date due to the meeting cycles and the break over the Christmas / New Year period. The reports were therefore not discussed.

4.2.1 Safety Experience Compliance Measurement Dashboard Variance Report
4.2.2 Dashboard & Variance Report – November 2018
4.2.3 National Patient Experience Survey Results – August 2018
4.2.4 OSM Local Report – June 2018

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

Note and receive the reports.

Carried.

4.3 Human Resources Report (Elizabeth Jeffs)

The report was taken as read.

4.3.1 Annual Leave Balances

Ms Jeffs provided key highlights:

- On track with other DHBs with turnover rates under 12%.
- Have engaged a new HR Reporting Manager who worked previously with the Waikato DHB and the Ministry of Health.
- The Chair asked whether there was a review of diversity of staff across all areas. Ms Jeffs advised that workforce planning is underway looking at diversity of staff / and workforce staff etc., which includes looking at what other resources could be put in place to assist. Workforce planning is to improve development in this area in terms of the right mix of people and to enable staff to better respond to patient needs. This will become a template for reviewing other areas going forward.
- The Committee asked whether there were any measures to ascertain whether staff were satisfied or not satisfied – were staff in this organisation under pressure etc., etc. Ms Jeffs said that this year in particular had been one of the hardest seen with the amount of strike notices received, however this was also the best year seen for turnover rates. Dr Johnson noted that a survey had been run in the past but these had not greatly engaged staff.
current hot topic would need to be chosen to really engage with staff and whether an external reviewer would maybe provide for better engagement. Ms Apa said that we would need to be very clear in what we want to find out, patterns, turnover, speaking out, the survey would need to be purposefully designed.

- The Chair asked whether CM Health was confident that there was no bullying in wards. Ms Jeffs advised that there were better work tools now available for reporting data but it was a question as to whether we were listening to the data.

5. CORPORATE REPORTS (FOR NOTING ONLY)

5.1 Facilities Service Report (Pauline Hanna)
The report was taken as read.

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

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

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

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

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

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

5.8 Middlemore Central (Dot McKeen)
The report was taken as read.
6. RESOLUTION TO EXCLUDE THE PUBLIC

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

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Public Excluded Minutes of 29 January 2019</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 For the reasons given in the previous meeting.</td>
</tr>
<tr>
<td>3.1 Patient Experience and Safety Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982). [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S9(2)(a)]</td>
</tr>
</tbody>
</table>

Carried

The open session of the meeting concluded at 3.15pm

Next meeting to be held on 13 March 2019

Signed as a true and correct record of the Counties Manukau District Health Board Hospital Advisory Committee meeting held on 29 January 2019.

Dr Lyn Murphy
Chair
Recommendation

It is recommended that the Board:

Receive the Chief Executive’s Report for the period from 12 December 2018 – 19 February 2019.

Prepared and submitted by: Margie Apa, Chief Executive Officer

News and Events

Health Select Committee

CMDHB had the annual review of the 17/18 financial year before the Health Select Committee. The review discussion was wide ranging and canvassed a number of issues including mental health, family violence, demand management and financial performance. Some questions referred to the 18/19 year but overall – despite the media report on less than 1 minute of discussion – we had an opportunity to tell our story and offer a more optimistic view of our future. Below is a photo of those who attended – Chair Vui Mark Gosche, CEO Margie Apa, Chief Finance Officer Margaret White and Acting CMO for the 17/19 year Dr. Vanessa Thornton. Parekawhia McLean attended also in observation. The photo includes our new ‘friends’ children from Lyall Bay primary school who were also on a Parliamentary buildings tour!
Welcome to Parekawhia McLean

We recently welcomed our new Director of Strategy and Infrastructure, Parekawhia McLean, with a beautiful Po owhiri held at Te Manukanuka o Hoturoa Marae, Auckland, attended by iwi leaders of the Waikato Tainui tribes (Heeni Katipa, sister of Kiingi Tuheitia, Rahui Papa and Tukoroirangi Morgan), CM staff, supporters, kaumaatua and dignitaries.

Parekawhia joins CM Health from the New Zealand Transport Agency where she was Central North Island Regional Director from September 2016. Prior to that, she was the Chief Executive Officer of Waikato-Tainui for six years. Parekawhia has more than 18 years of public policy and public sector management experience including being an advisor to three prime ministers during her time at the Department of the Prime Minister and Cabinet. She brings significant stakeholder management and governance experience to the role. For almost seven years she was director of her own company dedicated to advancing the creative potential of Maaori knowledge, people and resources.

In September 2017, Parekawhia was elected for a three year period as Chair of Te Whakakitenga o Waikato - the governing tribal body of Waikato-Tainui.
**Mobile Surgical Ward at SuperClinic**

The SuperClinic at Manukau has recently benefited from a state-of-the-art mobile surgical bus, providing low risk, specialist day-surgery services in areas including orthopaedics, gynaecology and general surgery.

The surgical bus, which was designed and manufactured in NZ, is a modern, fully equipped operating theatre that can operate standalone or be connected to a host site for essential services.

It is the brainchild of Canterbury-based Mobile Health, which has for the past 17 years worked in partnership with the Ministry of Health and District Health Boards. A team made up of a nurse leader, clinical nurse and anaesthetic technician travel with the bus, which is kitted with a full mobile, state-of-the-art theatre, with local staff assisting. The mobile team was able to conduct around 141 procedures over the Christmas and New Year period.

The bus has helped local patients receive treatment in a timely manner and feedback shows patients appreciate they're getting the help they need.

![Mobile Surgical Ward at SuperClinic](image)

**Building begins for Dental Facility**

The first sod has been turned in preparation for building a new dental facility on the grounds of the Manukau SuperClinic. A dawn blessing was attended by representatives from Manawhenua, the University of Otago, Savoy Construction and CM Health.

The dental facility is a partnership between University of Otago and CM Health, and will offer teaching as well as low-cost treatment provided, under supervision, by students in their final year of the Bachelor of Dental Surgery. The two-story facility will have 32 dental chairs. Construction is due to be completed in 2020.

**Ward 21**

Plans are underway for our new maternity ward at Middlemore Hospital, which should be ready sometime in April 2019. The new ward will be located in Ward 21 until a new Women’s Health building is completed in about five years. It will operate in addition to the 45-bed existing maternity ward.

This new ward will primarily be used for antenatal care while the existing ward will focus on postnatal care, with dedicated transitional care capacity for babies and their mothers.
**Free shuttle for staff and patients**

Two new shuttle services have recently been introduced. These enable staff and patients to catch a free ride from Manukau and/or Papatoetoe train stations to Middlemore Hospital and to Manukau SuperClinic. One service runs from Middlemore Hospital, Manukau Train Station and Manukau SuperClinic and back again. The other service runs from Middlemore Hospital, Papatoetoe Train Station, Manukau Train Station and Manukau SuperClinic, and back again.

Patients with an outpatient appointment at Middlemore Hospital, who are able to independently enter and exit a bus using the steps, can show a copy of their appointment letter to the driver and catch the shuttle to Middlemore Hospital.

**To Tohu Mataapono (Living Our Values) CEO Awards**

Our new CEO awards are currently in the early planning stage. They will be named Te Tohu Mataapono (Living Our Values) Awards and be used to recognise people who demonstrate CMH values in their respective work areas – going above and beyond for our patients, their families and colleagues. Patients can also show how much they appreciate our people by nominating them.

Nominations will be run very similar to the already successful Local Heroes awards programme at ADHB. The internal communications team is arranging to meet the ADHB Communications team who manage the awards process; and a detailed communications plan will be developed following the visit.

**Christmas at Counties**

Once again the services around CM Health embraced the Christmas spirit and decorated their areas, including the Communications team erecting a tree in the main foyer.
Competition for the best Christmas decoration was strong, with entries from twenty-four services. The winners were the Acute Dietician team members. This year about twenty-five staff also volunteered to perform a series of hymns and Christmas songs to entertain staff and patients. Once again, the choir master from Kings College, Chris Artley, gave up his time to lead the group in several practices and play keyboard as the accompanist on the day of performance.

**Lunar New Year**

Following on from our very successful Christmas decoration competition, CM Health is celebrating the Lunar New Year and the Year of the Pig, by running a decoration competition to win 88 fortune cookies.

The Lunar New Year is celebrated by people of Asian origin worldwide, including those of Chinese, Vietnamese, Koreans and Taiwanese heritage. Celebrations begin with the first new moon, this year on February 5, and ends two weeks later, with the first full moon of the lunar calendar in February.

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**Our People**

*Growth in medical leaders with formal specialist qualification in medical administration*

In December 2018 Dr Peter Watson, Clinical Director of our Mental Health Service, passed the final examinations to become a Fellow of the Royal Australasian College of Medical Administrators (FRACMA). FRACMA is the formal qualification for doctors in New Zealand and Australia who specialise in Medical Administration, a specialty recognised for vocational registration with the Medical Council of New Zealand. Increasingly FRACMA is viewed as a desirable, sometimes essential, qualification for doctors undertaking leadership roles in health services.

Dr Watson is just the latest in a series of senior doctors who have completed their FRACMA training while working at CM Health and his addition to the group now brings to six the number of FRACMA-qualified clinical leaders employed here. This means that we now employ almost 20% of the total number of FRACMA-qualified doctors in New Zealand. That we have so many is a signal of the special value placed on medical leadership at CM Health and of the high level of interest amongst our Senior Medical Officers in developing their skills in leadership and management. As the group expands our capacity to interest and train others also grows and we currently have another trainee enrolled in the programme and more considering it.
The six CM Health FRACMAs – Dr Clive Bensemann, Dr Gloria Johnson, Dr David Hughes, Dr Mary Seddon, Dr Vanessa Thornton and Dr Peter Watson - are pictured below.

Facilities

Planning for Manukau Health Park

The Steering Group for the CM Health project: Development of Elective and Ambulatory Services at Manukau Health Park had its first meeting 23 January 2019. It is a multidisciplinary group, chaired by the Chief Medical Officer, Gloria Johnson, with Andrew Connolly as Clinical Lead and Pauline Hanna, Senior Responsible Owner.

The purpose of this steering group is to deliver a plan of ambulatory and elective services for Manukau Health Park over the next 10 years. This plan is expected to be delivered over a six month period, be aligned to the CM Health strategy, and take account of other future developments in the community as well as the southern corridor. The steering group will look to international best practice to inform its discussions.

Updates

Going forward, I have asked our Clinical Directors to provide a deep-dive update on their respective services. This month, I have invited Dr Jon Mathy, our Clinical Director of Cancer Services, to give an update on current and upcoming projects.

Priorities for Cancer Services

At the “Cancer Care at Crossroads” conference held in Wellington last week, the Minister of Health and the Director-General outlined the following Ministerial strategic priorities for cancer:

1. Refresh national cancer action plans (last outlined greater than 10 years ago)
2. Prioritise equity and sustainability
3. Improve state of health facilities and capacity in light of current and predicted demand (750M already allocated to funding facilities this year)
4. Consider investment in a national cancer specific information system
5. Re-evaluate and support an integrated cancer workforce  
6. Assess and adopt highly effective new therapies

CMH’s goal in cancer service development is to advocate for our community, to inform and strategically guide executive leadership, and work together to facilitate development and implementation of evolving regional and national cancer plans. Our overarching priority is achieving equity for Maaori, Pacific and those in socioeconomic deprivation.

Current Projects Underway

1. Local Delivery of Medical Oncology
   This project is to support the relocation of the infusion centre to the Manukau site. This includes understanding of current infusion volumes as well as engagement of both population health and Information Systems teams to include modelled utilisation projections over the next 5-10 years.

   Preliminary analysis:  
   Current utilization of the infusion centre is well supported and steadily increasing to accommodate local delivery, with an average of 80 hours per month over the last 3 months.
   For purposes of facilities planning with a view to regional planning and access equity, future oncology infusions need to consider other indications for transfer of CMDHB patients to ADHB for medical oncology (including immunotherapy, which affects numerous types of tumours).

2. Local Delivery of Radiation Oncology
   We are defining the volumes, and treatment demographics of CMDHB patients transferred to ADHB for radiotherapy (both current and modelled utilization over the next 5-10 years) to evaluate the role of a possible radiotherapy bunker in the CM area in conjunction with regional providers.
   The analysis will include impact to equity of delivering radiation oncology locally.

   Initial analysis:  CMDHB breast cancer patients have a lower radiation oncology intervention rate than the national average by 9% (and a lower rate relative to ADHB breast cancer patients). This suggests inequity in access that could be addressed by supporting a regional radiation oncology/local delivery strategy.
3. Analysing where our patients go to for inpatient cancer care, by the different types of specialties and tumours

We are doing this in order to advise opportunities for moving some patients to other DHBs and bringing certain types of patients back to Counties. This will be put into a regional context. This analysis includes multidisciplinary and surgical oncology care.

Preliminary analysis:
About 20% of inpatient cancer care for CMH patients has consistently gone to ADHB for treatment over the past 8 years (see Table below)

Where people living in CMH were hospitalised with a cancer diagnosis from 2011/12 to 2017/18

<table>
<thead>
<tr>
<th>Facility location</th>
<th>11/12</th>
<th>12/13</th>
<th>13/14</th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMDHB providers</td>
<td>79%</td>
<td>81%</td>
<td>79%</td>
<td>78%</td>
<td>77%</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>ADHB providers</td>
<td>20%</td>
<td>19%</td>
<td>20%</td>
<td>21%</td>
<td>22%</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td>Other providers</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.8%</td>
<td>1.1%</td>
<td>1.1%</td>
<td>1.0%</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

The four most common specialties referring CMH patients to other DHBs to receive their cancer care are Urology (64%); Ear, Nose and Throat (37%); Haematology (36%); and Gynaecology (17%). Of these, the Ear, Nose and Throat specialty demonstrates greatest service gaps and least inpatient resource allocation amenable to CMH development. On the other hand, a multi-campus development of plastic surgical services could significantly decompress inpatient resource utilisation at CMH and could be explored with the section head.

4. Co-design of a Head & Neck Lump referral pathway with community GP liaison

Data has consistently identified Ear, Nose and Throat as a challenged specialty for meeting evaluation and treatment timelines. Clinical investigation includes low cancer conversion rates from referral, which is a problem shared regionally (e.g., neck lump 5%, hoarseness 3%, swallowing difficulty 3%, referred ear pain 3%). Clinical leadership led by CMH and extending across all three DHBs have been engaged to extend pre-referral community workup that would improve these rates.

5. Regional Head & Neck Service Implementation

The SLA (Service Level Agreement) based framework for regional Head and Neck service delivery based on case complexity has been approved and now requires implementation. This is a substantial body of work with enormous opportunity to rethink funding models, regional workforce appointments, regional training appointments, and regional clinical trial support based on tumour stream and complexity. The process is being watched closely by the Ministry as a framework that
could be applied supra-regionally and nationally and extended to other types of tumours. Accordingly, we are working diligently to ensure strong on-going representation from CMH with clear communication to clinical and executive leadership throughout this process.

Upcoming Projects

1. **Manukau Health Park Redevelopment**
   In concert with infusion centre relocation, expanded local delivery of oncology services and ambulatory care initiatives, there is opportunity to lead the way regionally on an optimal patient-centred, integrated multidisciplinary outpatient oncology clinic.

2. **National Cancer Quality Performance Indicators (QPIs)**
   The Ministry has signalled that existing indicators for Faster Cancer Treatment (FCT) will be supplemented by a new category of performance indicators - starting with bowel cancer and subsequently extending to other tumour streams.

3. **Regionalisation of academic cancer services and clinical trials**
   Clinical trials have been shown to reduce inequity, reduce treatment variation, improve outcome, improve patient satisfaction and introduce new treatment options for cancer patients. In concert with Middlemore Clinical Trials we are looking to expand CMH access to clinical trials in tandem with clinical work on regional service provision.
## Performance and Outcomes Priorities

### Health Target Summary – Quarter 2 2018/19

<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Preliminary results</th>
<th>Achievement Quarter 2 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Departments</td>
<td><strong>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</strong></td>
<td>NOT ACHIEVED</td>
</tr>
</tbody>
</table>

**December 2018:** 87% total population (Māori: 86%, Pacific: 87%; target 95%)

**Note:** Although we are still below target, performance has improved slightly from Quarter 1 (Q1 results- total population: 84%, Māori: 84%, Pacific: 83%). There are multiple initiatives underway to improve patient flow and work towards achievement of the target:

- 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. Analysis of the full trial results has not yet been completed but positive effects have been observed and feedback from patients has been positive.
- Medical and surgical wards continue aiming to get 30% of patients to the discharge lounge by 11am. Results are variable and work toward improving results continues to be a part of the organisation’s Every Hour Counts project. The Patient Flow project has identified a pilot ward for testing new discharge processes designed to improve performance against this measure.
- Recruitment of Care Capacity Demand Management (CCDM) FTE has been approved by the DHB and the Ministry of Health and is currently underway.
- New roles have been appointed to the APAC team.
- Introduction of home-based wards and changes to the model of care in acute medicine began in December 2018, with the aim of improving flow to inpatient wards.
- 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 resource and capacity to address the level of presentations continue to be barriers to achieving the target. Approval was not received to recruit extra providers such as SMOs, MOSS, NPs or CNS and it remains...
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Preliminary results</th>
<th>Achievement Quarter 2 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Surgery*</td>
<td>difficult to provide an acceptable level of response and meet seen by times with the current level of resource.</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td>Faster Cancer Treatment</td>
<td>Number of publicly funded, case mix included, elective and arranged discharges for people living within the DHB region- Counties Manukau Health to deliver 20,930 Elective Surgical Discharges (ESD). November 2018: Actual delivery of ESD was better than the total planned volumes of ESD year to date (10,464 versus 10,427). There was a positive variance of 37 or 100.4% of planned.</td>
<td>NOT ACHIEVED</td>
</tr>
<tr>
<td>Immunisation</td>
<td>95% of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Maaori and Pacific population groups). December 2018: 93% total population (Maaori: 83%, Pacific: 94%; target 95%)</td>
<td>NOT ACHIEVED</td>
</tr>
<tr>
<td>Performance measure (previous Health Targets)</td>
<td>Preliminary results</td>
<td>Achievement Quarter 2 2018/19</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Note: The total coverage at eight months is 93%, remaining the same as last quarter. There has been a decrease in Maaori coverage from 84.5% to 83% and we are not achieving equity for Maaori babies. The challenges to achieving the target included the following:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The social dynamic of families on the move and the multiple visits required before an appointment is kept or engagement is made. This will be considered when the incentive programme is introduced in February.
- The mobility of families during the holiday season resulted in the Outreach Immunisation Service (OIS) immunising fewer babies.
- Families declining OIS appointments due to other commitments, not wanting upset children over the holiday season and not being home during the past month impacted the immunisation coverage.

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. |

**Raising Healthy Kids**

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

November 2018 (six-month result): 100% total population (Maaori: 99%, Pacific: 100%; target 95%)

| Tobacco Primary |

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

December 2018: 89% total population (Maaori: 88%, Pacific: 89%; Asian: 92%; target 90%)

Note: Preliminary PHO results indicate that for Q2, CM Health has just missed the 90% target for Better Help for Smokers to Quit with performance at 89.2%. However we believe that, as in previous years, performance will increase before the end of the financial year. This quarter is always challenging with many different priorities competing for practice time/attention.

We are concerned to note that performance for Maaori
continues to be lower than other ethnicities and did not reach the target. However, performance is higher than it has been in previous months so we are hopefully seeing the impact of the activities in the Metro Auckland SLM Improvement Plan, many of which are particularly focused on engaging with Maaori.

There are multiple activities underway to support achievement of the target, including the following:

- **Active Clinical Leadership/Clinical Champions**: 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, etc.

- **Active, Dedicated Management to Support ABC Activities In General Practice**: 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. In particular, some PHOs report that additional calling resource needs to be provided throughout the year for some practices to ensure that performance doesn’t shift too significantly (as it then is challenging to engage the practice to increase it again). Most PHOs have used significant extra resource over the last quarter to increase performance. They are not sure if they will be able to continue to provide this level of investment in the coming year.

- **PHO Activities to Increase Delivery of ABC in General Practice**: As part of the focus on cessation referral under the Amenable Mortality SLM, we have recently held a 2h workshop with PHOs to stocktake all regional existing activity in this area (of which there is a considerable amount), and identify gaps/areas of innovation for sharing. Under the SLMs data work which is
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Preliminary results</th>
<th>Achievement Quarter 2 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>on-going (and includes the development of interactive dashboards for PHOs and practices), we will soon begin receiving smoking prevalence data at the practice level from all PHOs, which we can use to prioritise practice support and other service planning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking</td>
<td>December 2018: 98% Maaori, 96% total population (Pacific: not reported; target 90%) &lt;br&gt; <strong>Note:</strong> CM Health has continued to achieve the 90% maternity Better Help for Smokers to Quit target in Quarter 2, for Maaori women and for the total population. Performance for Maaori and the total population have both increased since Quarter 1 (Quarter 1 results: Maaori 93%, total population 92%). This builds on strong performance in previous years, with CM Health achieving the target for wahine Maaori and the total population every quarter since Quarter 3 2016/17.</td>
<td>ACHIEVED</td>
</tr>
</tbody>
</table>

**ACHIEVED:** Preliminary results indicate the target was met in Quarter 2 2018/19  
**NOT ACHIEVED:** Preliminary results indicate the target was not met in Quarter 2 2018/19  
* Performance against the Elective Surgery target is reported one month in arrears.  
** Data provided from the MOH quarterly (for previous 6 months). Result reflects percentage of children identified as obese for whom a referral has been sent and that referral has been acknowledged.
Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 28 November – 28 December 2018.

Prepared and submitted by Donna Baker, General Manager Communications and Engagement and Pauline Hanna, Acting Director Strategic Development and Facilities.

Purpose

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

External Communications

Proactive Media

The Communications team proactively promoted a number of positive story ideas over this period, through local media and on the CM Health website.

These included media releases on the health science academies paying off for local Pasifika students, recognition of CM Health’s efforts on sustainability, CM Health’s partnership with local businesses to help employees go Smokefree and a social media campaign led by CM Health, working with Police and St John Ambulance to ease up on the drink over the festive season.

‘Please don’t’ – social media campaign in support of first responders

CM Health Communications lead the development of a campaign working with our Emergency Department, St John Ambulance, Fire Service and NZ Police to encourage people to think about the way they interact with first responders during the holiday period. Two videos were created – a short Facebook video featuring all four organisations, and a longer video which was embedded in each organisation’s website. The Facebook video proved extremely popular with more than 46,000 views and 219 shares. The videos will continue to be featured on social media during holiday periods throughout the year.

Radio NZ – Retreat rooms at Tiaho Mai

Communications facilitated a visit to Tiaho Mai mental health unit by Radio NZ Checkpoint to look at retreat rooms. An interview was organised with a clinical specialist. Other queries were also received with regards to mental health.

CPE/CRO

External Communications managed the release of a CMDHB statement on a multi-drug resistant organism identified in two different patients. There was initial media interest and extensive information that had previously been prepared for the website assisted to provide relevant details for journalists.
Planning for Junior Doctors Strike

Planning was progressed in the lead up to the Christmas holidays in preparation for the junior doctors 48 hour strike that commenced 15 January. Communications prepared information for the external website, including a media release to inform the public about preparation for the strike.

Proactive Releases

- CM Health recognised for sustainability effort with renewal of its Certified Emissions, Measurement and Reduction
- Multi-drug resistant organism identified at Middlemore Hospital
- Students making a difference at CM Health
- Health Science Academies pay off for local Pasifika students
- CM Health partners with local businesses to help employees go Smokefree
- Social media campaign to ease up on the drink over festive season working with Police and St John Ambulance

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.

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

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

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

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

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

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

Connect+ Christmas Edition
The Christmas edition of Connect+ was published in December celebrating 2018’s key achievements. Connect+ was read 73 times online, for an average of 5 minutes 39 seconds. The first edition of 2019 is due to be published early March 2019.

Internal Communications

Midwifery Employee Representation and Advisory Service (MERAS) and NZ Resident Doctors’ Association (RDA) strike action

The internal communications team has continued to provide support to the contingency planning group. The team has also participated in all planned communications teleconference calls with National office. Recognising the importance of consistent messaging, the team has worked in collaboration with both Auckland and Waitemata DHBs. All staff emails from the CEO and Chief Medical Officer have been sent to update staff on the situation. Separate pages have been established on Paanui to post regular updates for both.
NZNO rally on car park safety at Middlemore

Internal communications worked closely with HR following notice by the NZNO that a rally was planned regarding safety concerns around staff parking. An email from the CEO was issued to all staff outlining the improvements that had already been put in place to help staff feel more safe and secure.

Organisational Development (OD) plans for 2019

We have continued working closely with the OD team to develop a communications plan to support a number of key initiatives. These include:

- Employee Value Proposition
- Values work
- Celebration of long service
- Welcome Day and on-boarding email for managers
- Advertising of roles – how we use social media better and improving the quality of advertising

Final Staff Forum for 2018

Final staff forum for 2018 was held in December and focused on our key achievements for 2018. Staff heard from key speakers on projects including major facilities work, the successful bowel screening programme; and the summer plan.

Team Counties blogs

Four Team Counties blogs and one CEO blog was published during this period. These blogs and others can be found on the Paanui homepage under the Team Counties blogs section.

- Lending a hand to the Pacific
- It started with a question
- Making every hour count
- When Christmas is hard
- CEO blog: 12 days of Christmas

Chief Nurse and Director of Patient and Whaanau Experience eUpdate

Internal Comms worked with Jenny Parr, Chief Nurse and Director of Patient Whaanau Experience to develop and disseminate her fortnightly eUpdate, emailed to over 1500 staff members mid-December.
Christmas at Counties Manukau

12 Days of Counties Christmas

A Christmas kiwiana design was produced for the billboard outside Middlemore Hospital.

This design was repurposed for use on each of our internal channels: Facebook, LinkedIn, Twitter, Paanui sliders, CM Health screensaver, and Daily Dose banner.

Choir Performance

Internal communications assisted to coordinate the performance; and ensured sufficient promotion to recruit singers and publicise the performance. We were fortunate to secure the King’s College choir master again to facilitate the staff choir performance.
Christmas Decorations Competition

The standard for 2018 was exceptionally high. We received entries from 24 services across CM Health. After all staff votes were counted, the Christmas Decoration Winners for 2018 were the Acute Dietician Team. This team are back to back winners for December 2017 and December 2018.

Stakeholders & Communities

A number of proactive stories were released internally and externally in December 2018; Emergency Q trial, Smokefree and DHL Smokefree partnership success story, Students producing a Wellness Directory during their placement in Counties Manukau Health.

Alcohol Harm Minimisation

- Working with the team to develop key messages for pregnancy, cancers and equity in the first quarter of 2019.

Ease up on the Drink Campaign

- Developed collateral, produced a video in partnership with St Johns and Counties Manukau Police, promoted and helped on the delivery of Alcohol Harm Awareness Week (3-9 December) in preparation for increased presentations in ED and the hospital due to excess drinking during the festive season.

Pre Testie Bestie

- Supporting the project team in developing the localisation strategy for HPA’s, Pre Testie Bestie campaign activation in the Counties Manukau area.

Recruitment for Midwives: produced a generic image to be used on recruitment ads for Midwives.

Papakura Birthing Unit video: interviews and b-roll footage is now complete. We are currently in the process of editing the video.

Preterm Birth prevention work with Maternity: initial meetings taking place which will lead to a comms plan.

Maternity clinic at SuperClinic: comms plan is in process.

Planned Proactive Care: supporting the team to communicate changes to PPC.

Dental Facility at Manukau SuperClinic: on-going communications support as required re the build.
Every Hour Counts: on-going communications support for the project team.

‘Live Stronger for Longer’ campaign: video on local man doing the strength and balancing classes is in the process of being filmed and edited.

Ko Awatea: Supporting the development of content for the redeveloped website and promoting internal and external improvement and research workshops, and produced a visual abstract to promote the research done at CM Health.

Women’s Health and Newborn Annual Report 2018/2019: planning the strategy for this year’s report and establishing the plan with the report’s contributors.

December/January OMM newsletter: the newsletter was published on 13 December 2018

Digital Channels

Website (www.countiesmanukau.health.nz)
In December we saw a small drop in traffic vs. the previous reporting period, which can be attributed to staff going on leave for the holiday period; as we must factor in that some traffic to the external website originates from staff. This can be supported by the more expansive distribution of “time of day” metrics, which typically is closely matched with normal business hours.

Audience Growth Metrics

<table>
<thead>
<tr>
<th></th>
<th>Total Followers</th>
<th>Follower increase</th>
<th>Messages Sent</th>
<th>Impressions</th>
<th>Impressions per Post</th>
<th>Engagements (incl. post clicks)</th>
<th>Engagements per Post</th>
<th>Post Clicks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health Facebook</td>
<td>8,393</td>
<td>+2.54%</td>
<td>23</td>
<td>138,794</td>
<td>6,034</td>
<td>21,357</td>
<td>928.6</td>
<td>15,224</td>
</tr>
<tr>
<td>Healthy Together Facebook</td>
<td>8,866</td>
<td>+0.48%</td>
<td>14</td>
<td>48,643</td>
<td>3,474</td>
<td>6,612</td>
<td>472.3</td>
<td>4,006</td>
</tr>
</tbody>
</table>

Figure 1 Web Site Data Metrics from Google Analytics

Social Media

December was a strong period of growth across all social channels. The CM Health Facebook page saw a significant increase in engagement, up 52% vs. the last reporting period – even with fewer posts. As we continue to tweak the number of posts for optimal performance, we see our reach rise across all channels.
CM Health Twitter

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fans</td>
<td>2,642</td>
<td>+0.72%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>22</td>
<td>+1.47%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>17,046</td>
<td>+0.72%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>94</td>
<td>+4.04%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>30</td>
<td>4.2</td>
</tr>
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</table>

CM Health Linkedin

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Change</th>
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<tbody>
<tr>
<td>Total Fans</td>
<td>6,513</td>
<td>+4.04%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>8</td>
<td>+1.47%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>20,998</td>
<td>+0.72%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>2,624</td>
<td>+4.04%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>2,047</td>
<td>255.88</td>
</tr>
<tr>
<td></td>
<td>1,705</td>
<td>25.88%</td>
</tr>
</tbody>
</table>

Figure 6 Summary of Reach and Engagement Metrics for each social media channel

<table>
<thead>
<tr>
<th>Totals</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fans</td>
<td>26,414</td>
</tr>
<tr>
<td>Change</td>
<td>+2.02%</td>
</tr>
<tr>
<td>New Facebook Fans</td>
<td>250</td>
</tr>
<tr>
<td>Change</td>
<td>+1.47%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>19</td>
</tr>
<tr>
<td>Change</td>
<td>+0.72%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>253</td>
</tr>
<tr>
<td>Change</td>
<td>+4.04%</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>522</td>
</tr>
<tr>
<td>Change</td>
<td>153.4%</td>
</tr>
</tbody>
</table>

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

CM Health Facebook

The CM Health Facebook Page was once again our best performing channel, with reach over 138,000. Our video ‘Please don’t’ promoting positive behaviour when dealing with first responders is one of our most popular videos to date; reaching more than 46,000 people. A post celebrating Dot McKeen’s contribution to the DHB achieved an engagement rate of 37%; leading the way this period.

Top 4 Posts by Reactions:

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First responders in Counties Manukau are routinely faced with challenging,</td>
<td>1,127</td>
<td>14</td>
<td>12.97%</td>
<td>46,226</td>
</tr>
<tr>
<td></td>
<td>distressing and even violent situations in their everyday work. They’re here</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>to help. Please don’t abuse their trust. These holidays, help them to help you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and let’s all have a great summer…...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>With Christmas around the corner, we want you and your whaanau to keep well</td>
<td>265</td>
<td>12</td>
<td>20.92%</td>
<td>10,707</td>
</tr>
<tr>
<td></td>
<td>and safe over the festive break. Here are three of our awesome staff from our</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Department to help you know where to go over the holidays…...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Over the festive season and holidays, we see an increase in alcohol-related</td>
<td>131</td>
<td>4</td>
<td>15.12%</td>
<td>13,843</td>
</tr>
<tr>
<td></td>
<td>accidents and emergencies. Many of these accidents and injuries can be</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>avoided by reducing alcohol intake….</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Today we say farewell to long time Counties Manukau Stalwart, Dot McKeen. Dot</td>
<td>271</td>
<td>34</td>
<td>37.71%</td>
<td>4,150</td>
</tr>
<tr>
<td></td>
<td>’s been an integral part of the CM Health whaanau for more than 40 years as a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>nurse and senior manager. Dot’s family, former colleagues and staff were on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>hand to say farewell...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Healthy Together Facebook

Following a strong reporting period, we’re pleased to report further growth. With an increase in channel growth, impressions, and engagement, this was a great period for our Healthy Together Page. Our followers continue to favour posts that promote health and wellbeing – our strongest performer this period was a post advertising the free contraception clinic held in Maangere; which reached 10k people.
Top 3 Posts by Reactions

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Just letting you know whaanau that we now have a free contraception clinic in Maangere on a Thursday afternoon from 12.30 – 4.30pm. You can make an appointment (09 254 4260), but you can also drop-in on the day, no appointment necessary. Please let your whaanau of child-bearing age know about this great service.</td>
<td>385</td>
<td>10</td>
<td>15.33%</td>
<td>10,015</td>
</tr>
<tr>
<td></td>
<td>With Christmas around the corner whaanau, we want you to keep well and safe over the festive break. Here are three of our awesome staff from our Emergency Department to help you know where to go over the holidays...</td>
<td>213</td>
<td>1</td>
<td>17.15%</td>
<td>6,215</td>
</tr>
<tr>
<td></td>
<td>Do you know a young person (16-24) looking for a career in health, but not quite sure where to start? We have a number of opportunities at CM Health as part of the Youth Employment Pledge...</td>
<td>185</td>
<td>19</td>
<td>11.09%</td>
<td>8,239</td>
</tr>
</tbody>
</table>

Figure 9 Top 4 Healthy Together Posts by reactions

CM Health LinkedIn

After a great period of growth for our LinkedIn channel, we saw a 4% increase in followers, as well as an increase in engagement, despite posting fewer messages. Photos of the Christmas celebrations around Middlemore was the most popular post this period; achieving a 27% engagement rate.

Top Posts by Engagement:

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We’re getting into the Christmas spirit here at Counties - check out some of these creative decorations across Middlemore Hospital and our satellite sites! The judging will take place on Monday but for now, here's a few of our entries. ...</td>
<td>85</td>
<td>1</td>
<td>27.95%</td>
<td>4,747</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau Health is trialling a digital information system to help patients receive the right care for them. Read more about this great initiative...</td>
<td>58</td>
<td>1</td>
<td>8.66%</td>
<td>2,477</td>
</tr>
<tr>
<td></td>
<td>A group of University of Auckland Bachelor of Health Science students who recently completed their community placement at CM Health had the opportunity to make an impact in the lives of people living in Counties Manukau</td>
<td>27</td>
<td>2</td>
<td>6.02%</td>
<td>1,895</td>
</tr>
</tbody>
</table>

Figure 11 LinkedIn Top Posts by engagement
CM Health Twitter

A steady period for Twitter this month. Messaging around the Green Prescription programme and Dot’s farewell were strong performers, which accounted for 25% engagement.

Top 5 Posts by impressions:

<table>
<thead>
<tr>
<th>Tweets</th>
<th>Top Tweets</th>
<th>Tweets and replies</th>
<th>Promoted</th>
<th>Impressions</th>
<th>Engagements</th>
<th>Engagement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health @cmhdh Dec 10</td>
<td></td>
<td></td>
<td></td>
<td>938</td>
<td>7</td>
<td>0.7%</td>
</tr>
<tr>
<td>CM Health @cmhdh Dec 6</td>
<td></td>
<td></td>
<td></td>
<td>935</td>
<td>4</td>
<td>0.4%</td>
</tr>
<tr>
<td>CM Health @cmhdh Dec 7</td>
<td></td>
<td></td>
<td></td>
<td>818</td>
<td>4</td>
<td>0.5%</td>
</tr>
<tr>
<td>CM Health @cmhdh Dec 5</td>
<td></td>
<td></td>
<td></td>
<td>782</td>
<td>3</td>
<td>0.4%</td>
</tr>
<tr>
<td>CM Health @cmhdh Nov 30</td>
<td></td>
<td></td>
<td></td>
<td>769</td>
<td>17</td>
<td>2.2%</td>
</tr>
<tr>
<td>CM Health @cmhdh Dec 4</td>
<td></td>
<td></td>
<td></td>
<td>730</td>
<td>5</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Figure 10: Top 6 Tweets by impressions
Social Listening

Peaks:
- Late November: Prime Minister’s Visit & Tiaho Mai Opening
- Late December: Chemical huffing explosion

<table>
<thead>
<tr>
<th>Volume (Social)</th>
<th>Volume 11/28/2018 to 12/24/2018 (Social)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/28/2018 to 12/24/2018</td>
<td><img src="image" alt="Graph" /></td>
</tr>
</tbody>
</table>

**Mentions**

479

-18.12%

<table>
<thead>
<tr>
<th>Sentiment (Social)</th>
<th>Sources 11/28/2018 to 12/24/2018 (Social)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/28/2018 to 12/24/2018</td>
<td><img src="image" alt="Sentiment Graph" /></td>
</tr>
</tbody>
</table>

- Positive: 26
- Neutral: 411
- Negative: 42

**Figure 12 Social volume, sentiment and sources**
Figure 13 Social reach and hours

Figure 14 Social influence, topics and weekdays
Peaks

- **December 19:** Flea breakout

Figure 15 social volume, sentiment and sources
Figure 16: Hours and reach

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 December 2018.

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

Purpose

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

Executive Summary

• Incident Reporting in December:
  Incident reporting remained consistent with November figures at 112, which were considerably, lower than the August – September 2018 figures of 133-142. Incidents primarily reported as, BBFE, violence and aggression; moving and handling and slips, trips and falls. There are investigations into the increase in BBFE incidents, partly due to an increase in awareness of the importance of reporting but also an issue with the incorrect disposal of sharpies. Slips, trips and falls have increased with wet surface conditions and inattention seeming to contribute to the injury figures.

Current Issues Update:

• Actions following ACC AEP Audit (November 2018):
  • Key areas for follow up: Contractor Management, Hazardous Goods Management are continuing with the Facilities team working with external contractors to achieve full compliance.
  • Action points on Injury Management to be reviewed with WellNZ to ensure close out and prepare for annual ACC Injury Management audit. A number of the action points relate to record keeping and follow up. Director HR and Manager OHS to review service level agreement and Case Management effectiveness with recommendations being prepared for March review.
  • ACC Audit review points from H&S Contractor to be considered and recommendations presented to the ELT H&S Committee in February/March 2019 with proposed close out dates for completion and resourcing.
  • Worker Participation – National programme signed off and CMH alignment framework being completed for presentation to ELT in February, delay due to ACC audit process. Proposed that once consultation completed MH service to be the pilot rollout of WP framework.
## Performance Scorecard

### Health and Safety Scorecard

December 2018

---

#### Lagging Indicators

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Reported Incidents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>112</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Visitor</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Number of Injury claims</td>
<td>11</td>
<td>&lt;35</td>
<td></td>
</tr>
<tr>
<td>Lost time incidents</td>
<td>2</td>
<td>&lt;5</td>
<td></td>
</tr>
<tr>
<td>Lost time injury frequency rate</td>
<td>14.60</td>
<td>&lt;10</td>
<td></td>
</tr>
<tr>
<td>Cost of Injury claims</td>
<td>$1,291</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Lost time injury severity rate</td>
<td>96.09</td>
<td>&lt;630</td>
<td></td>
</tr>
</tbody>
</table>

#### Leading Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at H&amp;S Orientation</td>
<td>92%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>H&amp;S Representative training completed</td>
<td>0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Pre employment health screening completed</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Staff hand hygiene</td>
<td>84%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

#### Achievement Criteria

<table>
<thead>
<tr>
<th>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>

#### Comment on Variations

**Indicators in Red**

- **LTIFR**: 12 month rolling average figure remains above the target at 14 vs 10. It is expected that the Moving and Handling training will positively impact LTI figures in 2019.

- **H&S Representative training completed**: The H&S Rep training sessions were not offered in December and will recommence in February 2019.

**Indicators in Orange**

- **Attendance at H&S Orientation**: 59 out of the 65 participants eligible to attend the orientation attended.
LTIFR

LTIFR rolling average Figure of 14.30 has been impacted by the January-February 2018 peak; when compared with the last 6 month activity the results are tracking below this figure with no further peak. The expectation is that even tracking will continue in 2019 with a further move downwards towards the target figure of 10.

Severity remains at just above the Australian benchmarking figure but appears to have a downward trend from the spike in March.

Injury Claim Data

<table>
<thead>
<tr>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total $ cost for month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lost days for month</td>
<td>$ total for month</td>
<td>$ total for month</td>
<td>$ total cover cost for month</td>
<td>Total $ cost for month</td>
</tr>
<tr>
<td>155.91</td>
<td>12,628.84</td>
<td>4,555.44</td>
<td>24,325.85</td>
<td>41,510.13</td>
</tr>
</tbody>
</table>
# Key Health and Safety Risks

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

<table>
<thead>
<tr>
<th>Risk: Occupational Health &amp; Safety - Aggression and Violence (Emergency Department, Mental Health, Community Mental Health)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Report Action</strong></td>
</tr>
<tr>
<td>• Steering group working with Queensland Health on CMH proposed programme and timeframe for rollout.</td>
</tr>
<tr>
<td>• Follow up presentation of Code Orange with co-ordination with Security Team and roll out within ED team.</td>
</tr>
<tr>
<td>• Security Team working on MAPA (Management of Actual or Potential Aggression) training, crisis prevention and intervention planning.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk: Hazardous Substances and New Organisms (HSNO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Action Point</strong></td>
</tr>
<tr>
<td>• H&amp;S Contractor rolled out the pre-qualification programme to existing contractors.</td>
</tr>
<tr>
<td>• ACC Audit recommendation to continue rolling out contractor management programme following initial pre-qualification phase.</td>
</tr>
<tr>
<td>• Hazardous Goods register/on site audit and programme to be finalised by F&amp;E Hazardous Goods Advisor.</td>
</tr>
</tbody>
</table>
## Risk: Occupational Health and Safety - Safe Moving and Manual Handling

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• M&amp;H training programme continues with continued focus on TROPHI wards.</td>
<td>• Frequency of training programme will increase to 2 days a week from 31/01/2019 to increase number of patient facing staff trained.</td>
</tr>
<tr>
<td>• Steering groups on Safety Culture and Equipment focus on assessment of equipment needed for wards/ costs and storage.</td>
<td>• Increase in qualified educators with on-going programme to increase number of educators.</td>
</tr>
<tr>
<td>• M&amp;H incidents have reduced compared to high of last month (29 reducing to 18).</td>
<td>• Specific project in Orthopaedic ward to address management of safe handling of bariatric patients under review.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• BBFE still tracking higher than previous month and higher than 12 month comparison figure. Lack of concentration and incorrect technique key reasons.</td>
<td>• BBFE increase correlates to increase in demand with Christmas period. Senior staff working with colleagues under pressure main cause.</td>
</tr>
<tr>
<td>• BBFE also caused through not using sharps bin and OHSS team follow up with operating theatres to understand reasons.</td>
<td>• New intake of new nurse graduates during induction OHN specifically addressing risks/safety measures relating to BBFE. Last intake saw reduction in incidents following induction briefing.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lowest incident rate for last 24 months.</td>
<td>• A number of slips, trips and falls relate to walking/running in common area corridors.</td>
</tr>
<tr>
<td>• Continuing discussion with Orderlies/Cleaners who remain at lower than previous years’ results.</td>
<td>• Review taking place with F&amp;E on the non-slip lino in the ‘rainbow’ corridor.</td>
</tr>
</tbody>
</table>

## Risk: Compliance - Health & Safety Training Framework

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• H&amp;S Rep training continues and now caught up on full year target figures.</td>
<td>• H&amp;S Rep training to recommence in Feb 2019.</td>
</tr>
<tr>
<td>• Recommended H&amp;S training plan to be presented in next Board meeting in Feb 2019, with training to commence in March 2019.</td>
<td>• Review refresher training for existing H&amp;S Reps with training provider.</td>
</tr>
<tr>
<td>• Resourcing plan to be presented to ELT following agreement on training plan for 2019.</td>
<td>• MH First Aid training programme to commence with a number of CMH team to attend pilot of MH101 in Feb 2019.</td>
</tr>
<tr>
<td></td>
<td>• Fundamentals of Management H&amp;S module under review and first cohort in April to deliver new programme.</td>
</tr>
<tr>
<td></td>
<td>• A new format H&amp;S Induction is under development. Change will be effective March 2019.</td>
</tr>
</tbody>
</table>
### Risk: Wellness – Employee Health and Wellbeing Programme (stress, fatigue, depression)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • Mental Health Awareness Week included:  
  o EAP/Mental Health First Aid presentations  
  o BBQ for staff at MSC  
  o Mindfulness session  
  o Mental Health client art exhibition  
• Flu campaign close out presentation as part of CEO Staff Forum.  
• Peer Vaccination awards celebration completed.  
• OHP presentation to Junior Doctors on fatigue management/sleep management.  
• Campaign supporting hand hygiene.  
| • Mental Health First Aid Training will occur in February.  
• Flu campaign national update in Feb with full rollout of campaign planned from 01 Apr 2019.  
• Review of access to OCC Health team by Maaori workforce and Pacific workforce to ensure equity of access. |

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • Air conditioning being fitted to Western Campus by F&E following incident reports on excessive heat in upper floor.  
• Audiometers delivered and roll out of annual hearing tests to commence.  
• Asbestos removal commenced at Galbraith Building with F&E supervision.  
| • Seasonal flea incidents being managed.  
• Follow up with cleaning staff to reduce incidents and management of patient isolation if appropriate to reduce cross-contamination.  
• Asbestos removal continues at Galbraith with closed off area with lobby of Galbraith. |

### Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
</table>
| • Worker Participation Agreement (WPA) draft framework to be presented to ELT/Board and then consulting with Unions early 2019.  
• H&S rep training completed for 2018.  
• Further discussion on workgroups, additional H&S Committees to be consulted with Unions.  
• Communication from H&S Committees through to ELT H&S Committee/Union to be finalised following consultation with Unions.  
| • Draft Worker Participation framework to be presented to ELT in February for review.  
• Agreed with PSA/MH service that following agreement on Worker Participation framework, MH service will be pilot for rollout of framework.  
• ELT H&S committee meeting in December reviewed membership of committee; action points to finalise terms of reference and ensuring Union delegate representation at committee meetings. |
Reported Incidents

Rolling year-on-year monthly comparison:

Previous 12 months – 89
Current 12 months – 112

Increase in year on year figure – result of consistent increase in reporting of aggression and violence, BBFE and M&H incidents.

Key Observations:

- **BBFE (31)**: Highest reported incident category. Increase from Nov figure of 22 and spike in Christmas/New Year reflected in this figure. OHSS team tracking trends and following up with services. New grad Nurse induction includes briefing by OHN on BBFE prevention to reduce incidents within this group.

- **Aggression and Violence (19)**: Consistent with Nov figure of 18. Investigation/improvements to controls and processes in place. ED continuing with Code Orange initiative and the swipe card pilot study all working to reduce the A&V incidents, at this stage still encouraging capture of all incidents.

- **Other (21)**: ‘awkward position/posture’ was high. Safe moving of objects/equipment contributory factor.

- **Moving & Handling (18)**: Slight decrease from November figure of 19.

- **Slips/ Trips/ Falls (17)**: Increased from the November figure of 14.
BBFE (Blood or Body Fluid Exposure)

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

Previous 12 months – 23
Current 12 months – 31
- BBFE incidents remain higher than previous 12 and 24 month results for same period. Increase in reporting contributes to these figures.
- SAP services are the highest incidents.
- OHSS tracking trends and following up with services to reduce reoccurrence.
- Cleaning services experiencing BBFE as a result of SAPs not placing used needles in sharps bin.
- Spike in Xmas/NY period due to high demand on SAP services.
- Causation profile:
  - Inattention/distract: 7
  - Patient condition/acts of others: 7
  - Job factor: 5
  - Fatigue/tiredness: 3
  - Unnecessary haste: 3
  - Defective tools/equipment: 2
  - Improper work techniques: 2
  - PPE not used: 2

**Aggression and Violence**

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

Previous 12 months – 19
Current 12 months – 25
- Incidents less than previous 12 month figure, although ED experiencing difficulty in capturing all the incidents may contribute to the decreased number.
- ED rolling out ‘Code Orange’ trial and including Security Services to enable better control of elevated behaviour.
- Mental Health remains highest area for reported incidents.
- Causation profile:
  - Behaviour – Aggressive/Violent: 17;
  - Assault – Verbal/Gesture: 2
Moving and Handling

Rolling year-on-year monthly comparison:

**Slips, Trips and Falls**

- **Previous 13 months – 17**
- **Current 13 months – 14**
  - Slips, Trips and Falls incidents have increased when compared with the year on year rolling average of 2016/2017.
  - MH services have the highest rates at 4 followed by SAP and EMIC.
  - Causation profile:
    - Slipped/ tripped/ stumbled: 6
    - Surface – slippery/ wet: 6
    - Repetitive handling/ movement; faulty equipment; human factors; stepping/ kneeling/ sitting on: 5

- **Previous 13 months – 18**
- **Current 13 months – 17**
  - Consistent with year on year rolling average.
  - M&H training programme rollout out with weekly programmes being delivered and train the trainer reviews from WDHB team.
  - SAP services have the highest reported M&H incidents.
  - Causation profile:
    - Awkward posture/equipment malfunction/job factors/action/behaviour of employee or patient/affiliate/human factors: 12;
    - Lifting/carrying/load size: 5;
    - Repetitive handling/movement: 1
Reported Incidents Summarised by Workforce and Division

Reported Incidents Summarised by Category & Workforce for December 2018

Reported Incidents Summarised by Division & Category for December 2018
Case and Claims Management:

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

Pending Claims requiring initial assessments and further investigation before a cover decision is made.

Complex claims may remain as pending up to 21 days, when a decision/or extension (awaiting further evidence with assessed by an OHP) pending decision to accept/decline claim.

ACC Audit reviewed Case Management and CMH retain tertiary accreditation for injury case management.

Vaccinations:

Vaccination programmes as part of the pre-employment screening programme have increased with clinics being full and concentration of activity related to intake of Graduate nurses and other staff commencing Jan/Feb 2019.

Clinic Appointments:

Increase in clinic appointments following increase in pre-employment screening.

Staff booking and not attending clinic appointments has decreased significantly. Follow up phone calls to identify key reasons for missing appointments are being conducted, although illness has contributed to this figure.

The Occupational Health Clinics have been full, due to the increase in referrals and the complexity of cases resulting in longer close out periods.
<table>
<thead>
<tr>
<th>Glossary for Monthly Performance Scorecard and Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lost time incidents</strong></td>
</tr>
</tbody>
</table>
| **Lost time injury Frequency Rate** | No of lost time Injuries per million hours worked.  
LTIFR (Lost Time Injury Frequency Rate) = (Number of Lost Time Injuries / Hours Worked) x 1,000,000. |
| **Injury Severity Rate** | Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked.  
LTISR (Lost Time Injury Severity Rate) = (Number of Lost Hours / Hours Worked) x 1,000,000. |
| **Notifiable Injury/illness** | (a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations.  
(b) any admission to hospital for immediate treatment  
(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance  
(d) any serious infection (including occupational zoonosis) to which carrying out out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals.  
(e) any other injury/illness declared by regulations to be notifiable. |
| **Notifiable Incident** | An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person’s health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident. |
| **Notifiable Event** | Death of a person, notifiable injury or illness or a notifiable incident. |
| **Pre-Employment** | Health screening for new employees. |
| **Worker** | An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer. |
| **Reasonably Practicable** | Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.e.g the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk |
## Glossary

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

It is recommended that the Board:

**Note** that this paper was endorsed by the Audit Risk and Finance Committee on 29 January 2019 to go forward to the Board meeting of 20 February 2019.

**Receive and note** this Finance and Corporate Business Report.

Submitted by: Margaret White – Chief Financial Officer

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMHU</td>
<td>Acute Mental Health Unit</td>
</tr>
<tr>
<td>CFIS</td>
<td>Crown Financial Information System</td>
</tr>
<tr>
<td>FFSC</td>
<td>Finance, Procurement Supply Chain</td>
</tr>
<tr>
<td>FSA</td>
<td>Food Service Agreement</td>
</tr>
<tr>
<td>IDF</td>
<td>Inter District Flows</td>
</tr>
<tr>
<td>ILoC</td>
<td>Integrated Locality Care</td>
</tr>
<tr>
<td>MBE</td>
<td>Ministry of Business, Innovation &amp; Employment</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>MIF</td>
<td>Monitoring Intervention Forum</td>
</tr>
<tr>
<td>NOS</td>
<td>National Oracle Solution</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
</tr>
<tr>
<td>PAYE</td>
<td>Pay As You Earn</td>
</tr>
<tr>
<td>PBFF</td>
<td>Population Based Funding Formula</td>
</tr>
<tr>
<td>PIR</td>
<td>Post Implementation Review</td>
</tr>
<tr>
<td>PSA</td>
<td>The New Zealand Public Service Association</td>
</tr>
<tr>
<td>RDA</td>
<td>Resident Doctors Association</td>
</tr>
<tr>
<td>SPMO</td>
<td>Strategic Project Management Office</td>
</tr>
<tr>
<td>TAP</td>
<td>Turnaround Plan</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>

Purpose

The purpose of this paper is to provide the Board with an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 29 January 2019.

**1.1 Financial Report for the period ended 31 December 2018**

The 31 December 2018 month consolidated result is $337k favourable (YTD $2.2m favourable) to budget.

The full year forecast for the year ended 30 June 2019 remains at a deficit of $45.051m. Due to Audit Risk and Finance Committee cycle dates, the full financial report is presented for the period ended 30 November 2018.

**1.2 Financial Report for the period ended 30 November 2018**

The 30 November 2018 month consolidated result is $1.496m favourable (YTD $1.812m favourable) to budget. Performance by operating arm is presented in table 1 below.
### Table 1: Statement of Performance by Operating Arm for the period ended 30 November 2018

<table>
<thead>
<tr>
<th>Net Result</th>
<th>Month</th>
<th>November 2018</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act $000</td>
<td>Bud $000</td>
<td>Var $000</td>
</tr>
<tr>
<td>Hospital Provider</td>
<td>606</td>
<td>(944)</td>
<td>1,550</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(2,810)</td>
<td>(2,722)</td>
<td>(88)</td>
</tr>
<tr>
<td>Provider</td>
<td>(2,204)</td>
<td>(3,666)</td>
<td>1,462</td>
</tr>
<tr>
<td>Funder</td>
<td>(619)</td>
<td>(786)</td>
<td>166</td>
</tr>
<tr>
<td>Governance</td>
<td>(143)</td>
<td>(10)</td>
<td>(132)</td>
</tr>
<tr>
<td>Surplus / (deficit)</td>
<td>(2,966)</td>
<td>(4,462)</td>
<td>1,496</td>
</tr>
</tbody>
</table>

**Provider**

Hospital Provider Position is $1.550m favourable (YTD $6.096m favourable) to budget. The key drivers are the reduced volumes and costs associated with a milder winter the impact of vacancies and additional revenue from ACC and Tahitian Burns.

Integrated care is $88k unfavourable (YTD $140k favourable), driven primarily by demand in the community as well as leave requiring bureau nursing cover.

**Funder**

The Funder Arm is $166k favourable (YTD $4.702m unfavourable) to budget, primarily driven by a $3.7m IDF wash up provision not budgeted and turn-around-plan (TAP) revenue generation initiatives that are yet to crystalize $2.2m YTD.

**Governance**

Governance Arm is $132k unfavourable (YTD $557k favourable) to budget primarily driven by vacancies.

*The full Financial Variance Report for the period ended 30 November 2018 is presented in Appendix 1 (Table 2) of this report.*
Appendix 1 – Financial Report for the period ended 30 November 2018

YTD 30 November 2018 the consolidated result is $1.812m favourable to budget.

Table 2: Statement of Revenue and Expenditure for the period ended 30 November 2018

<table>
<thead>
<tr>
<th>Net Result</th>
<th>November 2018</th>
<th>Full Year Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Year to Date</td>
</tr>
<tr>
<td></td>
<td>Act $000</td>
<td>Bud $000</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>140,399</td>
<td>140,819</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>4,479</td>
<td>2,957</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>144,878</td>
<td>143,776</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>54,169</td>
<td>56,691</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,892</td>
<td>993</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>6,378</td>
<td>5,854</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>61,734</td>
<td>61,092</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>10,414</td>
<td>10,678</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>7,220</td>
<td>6,660</td>
</tr>
<tr>
<td>Operating Expenditure</td>
<td>141,808</td>
<td>141,968</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>3,070</td>
<td>1,808</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,946</td>
<td>3,163</td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>3,091</td>
<td>3,108</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(2,966)</td>
<td>(4,462)</td>
</tr>
</tbody>
</table>

Commentary on Major Variances:

**Crown Revenue**

November 2018 month was $420k unfavourable to budget (YTD $1.473m favourable), reflecting the following:

- TAP revenue initiatives shortfall $445k unfavourable (YTD $2.223m unfavourable);
- Mental Health and Health of Older People unbudgeted pay equity $1m favourable (YTD $1.9m favourable) with matching additional costs in provider payments;
- IDF inflows adjustment to contract YTD $1.303m favourable;
- Additional ACC arrears revenue $97k unfavourable (YTD $1.6m favourable);
- HWNZ training costs, invoiced ahead of plan $100k favourable (YTD $302k favourable);
- Bowel screening volumes variance to contract $44k unfavourable (YTD $437k unfavourable).
Other Revenue
November 2018 month was $1.523m favourable to budget (YTD $4.411m favourable), reflecting the following:
• Favourable timing of Pacific contract revenue (offset by cost) $244k favourable (YTD $1.5m favourable);
• Retail pharmacy sales $103k favourable (YTD $552k favourable);
• Tahitian burns additional billing $32k favourable (YTD $869k favourable);
• Interest received $99k favourable (YTD $455k favourable) due to better than Budget cash position;
• Closeout of the Ko Awatea Joint Venture asset.

Personnel and Outsourced Personnel
Net personnel costs for November are $1.623mk favourable (YTD $5.45m favourable). Continued vacancies across the services (combination of lower acute demand and services holding vacancies where appropriate) and the impact of the nursing strike has resulted in FTE and dollar costs under budget, with partial offsets in YTD unrealised TAP savings and outsourced personnel. Actual FTE’s including outsourced were 150 FTE favourable YTD.

Outsourced services
Outsourced Clinical Services were $525k unfavourable (YTD $2.741m unfavourable) Driven by Pacific contract costs higher than budget, offset by revenue, $248k unfavourable (YTD $1.2m unfavourable); an agreed overspend in Surgical services to meet the MOH Elective contract, $158k unfavourable (YTD $630k unfavourable) and increased YTD MRI outsourcing due to a delayed replacement of the MRI machines in CSB, $165k unfavourable (YTD $555k unfavourable).

Additional MRI outsourcing costs of $1M has been forecast to address the wait list volumes due to staff shortages and the delayed implementation of the new machines.

Provider Payments
November was $643k unfavourable to budget (YTD $5.859m unfavourable), reflecting the following:
• IDF wash up provisioning greater than budget, primarily ADHB $1.2m unfavourable (YTD $4.9m unfavourable);
• Mental Health unbudgeted pay equity $252k (YTD $1.16m unfavourable), offset by revenue; and
• Maori Health savings target shortfall $74k unfavourable (YTD $393k unfavourable), Pacific Health NGO costs relating to 17/18 not accrued (Nov YTD $311k unfavourable) and the remaining balance being partly offset by additional revenue.

Clinical supplies
Unrealised TAP savings in Provider of $295k month (YTD $1.4m) offset by lower clinical equipment leasing costs $123k favourable (YTD $638k favourable).

Infrastructure costs
November was $560k unfavourable to budget (YTD $966k unfavourable), reflecting the following:
• Cost of goods sold increase due to higher pharmacy sales (offset by revenue) $102k (YTD $565k);
• Unbudgeted legal and consultant costs (inc Ebert) YTD $270k;
• Offset by gain on sale of land in August (YTD $377k) that was not accounted for in 2017/18.
### Table 3: Statement of Financial Position as at 30 November 2018

<table>
<thead>
<tr>
<th></th>
<th>Act $000</th>
<th>Budget $000</th>
<th>Var $000</th>
<th>Oct-18 $000</th>
<th>Movement $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Bank</td>
<td>32,148</td>
<td>2,758</td>
<td>29,390</td>
<td>31,997</td>
<td>151</td>
</tr>
<tr>
<td>Trust</td>
<td>2,827</td>
<td>2,811</td>
<td>16</td>
<td>2,824</td>
<td>3</td>
</tr>
<tr>
<td>Prepayments</td>
<td>3,068</td>
<td>637</td>
<td>2,431</td>
<td>2,804</td>
<td>264</td>
</tr>
<tr>
<td>Debtors</td>
<td>50,493</td>
<td>57,241</td>
<td>(6,748)</td>
<td>51,480</td>
<td>(987)</td>
</tr>
<tr>
<td>Inventory</td>
<td>7,782</td>
<td>8,940</td>
<td>(1,158)</td>
<td>7,728</td>
<td>54</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>101,646</td>
<td>77,715</td>
<td>23,931</td>
<td>102,161</td>
<td>(515)</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>629,205</td>
<td>680,536</td>
<td>(51,331)</td>
<td>629,205</td>
<td>-</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>4,209</td>
<td>4,850</td>
<td>(641)</td>
<td>4,636</td>
<td>(427)</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>852,482</td>
<td>904,501</td>
<td>(52,019)</td>
<td>852,909</td>
<td>(427)</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(196,233)</td>
<td>(197,200)</td>
<td>967</td>
<td>(193,714)</td>
<td>(2,519)</td>
</tr>
<tr>
<td><strong>Net Cost</strong></td>
<td>656,249</td>
<td>707,301</td>
<td>(51,052)</td>
<td>659,195</td>
<td>(2,946)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>88,521</td>
<td>37,372</td>
<td>51,149</td>
<td>85,897</td>
<td>2,624</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>744,770</td>
<td>744,673</td>
<td>97</td>
<td>745,092</td>
<td>(322)</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>46,445</td>
<td>55,239</td>
<td>(8,794)</td>
<td>46,445</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>892,861</td>
<td>877,627</td>
<td>15,234</td>
<td>893,692</td>
<td>(837)</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>102,386</td>
<td>97,947</td>
<td>4,439</td>
<td>97,543</td>
<td>4,843</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>8,761</td>
<td>6,429</td>
<td>2,332</td>
<td>10,330</td>
<td>(1,569)</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>14,361</td>
<td>14,600</td>
<td>(239)</td>
<td>18,714</td>
<td>(4,353)</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>14,016</td>
<td>14,275</td>
<td>(259)</td>
<td>25,345</td>
<td>(11,329)</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>122,680</td>
<td>109,599</td>
<td>13,081</td>
<td>108,144</td>
<td>14,536</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>262,204</td>
<td>242,850</td>
<td>19,354</td>
<td>260,076</td>
<td>2,128</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(160,558)</td>
<td>(165,135)</td>
<td>4,577</td>
<td>(157,915)</td>
<td>(2,643)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>630,657</td>
<td>634,777</td>
<td>(4,120)</td>
<td>633,622</td>
<td>(2,965)</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>22,948</td>
<td>22,948</td>
<td>-</td>
<td>22,948</td>
<td>-</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>2,825</td>
<td>2,810</td>
<td>15</td>
<td>2,823</td>
<td>2</td>
</tr>
<tr>
<td>Insurance Liability</td>
<td>1,155</td>
<td>1,155</td>
<td>-</td>
<td>1,155</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>26,928</td>
<td>26,913</td>
<td>15</td>
<td>26,926</td>
<td>2</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>408,990</td>
<td>414,932</td>
<td>(5,942)</td>
<td>408,990</td>
<td>-</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>291,395</td>
<td>291,399</td>
<td>(4)</td>
<td>291,395</td>
<td>-</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(96,656)</td>
<td>(98,467)</td>
<td>1,811</td>
<td>(93,689)</td>
<td>(2,967)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>603,729</td>
<td>607,864</td>
<td>(4,135)</td>
<td>606,696</td>
<td>(2,967)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>630,657</td>
<td>634,777</td>
<td>(4,120)</td>
<td>633,622</td>
<td>(2,965)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- Closing bank was $29.390m favourable to budget. Net cash flows from operations (revenue, expenses and payroll) was $4.716m favourable to budget. (refer cash flow variance explanation for further details).

- Debtors were $6.748m lower than Budget as a result of improved collections and timing differences.

- Net Fixed Assets and Investment in Associates are $8.697m lower than budget reflecting timing of major capital projects spend (including an assumption regarding IT assets planned to be transferred to healthAlliance in September 2018 however the workings regarding the transfer is still in progress).

- Creditors are $4.439m favourable to Budget due to timing differences in Accounts Payable.

- Income In Advance was higher than Budget by $2.332m largely due to recovery of a bond for the AMHU Project now transferred from Accrued Creditors.

- Employee entitlements were $13.081m greater than budget mainly reflecting timing.

- The favourable working capital variance to Budget of $4.577m is mostly attributable to the timing matters detailed above.
### Table 4: Statement of Cash flow for the period ended 30 November 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>Act $ 000</th>
<th>Budget $ 000</th>
<th>Var $ 000</th>
<th>Act $ 000</th>
<th>Budget $ 000</th>
<th>Var $ 000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from Operating activities</strong></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>
</tr>
<tr>
<td>Crown Revenue</td>
<td>139,741</td>
<td>138,718</td>
<td>1,023</td>
<td>714,258</td>
<td>703,829</td>
<td>10,429</td>
</tr>
<tr>
<td>Other</td>
<td>4,399</td>
<td>2,984</td>
<td>1,415</td>
<td>18,652</td>
<td>14,710</td>
<td>3,942</td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(90,498)</td>
<td>(88,362)</td>
<td>(2,136)</td>
<td>(458,361)</td>
<td>(448,015)</td>
<td>(10,346)</td>
</tr>
<tr>
<td>Employees</td>
<td>(50,962)</td>
<td>(55,376)</td>
<td>4,414</td>
<td>(261,278)</td>
<td>(280,093)</td>
<td>18,815</td>
</tr>
<tr>
<td>Capital charge</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash from Operations</strong></td>
<td>2,680</td>
<td>(2,036)</td>
<td>4,716</td>
<td>13,271</td>
<td>(9,569)</td>
<td>22,840</td>
</tr>
<tr>
<td><strong>Cash flows from Investing activities</strong></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>
</tr>
<tr>
<td>Fixed assets</td>
<td>(2,624)</td>
<td>(4,603)</td>
<td>1,979</td>
<td>(14,922)</td>
<td>(24,664)</td>
<td>9,742</td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>(100)</td>
<td>100</td>
<td>(447)</td>
<td>(2,300)</td>
<td>1,853</td>
</tr>
<tr>
<td>Interest rec.</td>
<td>157</td>
<td>59</td>
<td>98</td>
<td>746</td>
<td>292</td>
<td>454</td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>15</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td><strong>Net cash from Investing</strong></td>
<td>(2,465)</td>
<td>(4,644)</td>
<td>2,179</td>
<td>(14,608)</td>
<td>(26,672)</td>
<td>12,064</td>
</tr>
<tr>
<td><strong>Cash flows from Financing activities</strong></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>
</tr>
<tr>
<td>Sale of Asset</td>
<td>(62)</td>
<td>-</td>
<td>(62)</td>
<td>443</td>
<td>-</td>
<td>443</td>
</tr>
<tr>
<td>Other Non-Current Liability</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1,775</td>
<td>7,716</td>
<td>(5,941)</td>
</tr>
<tr>
<td><strong>Net cash from Financing</strong></td>
<td>(61)</td>
<td>-</td>
<td>(61)</td>
<td>2,218</td>
<td>7,716</td>
<td>(5,498)</td>
</tr>
<tr>
<td><strong>Net increase / (decrease)</strong></td>
<td>154</td>
<td>(6,680)</td>
<td>6,834</td>
<td>881</td>
<td>(28,525)</td>
<td>29,406</td>
</tr>
<tr>
<td>Opening cash</td>
<td>34,829</td>
<td>9,446</td>
<td>25,383</td>
<td>34,102</td>
<td>31,291</td>
<td>2,811</td>
</tr>
<tr>
<td><strong>Closing cash</strong></td>
<td>34,983</td>
<td>2,766</td>
<td>32,217</td>
<td>34,983</td>
<td>2,766</td>
<td>32,217</td>
</tr>
</tbody>
</table>

**Reconciliation Summary**

<table>
<thead>
<tr>
<th>Net Surplus/(Deficit)</th>
<th>(2,967)</th>
<th>(4,461)</th>
<th>1,494</th>
<th>(21,690)</th>
<th>(23,500)</th>
<th>1,809</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add/(Less) non-cash items</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depn</td>
<td>2,947</td>
<td>3,165</td>
<td>(218)</td>
<td>15,600</td>
<td>15,817</td>
<td>(217)</td>
</tr>
<tr>
<td></td>
<td>(20)</td>
<td>(1,296)</td>
<td>1,276</td>
<td>(6,090)</td>
<td>(7,683)</td>
<td>1,592</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>
</tr>
<tr>
<td>Gain on Disposal</td>
<td>62</td>
<td>-</td>
<td>62</td>
<td>(443)</td>
<td>-</td>
<td>(443)</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>
</tr>
<tr>
<td>Debtor and Other Receivables</td>
<td>(723)</td>
<td>(2,159)</td>
<td>1,436</td>
<td>(3,526)</td>
<td>(1,083)</td>
<td>(2,443)</td>
</tr>
<tr>
<td>Inventories</td>
<td>54</td>
<td>(50)</td>
<td>104</td>
<td>(745)</td>
<td>(413)</td>
<td>(332)</td>
</tr>
<tr>
<td>Creditors</td>
<td>(521)</td>
<td>1,469</td>
<td>(1,990)</td>
<td>13,421</td>
<td>(390)</td>
<td>13,811</td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>3,828</td>
<td>-</td>
<td>3,828</td>
<td>10,654</td>
<td>-</td>
<td>10,654</td>
</tr>
<tr>
<td><strong>Net Cash flow from Operations</strong></td>
<td>2,680</td>
<td>(2,036)</td>
<td>4,716</td>
<td>13,271</td>
<td>(9,569)</td>
<td>22,840</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- Cash-flow from Other Revenue is $1.415m favourable to budget mainly due to additional ACC/Tahitian Burns revenue.

- Payments to suppliers were $2.136m higher than budget mainly as a result of variations to the planned timing of supplier payments in the budget.

- Employee Payments were $4.414m favourable to budget representing net favourable personnel costs for the month and the timing of the payment of payroll accruals.

- Fixed Assets $1.979m unfavourable to budget representing the timing of capital spend for major capital projects.
Information Paper
Counties Manukau District Health Board
Hospital in the Home Update

Recommendation

It is recommended that the Board:

Receive this update on the status of Hospital in the Home.

Note this report was endorsed by the Executive Leadership Team on 12 February to go forward to the Board.

Prepared and submitted by: Penelope Magud, General Manager Locality Services on behalf of Campbell Brebner, Chief Medical Advisor for Primary Care.

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APAC</td>
<td>Acute and Post Acute Care Team</td>
</tr>
<tr>
<td>HiTH</td>
<td>Hospital in the Home</td>
</tr>
<tr>
<td>MAU</td>
<td>Medical Assessment Unit</td>
</tr>
<tr>
<td>SMO</td>
<td>Senior Medical Officer</td>
</tr>
</tbody>
</table>

Purpose

The purpose of this paper is to provide an update on the implementation and utilisation of the Hospital in the Home pathway.

Executive Summary

There has been an increased in the utilization of the Hospital in the Home pathway since the last update to ELT in November 2018. The increase in Hospital in the Home utilization has resulted from dedicated senior leadership and clinical support for the pathway. From 4th December 2018, Carl Eagleton took on the clinical leadership of Hospital in the Home which resulted in an immediate and sustained increase in referrals. This leadership and committed support for Hospital in the Home has had a roll on effect to other General Medical SMO’s who have also now trialed the pathway and provided positive feedback.

Also integral to the increased utilization have been the close working relationship we have developed with the APAC Team and the newly appointed Transition Coordinators. In addition to this Community Central also had staff attend ward handovers throughout December leading to increased awareness of the range of clinical care that can and is currently delivered outside of the hospital.

A total of 65 patients have been admitted to Hospital in the Home since it commenced in June 2018. With a total of 26 patients admitted to the pathway since December 2018. We are now observing a more consistent flow of referrals and appropriate patient identification.
Average Length of Hospital Stay: 6.3 days
Average Length of Hospital in the Home Stay: 5.5 days
<table>
<thead>
<tr>
<th>Risk/Issues</th>
<th>Mitigation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedicated clinical leadership is essential to the success of Hospital in</td>
<td>The Division of Medicine is undertaking a focused international recruitment drive to recruit a clinician with proven experience and leadership within the</td>
</tr>
<tr>
<td>the Home and the current leadership cover will not be sustainable in the</td>
<td>Hospital in the Home approach.</td>
</tr>
<tr>
<td>longer term.</td>
<td></td>
</tr>
<tr>
<td>District Nurse capacity has been at times limited by available resources</td>
<td>A review of current District Nursing rostering practices is being undertaken to ensure adequate staff are rostered to deliver care. More training will</td>
</tr>
<tr>
<td>and other priority acute workload.</td>
<td>be offered across the District Nurses to ensure there is a greater pool of staff available to meet increasing clinical demand. We will also review the</td>
</tr>
<tr>
<td></td>
<td>need to create a centralised roster for Hospital in the Home that can deliver care across the district.</td>
</tr>
<tr>
<td>Reporting of Hospital in the Home utilisation is currently done in</td>
<td>We recommend that all reporting of Community Health Service utilisation is done under the Every Hour Counts Programme. This will enable greater visibility of</td>
</tr>
<tr>
<td>isolation from all acute workflow to the Community Health Service.</td>
<td>the utilisation of all community based treatment pathways.</td>
</tr>
<tr>
<td>Delays in community laboratory testing has occurred through referrals to</td>
<td>A meeting is being held with LabTests to refine the referral processes to the LabTest home visiting team. In addition to this we are exploring the potential of</td>
</tr>
<tr>
<td>LabTests not being received.</td>
<td>training our District Nurses with phlebotomy skills to increase the point of care testing and avoid the need to refer on.</td>
</tr>
</tbody>
</table>

### 2019 Implementation Plan

In accordance with the revised work streams of the Every Hour Counts Programme, a new stream focused on Optimising Access to Community Services has been introduced. This provides an opportunity to optimise the transition of care for patients between Secondary Services and the Community Health Service which includes maximising access to all existing community based pathways such as ‘Nursing in the Home’, ‘Rehab in the Home’ and ‘Long Term Needs in the Home’. Hospital in the Home fits as a dedicated pathway under the wider umbrella of ‘Nursing in the Home’ services provided across the Community Health Service.
As part of the Optimising Access to Community Services a dedicated communications work package will focus on increasing awareness of the clinical care provided within the Community Health Service along with wider promotion of the Hospital in the Home pathway. This will not only focus on increasing awareness of community based care to secondary care clinicians but also provide improved awareness of the Hospital in the Home model of care across Primary Care.

To date Hospital in the Home has focused implementation across the Division of General Medicine with patients identified primarily during a ward admission. It is our intention that implementing dedicated SMO resource focused on Hospital in the Home within MAU there will be greater utilisation of the pathway as an alternative to inpatient admission. This approach is in line with international models where they aim to 2-3% of overnight presentations to be admitted to HiTH and 30% of all ward admissions to transfer to HiTH as a supported discharge.

Over the past couple of months we have worked alongside the Outpatient Intravenous Antibiotic (OPIVA) Team to review how a wider range of antibiotic regimes could be delivered within the patient’s home as an alternative to existing residential care or hospital based treatment. This approach is in line with how Hospital in the Home services are delivered internationally and came through as a strong theme at the recent Hospital in the Home Conference we attended in Brisbane.

As indicated at the commencement of Hospital in the Home a full evaluation review would take place. Now that we have reached sufficient numbers to undertake a review an evaluation will undertaken from both the clinical outcome and cost perspective.

Appendix

1. Community Health Service End of Winter Report 2018
Community Health Service
End of Winter Report

May - September 2018

All Referrals to Community Health Service via Community Central

Winter 2017

Referrals to Community Central

Number of Referrals by Triage Category

Number of Referrals to Community Central by Time Received

Average Number of Referrals by Day of Week

Winter 2018

Referrals to Community Central

Number of Referrals by Triage Category

eReferrals implemented June 17
Community Health Service Referrals by Service Type

Highest Daily Referral Volume

Winter 2017
171 per day  
(17/8/2017)

Winter 2018
207 per day  
(7/5/2018)

Community Health Team Referrals
Locality

- Eastern CHT: 22%
- Franklin CHT: 17%
- Mangere/Otara CHT: 32%
- Manukau CHT: 29%
Information Paper
Counties Manukau District Health Board
External Signage Review

Recommendation

It is recommended that the Board:

Receive the updated Report on the Middlemore Campus External Wayfinding and Signage review for Middlemore Hospital campus.

Note that the review is in response to an action item from the Board meeting of 6 December 2017, where a review of the Middlemore campus signage was requested to be undertaken by a traffic/transport management expert.

Note that paper was endorsed by the Executive Leadership Team on 5 February 2019 to proceed to the Board, with some additional suggestions as discussed below.

Note that the work detailed in this report is underway and will be completed within budget this fiscal year.

Prepared and submitted by: Pauline Hanna, Acting Director Strategy & Infrastructure

Purpose

In response to the action item requested by the Board, Isobel Gabites from Natural Textures was approached to undertake the review of external wayfinding and signage of the Middlemore Hospital Campus. Her report is appended for your information.

When presented and discussed with the ELT on 5 February, the additional recommendations were made which will be explored further and implemented:

1. The need for a designated route which is safe for visitors and visible at night, that takes people back to the Emergency Department out of hours.
2. That the multi-disciplinary Steering Group that was established for the original Wayfinding project in 2014 and included consumer representation, be re-established to provide ongoing oversight.
3. That this Steering Group consider how we may use electronic means of directing patients and visitors on the Middlemore campus, such as providing a Wayfinding App.
4. That the CM Health Communications Team:
   a. take responsibility for working with the Steering Group to assess ongoing needs, design and recommend signage placement in accordance with the Signage Manual.
   b. are responsible for the Signage Manual and keeping it current, working with Facilities and Engineering, to make changes to the Specifications.
5. That we undertake an annual review of the external wayfinding and signage on the Middlemore campus.

Appendix

1 – Review of External Wayfinding & Signage for Middlemore Hospital Campus.
Review
External Wayfinding & Signage
Middlemore Hospital Precinct

Isobel Gabites

November 2018
Review of External Wayfinding / Signage at Middlemore Hospital Precinct

November 2018

1. Background
2. Review
3. Solutions
4. Recommendations

1. BACKGROUND

The current external signage at Middlemore Hospital was installed during 2014. Overseeing the rollout was a steering group comprising managerial, medical, operational and community representation. Input had also been sought from services and community groups. It had been reviewed by the disability consultant. Sign Manuals were produced for both Interior and Exterior Signage which include rationale, brand, sign family, graphic layout and language parameters. The manuals were lodged with Facilities and with Communications.

Not all the components of the holistic wayfinding package were undertaken, whether due to budget constraints, because disruptive work on buildings was pending, or by virtue of project managers not fulfilling the needs of the entire package:

- The old Emergency and Kids First street pylon signs were not upgraded (logos only)
- A proposed footpath trail from Galbraith (or Emergency) around to the Main Entrance was deemed too expensive
- Upgrades to the state and the accessibility of the external route between Station Entrance and Main Reception were deemed to fall outside the scope of the wayfinding programme’s budget
- Illumination of the Middlemore Hospital sign on Scott’s face over the Main Entrance was put on hold pending the re-cladding of Scott
- The large billboard at Gate 1, which was considered a visual distraction, was to have been relocated to one of the clinics
- The reconstruction of the fence outside Station Entrance, which impedes visibility of the Birthing car park pylon sign, was never undertaken as requested

Subsequent to the rollout of the sign package in 2014 parking payments systems have changed (from external kiosks to internal kiosks); the parking firm has changed; Galbraith has had a new entrance constructed. New buildings or part-buildings have been opened (Tiaho Mai, Harley Grey Entry B) and some services expanded or relocated into new buildings (e.g. Building 34). Of particular concern are:

- A wayfinding map and after-hours instructions sign at Station Entrance was removed during entrance renovations and never re-instated
- Messaging regarding pay stations on some car park signage has not been updated, and on others it has been updated but not in the style or font of the original signage. Responsibility is discussed in section 4.
- Secure Parking has degraded the simple, clean style of signage CMH had tried to achieve around the
precinct by smothering car park signage with their brand (messaging which is irrelevant and which ‘overloads’ the essential communication). Responsibility is discussed in section 4.

- New circulation around Tiaho Mai requires re-messaging of existing (damaged) signs
- In addition, Ko Awatea (Stage 2) temporary signage or signs that had temporary messaging on them, can now be reinstated.

2. REVIEW

2.1 Feedback

The response from reception staff at Main Reception is overall one of satisfaction with improvements that external signage has made for their task, although they do ask for tear-off pads with a precinct map [pers.comm reception staff]. This is another item that had been cut back due to funding issues - noted only, as it is not entirely relevant to External Signage review.

Past problems at car park exits have reduced in frequency according to Security [pers. comm. CMH staff]

However, a number of wayfinding problems remain, and the intention here is to highlight them and provide solutions and/or recommendations.

- One case was reported this year of parents taking a stricken child to Kidz First rather than Emergency, costing precious time in treatment as a result Refer 3.4.1, 3.4.2
- Ongoing issues for after-hours visitors and birthing women occur between Galbraith and Main Reception which are only partly overcome by having security staff visible and active in the Galbraith foyer. It is important at this point to mention that personalised assistance is always a preference in solving a wayfinding challenge, but visual communication for directions and orientation remains an important backup. Refer 3.6.1, 3.7.1
- The external (after-hours) route between Station Entrance and Main Reception remains poorly identified, poorly illuminated and with portable-building obstacles. Refer 3.6.1
- The external route between Main Reception and Emergency remains reliant on signs at intervals as prompts, then once on Hospital Road, is reliant on visibility of Emergency Pylon (and façade signage once closer). Although this is less than optimal, marking such a heavily used pavement along Hospital Road (whether using paint or catseyes) is problematic. Upgrading the route from Main Reception to Station Entrance should assist for at least part of the journey. Refer 3.6.1
- Building 34 on Western Campus runs clinics but there is no wayfinding to that destination Refer 3.7.2
- Changes made to car parking messaging by the parking firm have (erroneously) removed directions to Tiaho Mai visitors Refer 3.4.3
- Sign creep! This is beginning to occur where perceived problems are ‘solved’ by further messaging rather than adapting the original messaging. The prime example is at the Birthing Car park entry where the obscuring or the pylon by the fence (works not completed in 2014) has resulted in yet another sign – on the fence; new street signs are appearing indicating Birthing,. Refer 3.5.1, 3.5.3

2.2 Future requirements

The major works involved with re-cladding Scott will seriously diminish the visibility and the dominance of the Main Reception entrance into Middlemore for as much as three years. At that stage, however, the entrance will be enhanced if the main signage there is illuminated as originally intended. Temporary measures are suggested in section 3. Refer 3.7.3, 3.7.4, 3.7.5
2.3 Review of existing signs

Details are tabulated below, but generally:

- All signs are in need of cleaning. Signs under vegetation require the most urgent attention. Note that most signage is only warranted when regular maintenance is undertaken to preserve the integrity of vinyls etc.
- Some sign faces are scratched or delaminated by vandals. The graphics were designed with this in mind and are mostly in easily replaceable small sections so that entire sign face replacement is not required.
- Neither the Emergency Pylon nor Kidz First pylon are currently illuminating.
- The Gate numbers on roundabout pylons were not designed to be illuminating; in retrospect this may have been a mistake as night-time clarity is poor. Reflective vinyl is recommended.
- The word Emergency on roundabout signs and Hospital Road pylons is not glowing as red at night as predicted. Reflective vinyl is recommended.
- Some additions to sign faces by other parties (Secure, CCTV stickers, older car parking additions) are undermining the quality and legibility of the original signs. There needs to be stricter policing of these activities.
- Curtail (and replace) the use of SECURE branding on messaging – it is not essential on every sign installed.
- Text has been replaced on some signs without reference to the wayfinding system.
- It has been suggested that on the first car parking advisory sign entering Gate 1 that ALL car parks be identified.
- A number of signs are obscured by tree growth, requiring some pruning work.

3. SOLUTIONS

The following table details amendments and maintenance required and new works proposed.

Codes used refer to the original manufacturing code where relevant.

* = picture included in Appendix for reference

| 3.1 | Cleaning | All signs. Cloth and soapy water only. |
| 3.2 | Repairs to structure | 3.2.1 Gate 2 roundabout sign – loose side panel  
3.2.2 Re-illumination of Emergency and Kidz First pylons  
3.2.3 Replacement of bulbs for 6 standard lights at the exit to Gate 1 to stronger LED units. NOTE Two bulbs are already faulty  
3.2.4 New floodlights located on verandahs at Galbraith (north side, east side) and Scott (Dialysis)  
3.2.5 Reclad the damaged mini-pylon at crossing to Emergency Entrance [Park-iti EXT-016] |
| 3.3 | Replace damaged graphics; removal of irrelevant messaging | 3.3.1 Replace the scratched blue panel on Station Entrance side of the Park 9 Birthing Pylon [EXT-008]  
3.3.2 Replace lowermost graphics panel on Station Entrance pylon sign [EXT-009]  
3.3.3 Remove screwed on “Visitor Parking Only” plaque on Park 4 entry pylon. Make good.  
3.3.4 Removal of temporary Ko Awatea detour text [EXT-164, EXT-158] and removal of Detour sign  
3.3.5 Remove CCTV sticker from Main Reception pylon. This is already a fully loaded |
| 3.4 | Update text / materials | 3.4.1 | Replace EMERGENCY on Gate 1 and Gate 2 (both sides) with **reflective red** vinyl |
|     |                        | 3.4.2 | Replace Gate numbers on Gate 1 & 2 pylons (both sides) with **reflective blue** vinyl |
|     |                        | 3.4.3 | Replace messaging at Colvin regarding Tiaho Mai parking (two signs EXT-096, EXT-099) |
|     |                        | 3.4.4 | New layout for graphics on Visitor Parking pylon, Gate 1, to incorporate parks 1 & 2 [EXT-026] |
|     |                        | 3.4.5 | New graphics for traffic directions between Tiaho Mai and Harley Gray [EXT-108] |
|     |                        | 3.4.6 | Pay station info for signs EXT-036, EXT-038, EXT-098 (reverse), EXT-099 |

| 3.5 | Reconfiguration of Galbraith fence | 3.5.1 | Removal of fence sign, |
|     |                                  | 3.5.2 | rewording of pylon if required, |
|     |                                  | 3.5.3 | reconfiguration of fence |
|     |                                  | 3.5.4 | Removal of blue sign on traffic lights (Birthling and public entrance) |

| 3.6 | Trail between Station Entrance and Main Reception, and illumination | 3.6.1 | Footpath trail (see Appendix 2). Use pale blue paint, 180mm wide continuous stripe, with added reflective particles for night-time reflectivity |
|     |                                                            | 3.6.2 | Replacement bulbs in standard lights at barrier arm alcove. |
|     |                                                            | 3.6.3 | New lights – locate downlights on the verandahs of Galbraith, rear entry to Galbraith, Dialysis/Ward 1 |

| 3.7 | New signs | 3.7.1 | Galbraith Entrance, After-hours info + map (note RECENTLY ADDED Women in Labour signs at lobby are acceptable) |
|     |          | 3.7.2 | Package for Building 34, Western Campus (see Appendix 3) |
|     |          | 3.7.3 | Main Reception Hoardings |
|     |          | 3.7.4 | Main Reception (Scott) illuminated sign above entrance (currently this is a stretched fabric over frame) |
|     |          | 3.7.5 | Main Reception (Scott) re-utilise light box for temporary directions and Building ID during re-cladding. Reinstate original signs once the light boxes need to be removed. |

| 3.8 | Billboard relocation | 3.8.1 | This had originally been mooted for Manukau Clinic precinct. It remains a visual distraction for drivers concentrating on traffic and directions, and appears out of scale for the intimacy of the intersection. I recommend that efforts to relocate the billboard are revisited. The Hospital Road pylons have billboard capability on their reverse faces. Currently they advertise the Pharmacy. This had always been intended as a replacement location for billboard material. |

| 3.9 | Tree pruning |
4. **RECOMMENDATIONS**

4.1 **Maintenance**

Regular washing (preferably twice a year minimum) removal of graffiti and reporting of damage is required to ensure the signs keep looking smart, legible and materials meet life expectancies.

Regular checks of signs and street lights is essential. Preferably weekly (security can assist).

4.2 **Responsibility for amendments, new signs, remedials**

There is a Sign Manual for External Signage, Middlemore Hospital which details principles for visual communication and methodology for appropriate sign types. It is not being adhered to.

At least three channels exist for signage management and wayfinding assessments: (i) Facilities, (ii) Communication team (iii) Car parking firm. It is preferable that the Communications Team take ownership of assessing needs, designs and placement in accordance to Sign Manual specifications, with maintenance, replacement of damage, funding etc being overseen/approved by Facilities. This will require close co-ordination between the two parties, and the explicit designation of the role in appropriate job descriptions, as overseeing visual communications (both externally and internally) is a significant task.

Services staff need to know who to approach in the first instance for queries about new signs, wording, sign placement. Even if the tasks are outsourced, there needs to be a known ‘go-to’ role on staff.

Outsourcing should NOT be to a sign company but to a wayfinding/visual communications expert.

Car parking messaging is part and parcel of the overall visual communications strategy for the precinct and ideally should be generated via the above process, but where changes have been required by the car parking firm, they would need to be the parties funding the sign production.

***
3.3.4

3.3.5

3.4.1
3.4.2
3.4.3

Rehabilitation Outpatients
Permit Parking Only
Payment at Esme Green Entry (Cashless), Proceed to Sir Edmund Hillary Entrance for cash payments
Ward visitors please use car parks 4 5

3.4.4

Tiaho Mai
Authorised Visitors
No Exit past this point
Exit via Gate 1

Colvin Complex
Outpatients Permit
Parking Only

The Tree House

Revise this section only
3.4.5

Visitor car parks
Pay station locations:
  - Esmé Green (Cashless)
  - Sir Edmund Hillary Entrance
  - Main Reception
Way out
Pay before you drive away

3.4.6

Pay station locations:
  - Esmé Green (Cashless)
  - Sir Edmund Hillary Entrance
  - Main Reception
Pay before you drive away

Staff: Use your card to exit this zone within 15 minutes

Parking: Take your ticket with you
Pay stations: Outside Edmund Hillary
3.5.1

3.5.3

3.5.4

3.7.1

replace temporary messaging on left side glazing

remove

new alignment of fence

remove

Doors open: 7am - 8pm

For access to other Hospital Wards go to Main Reception

KIDZ FIRST South Gate (Gate 2)

Maternity visiting hours:

Births - after hours, security staff will let you in

Visitors are welcome between 2pm - 8pm

We welcome husbands / partners to our ward between 7am - 8pm 2pm - 8pm

YOU ARE HERE

Main Reception

EMERGENCY 094

094
3.7.4 change to Light Box once cladding completed

3.7.3 Hoarding sign

3.7.5
Start under sign outside Station Entrance

Keep to inner edge of pavement

Add downlight at this verandah

Barrier arms alcove - upgrade lights to LED
Although this route, detouring away from Park 2, is not the desire line it is the safest.

Add downlights at this verandah.

Past entry to Dialysis.
Downlights on this verandah.
Building 34 Wayfinding Package

This is still in progress, but will include:

1. Inclusion on all external precinct references to Western Campus (as a Building Number)
2. Inclusion in the Clinics listings for InfoHub maps (inside the main hospital)
3. Inclusion (as Building Number) on the street pylon entering West Gate
4. Inclusion on the directional pylon near the railway line which also contains car parking directions
5. A new map specifically for Western Campus (*appropriate location to be determined*).
6. A directional prompt sign in a *location to be determined*.
Information Paper
Counties Manukau District Health Board
Maaori and Pasifika Quarterly Workforce Report (July to September 2018 data)

Recommendation

It is recommended that the Board:

Receive the Maaori and Pasifika quarterly workforce reports (July to September 2018 data).

Note this report was endorsed by the Executive Leadership Team on 12 February to go forward to the Board.

Prepared and submitted by Elizabeth Jeffs, Director HR

Purpose

The Board requested the review the Maori & Pasifika quarterly workforce reports.

Executive Summary

Māori workforce

- The number of Māori RMOs in the region decrease from 78 in the previous quarter to 70 in this quarter. As overall RMO numbers have decreased by 4.8% (1,450 to 1,381), this does not impact the number of additional Māori RMOs required to meet the working population based target. The 70 Māori RMOs employed compares favourably to 53 employed a year ago in the September 2017 quarter.
- Waitemata DHB has increased the number of Māori nurses employed from 105 to 115 since the previous quarter.
- The number of Māori midwives employed in the region has decreased from 41 in the previous quarter to 34, mainly in Counties Manukau where numbers have dropped from 17 to 11. As a result 27 additional Māori midwives are required in the region to meet the working population based target.

Pasifika workforce

- There were four fewer Pasifika RMOs in the region (from 59 in the previous quarter to 55). Five left WDHB and two left ADHB. Counties Manukau DHB employed three.
- Nineteen more Pasifika nurses were employed in the region since the previous quarter (up from 558 to 577). A year ago only 508 Pacific nurses were employed however a further 513 Pasifika nurses are needed to achieve the working population based target.
- The number of Pasifika midwives increased from seven to 14 since the previous quarter. The additional seven were all employed at CMH. Regionally 46 Pasifika midwives are required to meet the target.

Appendices

1. Workforce Ethnicity Pacific Report July to September 2018 data
2. Workforce Ethnicity Maaori Report July to September 2018 data
Report Observations:

**RMOS:** For Pacific RMOS, there is a net decrease of 4 RMOS (from 59 in the previous quarter to 55 in the current quarter) across the region. This is a result of a decrease of 5 and 2 Pacific RMOS for Waitemata and Auckland DHB respectively while Counties Manukau DHB saw an increase of 3 Pacific RMOS.

**Nurses:** The Northern region has increased its number of Pacific nurses employed from 558 to 577 (19%) thus reducing the number of Pacific nurses required from 540 to 513 (27%). This is a substantial achievement considering the same quarter last year (Sep-17) only 508 Pacific nurses were employed. Most of the increase can be contributed to the Auckland DHB’s increased number of Pacific nurses employed from 201 to 216 (15%).

**Midwives:** There has been an encouraging increase (from 7 in the previous quarter to 14 in the current quarter) in the number of Pacific midwives employed in the Northern region. All additional 7 Pacific midwives are employed by the Counties Manukau DHB. This has brought the number of extra Pacific midwives required for the Northern region from 54 down to 46.

### Current Quarter Snapshot - % Pacific Employed

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>1.8%</td>
<td>4.0%</td>
<td>2.8%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Nurse</td>
<td>1.0%</td>
<td>2.8%</td>
<td>6.2%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Midwife</td>
<td>0.0%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>0.0%</td>
<td>8.3%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dietitian</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.6%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.0%</td>
<td>1.4%</td>
<td>4.0%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0.0%</td>
<td>4.7%</td>
<td>0.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>All Workforce</td>
<td>1.1%</td>
<td>5.2%</td>
<td>8.5%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

**2025 % Pacific Target:** 21.0%

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

### Current Quarter New Starts and Leavers

<table>
<thead>
<tr>
<th></th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>-1</td>
<td>-4</td>
<td>-23</td>
<td>-18</td>
</tr>
<tr>
<td>Nurse</td>
<td>-1</td>
<td>-2</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Midwife</td>
<td>-1</td>
<td>-1</td>
<td>1</td>
<td>51</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>-3</td>
<td>-3</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>Dietitian</td>
<td>-2</td>
<td>2</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>-1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>-3</td>
<td>-3</td>
<td>3</td>
<td>26</td>
</tr>
<tr>
<td>All Workforce</td>
<td>-16</td>
<td>1</td>
<td>1</td>
<td>33</td>
</tr>
</tbody>
</table>

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

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

Workforce Groups

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

ANZSCO codes for Priority workforce group are:

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

Ethnicity

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

MoH Level 2 codes are grouped as follows:

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

RMOS: Whilst the number of Māori RMOS for the Northern Region continues to drop this quarter (from 78 in the previous quarter to 70 in the current quarter, mainly due to Auckland DHB's Māori RMOS employed decreasing from 36 to 27), there is actually no change in extra Māori RMOS required. This is because the overall number of RMOS also decreased from 1,450 to 1,381 (4.8%). In spite of the decrease, the 70 Māori RMOS employed in the current quarter (Sep-18) are still much higher than the 53 employed in Sep-17.

Nurses: The extra Māori nurses required for the Northern region this quarter has decreased from 570 in the previous quarter to 565 in the current quarter. This is mainly due to Waitemata DHB’s increased number of Māori nurses employed from 105 to 115.

Midwives: The number of Māori midwives employed across the Northern region has decreased (from 41 the previous quarter to 34 the current quarter) after the increase last quarter (from 37 to 41). This is mainly due to Counties Manukau DHB's number of Māori midwives decreasing from 17 to 11. The number of extra Māori midwives required for the Northern region increased from 22 in the previous quarter to 27 in the current quarter.
1. Data is sourced from HWIP data extracts submitted by DHBs to DHBSS.
2. Figures and calculations of percentages are based on headcount, not FTE.
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</tr>
</tbody>
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<tbody>
<tr>
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</tr>
<tr>
<td>Pacific</td>
<td>40 Asian NFD, 41 Southeast Asian, 42 Chinese, 43 Indian, 44 Other Asian</td>
</tr>
<tr>
<td>Asian</td>
<td>10 European NFD, 11 NZ European/Pakeha, 12 Other European, 51 Middle Eastern, 52 Latin America/Hispanic, 53 African, 54 Other MELAA, 61 Other</td>
</tr>
<tr>
<td>Other</td>
<td>94 unknown dimension, 95 Declined to state, 97 Unspecified, 99 Not stated, No value recorded</td>
</tr>
</tbody>
</table>
Recommendation

It is recommended that the Board:

Receive the overview of the 2019/20 planning guidance, key planning messages and proposed approach and timeline for the development of the 2019/20 Annual Plan.

Note this paper was endorsed by the Executive Leadership Team on 5 February 2019 to go forward to the Board.

Note the focus of the 2019/20 planning guidance on achieving measurable progress toward health equity, responding to unmet need, cross-sector collaboration and fiscal responsibility.

Prepared and submitted by: Alanna Soupen, Planning Advisor on behalf of Pauline Hanna, Acting Director Strategy & Investment

Purpose

To provide the Board with an overview of the 2019/20 planning guidance, key planning messages and approach and timeline for development of the 2019/20 Annual Plan.

Background

The 2019/20 initial Annual Planning guidance was provided to DHBs on 20 December 2018, with a first draft Annual Plan due to the Ministry of Health by 5 April 2019 and a final Annual Plan by 21 June 2019.

Prior to planning guidance being received, the Planning Team provided the CM Health Executive Leadership Team (ELT) with a preliminary approach and timeline for the 2019/20 Annual Planning Cycle (27 November 2018 ELT meeting). This paper presents the revised timeline and approach based on the 2019/20 Annual Planning guidance.

Note on the 2018/19 Annual Plan: The majority of CM Health’s 2018/19 Annual Plan has been approved by the Ministry of Health. The Plan will be published once full approval has been received (expected by February 2019).

Discussion

1. 2019/20 Minister’s Letter of Expectations and government planning priorities

The Minister’s Letter of Expectations for 2019/20 (Appendix 1) identifies the following areas of focus for DHBs:

- Achieving equity with an explicit focus on achieving equity for Māori across the life-course.
- Recognising unmet need as a significant barrier to achieving health equity and addressing areas of unmet need, particularly for Pacific peoples and for other population groups with poorer health outcomes.
- Integration and strong cross-sectoral collaboration
• **Fiscal responsibility** and maintaining expenditure growth in line or lower than funding increases, with a focus on ensuring appropriate skill mix, FTE growth and use of the full range of available workforce and settings.

The planning guidance identifies the following six high-level government planning priorities for 2019/20:

1. Strong fiscal management
2. Strong and equitable public health and disability system
3. Mental health and addiction care
4. Child wellbeing
5. Primary health care
6. Public health and the environment

Each government planning priority is linked to a number of priority areas for which DHBs are expected to identify actions. The full list of priority areas can be found in the 2019/20 Annual Planning guidance, which can be accessed at [https://nsfl.health.govt.nz/dhb-planning-package/201920-planning-package](https://nsfl.health.govt.nz/dhb-planning-package/201920-planning-package). Priority areas which are new for 2019/20 are identified in following section.

2. **Key differences between the 2018/19 and 2019/20 Annual Planning guidance**

A new outcomes framework has been introduced for 2019/20 (Figure 1 below). The framework links the government’s overarching priority outcomes with the government’s vision for Māori health (Pae Ora – Healthy Futures) and targeted health system outcomes.

![Figure 1: 2019/20 outcomes framework](image-url)
Figure 2 shows the connections between the government’s targeted health system outcomes and 2019/20 planning priorities. The 2019/20 performance measures framework provides a further level of detail on the links between the planning priorities and specific DHB accountability measures in 2019/20 (refer Appendix 2 for an overview of these links).

Figure 2: Connection between the whole of government priorities and health system priorities

In 2019/20 DHBs will need to align their Annual Plan actions to both the government priority outcomes and health system outcomes identified by the framework, rather than the NZ Health Strategy as in previous years. To support this, the Planning team is working with the Ministry to clarify the linkages between framework components, with a specific focus on the role of Pae Ora.

Table 1 below summarises the key differences by section between the 2018/19 and 2019/20 planning guidance, including those priority areas which have been added and removed.

Table 1: Key differences between the 2018/19 and 2019/20 Annual Planning guidance

<table>
<thead>
<tr>
<th>Section in 2019/20 guidance</th>
<th>Page</th>
<th>Key change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Health Equity in DHB Annual Plans</td>
<td>7</td>
<td>New focus on <em>measurable progress</em> toward health equity with additional guidance added to support development of equitable outcomes actions.</td>
</tr>
<tr>
<td>2.2 Māori health</td>
<td>8</td>
<td>Section added for 2019/20; requires DHBs to specify the processes DHBs use to meet their obligations as a Treaty partner.</td>
</tr>
<tr>
<td>2.3 Responding to the Guidance</td>
<td>8</td>
<td>New outcomes framework for 2019/20.</td>
</tr>
<tr>
<td>2.4 Government Planning Priorities</td>
<td>9</td>
<td>Previous (2018/19) priority areas linked to the six government planning priorities identified in the guidance.</td>
</tr>
<tr>
<td>2.4.1 Strong and equitable public health and disability system (formerly ‘System Settings’ in the 2018/19 guidance)</td>
<td>12-27</td>
<td><strong>New priority areas added</strong> including: Engagement and obligations as a Treaty partner, Cross-sectoral collaboration, Strategic Health Measures, Planned Care (revision of ‘Access to Electives’), Acute Demand (revision of ‘Shorter Stays in ED’), Rural Health, Bowel Screening, Healthy Food and Drink, Workforce &amp; Data and Digital (the latter two both moved from Section 4 into Section 2). <strong>Priority areas removed</strong>: Strengthening Public Delivery of Health Services and Fiscal Responsibility.</td>
</tr>
<tr>
<td>2.4.3 Child wellbeing</td>
<td>40-43</td>
<td><strong>New priority areas added</strong> including: First 1000 days, Family Violence and Sexual Violence and SUDI.</td>
</tr>
<tr>
<td>2.5.5 Primary Health Care</td>
<td>44-48</td>
<td><strong>Priority area removed</strong>: System Level Measures. The Access priority area is</td>
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</table>
Section in 2019/20 guidance | Page | Key change(s)
--- | --- | ---
also now a subsection under Primary Health Care Integration. Additionally, the previous CVD & Diabetes priority area has been revised as ‘Diabetes and other long-term conditions’.

2.4.5 Environmental sustainability and drinking water safety | 52 | **New priority areas added:** Drinking Water

5. Performance measures | 56 | New nomenclature developed for performance measures, to align measures to the government’s six planning priorities. Draft performance monitoring framework currently open for consultation.

3. **2019/20 Annual Planning approach and timeline**

The Planning team will work closely with CM Health’s Māori Health team, Pacific and Asian health gains and Population Health throughout the 2019/20 Annual Planning cycle. We are committed to ensuring that our annual planning processes meet our obligations as a Treaty partner and support our services to develop an Annual Plan which supports our commitment to achieving health equity for Māori, our Pacific communities and other communities facing health inequities.

Appendix 3 summarises the proposed 2019/20 Annual Plan approach and timeline, including key ELT, Board and committee dates and planning activity focus by month. This includes key points of engagement with our Māori Health team and health gains advisors during the planning cycle.

4. **2019/20 Annual Planning messages for services**

The Planning Team has worked with Counties Manukau DHB’s Chief Executive to identify the areas of strategic focus for services in 2019/20.

In 2019/20 CM Health will focus on resourcing those areas where we need to meet our statutory and/or regulatory obligations, to provide a level of service coverage to our population and implement the Government’s priorities. We will continue to be focused on sustaining our workforce, addressing areas of pressure and continuing the investment in infrastructure and future planning to prepare for the population growth consistent with the Northern Region Long-term Investment Plan (NRLTIP). Areas of focus for 2019/20 planning will therefore be:

1. **Unmet need:** Services should review areas where:
   - There are wait lists or overdue specialist assessments and follow ups.
   - Screening wait times have exceeded what might be regarded as normal or equitable (compared to other DHBs).
   - There are breaches related to the Operational Policy Framework or Service Coverage Schedule expectations, or what is considered appropriate for that service e.g. gynaecology electives, ophthalmology follow ups, retinal screening.

2. **Equity:** Services should focus on an achievable number of specific and measurable actions that will have the greatest impact on improving access to healthcare for Māori, Pacific and Quintile 5 patients:
   - This may include innovative service changes that will make services more accessible for high-needs patients earlier in their disease progression, or changes that will target specific population groups known to be late or non-presenters.
   - Actions may include targeting Asian populations who require specific focus because of their high prevalence of some conditions or use of services (e.g. diabetes, mental health). These actions could include reducing did not attends or delays in treatment.

Appendices
1. 2019/20 Minister Letter of Expectations *(attached as separate document)*
2. Summary overview of the DHB accountability measures for 2019/20
3. 2019/20 Annual Planning approach and timeline
Appendix 2: Summary overview of the DHB accountability measures for 2019/20


| Government priority outcomes | Improving the wellbeing of New Zealanders and their families | Pae Ora Healthy Futures | Vision |
|------------------------------|-------------------------------------------------------------|----------------------------|
| Ensure everyone who is able to, is earning, learning, caring or volunteering | Support healthier, safer and more connected communities | Make New Zealand the best place in the world to be a child | All New Zealanders live well, stay well and get well |

<table>
<thead>
<tr>
<th>2019/20 DHB accountability measures</th>
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<tr>
<td>Note: some measures such as those under review as part of the planned care work and whanau ora are not currently included in this table.</td>
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<table>
<thead>
<tr>
<th>Strong system SS 03 Ensuring delivery of service coverage</th>
<th>Strong system SS01: Faster cancer treatment (31 days)</th>
<th>Child Wellbeing CW01: Oral Health- Mean DMFT score at school Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong system SS05: Ambulatory sensitive hospitalisations (ASH adult)</td>
<td>Mental health MH01: Improving the health status of people with severe mental illness through improved access</td>
<td>Child-wellbeing CW02: Children caries-free at five years of age</td>
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<tr>
<td>Mental health MH04: Mental Health and Addiction Service Development (to be reviewed following decisions that are made in regard to the MH&amp;A Inquiry).</td>
<td>Mental health MH02: Improving mental health services using wellness and transition (discharge) planning.</td>
<td>Child wellbeing CW03: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years</td>
</tr>
<tr>
<td>Strong system SS04: Delivery of actions to improve Wrap Around Services for Older People</td>
<td>Mental health MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds</td>
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<tr>
<td>Strong system SS 05: Better help for smokers to quit in public hospitals</td>
<td>Primary health care PH01: Improving system integration and SLMS</td>
<td>Child wellbeing CW04: Improving the number of children enrolled in and accessing the Community Oral Health Service.</td>
</tr>
<tr>
<td>Child Wellbeing CW06: Improving breast-feeding rates</td>
<td>Strong system SS02: Delivery of Regional Service Plans</td>
<td>Primary health care PH02: Improving the quality of data collection in PHO and NHI registers</td>
</tr>
<tr>
<td>Child wellbeing CW07: Improving newborn enrolment in General Practice</td>
<td>Strong system SS10: Shorter stays in Emergency Departments</td>
<td>Primary health care PH03: Improving Maori enrolment in PHOs to meet the national average of 90%</td>
</tr>
<tr>
<td>Strong system SS07: improving breast screening coverage and rescreening</td>
<td>Strong System SS11: Faster cancer treatment (62 days)</td>
<td>Mental health MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders</td>
</tr>
<tr>
<td>Strong system SS08: Improving Cervical Screening coverage</td>
<td>Strong system SS13: Improved management for long term conditions</td>
<td>Child wellbeing CW10: Raising healthy kids</td>
</tr>
<tr>
<td>Strong system SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections</td>
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<tr>
<td>Mental health 06: Output delivery against plan</td>
<td></td>
<td>Child wellbeing CW 12: Youth mental health</td>
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<tr>
<td>Child wellbeing CW08: Increased Immunisation</td>
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<tr>
<td>Primary health care PH04: Better help for smokers to quit (primary care)</td>
<td></td>
<td>Child wellbeing CW13: Reducing rheumatic fever</td>
</tr>
<tr>
<td>Child wellbeing CW09: Better help for smokers to quit (maternity)</td>
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<tr>
<td>Child wellbeing CW11: Supporting child wellbeing</td>
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### Appendix 3: Updated 2019/20 Annual Planning approach and timeline

<table>
<thead>
<tr>
<th>Month</th>
<th>Key activities</th>
<th>Key dates</th>
<th>Status</th>
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<tbody>
<tr>
<td>Nov-18</td>
<td>• Invite feedback from health gains teams on how advice and support to services can best be provided&lt;br&gt;• Table preliminary 19/20 planning approach with ELT</td>
<td>Maaori Health Management team: 16 November 2018&lt;br&gt;ELT: 27 November 2018</td>
<td>✔️</td>
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<tr>
<td>Jan-18</td>
<td>• Distribute planning guidelines to business&lt;br&gt;• Distribute planning templates and key planning messages to services&lt;br&gt;• Table updated 19/20 planning approach and overview of guidance with ELT&lt;br&gt;• Planning team, Maaori Health and health gains advisors review planning guidance and identify the best approach to supporting services&lt;br&gt;• Initial planning discussions between services, Maaori health and health gains teams</td>
<td>This meeting</td>
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<td>Jan/Feb-19</td>
<td>• Services compile initial drafts of Section 2&lt;br&gt;• Services notify Planning Team of proposed service changes&lt;br&gt;• ELT advised of proposed service changes.</td>
<td>ELT: 26 February 2019</td>
<td></td>
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<tr>
<td>Feb/Mar-19</td>
<td>• Guidance updates received; distribute to services/GMs&lt;br&gt;• Action owners revise actions based on feedback and updated guidance&lt;br&gt;• 1st draft Annual Plan compiled, including 1st draft SOI and SPE ('planning documents').&lt;br&gt;• Review SLM Plan guidance and participate in consultation as required</td>
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<tr>
<td>Mar-19</td>
<td>• MoH advised of proposed service changes&lt;br&gt;• Table 1st draft planning documents with ELT and recommend forwarding to ARF&lt;br&gt;• Table 1st draft planning documents with ARF and recommend forwarding to Board.&lt;br&gt;• Table 1st draft planning documents with Board and request approval to submit to MoH.&lt;br&gt;• 1st draft Annual Plan, SOI and SPE submitted to MoH</td>
<td>MoH: 8 March&lt;br&gt;ELT: 5 March 2019&lt;br&gt;ARF: 13 March 2019&lt;br&gt;Board: 3 April 2019&lt;br&gt;MoH: 5 April 2019</td>
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<td>Apr-19</td>
<td>• Revise Annual Plan based on MoH feedback/updated guidance received&lt;br&gt;• Ensure alignment between Annual Plan and SLM Plan&lt;br&gt;• Maaori Health and health gains advisors review draft actions and provide feedback to action owners&lt;br&gt;• Action owners revise sections based on above feedback</td>
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<td>May-19</td>
<td>• Distribute and respond to informal MoH feedback on the Annual Plan – feedback to be received from 10 May&lt;br&gt;• Distribute and respond to formal MoH feedback on the Annual Plan – feedback to be received from 17 May&lt;br&gt;• Table final draft Annual Plan with ELT and recommend forwarding to ARF. Request CE signature of Annual Plan, SOI and SPE. Recommend all planning documents forwarded to ARF/Board.&lt;br&gt;• Covers for planning documents designed</td>
<td>ELT: 21 May 2019</td>
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<tr>
<td>Month</td>
<td>Key activities</td>
<td>Key dates</td>
<td>Status</td>
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<tr>
<td>Jun-19</td>
<td>• Table final draft Annual Plan with ARF/Board and request ARF/Board signature of planning documents</td>
<td>ARF/Board special meeting: 5 June</td>
<td></td>
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<tr>
<td></td>
<td>• Final technical changes, editing and proofreading</td>
<td>21 June 2019</td>
<td></td>
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<td></td>
<td>• Final signed Annual Plan sent to the Minister</td>
<td>21 June 2019</td>
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<td>• Final signed SOI/SPE sent to MoH for approval for tabling</td>
<td>21 June 2019</td>
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<td>• Hard copies of signed SOI/SPE sent for tabling</td>
<td>Within 15 working days of approval being received</td>
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<td></td>
<td>• Final approved planning documents published on DHB website</td>
<td>Within 10 working days of tabling</td>
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Vui Mark Gosche
Chair
Counties Manukau District Health Board
m.gosche@outlook.com

Dear Mark

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government’s expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government’s goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders’ lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB’s performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.
Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government’s priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers’ prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you to ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs’ future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.
DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council’s requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader “Planned Care” programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population’s needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care
Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government’s response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.
Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government’s vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child’s life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery

High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025

I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability

I expect you to continue to contribute to the Government’s priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing
carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB’s Healthy Food and Drink Policy. This includes increasing the number of food options categorised as ‘green’ in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to ‘normalise’ healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes
Your DHB’s 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health
Information Paper
Counties Manukau District Health Board
Addressing Inequity in Maaori Childhood Immunisation Coverage Update

Recommendation

It is recommended that the Board:

Receive this report on addressing inequity in Maaori Childhood immunisation coverage.

Note this paper was endorsed by the Executive Leadership Team on 29 January to go forward to the Board.

Note the progress made on the initiatives to address the disparities in Maaori immunisation coverage.

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

Prepared and submitted by: Dr Mataroria Lyndon, Katarina Komene, Claudelle Pillay, Carmel Ellis on behalf of Aroha Haggie

Purpose

The purpose of this paper is to update ELT on the new initiatives to address the disparities in immunisation coverage for Maaori pepi/tamariki compared to total population in CM Health at the 8-month milestone.

Executive Summary

A previous paper ‘Addressing Inequity in Maaori Childhood Immunisation Coverage’ was presented to ELT in September 2018 and recommended a multifaceted approach to address the inequity in Maaori immunisation coverage in Counties Manukau. Firstly, we proposed an incentive scheme pilot to increase attendance at Outreach Immunisation Service (OIS) appointments. Secondly, we proposed the OIS could work more closely with Maaori health providers to further improve whaanau engagement and integration with community Whaanau Ora services. Finally, a range of systems approaches were considered including enhancing general practice models of care and increasing opportunistic immunisations. This paper provides a brief overview of the design process and plan for these initiatives and the next steps for piloting.

Background

A well-executed, universal immunisation programme is a cornerstone of public health and a highly effective way to prevent infectious disease [1]. A national target for immunisation was first conceived in New Zealand (NZ) 1993/1994 as a mechanism to reduce vaccine preventable diseases, and to support engagement with primary care [2].

Since the introduction of the NIR, ongoing health targets and significant investment to support improving immunisation, coverage rates have increased in NZ for all ethnic groups. Currently, despite overall coverage in Counties Manukau being above the national average, an equity gap continues with rates of immunisation lower among Maaori compared with non-Maaori across all age points. Data for the 8-month-old target is presented in Figure 1. Lower rates of immunisation place these children at greater risk of contracting vaccine-preventable diseases such as pneumococcal meningitis or pertussis [1, 3].
Analysis of our progress towards achieving the eight-month immunisation in 2017/18 (Quarter 1 to Quarter 4), shows that we are missing an average of 43 Maaori children each quarter (9.6% of the eligible population) which contributes to the equity gap in coverage (Table 1). A full break by ethnicity is provided in Appendix 1.

Table 1. Maaori immunisation coverage in Counties Manukau (Quarter Q1 to Q4 17/18)

<table>
<thead>
<tr>
<th>Quarter (2017-2018)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
<th>Coverage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible</td>
<td>470</td>
<td>455</td>
<td>438</td>
<td>423</td>
<td>1786</td>
<td></td>
</tr>
<tr>
<td>Fully Immunised by target age</td>
<td>420</td>
<td>388</td>
<td>380</td>
<td>357</td>
<td>1545</td>
<td>86.5%</td>
</tr>
<tr>
<td>Declined Immunisations</td>
<td>15</td>
<td>21</td>
<td>13</td>
<td>20</td>
<td>69</td>
<td>3.9%</td>
</tr>
<tr>
<td>Cohort which we have the ability to influence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Immunised but after target age</td>
<td>27</td>
<td>22</td>
<td>26</td>
<td>17</td>
<td>92</td>
<td>5.2%</td>
</tr>
<tr>
<td>*Not Fully Immunised target age-passed (catching up on earlier missed immunisations)</td>
<td>8</td>
<td>24</td>
<td>19</td>
<td>29</td>
<td>80</td>
<td>4.4%</td>
</tr>
<tr>
<td>Total missed by target age</td>
<td>35</td>
<td>46</td>
<td>45</td>
<td>46</td>
<td>172</td>
<td></td>
</tr>
</tbody>
</table>

Objectives

The aim of the initiatives proposed is to increase the number of timely immunisations for Maaori pepi/tamariki by the 8-month target by:

(a) Providing appropriate incentives for engaging in immunisation appointments with OIS
(b) Implementing a brief screening and referral tool for immunisations within current CM Health programmes (Smokefree Incentives Scheme and SUDI Risk Calculator project)
(c) Increasing collaboration between the OIS and Maori Health providers to enable better engagement with Maaori whanau and integration with community Whaanau Ora services
(d) Increasing the education and health literacy for whaanau around the benefits of immunisation
Contribute to the evidence base of whether incentives support whaanau to engage in immunisation appointments and to provide key learnings to inform wider implementation

Proposal

This section provides an overview of the design process and plan for these initiatives and the next steps for piloting.

Piloting an incentive scheme to engage with Outreach Immunisation Service

Incentivising engagement with immunisation services has shown evidence of effectiveness internationally [5] through financial or material incentives and is consistent with the success of our Smokefree incentives programme. We propose a pilot that incentivises engagement with the OIS. Piloting with the OIS means the pilot is targeted and restricted rather than an incentive programme for those already regularly receiving immunisation through primary care.

Target population

The proposed pilot targets Maaori whanau who are not engaging in their immunisation appointments with primary care and have therefore been referred to the OIS service. For the previous 12 months to November 2018, there were 964 Maaori pepi and tamariki referred to the OIS. On average the OIS contacts whanau 7-13 times before a pepi is immunised (this includes phone calls, text messages, and home visits). Of the 964 referrals, 804 would need rigorous follow up and only 160 would be easily engaged (source: OIS correspondence). Only 154 (16%) of the cases referred to OIS return to their GP for future immunisations.

With current information available it is difficult to segment and identify which of the 964 referrals are most likely to not attend their appointment with OIS. However, as the clear majority require vigorous follow up and multiple contacts with OIS before baby is immunised, we propose all Maaori babies who are referred to the OIS be eligible to receive an incentive for attending their appointment.

Programme scope

This initiative will seek to demonstrate whether using incentives can motivate whaanau to engage with OIS for their immunisation appointment which can contribute to the likelihood of receiving timely immunisation. A pilot over one year will seek to streamline the incentive schedule and report on the efficacy of the incentives.

The pilot could include a range of incentives (or koha) such as grocery or petrol vouchers, or baby products, that will be received during the OIS appointment. After consultation with OIS (see Appendix), the OIS team have recommended baby products (ie nappies) and a $20 grocery or petrol voucher as a practical and useful incentive that whaanau respond to positively. These incentives will be offered during the first appointment and follow up visits in the lead up to the eight month immunisation milestone.

Learnings will be adapted from the immunisation incentive scheme for four-year olds which commenced in November 2018, led by the Public Health Nursing (PHN) team. A $40 petrol voucher is offered as an incentive for attending the clinic appointment. The purpose of starting the programme with the older cohort was to move the outreach service to the DHB PHN team to free up capacity for the Well Child outreach team to focus on the younger tamariki. The programme team have observed a noticeable increase in attendance following the introduction of the incentive.

Service delivery model

The incentive scheme is being co-developed and delivered with the OIS which will form the basis for a service level agreement between CM Health Childhealth and OIS (via Plunket). OIS team members will
manage incentive stock inventory and delivery of the incentive to whaanau who attend the scheduled OIS appointments. The SLA will include the terms and conditions between the parties and other relevant service and reporting requirements agreed between the parties.

Evaluation

Co-design process with evaluators, key stakeholders and project team, including design of evaluation framework, methods, data collection, database development, and project resources is underway.

We have engaged the Ko Awatea evaluation team for advice on methods for evaluation. A randomised control trial evaluation design can provide the greatest evidence of programme effectiveness whereas a pre/post study design can only demonstrate limited attribution of effectiveness. However, pre/post evaluation design is more feasible, less costly, and logistically easier to conduct compared with an RCT. Therefore, we recommend that a pre/post evaluation design is conducted.

Expected Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Year 1 01 July 2019 to 30 June 2020</th>
<th>Year 2 01 July 2020 to 30 June 2021</th>
<th>Year 3 01 July 2021 to 30 June 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Costs Subtotal</td>
<td>$28,000.00</td>
<td>$28,000.00</td>
<td>$28,000.00</td>
</tr>
<tr>
<td>Programme Activities (cost of incentives)</td>
<td>$80,000.00</td>
<td>$80,000.00</td>
<td>$80,000.00</td>
</tr>
<tr>
<td>Research and evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working Expenses Subtotal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Implementing a brief screening and referral tool for immunisations within current CM Health programmes (Smokefree Incentives Scheme and SUDI Risk Calculator project)

We have engaged the Smokefree and SUDI teams to incorporate an immunisation brief screening and referral tool into their respective programmes. We have a shared view that the same whanau who are involved with these teams are likely those who are missing immunisations.

As a starting point, we cross-matched the NHI numbers of pepi/tamariki born into the Smokefree Incentives programme with the National Immunisation Register to identify the percentage of these pepi/tamariki that were immunised on time. The findings are summarised in Table 2 which shows a high proportion of pepi/tamariki not being immunised on time.
Table 2: Number of immunisations received by Maaori pepi/tamariki born to mothers within the Smokefree programme for the period August 2013 – September 2018.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Number Immunised by the specified milestone</th>
<th>Not Immunised by the specified milestone</th>
<th>% immunized by the specified milestone</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 week Immunisation</td>
<td>391</td>
<td>417</td>
<td>48%</td>
<td>808</td>
</tr>
<tr>
<td>3 months Immunisation</td>
<td>441</td>
<td>345</td>
<td>56%</td>
<td>786</td>
</tr>
<tr>
<td>5 months Immunisation</td>
<td>360</td>
<td>392</td>
<td>48%</td>
<td>752</td>
</tr>
<tr>
<td>8 Months Immunisation</td>
<td>369</td>
<td>334</td>
<td>52%</td>
<td>703</td>
</tr>
</tbody>
</table>

The CM Health Immunisation Nurse Leader is working with the Smokefree Team Lead to design a screening and referral tool for immunisations that will be integrated into the Smokefree Team assessment forms. We envisage this work will contribute to increasing timely immunisation for children of whanau enrolled in the programme.

The SUDI team are to pilot the “Safe-sleep calculator” with Community LMC midwives to identity those babies at high risk of SUDI. Through a data matching process, we would like to test the hypothesis that the infants at higher risk of SUDI -scoring high on the Safe Sleep Calculator, will also be infants less likely to be immunised on time and therefore will provide an opportunity for proactive interventions before babies are late for immunisations.

Increasing collaboration between the OIS and Maaori Health providers to enable better engagement with Maaori whaanau

Our network of Maaori health providers could work alongside the OIS to further improve whaanau engagement and support the social and cultural needs of whaanau. As part of the engagement with a Maaori health provider, additional social supports, care coordination, and culturally appropriate services could be provided by the community Whaanau Ora services if indicated.

As a starting point for engagement between OIS and providers, we have organised a networking event between CM Health Immunisation team, OIS and Maaori Health Providers. This will provide OIS an opportunity to understand the services that the providers offer to whanau, and to build relationships to enable referrals between OIS and Whanau Ora services.

In summary

This paper has outlined a range of new initiatives including: 1) Piloting an incentive scheme to engage with Outreach Immunisation Service, (2) Implementing a brief screening and referral tool for immunisations within current CM Health programmes; and (3) Increasing collaboration between the OIS and Maaori Health providers to enable better engagement with Maaori whaanau. The aim of the initiatives proposed is to address the disparities in immunisation coverage for Maaori pepi/tamariki.
Appendix: Advice received from Outreach Immunisation Service (OIS) for developing an incentive scheme

Who are these families, what are some of the signs that will help us identify families who may benefit from the incentive program to engage sooner

- Address, high needs areas
- Hard to tell which families as you often don’t know until they open the door
- Would be good to have it available for all Maori whanau to offer when doing first phone call/txt message or leaving calling cards with a pic of nappies an wipes so family knows what they will get if they contact us

At what stage of the relationship with OIS do we think introducing an incentive will be helpful and will subsequent incentives be more helpful than a one off or not

- Families don’t ask for nappies but do appreciate the ones they have given out from our supply
- Multiple is often helpful and helps with engagement as they will open the door to the Plunket car if they have received nappies before
- When texting staff will ask about sizes etc so they have a supply
- When onbooking the client at the time of the visit for catchups they will keep a note of what to bring for the whanau to the next visit.

Which will be more user friendly and manageable for the team a voucher or the actual item like a pack of nappies

- Physical packs of nappies and wipes more tangible
- Helpful to give them a pack as they may have trouble getting out and about (hence why imms delayed) and so a voucher isn’t always helpful

What support if any will OIS need to make this happen

- Storage space
- Wide variety of sizes/ gender

Is there anything else to consider

Team want to try and see how it goes didn’t feel able to give more feedback than above as each case is so unique. Biggest challenge is finding the family in the first place and we discussed how the incentives might look at that point – texting to say – “get back to me to claim your free pack of nappies” etc

Re incentives

Feedback from staff that it’s great to have a supply of nappies to give out to families. Often they don’t know until in the home or front door is opened as to whether they feel nappies will help. They give nappies to anyone with kids that they feel would benefit even if baby isn’t there when they cold-call them. They think this helps with future engagement as it’s not like they only give the nappies when they actually do the vaccination.
# Counties Manukau District Health Board Meeting

## Resolution to Exclude the Public

**Resolution**

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

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Excluded Minutes of 12 December 2018 and Actions</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
</tr>
<tr>
<td>Public Excluded Minutes of the Audit Risk &amp; Finance Committee and the Hospital Advisory Committee</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [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>Health &amp; Disability System Review</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confidentiality of Advice by Officials Withholding the information is necessary to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by officials. [Official Information Act 1982 S9(2)(f)(iv)]</td>
</tr>
<tr>
<td>Specialised Rehabilitation Indicative Business Case</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [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>
| Philips Master Maintenance Services Agreement | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Negotiations  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial negotiations. [Official Information Act 1982 S9(2)(j)] |
| Relocation & Expansion of Radiology Services | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)] |
| Contract for Supply of Haemodialysis Equipment, Services & Consumables | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities & Negotiations  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i)&(j)] |
| Contract for Supply of Taxi & Patient Transport Services | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities & Negotiations  
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| IAAS Business Case | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities & Negotiations  
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<table>
<thead>
<tr>
<th>Topic</th>
<th>Reason</th>
<th>Official Information Act 1982</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Acute Care Services Update</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>
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</tr>
<tr>
<td><strong>AMHU Stage 2 Procurement &amp; Funding – Ratification of Circular Resolution</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>
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</tr>
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<td><strong>Social Wellbeing Board Update</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>
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</tr>
<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>
<td>[Official Information Act 1982 S9(2)(ba)(ii)]</td>
</tr>
<tr>
<td><strong>LTC Model of Care Update – Transition Plan</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>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td><strong>Commercial Activities &amp; Negotiations</strong></td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations.</td>
<td>[Official Information Act 1982 S9(2)(i)&amp;(j)]</td>
</tr>
<tr>
<td><strong>CEO Update</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>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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