Counties Manukau District Health Board

Board Meeting Agenda

Wednesday, 25 March 2015 at 1.30 – 4.30pm, Innovation Lab, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

Time	Item
1.00 – 1.30pm	**Board Only Session**
	1. **Welcome**
1.30 – 1.35pm	2. **Governance** 2.1. Attendance & Apologies – Arthur Anae 2.2. Conflicts of Interest/Specific Interests 2.3. Confirmation of Public Minutes – 11 February 2015 2.4. Action Items Register
	3. **Strategy**
1.35 – 1.45pm	3.1. Chair's Report (Verbal Update)
1.45 – 1.55pm	3.2. Chief Executive's Report
1.55 – 2.10pm	3.2.1. Values Refresh Presentation (Beth Bundy)
2.10 – 2.20pm	3.2.2. Annual Plan 2014/15 Q2 Report (Marianne Scott)
2.20 – 2.40pm	3.2.3. Patient Information Strategy & Plan 2015 & Presentation (Phillip Balmer)
	4. **Presentation**
	5. **General Business**
2.40 – 2.45pm	6. **Resolution to Exclude the Public**
	7. **Confidential**
2.45 – 2.50pm	7.1. Confirmation of Confidential Minutes – 11 February 2015
2.50 – 2.55pm	7.2. Action Items Register
2.55 – 3.00pm	7.3. Appointment to CPHAC Committee (Sandra Alofivae)
3.00 – 3.10pm	7.4. Health & Safety Quarterly Report (Beth Bundy/Beverley Stone)
3.10 – 3.20pm	7.5. Otahuhu Boundary Change (Doone Winnard)
Afternoon Tea Break	
3.25 – 4.00pm	7.6. Northern Region Electronic Health Record (NEHR) Project & Regional Information Strategy (RIS 10-20) Refresh (Sarah Thirlwall/Gloria Johnson/Will Reedy)
4.00 – 4.15pm	7.7. Project SWIFT Update (Sarah Thirlwall)
4.15 – 4.20pm	7.8. IS Strategic Projects Update (Sarah Thirlwall)
4.20 – 4.35pm	7.9. Health Targets - 2014/15 Quarter 1 Progress Report (Pauline Hanna)
4.35 – 4.45pm	7.10. APAC Update (Jonathon Gray)
4.45 – 5.00pm	7.11. Planning & Funding Annual Plan 2015/16 (Ron Pearson)

Next Meeting: 6 May 2015
Innovation Lab, Ko Awatea, Middlemore Hospital, Otahuhu

Board Member Attendance Schedule 2015

Name	Jan	11 Feb	25 Mar	6 May	17 June	29 July	9 Sept	21 Oct	2 Dec
Lee Mathias (Chair)	No Meeting	✓							
Wendy Lai (Deputy Chair)		✓							
Arthur Anae		✓							
Colleen Brown		✓							
Sandra Alofivae		✓							
Lyn Murphy		✓							
David Collings		✓							
Kathy Maxwell		✓							
George Ngatai		✓							
Dianne Glenn		✓							
Reece Autagavaia		✓							

*** Attended part meeting only**

BOARD MEMBERS' DISCLOSURE OF INTERESTS March 2015

Member	Disclosure of Interest
Dr Lee Mathias, Chair	• Chair Health Promotion Agency • Deputy Chair Auckland District Health Board • Director, Pictor Limited • Director, iAC Limited • Advisory Chair, Company of Women Limited • Director, John Seabrook Holdings Limited • Chairman, Unitec • External Advisor, National Health Committee • Director, Health Innovation Hub • Director, healthAlliance Ltd • Director, healthAlliance (FPSC) Ltd • MD Lee Mathias Limited • Trustee, Lee Mathias Family Trust • Trustee, Awamoana Family Trust • Trustee, Mathias Martin Family Trust
Wendy Lai, Deputy Chair	• Board member and partner at Deloitte • Board member Te Papa Tongarewa, the Museum of New Zealand • Chair, Ziera Shoes
Arthur Anae	• Councillor, Auckland Council • Member The John Walker 'Find Your Field of Dreams' • Chairman, NZ Good Samaritan Heart Mission to Samoa Trust
Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member of Advisory Committee for Disability Programme Manukau Institute of Technology • Member NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Chair IIMuch Trust • Director, Charlie Starling Production Ltd • Member, Auckland Council Disability Advisory Panel

Dr Lyn Murphy	• Member, International Society for Pharma-coeconomics and Outcomes Research (ISPOR). • Member of the New Zealand Association of Clinical Research (NZACRes) • Senior lecturer in management and leadership at Manukau Institute of Technology • Member, ACT NZ • Director, Bizness Synergy Training Ltd • Director, Synergex Holdings Ltd • Associate Editor NZ Journal of Applied Business Research • Member Franklin Local Board
Sandra Alofivae	• Member, Fonua Ola Board • Board Member, Pasefika Futures
David Collings	• Chair, Howick Local Board of Auckland Council • Member Auckland Council Southern Initiative
Kathy Maxwell	• Director, Kathy the Chemist Ltd • Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd) • Editorial Advisory Board, New Zealand Formulary • Member Pharmaceutical Society of NZ • Trustee, Maxwell Family Trust • Member Manukau Locality Leadership Group, CMDHB • Board Member, Pharmacy Guild of New Zealand
Dianne Glenn	• Member – NZ Institute of Directors • Member – District Licensing Committee of Auckland Council • Life Member – Business and Professional Women Franklin • Member – UN Women Aotearoa/NZ • Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust • Life Member – Ambury Park Centre for Riding Therapy Inc. • CMDHB Representative - Franklin Health Forum/Franklin Locality Clinical Partnership • Vice President, National Council of Women of New Zealand
George Ngatai	• Arthritis NZ – Kaiwhakahaere • Chair Safer Aotearoa Family Violence Prevention Network • Director Transitioning Out Aotearoa • Director BDO Marketing • Board Member, Manurewa Marae

	• Conservation Volunteers New Zealand • Maori Gout Action Group • Nga Ngaru Rautahi o Aotearoa Board
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Member, Auckland Council Pacific People's Advisory Panel • Member, Tangata o le Moana Steering Group • Employed by Tamaki Legal • Board Member, Governance Board, Fatugatiti Aoga Amata Preschool

BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 11 February 2015

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
David Collings	Potential Botany Land Development	Mr Collings declared a specific interest in relation to the Potential Botany Land Development, being a member of the Howick Local Board.	4 September 2013	That Mr Collings' specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations or decisions.
David Collings	Innovation Hub	Mr David Collings has a conflict of interest in regard to ATEED (being a member of the Local Community Board, which is part of the Auckland Council) and will be involved in the Innovation Hub.	5 October 2011	The Board notes that Mr Collings has a conflict of interest in regard to the Innovation Hub. He may participate in the deliberations of the Board in relation to this matter because he is able to assist the Board with relevant information, but is not permitted to participate in decision making.
Wendy Lai	HBL – Food & Laundry & FPSC Programme	Ms Lai declared a specific interest in regard to Deloitte providing support to HBL in the food and laundry and FPSC Programme. Deloitte has mainly been providing Oracle implementation resources to FPSC. Ms Lai is not directly involved with this work.	12 February 2014	That Ms Lai's specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.
George Ngatai	Community Services Pharmacy Funding Policy	Mr Ngatai declared a specific interest in terms of their GP Service being like to use a local Pharmacy.	13 August 2014	That Mr Ngatai's specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting.

Wendy Lai	HBL Business Cases	Ms Lai declared a specific interest in regard to Deloitte's involvement with HBL on this work.	13 August 2014	That Ms Lai's specific interest be noted and that she may not participate in either the deliberations or determination of the Board in relation to this matter and is asked to leave the room.
Wendy Lai	Ko Awatea Panel Advisory Services	Ms Lai advised that Deloitte have been shortlisted to provide Panel Advisory Services to Ko Awatea. This work does not have any involvement with the APAC Business Case	5 November 2014	Noted. Ms Lai advised on the 3 December 2014 that Deloitte have now been selected to work with the Ko Awatea team to improve commercial awareness and increase income levels.

Minutes of Counties Manukau District Health Board

Held on Wednesday, 11 February 2015 at 1.30 – 4.30pm, Innovation Lab, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

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Present:	Dr Lee Mathias (Chair), Ms Wendy Lai, Mrs Dianne Glenn, Mrs Kathy Maxwell, Anae Arthur Anae, Mr Reece Autagavaia, Mr George Ngatai, Dr Lyn Murphy, Mrs Colleen Brown, Mrs Sandra Alofivae
In attendance:	Mr Ron Pearson (Acting Chief Executive), Mrs Lyn Butler (Board Secretary)
Apologies:	Mr Geraint Martin (Chief Executive)

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1. **Welcome**
   The Chair welcomed members to the meeting, and also Mr Jarred Williamson from the Eastern Courier and Mr Wilmason Jensen, from ProCare, who joined the public section of the meeting.

2. **Governance**

2.1. Attendance & Apologies

Apologies from Mr Geraint Martin, Chief Executive, were noted.

Mr Anae noted his apologies for the March Meeting.

2.2. Conflicts of Interest/Specific Interests

Mrs Colleen Brown, Mr Arthur Anae and Mr Reece Autagavaia all advised changes to their Disclosures of Interest, which were noted accordingly.

The Specific Interests Register was noted.

2.3. Confirmation of Public Minutes – 3 December 2014

Resolution

That the Public Minutes of the Board Meeting held on **Wednesday, 3 December 2014**, were taken as read and confirmed as a true and correct record.

Moved: Wendy Lai **Seconded:** Dianne Glenn **Carried:** Unanimously

2.4. Action Items Register

Noted.

Population Based Funding – The Population Health Team will be bringing a paper to the April Meeting. Mr Pearson is to follow up on the letter to the Minister, and explain the Board's considerable concerns to MoH on the funding anomaly.

The Chair requested an update on APAC at the March Meeting.

3. **Strategy**

3.1. Chair's Report (verbal update) (Lee Mathias)

HBL Transition – the Transition Group has held three meetings to date. Matters are progressing well. The Northern Region are awaiting the Contract. The Chair, as a Board Member of healthAlliance, has requested a three page precis of the 750 page document.

Due diligence is being undertaken by internal staff, with external work being carried out by Ernst & Young.

Three Business Cases have been reviewed. A staged rollout will be undertaken on Food. FPSC is very dynamic, with many changes on a weekly basis. The Executive are to follow up on some areas. Some DHBs will require assistance.

The next Regional Governance Meeting is on the 12 February. Regional CIOs/CFOs have a Regional IT Strategic Workshop that afternoon.

3.2 Chief Executive's Report (Ron Pearson, Acting Chief Executive)

The report was taken as read.

Mr Pearson highlighted some key points:

- Strategy & Values Refresh – these are being reviewed to ensure they are still applicable, particularly in view of the spectrum of focus now on the whole of community. Extensive work is underway and a paper will come to the Board in due course.

- Project Swift – a detailed presentation will be provided later in the meeting. There is a very high clinical interest, with approximately sixty people having put their names forward. These will be reviewed to ensure the correct selection of people. This project will be aligned with the Wicked Project to ensure regional working.

- Planning – work is well underway, with detailed focus now at a Divisional level to ensure that the provision of clinical services can be managed with the funding available. A paper will come to Board in March.

- Health & Safety Audit – an external audit has indicated that most areas are very good, with only two areas highlighted as requiring attention. Work is underway and the 'risk' has already been reduced, with work continuing. This has been signed off by independent auditors.

- Finance – December has been a tough month. January is currently $100-150K off budget, but there is confidence it will be achieved. Teams are pushing hard each month to remain in budget for year end.

  Organisational performance has been excellent, but there are two key areas still providing challenges; the HBL savings delay and procurement savings, with three quarters of the target currently being achieved.

Ms Lai queried the Mental Health Blueprint funding. Mr Pearson is to look into.

Resolution
That the Chief Executive's Report be received.
Moved: Colleen Brown **Seconded:** Dianne Glenn **Carried:** Unanimously

4. **Presentations**
None.

5. **General Business**
None.

6. **Resolution to Exclude the Public**
Individual reasons to exclude the public were noted.

Resolution
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health & Disability Act 2000, that the public now be excluded from the meeting as detailed in the above paper.
Moved: David Collings **Seconded:** George Ngatai **Carried:** Unanimously

The meeting was re-opened to the public.

The meeting closed at 4.40pm. The next Meeting of the Board will be **Wednesday, 25 March 2015** at Ko Awatea, Middlemore Hospital.

The Minutes of the Meeting of the Counties Manukau District Health Board of **Wednesday, 11 February 2015** are approved.

Signed as a true and correct record on **Wednesday, 25 March 2015.**

Chair ________________________________

Dr Lee Mathias (Chair)

Recommendation (moved / seconded)

Counties Manukau District Health Board
Action Items Register (Public)

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
11 February	CE Report - Planning	Planning - A paper will come to Board in March. Ms Lai queried the Mental Health Blueprint funding. Mr Pearson is to look into.	March March	R Pearson R Pearson	Paper included in March meeting papers. Blueprint funding ceased a few years ago. The ring fencing of Mental Health monies remains.	✓ ✓
11 February	Action Items	The Chair requested an update on APAC at the March Meeting.	March	J Gray	Paper included in March meeting papers.	✓
11 February	Action Items	Population Based Funding – The Population Health Team will be bringing a paper to the April Meeting. Mr Pearson is to follow up on the letter to the Minister, and explain the Board's considerable concerns to MoH on the funding anomaly.	March	R Pearson	Ron Pearson has again followed this up with MoH and will provide a verbal update at the March meeting.	✓
3 December	2014/15 Quarter 1 Report	Ms Lai requested Mr Martin provide an update as to what the impact will be on areas that are currently orange on the report and are unlikely to meet the target.	February	G Martin	Pauline Hanna to lead project to ensure maximum improvement from orange to green. A monthly progress report will be provided to the Board from March.	✓
3 December	Population Based Funding Changes	The Chair advised that she has approached the Chair of Auckland District Health Board and Mr Martin to consider the implications of population based funding changes and will discuss further at either the CPHAC meeting of 21 January 2015 or the Board Meeting of 11	February	L Mathias/ G Martin	Discussed at CPHAC. Population Health team have been tasked to produce an options paper for March.	✓

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
		February 2015.				
1 October	CE Strategic Discussion	Mr David Moore of Sapere Group, one of the leading research agencies, has been engaged to look at economic models, datasets, etc. A report will be provided to the Board when the work has been completed. A new Health Services Plan will be worked on over the next few months, with the Plan coming to the Board in June. Initial findings will be presented to the May meeting.	 June May	G Martin/ B Hefford	An update has been included in the CE Report.	

Counties Manukau District Health Board
Chief Executive's Report

Recommendation

It is recommended that the Board **receive** the Chief Executive's Report.

Prepared and submitted by Geraint Martin, Chief Executive

1.0 **Introduction**

1.1 As routine, my report is set out in three sections:

- **Strategic** – with a special focus on planning for 2015/16.
- **Operational** – including the reports from the Director of Strategic Development, Director of Corporate & Business Services and Director of Ko Awatea.
- **Compliance** – no new items to report, but there is an update on health & safety.

2.0 **Strategic**

2.1 **Strategy & Values Refresh**

Beth Bundy, GM HR, will present to the Board as part of my report to brief on:

- The process of how we are consulting with patients, stakeholders and staff on how we see ourselves and how we compare to our stated values. There has already been significant staff interest and involvement, and we aim to get a very high sample rate to inform our thinking.
- In addition, a sub group of the ELT has been established to refine and firm up what will be our strategic objectives for 2020.

Along with a Communications Strategy, these three pieces of work will be presented to the Board for further input and subsequently approval for inclusion in this final draft of our Annual Plan 2015/16.

Following the Board's feedback from December, drafting of the Strategic Plan is in progress that will aim to achieve the following:

- Replace the current Vision with a shorter statement of strategic intent that reflects our goal to be ***'Healthy Together 2020'*** and reflect that we aim to ***"improve the health of Counties Manukau Health communities and those that need us quickly, safely and with compassion"*** (draft wording work in progress).
- A goal that reflects our desire to measure in some way the impact on our community by restoring health and extending life by some measure of years and/or quality of life. The original intent to express this in the form of 'giving back 300,000 life years' [wording is work in progress] to better balance the desire to have a measureable goal (extending life or improved quality of life that can be influenced by the healthcare

system) but also be able to ***translate this with meaning*** in multiple contexts e.g. service setting, target population group, individual staff, individual patient and/or their whaanau and family.
- Replace the 'Achieving a Balance' strategic framework with three Mission statements that build on the Triple Aim – Healthy People, Whaanau and Families; Healthy Communities; Healthy Services. The framework will also describe clear actions showing how programmes and portfolio of work contribute to the overall strategic intent.

The MoH are meeting with me mid-March to brief us on the MoH's own strategy forming process and ensure that we are aligned in our approaches. The Director, Strategic Development is also working with Andrew Old, Director, Strategy for ADHB/WDHB to ensure there is regional alignment in our approaches.

The next iteration will clarify and be more specific about what we really mean by each of these three Missions and what programmes of work or change that community/staff will see that reflects the intent. The specificity will refer to and build on existing work 'in flight. The collective whole aims to reflect that we are maintaining our strategic shape to:

- Continue to build on primary care as ***the healthcare home*** for our community, setting as many services as possible to support and enable primary care as the front line through Localities and community based provision
- Sustain ***high quality hospital/specialist services*** and an acute care system for those that need it most while
- Living within our means.

Mission	Actioned by
Healthy People, Whaanau and Families **.. are part of the healthcare team and active in their health and wellbeing**	Reinforce primary care as the ***healthcare home and front door*** to the healthcare system by reorganising services in locality settings to support primary care expanded At Risk Individual programmes to a wider group of vulnerable patients and their families beyond adults with long term conditions eg children, pregnant women, young people establish Whaanau ora/Fanau Ola case management of vulnerable families that works across the whole system expanded Manaaki Hauora – self management programme front door to healthcare system through 6 Community Hubs that comprise community central SWIFT enabled access to healthcare information, services and technology that supports self-management and health literacy
Healthy Communities **.... healthcare is part of the fabric of community life that influences lifestyle & behavioural choices**	reduce smoking prevalence to 15% by 2018 and on track to reach 5% by 2025 [to determine a 2020 target] minimize harm from alcohol join up experience and continuity of care for mama, pepi/tamariki – mums and babies – in the First 2000 Days of life implement Healthy Families NZ and it spread across the District in support of the AH+ alliance front door to healthcare system through 6 Community Hubs that comprise community central SWIFT enabled access to information on population segments that enable targeting of
Healthy Services **… skilled people that are well equipped & supported to deliver effective, kind, safe, excellent care**	Values led people and organisation development Advance quality and safety agenda Do what we must do – excellent performance in national targets Whole of System portfolio of projects and service improvements in key areas that drive acute demand growth eg musculoskeletal, metabolic syndrome, mental health, cardiovascular and respiratory Implement community health integration through Locality Leadership Teams, shift of services into Community Hubs and SWIFT enabled productivity and workforce efficiencies Workforce development to attract and retain great people, better Assets and infrastructure that enable whole of system working (e.g. diagnostics, 6 community hubs) using mix of public and private capital investment Environmentally sustainable practices.

Values Refresh

The Values Refresh process has to date received 780 responses against a target of 3,000 (nb overall headcount of staff is est 6,000) by 8 May. This is likely to be an understatement as many hard copy responses were received that reflect the feedback from teams of people. The aim is to achieve more than 3,000 responses to ensure that the value set that are finalised are built on at least half of our staff responding. This first stage is an 'Engage' phase where responses are being gathered to inform insights on what staff and patients perceive and/or experience.

This will culminate in a 'Listening Week' beginning 28 April where workshops and facilitated listening sessions will be held with staff and patients to offer deeper insights on how they experience our organisation. The Listening Week will comprise the following sessions:

- **In Our Shoes**: This session is for <u>all</u> staff to attend and provide feedback on their experiences working at CM Health, to help us understand how we can increase the good days and learn from and improve on the bad experiences. We need 100 staff to attend each *In Our Shoes* session. Staff are only expected to attend <u>one</u> of the five sessions.
- **In Your Shoes**: This session is for patients to attend and share the good and bad experiences of the care they received while at CM Health. Staff will be invited to assist in two ways - as a listener and/or a facilitator. Staff can attend multiple sessions.
- **Leading with Values:** This session is for those with leadership roles to build skills to role model and manage values, attitude and behaviours. Staff are only expected to attend <u>one</u> of the two sessions.

2.2 **Planning for 2015-16**

Detailed work has now begun with the formation of the Financial & Service Sustainability Group. Led by the CFO, this is meeting fortnightly to identify and prioritize our budget setting.

Whilst difficult decisions will need to be made, the ELT and the Financial Sustainability Group has re-affirmed the following principles:

- Decisions will be made using our strategic context, i.e. delivery of the Triple Aim.
- Decisions will be made which will progress our strategic direction, i.e. safe, timely and compassionate care when we are needed and a focus on improving the health of citizens and whanau.
- Our focus will be reducing demand for hospital care through locality development.
- Our aim will be to improve the quality of services, to re-design and work smarter so we can continue to provide and extend the range of care we need to in a sustainable financial way.
- Our methodology will be to involve staff at all levels in generating ideas and solutions.
- We will balance our books.

We have used these principles very effectively to manage our financial strategy since 2009, and the strong general buy in and consistency of principle and direction has greatly aided effective decision making.

The general areas for focus are:

- Maximising value.
- Cost improvements in both operations arms of the organisation. We have used service level analysis for some time.
- Review of the cost of patient flows.
- Re-design of community services, especially with a view to accelerating integration service improvement and cost reduction. First cabs off the rank are Rehabilitation, Maternity and Renal Dialysis.

Although it was anticipated a joint strategic paper by Benedict Hefford and Phillip Balmer was to be produced for this Board Meeting, it has been agreed that rather than publish additional papers, we should integrate this with the Annual Plan process per se.

2.3 Speeding up Localities

The development of a locality-based 'master services plan' is progressing with the assistance of Sapere Research Group who are analysing a database of several million in-patient and out-patient events matched with primary care data.

The aim is to identify the gap between current infrastructure (in terms of major sites and facilities in each locality) and what's optimally needed to support the emerging model of integrated care. A 'long list' of services and interventions that can potentially be delivered in community settings/hubs with reasonable cost and quality is being identified, along with an analysis of the current pressure points and high growth areas for hospital services. Ultimately we want to establish a potential core set of services that will help manage acute demand by giving residents' access to community hub based care within a reasonable distance/time. Information is being gathered through interviews, workshops, stocktakes, data analysis and literature searches.

The analytical and planning work to arrive at a draft plan is complex with many interrelated factors that need to be considered, however, discussions with PHOs, general practices, clinicians and managers will continue to progress the thinking over the next few weeks. The draft plan will be presented to the Board for initial feedback in May.

3.0 Operational

3.1 The Board will see from the accompanying reports that the DHB:

- Continues to maintain a strong fiscal position, remaining on track to deliver end of year objectives.
- Continues to deliver a high level of service performance, maintaining delivery against key targets.

3.2 The Project Team for improving performance has started its work, and progress plans have been developed in each area and by end of the financial year performance important targets will have been delivered. The budgeted areas are:

- Cervical Screening
- Faster Access to Cancer Surgery
- Radiology
- Gastro-enterology

A progress report will be made through HAC & CPHAC in the coming months.

3.3 It is important to draw the Board's attention to our continuing high performance in ED. Winter planning is well advanced and will be presented to HAC.

There are seven teams that provide ‘corporate services’ and two direct patient support services (Maaori and Pacific cultural support) in the Strategic Development Directorate. The table below highlights progress on key business as usual or initiatives as at end February. The table also highlights risks that are of organisation concern.

Team	Highlights	Risks
Strategic Planning	**Strategy Refresh** – drafting to be prepared for stakeholder input and review by end of March. See CE Report for update. Ministry of Health is meeting with CMH mid-March to discuss the process for national Health Strategy development and alignment with CMH. **2015/16 Annual Planning** – first draft has been submitted to MoH/NHB on 13 March.	CMH’s strategy and national strategy do not align. Annual Plan activity do not match available budget and resources.
Population Health	**Life Expectancy:** Alistair Woodward ex Head of School, School of Population Health, University of Auckland spoke at Grand Round on 5 March. The key messages of this research were to confirm that life expectancy is not only increasing but older people were more likely to be healthier with compressed morbidity in the very short period before death. The implications of longer healthier life in the population to be considered in HR (staff), service design and end of life work programmes. **Publication:** Papers in the pipeline to be prepared/currently being edited for publication and wider dissemination: • Top 5000 high cost patients • PHO enrolment (to be edited for NZMJ) • Testsafe analysis on people with diabetes • Census 2013 Update for CMH as part of strategy update	n/a
Maaori Health Development	**Integrated Service Agreement** (devolution): contract variation to NHC to repatriate contract management functions to CMH have been formally initiated. A paper will be submitted to board to consider contract changes. This is because the original decision to devolve was made at Board level. **Te Rapunga Paeora** (inpatient cultural support service) consultation on model of care changes have closed and decision making on new model of care and implications for staff to be determined before 31 March. Feedback is generally in support of **Whakatairanga Paeora** – The Maaori Team are developing a calendar of events for the year to celebrate Maaori health excellence and innovation. These include: • Hui Kaikookiri Paeora (2) - Hui or Maaori staff & equity champions • Ngaa Whainga Hiringa Rapunga Paeora (4) - Maaori health leadership excellence seminars inviting excellent practices in the District and nationally • Te wiki o te reo Maaori - Maaori language week celebrations • Matariki - Maaori new year celebrations • Indigenous Health Gains conference - a national and international conference to run jointly alongside APAC	NHC viability to contribute to full integrated whaanau ora service development programme at risk if contract management functions are repatriated to the DHB.
Pacific Health Development	**Integrated Service Agreement (ISA):** The ISA is extended to 30 June 2015. ADHB and WDHB agreed that DHB ISA contracts with AH+ from 1 July 2015 onwards will be aligned to the agreed Outcomes Framework. A workshop to refine and finalise the indicators and	

	measures for reporting on those outcomes will be held at MMH in February 2015. Concurrent activities include finalising a pricing model / structure / process; ensuring Pacific providers have good understanding of the changes moving forwards – AH+ are providing change management support. **Fanau Ola:** A total of 180 new primary clients (593 fanau members) were registered for the month of January 2015. Full extent of Fanau Ola in the community needs to be collated and coordinated and data/statistic to support services and outcomes for Fanau.	
SPMO	**Whole of system portfolio** for renal from prevention – primary – secondary in the process of development. Other portfolio work comprises: • ***End of Life care:*** joined up effort to reduce comfort cares provision in hospital and ensure transition to community at end of life • ***Capacity and Production Planning:*** in gastroenterology and radiology as part of infrastructure and workforce development. **Achieving a Balance:** The two remaining Achieving a Balance programmes currently supported by SPMO resource will be considered for transition to a 'business as usual' from 1 July. Discussions will be held with Sponsors over the Feb-March period to align with implications for the 15/16 year.	Clarity on accountability during transition is lost.
Communications	***New corporate website:*** The new site is planned to go live by the end of March. To keep costs down, the bulk of the work, namely the programming and design, has been produced in-house. The project is a joint production between the communications team and Ko Awatea. New features will include: • reorganising information so that it's easy to find • giving you clear guidance on completing tasks • rewriting content in plain English • making a website that can be viewed on any device, including smartphones and tablets • improving accessibility by meeting the New Zealand Government Web Standards • using the Government's common web platform to ensure consistency and information security. ***Social Media*** We continue to grow our social media channels on Facebook, Twitter, Linkedin, YouTube and Google+. Linkedin is our most popular social media channel with 2,393 followers. The most popular post in social media was a post on the House Officer of the Month for December – Morisha Ali with over 205 likes and 37 comments. It is evident that our followers enjoying viewing positive stories about our staff. ***Branding* -** The guidelines for use of the organization brand have been updated.	
Human Resources	**Industrial Relations:** Recent national GM HR meetings identified the risk of industrial action in the process of bargaining significant MECA – NZNO and PSA. ELT confirmed that CMH will continue to bargain jointly with national DHBs as an employer group supported by DHB Shared Services. The terms of negotiation will be challenged in an environment of low inflation and employee representative organisations agitating about the relative impact on Auckland workforces who face higher costs of living. **Workplace Health and Safety:** Workplace Health and Safety Report is attached as a separate paper.	Industrial relations bargaining for significant MECA (PSA, NZNO) may culminate in industrial action.

Deep Dive Population Based Funding Formulae Review

This section will take a 'deep dive' or focus in depth on activities in the work programme. This month we focus on opportunities to engage with the Ministry of Health in relation to the PBFF and the potential uses of dataset linkage to improve patient journeys and quality of care.

Dr Wing Cheuk Chan, Public Health Specialist in the Population Health Team is part of the national PBFF technical advisory group. This group exists to contribute to the Ministry-led review of the PBFF formula and process and comprises other national DHB and wider stakeholder expertise (not representation). A key issue is what population is used to determine the PBFF weighting for each DHB. The discrepancy between the number of unique individuals domiciled in a DHB area who received DHB funded health services (as defined by the health service utilisation population used in CM Health) and the Stats New Zealand estimated population is material in those PBFF calculations.

In progressing dialogue with MoH re improving elements of our access to data sets to support population analyses, we have had the opportunity to express technical and capacity support to MoH to reinvigorate the national Health Tracker (a national version of the health service utilisation population). This could provide a potential alternative to using the Census-derived Estimated Resident Population as the basis for the PBFF DHB weightings. Almost all of the components of the PBFF will be reviewed. CMH supports the use of the Health Tracker as this is likely to inform funding allocations based on who **actually** uses services and are receiving care by a DHB rather than estimations of population that are then extrapolated into allocation formulae.

Wing has also been invited to present his TestSafe diabetes/ chronic renal impairment work to the MoH health and disability intelligence team. This highlights the opportunity to use linked datasets to identify cohorts of patients for whom there are significant opportunities to improve care with proven benefits via live NHI feedback to clinicians responsible for their care. A practical implications of this analysis is that the opportunity to proactively enrol or refer segments of people for whom we have data that suggest deteriorating health. This is in contract to waiting for patients to see their GP or primary care professional which may then trigger a referral into programmes such as ARI.

FINANCIAL POSITION at February 2015
(Interim Report)

Summary:
The persistent trend of tight fiscal performance is making it increasing hard to stay on budget with the month producing a slight negative variance of $13k; Year to date remains challenging, favourable however by $109. While only a very minor unfavourable variance in the month the fact that we were unable to absorb such a small amount reflects the increasing tightness.
At this point in time the organisation is still on target to come in on budget (subject to the anticipated gain on sale of land at Botany ($3.0m). The last four months have a budget loss of $3,413k, offset by the sale of land $3,007. Current position $3,522 less budget loss (3,413) var. favourable $109k plus land sale ($3,007); final position $3,116 v's budget $3,000.

Month / Year to date
The consolidated result for the month was a slight unfavourable variance of $13k, with the actual result being a surplus of $2,747k v's budget $2,760k. The year to date result is a favourable variance of $109k, with actual $3,522k v's budget $3,413k surplus.

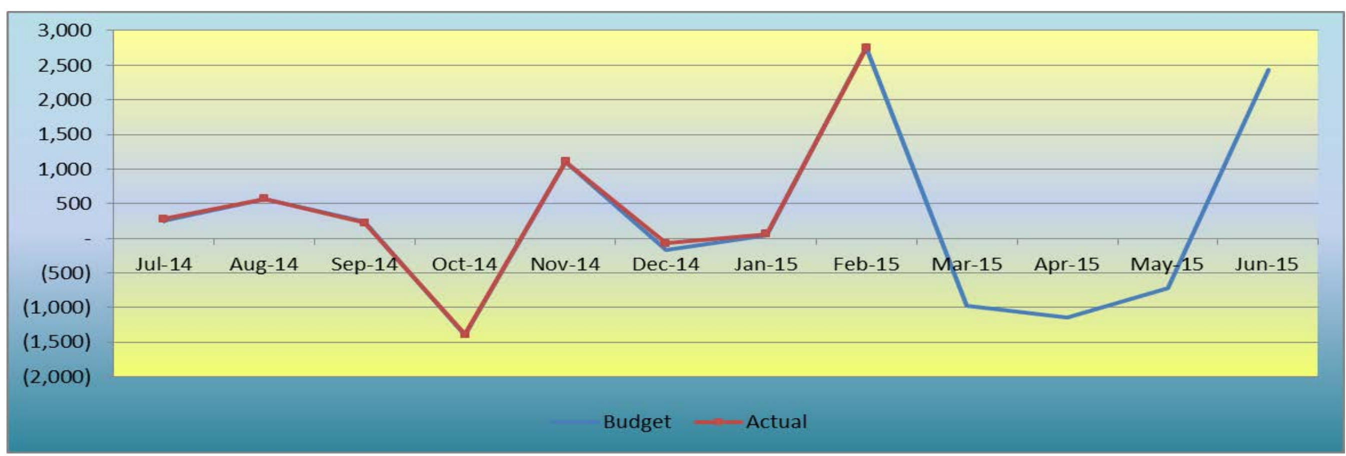
The Funder Arm was $396k favourable to budget and year to date $1,853k favourable. Community pharmacy continues to produce an unfavourable variance to budget. As per previous months the trend is for Aged Residential Care (over 65s) demand to continue to be below budget which is the main driver for the months and year to dates favourable result. This trend is contrary to previous history and forecast projections with no specific driver apparent but can reverse just as quickly

The Provider Arm consolidated, produced a result that was unfavourable to budget by $7k but year to date is favourable $119k. The Hospital side of the provider arm was unfavourable for the month by $26k and year to date $123k favourable. HBL saving for linen and laundry have not been achieved and are likely to be delay until the start of the New Financial Year, costing the organisation over $1m in lost savings.

Governance was unfavourable for the month by $(402)k and year to date $(1,863)k unfavourable, primarily driven by continuing costs related to Project SWIFT $(213)k which at this point in time are unable to be capitalised, as well as consultancy around Planning and Funding $(35)k Strategic (Vision and Values $57k), Management (S&P $54k) and Maori (39k).

Statement of Performance by Operating Arm

Month February 15			Net Result	YTD February 15				Full year	
Act	**$000**	**Var.**	**$000**	**Act**	**Bud**	**Var.**	**Last year**	**Bud**	**Forecast**
3,911	3,938	(27)	*Hospital Provider*	14,360	14,237	123	11,315	16,713	17,931
(702)	(805)	103	*Integrated Care*	(5,753)	(6,440)	687	(1,337)	(9,590)	(9,626)
(893)	(1,045)	152	*Ko Awatea*	(8,512)	(8,987)	475	(8,658)	(13,413)	(13,490)
(149)	87	(236)	*HBL*	(1,229)	(63)	(1,166)	(1,132)	(714)	(1,738)
2,167	2,175	(8)	*Provider*	(1,134)	(1,253)	119	188	(7,004)	(6,923)
983	586	397	*Funder*	6,521	4,667	1,854	5,595	6,996	7,644
(404)	(1)	(403)	*Governance*	(1,864)	(1)	(1,863)	(228)	1	(724)
-	-	-	Gain on Sale	-	-	-		3,007	3,007
2,746	**2,760**	**(14)**	***Surplus (deficit)***	**3,523**	**3,413**	**110**	**5,555**	**3,000**	**3,004**



Volume Summary (February 2015)

Total WIES

Month						Year to date				
Act	Bud	Var.	%	Last. Yr.		Act	Bud	Var.	%	Last. Yr.
4,269	4,528	(259)	(5.7)%	4,527	*Acute*	40,949	40,498	451	1.11%	40,146
1,281	1,400	(119)	(8.5)%	1,254	*Elective*	11,620	11,760	(140)	(1.2)%	11,662
5,550	**5,928**	**(378)**	(6.4)%	**5,781**	***Total***	**52,569**	**52,258**	**311**	0.60%	51,808

Discharges

Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
5,495	5,314	181	3.4%	*Acute*	48,100	47,068	1,032	2.19%
1,095	1,137	(42)	(3.7)%	*Elective*	11,021	11,188	(167)	(1.5)%
6,590	**6,451**	139	2.2%	*Total*	**59,121**	**58,256**	**865**	1.48%
0.84	**0.90**	0.05	6.0%	***Ratio WIES to discharges***	**0.89**	**0.90**	**0.01**	0.88%

Volumes Other

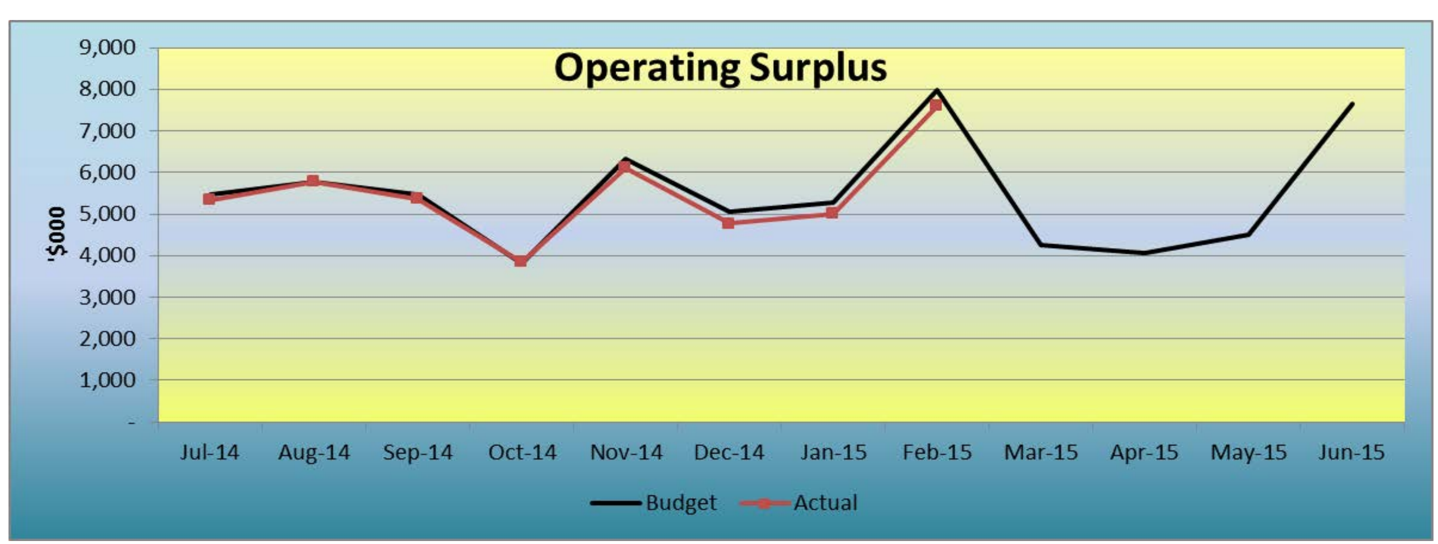
Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
534	526	8	1.52%	*Birth Numbers*	4,835	4,832	3	0.06%
4,265	4,022	243	6.04%	*Renal Dialysis*	36,622	34,417	2,205	6.41%
26,000	29,064	(3,064)	(10.5)%	*Outpatient Summary*	236,085	246,099	(10,014)	(4.1)%
2.3	2.6	(0.3)	(11.5)%	*ALOS*	2.5	2.5	-	-

Renal growth is now growing at an average of 6.41%.

Statement of Performance (February 2015)

Month				Year to Date				Full Year	
Act	Bud	Var.	*$000*	Act	Bud	Var.	Last year	Bud	Forecast
			Revenue						
120,179	121,225	(1,046)	*Crown*	965,541	970,696	(5,155)	936,805	1,456,397	1,455,400
3,121	2,710	411	*Other*	24,712	22,218	2,494	24,668	32,246	32,597
123,300	**123,935**	**(635)**	***Total Revenue***	**990,253**	**992,914**	**(2,661)**	**961,473**	**1,488,643**	**1,487,996**
			Expenses						
43,192	43,100	(92)	*Personnel*	357,590	362,252	4,662	347,556	556,961	541,174
5,286	4,613	(673)	*Outsourced*	43,461	37,719	(5,742)	43,447	46,607	59,503
53,472	54,853	1,381	*Funder Provider payments*	430,586	438,830	8,244	423,059	657,917	653,550
8,044	7,880	(164)	*Clinical Sup.*	69,232	63,747	(5,485)	64,374	97,038	104,019
5,709	5,507	(202)	*Infrastructure*	45,548	45,183	(365)	43,419	67,471	67,307
115,703	**115,953**	**250**	***Operating Exp***	**946,417**	**947,731**	**1,314**	**921,855**	1,425,994	1,425,553
7,597	**7,982**	**(385)**	***Surplus after operating Exp.***	**43,836**	**45,183**	**(1,347)**	**39,618**	62,649	62,443
2,718	2,847	129	*Depn.*	21,997	22,770	773	20,342	34,156	34,157
976	1,280	304	*Interest*	8,487	10,240	1,753	4,870	15,360	14,539
1,157	1,095	(62)	*Capital Chg.*	9,829	8,760	(1,069)	8,851	13,140	13,751
-	-	-	*Gain on Sale*	-	-	-		3,007	3,007
2,746	**2,760**	**(14)**	***Net Surplus***	**3,523**	**3,413**	**110**	**5,555**	**3,000**	**3,004**

Better than 5%	Worse than 5%



FINANCIAL POSITION at January 2015

Summary:

The continuing trend of tight fiscal performance is making it increasing hard to stay on budget, but at this point in time the organisation is still on target to come in on budget (subject to the anticipated gain on sale of land at Botany ($3.0m). The organisation has seen slower procurement savings and HBL being behind on delivery of savings (Linen and Laundry). These have been offset by a tightening within other areas of the business.

Month / Year to date

The consolidated result for the month was a slight favourable variance of $10k. The actual result was an actual surplus of $59k v's budget $49k, with the year to date result a favourable variance of $124k, actual $777k v's budget $653k surplus.

The Funder Arm was $24k unfavourable to budget and year to date $1,457k favourable. Community pharmacy saw a year to date adjustment resulting in an unfavourable variance to budget. As per previous months the trend is for Aged Residential Care (over 65s) demand to continue to be below budget which is the main driver for the months and year to dates favourable result. This trend is contrary to previous history and forecast projections with no specific driver apparent but can reverse just as quickly.

The Provider Arm consolidated, produced a result that was favourable to budget by $88k and year to date a favourable $127k. The Hospital side of the provider arm was favourable for the month by $67k and year to date $150k favourable. HBL saving for linen and laundry have not been achieved and are likely to be delayed until the start of the New Financial Year. High volumes continue in Emergency Care (9,027 discharges vs budget 8,450) 6.8% increase for January.

Governance was unfavourable for the month by $(54)k and year to date $(1,457)k unfavourable, primarily driven by continuing costs related to Project SWIFT which at this point in time are unable to be capitalised, as well as consultancy around Planning and Funding and Transition management.

Forecast:

The high level forecast shows the organisation is still on target to achieve a $3.0m surplus (subject to the anticipated gain on sale of land at Botany ($3.0m). There is a requirement that organisation achieves all of its saving targets or finds substitute savings. Further delays and reductions in HBL initiatives rollouts such as Linen and Laundry, will directly impact on the second six months results, necessitating even greater effort around operational efficiencies and sustainability achievement of all targets.

Statement of Performance by Operating Arm

Month January 15			Net Result	YTD January 15				Full year	
Act	$000	Var.	$000	Act	Bud	Var.	Last year	Bud	Forecast
1,387	1,320	67	*Hospital Provider*	10,449	10,299	150	7,758	16,713	17,931
(654)	(805)	151	*Integrated Care*	(5,051)	(5,635)	584	(1,660)	(9,590)	(9,626)
(1,030)	(1,134)	104	*Ko Awatea*	(7,619)	(7,942)	323	(7,649)	(13,413)	(13,490)
(149)	85	(234)	*HBL*	(1,080)	(150)	(930)	(1,014)	(714)	(1,738)
(446)	(534)	88	*Provider*	(3,301)	(3,428)	127	(2,565)	(7,004)	(6,923)
559	583	(24)	*Funder*	5,538	4,081	1,457	5,018	6,996	7,644
(54)	-	(54)	*Governance*	(1,460)	-	(1,460)	(369)	1	(724)
-	-	-	Gain on Sale	-	-	-	-	3,007	3,007
59	**49**	**10**	***Surplus (deficit)***	**777**	**653**	**124**	**2,084**	**3,000**	**3,004**

Monthly Result (not cumulative)

Volume Summary (January 2015)

Total WIES

Month						Year to date				
Act	Bud	Var.	%	Last. Yr.		Act	Bud	Var.	%	Last. Yr.
4,620	4,822	(202)	(4.2)%	4,617	*Acute*	35,970	35,619	351	0.99%	36,501
1,103	1,252	(149)	(11.9)%	1,239	*Elective*	10,291	10,360	(69)	(0.7)%	10,391
5,723	**6,074**	**(351)**	(5.8)%	**5,856**	***Total***	**46,261**	**45,979**	**282**	0.61%	46,892

Discharges

Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
5,695	5,444	251	4.6%	*Acute*	42,639	41,753	886	2.12%
973	1,130	(157)	(13.9)%	*Elective*	9,813	9,876	(63)	(0.6)%
6,668	**6,574**	94	1.4%	*Total*	**52,452**	**51,629**	**823**	1.59%
0.86	**0.89**	0.03	3.6%	***Ratio WIES to discharges***	**0.88**	**0.89**	**0.01**	0.97%

Volumes Other

Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
598	626	(28)	(4.50)%	*Birth Numbers*	4,301	4,200	101	2.40%
9,027	8,450	577	6.83%	*ED Volumes*	64,843	62,926	1,917	3.04%
4,681	4,472	209	4.67%	*Renal Dialysis*	32,357	30,395	1,962	6.46%
25,348	27,486	(2,138)	(7.8)%	*Outpatient Summary*	209,228	217,030	(7,802)	(3.6)%
2.5	2.5	-	-	*ALOS*	2.5	2.5	-	-

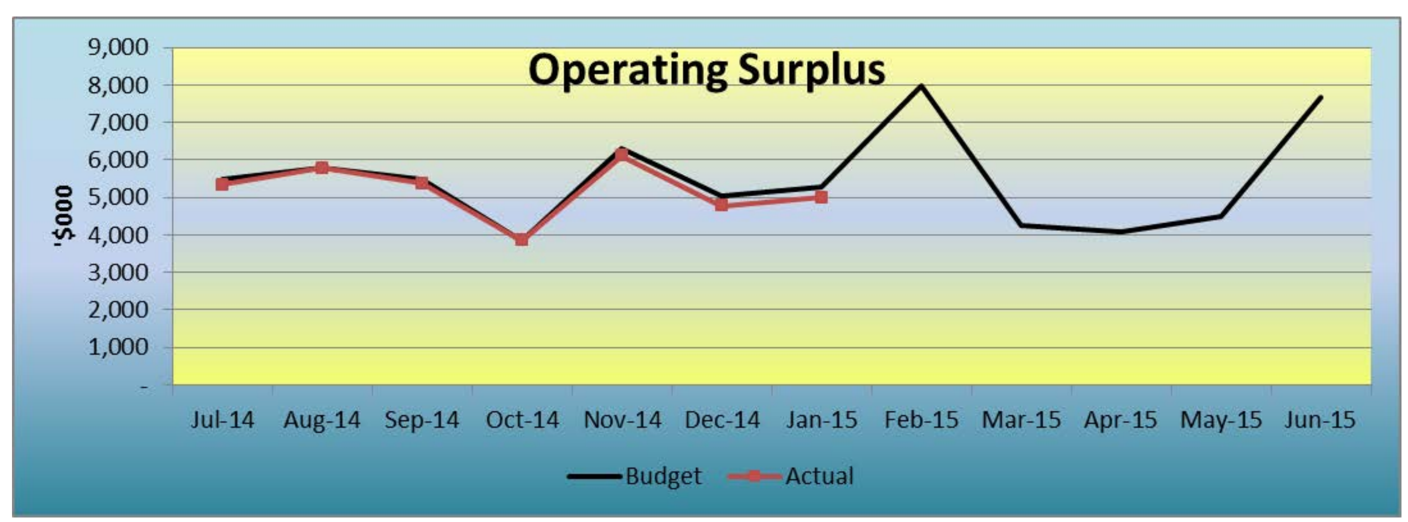
Renal growth is now growing at an average of 6.46% along with ED volumes (YTD Dec 14) at 3.04%.

Statement of Performance

Month Act	Month Bud	Month Var.	$000	YTD Act	YTD Bud	YTD Var.	YTD Last year	Full Year Bud	Full Year Forecast
			Revenue						
120,589	121,218	(629)	*Crown*	845,362	849,471	(4,109)	819,234	1,456,397	1,455,400
2,545	2,736	(191)	*Other*	21,591	19,508	2,083	21,977	32,246	32,597
123,134	**123,954**	**(820)**	***Total Revenue***	**866,953**	**868,979**	**(2,026)**	**841,211**	**1,488,643**	**1,487,996**
			Expenses						
44,601	46,437	1,836	*Personnel*	314,398	319,152	4,754	306,434	556,961	541,174
5,837	4,611	(1,226)	*Outsourced*	38,175	33,106	(5,069)	38,234	46,607	59,503
54,327	54,853	526	*Funder Provider payments*	377,114	383,977	6,863	369,226	657,917	653,550
7,831	7,333	(498)	*Clinical Sup.*	61,188	55,867	(5,321)	56,797	97,038	104,019
5,536	5,451	(85)	*Infrastructure*	39,839	39,676	(163)	38,707	67,471	67,307
118,132	**118,685**	**553**	***Operating Exp***	**830,714**	**831,778**	**1,064**	**809,398**	1,425,994	1,425,553
5,002	**5,269**	**(267)**	***Surplus after operating Exp.***	**36,239**	**37,201**	**(962)**	**31,813**	62,649	62,443
2,701	2,845	144	*Depn.*	19,279	19,923	644	17,972	34,156	34,157
1,083	1,280	197	*Interest*	7,511	8,960	1,449	4,114	15,360	14,539
1,159	1,095	(64)	*Capital Chg.*	8,672	7,665	(1,007)	7,643	13,140	13,751
-	-	-	*Gain on Sale*	-	-	-	-	3,007	3,007
59	**49**	**10**	***Net Surplus***	**777**	**653**	**124**	**2,084**	**3,000**	**3,004**

Better than 5%	**Worse than 5%**

Monthly Operating Result (not cumulative)



Revenue

Month Act	Month Bud	Month Var.	$000	YTD Act	YTD Bud	YTD Var.	Full Yr. Bud
67,217	67,484	(267)	*Provider*	476,986	473,682	3,304	778,434
116,909	117,286	(377)	*Funder*	817,469	821,010	(3,541)	1,363,247
(62,023)	(61,850)	(173)	*Elimination*	(434,817)	(432,952)	(1,865)	(715,366)
1,031	1,034	(3)	*Governance*	7,315	7,239	76	15,085
123,134	**123,954**	**(820)**	***Total***	**866,953**	**868,979**	**(2,026)**	**1,441,400**

Provider: unfavourable for the month of January. The main drivers for the current month's variance are:

- ***Government Revenue*** CTA Nursing timing of revenue to budget, ACC revenue phasing reflects a variance for the month; Integrated care additional income for Mana Kids programmes (offset by cost); No additional revenue was taken up for Acute Spines in Jan15.
- ***Patient/Consumer Sourced;*** There were no Tahitian burns patients that presented in January, this is offset against Non-resident additional billings for the month (offset by bad debts).
- ***Other Income;*** Interest received is above budget for the month; donation revenue delay in project uptake; Pharmac rebate transferred to Clinical Support division.
- ***Funder Payments;*** Variation in revenue phasing from Funder for contracts outside base funding ie: 20k days and localities

Staff Costs

Month Act	Month Bud	Month Var.	$000	YTD Act	YTD Bud	YTD Var.	Full Yr. Bud
43,950	45,763	1,813	Provider	309,214	314,433	5,219	519,227
651	674	23	Governance	5,184	4,719	(465)	9,898
44,601	**46,437**	**1,836**	**Total**	**314,398**	**319,152**	**4,754**	**529,125**

Month Act	Month Bud	Month Var.	$000	YTD Act	YTD Bud	YTD Var.	Full Yr. Bud
14,070	14,757	687	Medical	98,611	101,866	3,255	169,096
17,292	17,255	(37)	Nursing	118,840	117,165	(1,675)	197,975
6,201	6,821	620	Allied Health	45,203	47,065	1,862	77,878
2,089	2,019	(70)	Support Personnel	14,260	14,196	(64)	21,966
4,949	5,585	636	Management Admin	37,484	38,860	1,376	62,210
44,601	**46,437**	**1,836**		**314,398**	**319,152**	**4,754**	**529,125**

- **Provider:** reflects a deliberate strategy to balance overall 2014/15 budget expectations. Vacancies across the organisation (representing 3.7% of budget FTE) have been part offset by internal bureau, overtime, casual staff and funded FTE's. A favourable net annual leave variance/other is part offset by stat days in lieu (, sick leave and study leave. For more details see FTE report later in the report.

Outsourced Services

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
651	461	(190)	*Medical*	4,544	3,238	(1,306)	4,860
206	37	(169)	*Nursing*	978	265	(713)	549
50	70	20	*Allied Health*	369	492	123	768
44	38	(6)	*Support*	292	265	(27)	444
230	162	(68)	*Management/Administration*	2,057	1,107	(950)	1,486
1,181	768	(413)	***Total Personnel***	8,240	5,367	(2,873)	8,107
2,657	2,544	(113)	*Corporate & Funder Services*	18,650	17,838	(812)	28,296
1,999	1,299	(700)	*Clinical Service*	11,285	9,901	(1,384)	18,864
5,837	**4,611**	**(1,226)**	***Total***	**38,175**	**33,106**	**(5,069)**	**55,267**

- **Provider:** are unfavourable for January (includes personnel, clinical and other).
  Integrated Care is the main contributor. The Mana Kids Programme (Rheumatic Fever) costs overspend is offset by additional revenue from MoH.
  Surgical Services, Outsourced surgical procedures continue to maintain the MoH ESPI 120 day targets.
  Mental Health. The service employed locum medical staff due to a national shortage of psychiatrists (part offset by favourable personnel costs).
  Kids & Womens. External bureau to address skill mix issues within the service.
  Medicine. External bureau used to cover annual leave and increase spend in initiatives (Sleep, Gastro, Nuerology).
- *Other Non-Clinical Outsourcing*.

Independent Service Provider ***(Demand driven expenditure)***

Month			***Major Categories***	YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
			Personal Health				
21,187	20,857	(330)	*IDF Personal Health*	145,833	145,997	164	245,784
9,014	8,350	(664)	*Pharmaceuticals*	59,646	58,447	(1,199)	99,096
7,079	6,976	(103)	*Primary Practice Services – Capitated*	49,613	48,831	(782)	81,144
611	575	(36)	*Child and Youth*	4,142	4,029	(113)	5,767
463	465	2	*Adolescent Dental Benefit*	3,265	3,256	(9)	5,664
266	247	(19)	*Chronic Disease Management and Education*	1,590	1,728	138	5,772
374	361	(13)	*Palliative Care*	2,621	2,528	(93)	4,332
343	426	83	*General Medical Subsidy*	2,401	2,985	584	4,176
1,291	1,993	702	*Other*	10,945	13,946	3,001	16,603
40,628	**40,250**	**(378)**	***Total Personal Health***	**280,056**	**281,747**	**1,691**	**468,338**

Other: is change in coding in budgeting between Personal Health and Mental health other.

			Mental Health				
1,226	1,226	-	IDF Mental Health	8,580	8,580	-	13,824
827	916	89	Community Residential Beds & Services	5,865	6,415	550	11,232
684	689	5	Other Home Based Residential Support	4,905	4,820	(85)	8,280
320	320	-	Dual Diagnosis – Alcohol & Other Drugs	2,221	2,243	22	3,636
272	272	-	Crisis Respite	1,903	1,903	-	3,267
357	326	(31)	Child & Youth Mental Health Services	2,491	2,289	(202)	3,561
175	164	(11)	Kaupapa Maori Mental Health Services - Community	1,221	1,148	(73)	1,975
160	185	25	Mental Health Community Service	1,078	1,296	218	1,785
410	741	331	Other	2,718	5,184	2,466	13,086
4,431	**4,839**	**408**	**Total Mental Health**	**30,982**	**33,878**	**2,896**	**60,646**

			Disability Support Services				
4,280	4,341	61	Residential Care: Hospitals	29,270	30,386	1,116	49,707
1,840	2,035	195	Residential Care: Rest Homes	13,245	14,245	1,000	23,076
1,567	1,730	163	Home Support	11,931	12,115	184	20,116
1,409	1,421	12	Other	10,059	9,947	(112)	15,808
9,096	**9,527**	**431**	**Total Disability Support Services**	**64,505**	**66,693**	**2,188**	**108,707**

57	**114**	**57**	**Total Public Health**	**791**	**803**	**12**	**852**
115	**123**	**8**	**Total Maori Health**	**780**	**856**	**76**	**1,308**
54,327	**54,853**	**526**	**Funder**	**377,114**	**383,977**	**6,863**	**639,851**

Note: this cost area has a Revenue/Cost match methodology i.e. as costs are incurred; Revenue is allocated, with a year end wash-up. Revenue currently is similarly down under Revenue: Funder.

Clinical Supplies

Month Act	Month Bud	Month Var.	$000	YTD Act	YTD Bud	YTD Var.	Full Yr. Bud
3,366	3,007	(359)	*Treatment Disposables*	25,129	23,221	(1,908)	40,569
632	581	(51)	*Diagnostic Supplies & Other Clinical Supplies*	5,044	4,378	(666)	7,345
917	883	(34)	*Instruments & Equipment*	7,625	6,779	(846)	11,786
289	240	(49)	*Patient Appliances*	2,073	1,843	(230)	3,217
1,244	1,131	(113)	*Implants & Prostheses*	9,648	9,016	(632)	15,983
1,225	1,202	(23)	*Pharmaceuticals*	9,770	8,551	(1,219)	14,582
158	289	131	*Other Clinical Supplies*	1,899	2,079	180	3,558
7,831	7,333	(498)	***Total***	61,188	55,867	(5,321)	**97,040**
			Explained by:				
			Volume greater than budget	(725)		(725)	
(91)		(91)	***Non Residents***	(609)		(609)	
(472)		(472)	***Saving targets***	(2,639)		(2,639)	
			PCT Revenue	(2,004)		(2,004)	
7,268	**7,333**	**65**	***Operational costs***	**55,211**	**55,867**	**656**	

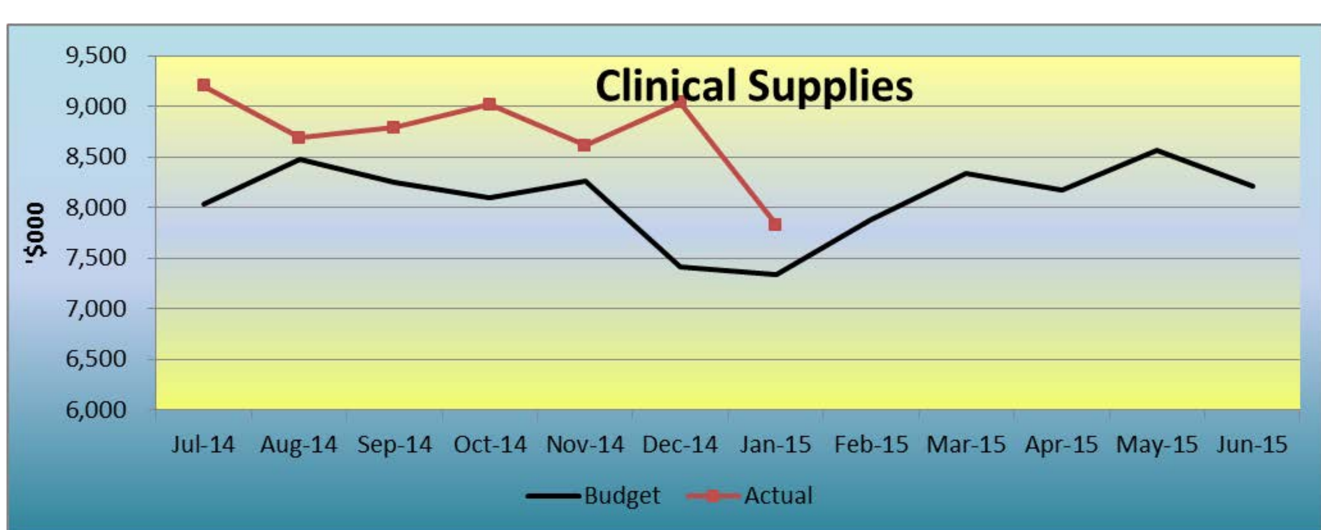
- **Provider:** unfavourable for the month.

  Delayed target procurement savings across the services are partially offset in other cost and revenue areas.

  Clinical Support. Drugs usage reduction based on surgical services volumes.

  Surgical Services. Use of stock piled inventory on hand during January.

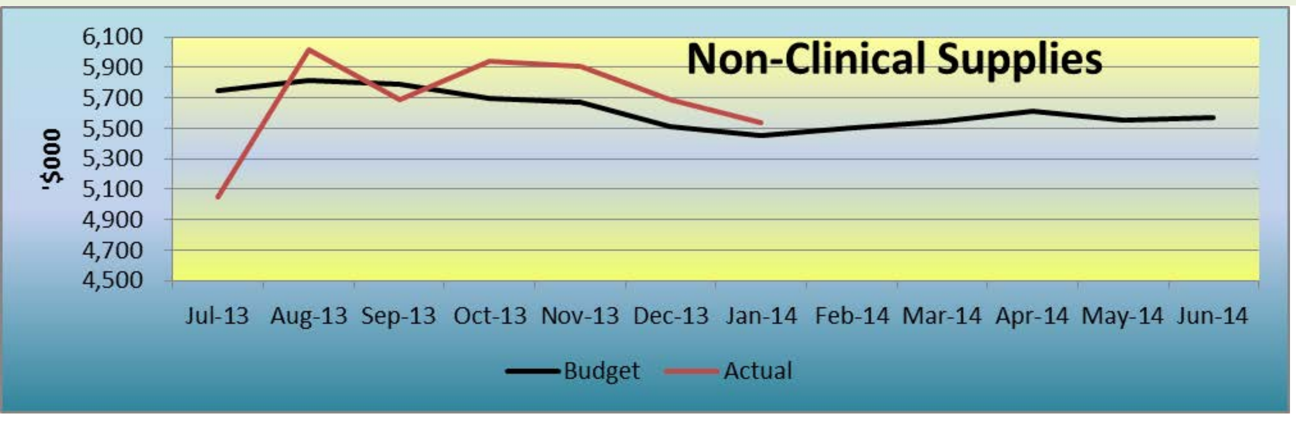
  Non-Clinical. Patient transport and lodging agreement with NTA (MoH National Transport and Accommodation) is favourable to budget reflecting a reduction in the number of patients that required transport in January. Ambulance/Air Ambulances costs were favourable for the month and Health Promotion costs were underspent.



Non-Clinical / Infrastructure (excluding Interest and Capital Charge)

Month				YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
5,208	5,156	(52)	*Provider*	36,809	37,615	806	89,056
328	295	(33)	*Governance*	3,030	2,061	(969)	4,053
5,536	5,451	(85)	***Total***	39,839	39,676	(163)	**93,109**

- **Provider:** unfavourable for January. The main expense drivers for the month are: Delayed target laundry procurement savings across the services
- Governance: Professional fees for project SWIFT



Interest and Capital Charge

Month				YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
244	**100**	**144**	*Interest - Received*	1,905	**700**	**1,205**	**1,200**
1,083	1,280	197	*Interest Paid - Debt*	7,511	8,960	1,449	13,450
839	**1,180**	**341**	***Net Interest Paid***	**5,606**	**8,260**	**2,654**	**12,250**
1,159	1,095	(64)	*Capital Charge*	8,672	7,665	(1,007)	12,996

- **Interest cost:** CMDHB level of borrowings is lower than budgeted delivering a $197k favourable interest cost variance for the month.
- **Capital Charge:** Timing of top up payments expected but not confirmed until March.

Ratios

Provider Arm (only)

Costs to Revenue (%) last six months

	Jan 15	Dec 14	Nov 14	Oct 14	Sep 14	Aug 14	July 14
Medical	20.85	20.81	20.05	21.03	20.61	20.29	20.56
Nursing	25.68	24.89	24.66	25.32	24.43	24.17	24.93
Allied	9.23	9.61	9.33	9.59	9.56	9.36	9.66
Support	3.11	3.13	2.96	3.03	2.88	2.89	2.93
Management	6.52	7.18	6.60	6.95	7.04	6.76	7.20
Personnel	**65.39**	**65.62**	**63.60**	**65.92**	**64.52**	**63.47**	**65.28**
Outsourced Pers.	1.85	2.10	2.01	1.73	2.01	1.67	1.62
Total Personnel	**67.23**	**67.72**	**65.61**	**67.65**	**66.53**	**65.14**	**66.90**
Outsourced Clinical Services	2.97	2.15	2.21	2.70	2.11	2.37	2.05
Outsourced Corp (hA)	3.70	3.61	3.72	3.60	3.71	3.80	3.50
Clinical Supplies	**12.99**	**14.38**	**13.95**	**14.51**	**14.34**	**13.94**	**14.90**
Infrastructure	13.77	13.21	13.74	14.42	14.06	14.52	13.12
Total	**100.66**	**101.09**	**99.23**	**102.88**	**100.75**	**99.76**	**100.47**

Provider cost as a percentage of revenue over the last four years and year to date

	2015 YTD	2014	2013	2012	2011
Medical	20.6	20.7	21.2	20.5	20
Nursing	24.9	25.1	25.5	24.7	24.3
Allied Health	9.5	9.7	9.7	9.5	9.2
Support	3.0	2.9	2.7	2.7	2.6
Man/Admin	6.9	6.8	7.2	7.8	7.7
Personnel	**64.8**	**65.2**	**66.3**	**65.2**	**64.0**
Outsourced Personnel	1.9	1.8	1.8	1.7	1.9
Total Personnel	**66.7**	**67.0**	**68.1**	**66.9**	**65.9**
Outsourced Clinical Supplies	2.4	2.7	2.9	2.8	3.4
Outsourced Corporate	3.7	3.7	3.4	3.3	2.4
Clinical supplies	14.1	14.0	14.4	14.7	14.6
Infrastructure	13.8	13.0	12.4	13.2	13.8
Total	**100.7**	**100.4**	**101.2**	**100.9**	**100.0**
Depn	4.0	3.8	3.1	2.8	3.6
Int	1.6	1.1	1.5	1.3	1.4
Capital Charge	1.8	1.7	1.7	1.7	1.7

Balance Sheet

		Actual	Budget	Variance	Opening 1st July 14	YTD Movement
Current Assets						
	Petty Cash	10	10	-	10	-
	Bank [1]	1,319	2,868	(1,549)	20,705	(19,386)
	Trust	876	860	16	865	11
	Prepayments	692	500	192	1,196	(504)
	Debtors	37,823	42,000	(4,177)	32,887	4,936
	Inventory	2,074	4,490	(2,416)	1,434	640
	Assets Held for Sale	12,503	12,503	-	12,503	-
Total current Assets		**55,297**	**63,231**	**(7,934)**	**69,600**	**(14,303)**
Fixed Assets						
	Land	110,020	62,430	47,590	110,020	-
	Buildings & Plant	612,602	731,380	(118,778)	710,607	(98,005)
	Investment Property	1,360	1,360	-	1,360	-
	Information Technology	2,745	2,955	(210)	4,145	(1,400)
	Information Software	323	780	(457)	4,391	(4,068)
	Motor Vehicles	3,932	4,508	(576)	4,292	(360)
	Total Cost	**730,982**	**803,413**	**(72,431)**	**834,815**	**(103,833)**
	Accum. Depreciation	(139,793)	(217,260)	77,467	(195,671)	55,878
	Net Cost	**591,189**	**586,153**	**5,036**	**639,144**	**(47,955)**
	Work In-progress	4,787	10,000	(5,213)	1,851	2,936
Total Fixed Assets		**595,976**	**596,153**	**(177)**	**640,995**	**(45,019)**
Investments (hA IT / HBL)		29,349	27,250	2,099	27,127	2,222
Total Assets		**680,622**	**686,634**	**(6,012)**	**737,722**	**(57,100)**
Current Liabilities						
	Creditors	80,367	95,816	(15,449)	91,817	(11,450)
	Income in Advance [1]	13,297	1,300	11,997	3,192	10,105
	GST and PAYE	(8,587)	5,000	(13,587)	6,761	(15,348)
	Loans (Crown and HBL shared banking)	40,000	40,000	-	40,000	-
	Payroll Accrual & Clearing	36,077	27,049	9,028	32,452	3,625
	Employee Provisions	77,296	81,400	(4,104)	81,249	(3,953)
Total Current Liabilities		**238,450**	**250,565**	**(12,115)**	**255,471**	**(17,021)**
Working Capital		(183,153)	(187,334)	4,181	(185,871)	2,718
Net Funds Employed		**$442,172**	**$436,069**	**$6,103**	**$482,251**	**$(40,079)**
Non-Current Liabilities						
	Term Loans	227,600	227,600	-	227,600	-
	Employee Provisions (non-current)	16,778	15,300	1,478	16,984	(206)
	Trust and Special Funds	872	860	12	864	8
	Insurance Liability- Non Current	1,337	1,300	37	1,337	-
Total Non-Current Liabilities		**246,587**	**245,060**	**1,527**	**246,785**	**(198)**
Crown Equity						
	Crown Equity	124,497	124,498	(1)	124,497	-
	Revaluation Reserve	134,373	127,443	6,930	175,031	(40,658)
	Retained Earnings – Provider	(77,812)	(77,171)	(641)	(74,511)	(3,301)
	Retained Earnings – Govern.	(19,611)	(16,644)	(2,967)	(18,151)	(1,460)
	Retained Earnings - Funder	34,138	32,883	1,255	28,600	5,538
Total Crown Equity		**195,585**	**191,009**	**4,576**	**235,466**	**(39,881)**
Net Funds Employed		**$442,172**	**$436,069**	**$6,103**	**$482,251**	**$(40,079)**

Commentary

Net borrowings: Long and short term debt less bank balance is $1.5m higher than budget, due to all DHB's received funding for January 15 on the last day of December (this had not happened for 4 years) and GST being paid out earlier. A stronger closing cash position, opening position $20.7m higher than budgeted and not drawing down on the final $30m facility for CSB.

Debtors: $4.7m lower than budget, $4.9m higher than June 14 due to timing of payments mainly by Crown organisations (MOH ACC and other DHB's).

MOH Debtors $000	**Total**	**Current**	**30 day +**
Invoiced	7,427	4,272	3,155
Accrued	211		
Total	**7,638**		

Accounts payable: $15.4m lower than budget and $11.4m lower than June 2014.

Net Fixed Assets: This level is $0.2m lower than budget. Due to the revaluation on Buildings there is movement between accumulated depreciation and Buildings Plant and Equipment of $72m. Also buildings were devalued by $40m in June 2014.

Investments in Associates:
Health Benefits Ltd, $ 7.5m for the FPSC project.
Note: we will need to continue to ensure that these investments have underlying value through the future success of HBL or its successors.
healthAlliance, $21.6m for ICT capital investment.

Payroll Accrual & Clearing: due to timing of payroll cut offs.

Income in Advance: due to all DHB's received funding for January 15 on the last day of December.

There are no other significant issues regarding the Balance Sheet

Cash flow

	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Cash flows from operating activities:						
Crown Revenue	3,976	121,051	(117,075)	851,175	846,479	4,696
Other	2,301	2,440	(139)	19,686	17,116	2,570
Interest rec.	244	100	144	1,905	700	1,205
Expenses						
Suppliers	101,529	76,585	(24,944)	552,566	510,298	(42,268)
Employees	45,816	41,194	(4,622)	314,932	319,252	4,320
Interest paid	1,083	1,281	198	7,511	8,963	1,452
Capital charge	-		-	-		-
Net cash from Operations	**(141,907)**	**4,531**	**(146,438)**	**(2,243)**	**25,782**	**(28,025)**
Fixed Assets	(1,152)	(1,966)	814	(14,918)	(15,821)	903
Investments (hA & HBL)	-	(249)	249	(2,222)	(2,766)	544
Restricted & Trust Funds	-	(1)	1	8	1	7
Net cash from Investing	**(1,152)**	**(2,216)**	**1,064**	**(17,132)**	**(18,586)**	**1,454**
Debt	-	-	-	-	-	-
Other non-current liability	-	-	-	-	-	-
Net cash from Financing	-	-	-	-	-	-
Net increase / (decrease)	**(143,059)**	**2,315**	**(145,374)**	**(19,375)**	**7,196**	**(26,571)**
Opening cash	145,264	1,423	143,841	**21,580**	(3,458)	25,038
Closing cash	**2,205**	**3,738**	**(1,533)**	**2,205**	**3,738**	**(1,533)**

Summary	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Opening cash	145,264	1,423	143,841	21,580	(3,458)	25,038
Operating	(141,907)	4,531	(146,438)	(2,243)	25,782	(28,025)
Investing	(1,152)	(2,216)	1,064	(17,132)	(18,586)	1,454
Financing	-	-	-	-	-	-
Closing cash	**2,205**	**3,738**	**(1,533)**	**2,205**	**3,738**	**(1,533)**

Commentary:

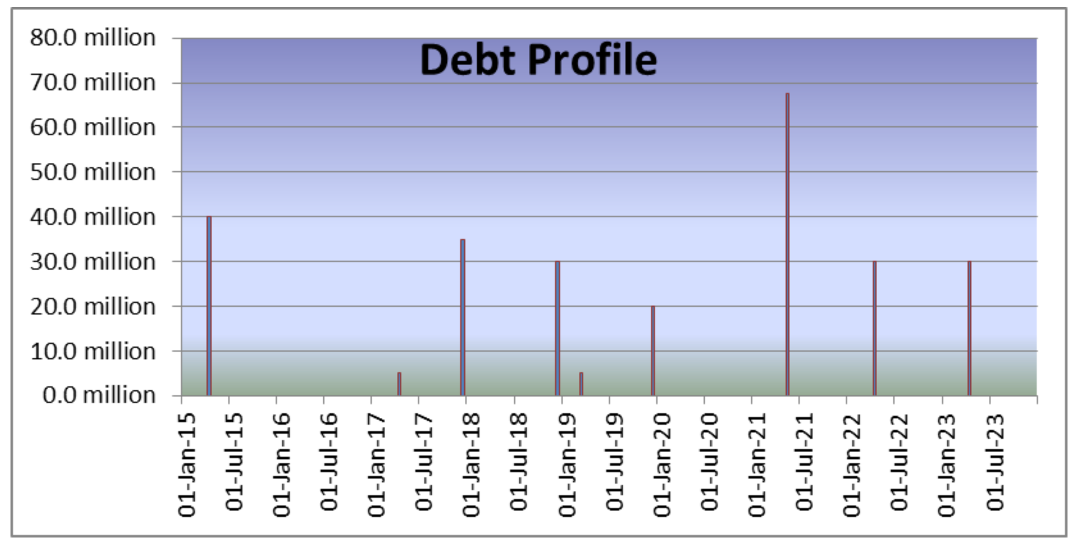
Cash from Operations

Timing due to funding: All DHB's received funding for January 15 ($120m) on the last day of December (this had not happened for 4 years). Therefore December saw two monthly funding deposits in the month and no funding in January. The other implication of receiving the early funding is that double GST had to be paid in January and the organisation will receive a very large credit in February.

Treasury
All term debt facilities are now through the MOH, with interest rates "locked in" at fixed rates. Working capital facilities remain with Westpac via Health Benefits Ltd ($64.4m). Both ASB/Commonwealth Bank ($10.0m) and Westpac ($10.0m) lease facilities are allowable by the Crown.

Crown Debt

Drawn ($ millions)	Date of Advance	Maturity	Interest rate	Rate
40.0*	17-Sep-07	15-Apr-15	6.33%	Fixed, Semi-Annual
5.0	16-Jul-12	15-Apr-17	3.32%	Fixed, Semi-Annual
15.0	15-Jul-08	15-Dec-17	6.36%	Fixed, Semi-Annual
10.0	28-Jan-09	15-Dec-17	4.41%	Fixed, Semi-Annual
5.0	03-Feb-09	15-Dec-17	4.41%	Fixed, Semi-Annual
5.0	20-May-09	15-Dec-17	5.65%	Fixed, Semi-Annual
10.0	30-Apr-10	15-Dec-18	5.88%	Fixed, Semi-Annual
20.0	20-Mar-13	15-Dec-18	3.30%	Fixed, Semi-Annual
5.0	15-Nov-11	15-Mar-19	5.13%	Fixed, Semi-Annual
13.0	27-Oct-09	15-Dec-19	6.10%	Fixed, Semi-Annual
7.0	27-Oct-09	15-Dec-19	6.10%	Fixed, Semi-Annual
5.0	20-Jun-12	15-May-21	3.45%	Fixed, Semi-Annual
42.6	29-Jun-12	15-May-21	4.22%	Fixed, Semi-Annual
20.0	18-Dec-12	15-May-21	3.56%	Fixed, Semi-Annual
30.0	15-Apr-13	15-Apr-22	3.45%	Fixed, Semi-Annual
30.0	20-Dec-13	15-Apr-23	4.91%	Fixed, Semi-Annual
5.0	20-May-09	15-Apr-23	4.74%	Fixed, Semi-Annual
$267.6			**4.76%**	**Weighted Average**



* We are unable to implement a Forward Rate Agreement until six months from maturity, but will be approaching the market in January / February 2015

FTE Reporting

Consolidated Statement of Personnel By Professional Group - January 2015	Month			Comparative	Year to date		
	Actual FTE	Variance FTE	Variance $000's	Variance to Prev Mnth	Actual FTE	Variance FTE	Variance $000's
Medical Personnel	754	30 F	$712 F	↑	769	21 F	$3,408 F
Nursing Personnel	2,535	(6) U	$(33) U	↑	2,581	(34) U	$(1,656) U
Allied Health Personnel	991	137 F	$611 F	↑	1,074	51 F	$1,804 F
Support Personnel	472	(2) U	$(71) U	↑	477	(2) U	$(65) U
Management/Administration Personnel	710	119 F	$594 F	↑	768	60 F	$1,727 F
Total (before Outsourced Personnel)	**5,462**	**279 F**	**$1,814 F**	↑	**5,669**	**96 F**	**$5,218 F**
Outsourced Medical	23	(8) U	$(212) U	↑	23	(8) U	$(1,458) U
Outsourced Nursing	18	(15) U	$(169) U	↑	12	(9) U	$(713) U
Outsourced Allied Health	4	2 F	$21 F	↓	4	1 F	$123 F
Outsourced Support	8	(1) U	$(6) U	↓	8	(1) U	$(27) U
Outsourced Mangement/Admin	36	1 F	$7 F	↑	47	(11) U	$(611) U
Total Outsourced Personnel	**90**	**(21) U**	**$(360) U**	↑	**95**	**(27) U**	**$(2,688) U**
Total Personnel	**5,552**	**257 F**	**$1,454 F**	↑	**5,764**	**69 F**	**$2,530 F**

The January favourable FTE variance reflects the FTE accrual methodology as it relates to the Christmas/New Year period that will be processed in February. Budget phasing includes the statutory day and stat day credits in the month the statutory day occurs. The expectation is that the favourable variance will negate in February.

- ***Medical personnel*** are favourable by 30FTE, $712k. This represents vacancies 19FTE, of which Mental Health has 9 vacancies due to a national shortage of psychiatrists (covered by locums), and Surgical Services 5FTE. Stat days in lieu, sick leave and overtime/casuals account for (20)FTE. 36FTE is mainly explained by a high incidence of annual leave taken during the Christmas/New Year period (includes a portion of annual leave paid out) and an estimated benefit from delayed recognition of statutory day credits.

- ***Nursing personnel*** are unfavourable by (6)FTE, $(33)k. This is attributable to 54FTE vacancies, primarily offset by overtime (24)FTE, internal bureau (48)FTE, casuals (16)FTE, net annual leave 57FTE, sick/study leave (34)FTE and estimated benefit from delayed recognition of statutory day credits 45FTE. Unbudgeted funded projects account for (13)FTE, stat days in lieu (24)FTE.

  Monthly target savings from the nursing and bed day initiatives amount to an estimated $150k per month. Refer to DON update on nursing project commenced in November.

- ***Allied Health personnel*** are favourable by 137FTE, $611k. High levels of vacancies exist within Allied Health of 61FTE. These vacancies have been partially covered by overtime and casuals (14)FTE, net annual leave 52FTE and estimated benefit from delayed recognition of statutory day credits 60FTE. Additional Funded FTE accounts for (18)FTE.

- ***Support personnel*** are unfavourable by (2)FTE, $(71)k reflecting 19FTE vacancies, offset by use of casuals (14)FTE, overtime (7)FTE and net annual leave (1)FTE.

- ***Management and Administration personnel*** are favourable by 1FTE, $7k primarily reflecting existing vacancies across the organisation 58FTE, partially offset by casuals (12)FTE. Additional Funded FTE accounts for (5)FTE and estimated benefit from delayed recognition of statutory day credits 48FTE.

Personnel Costs per FTE

(Rolling average)

	Jan 15	**Dec 14**	**Nov 14**	**Oct 14**	**Sep 14**	**Aug 14**	**July 14**	**June 14**
Medical	166,122	166,148	166,418	166,387	165,785	165,500	165,650	165,536
Nursing	76,784	76,853	77,041	77,028	76,879	76,537	76,674	76,560
Allied Health	70,776	70,790	70,538	70,320	70,283	70,062	70,088	70,141
Mgmt/Admin/Clerical	73,223	73,120	72,714	72,318	72,394	72,020	71,974	71,629
Support	50,351	50,570	50,259	50,206	50,369	50,207	50,346	50,369

The table below shows the Management Admin cap return to the MoH each month.

Counties Manukau Only	**Jan 15**	**Dec 14**	**Nov 14**	**Oct 14**	**Sep 14**	**Aug 14**
Accrued FTE (as per MOH template)	760.7	818.8	854.5	817.0	846.2	839.1
Annual Leave loading	(75.9)	(75.8)	(75.6)	(75.7)	(77.0)	(76.7)
FTE's on holiday	158.6	98.8	61.0	99.5	81.6	89.8
Payroll FTE's	843.4	841.8	839.9	840.8	850.8	852.2
Contractors / Consultants (FTE equivalent)	11.0	11.0	11.0	11.0	11.0	11.0
Vacancy	13.1	14.7	16.6	15.7	5.7	4.3
Total	867.5	867.5	867.5	867.5	867.5	867.5
Number submitted Jan 09 for 31 Dec 08	867.5	867.5	867.5	867.5	867.5	867.5
Variance	-	-	-	-	-	-

Ko Awatea

Ko Awatea delivers a comprehensive portfolio of organisational support functions including data analysis and support, Learning and Development, Workforce, Libraries, Quality Improvement, Research Office and research support, Digital services, clinical simulation, evaluation and knowledge management. Ko Awatea has created a very significant change capability, locally, regionally and nationally. Over 750 frontline staff have trained in the model for improvement and had experience in a change project. We have also delivered core leadership training to 80 emerging clinical and non-clinical leaders in our staff and in depth leadership training for 16 Counties emerging leaders. We are in discussions with the Leadership Institute led by Dr Lester Levy to develop a joint program for leadership for Doctors. Regionally and nationally we have led training of Improvement advisors in every DHB, and engaged them in an active network. Additionally we have built capability and capacity for change and improvement through regional and national campaigns (see below).

Ko Awatea acts as an engine for transformation primarily locally, but also regionally and nationally, with a strategy of building 'will', harvesting and generating 'ideas', and efficiently 'executing change'.

The vision for Ko Awatea is "Learning globally, impacting locally" and our mission is to "improve together to ensure Counties has the best healthcare system in Australasia by December 2015."

Key themes of this transformation work currently include:

- Education and capacity/capability building
- Collaborative improvement
- Networking resources
- Spreading organising skills and practice to support our community
- Reshaping knowledge, data and decision support infrastructure to be fit for 21st century
- Building rapid improvement skills and discipline into frontline
- Building leadership
- Community organising
- Creating an education centre that provides a space conducive to learning
- Building a workplace that reflects our community

In addition to these functions Ko Awatea is also charged with generating revenue for the District Health Board.

We will highlight one key area of our activity in each report:

This month we would like to focus on library services and knowledge management.

'Shared knowledge empowers communities and transforms lives'.

By the provision of excellent resources and services to support ubiquitous access to information and knowledge resources by Counties Manukau Health staff, partners and stakeholders, the Counties Manukau Health Library enables knowledge sharing, collaboration and knowledge creation.

A review of library services in 2014 expanded the role of the library from knowledge discovery and access to collections for clinical staff to provision of resources and services that enable knowledge sharing, collaboration and knowledge creation across clinical, allied health, project and primary care teams. Proactive development and curation of targeted resources and embedded research and project support are cornerstones of the new vision.

High level priorities identified in the review include:

- Redefining librarian roles to emphasise: capability building and empowerment of users; embedded support and collaboration with departments, teams and projects; and alignment with strategic institutional objectives and priorities
- Utilising technology to ensure library systems and processes for managing and providing ubiquitous access to resources are fit for purpose
- Exploring opportunities for high level collaboration and cooperation between Northern Regional DHB partner libraries and Health Alliance in relation to rationalisation of ICT infrastructure, the procurement of resources and the delivery of services
- Engaging with PHOs in Counties Manukau to improve access to information and resources to our partners and stakeholders.
- Strengthening the integration and flow of information and resources between clinicians and academics and between primary and secondary health care providers and the community.

Latest technologies and practices will be utilised to provide ubiquitous (24/7 and mobile) access to resources and to allow personalisation/customisation of each user's information environment. The focus is on provision of seamless access and creating a culture of self-reliance of users, removing dependence upon intermediaries for simple knowledge discovery and access.

A greater emphasis has been placed upon provision of high level research support to CM Health projects, research and development.

Embedded library information specialists are actively supporting CM Health priorities including: Health literacy; Project Swift; Maaori Health; Pacific Health; Enabling High Performing People; Patient and Whaanau Centred Care; and Manaaki Hauora – Supporting Wellness.

Resource and Technology Initiatives completed in 2014 include:

- Migration of all print journal collections to 24/7 online access and enabling seamless access to the full text collection via Google scholar, Uptodate and pubmed. Expansion of the library's e-book collection to more than 1300 titles

- Development of customised online resource collections to support the work of teams and projects across more than twenty-five clinical and allied health specialties

- Renegotiation of contracts and agreements with vendors to provide remote access to online databases, journals, e-texts and clinical guidelines to our PHOs. This collection currently includes Medline Complete, CINAHL Compete, and ClinicalKey and is accessible to PHOs via the MyAthens online gateway

- Development of a library website to support enhanced access to health information resources for patients and the community including the creation of online clearinghouses to support Māori and Pacific health research - *see* http://www.healthpoint.co.nz/public/other/counties-manukau-health-library-database/

Current Initiatives include:

- Working closely with Health Alliance network managers and architects to implement new protocols for internet access to online library resources to ensure better redundancy across ADHB, Waitemata DHB and Counties Manukau Health and to reduce duplication between the three DHBs

- Discussions with the Ministry of Health in regards to a possible takeover of management of the Health Improvement and Innovation Resource Centre (HIIRC) portal by Ko Awatea

- Exploring options for migration to a new library management software solution to improve efficiencies and provide an enhanced user experience. The new solution will include a seamless discovery layer providing integrated access to all digital resources, mobile access and the potential for integration with other DHB library collections

Knowledge Management is part of a new suite of capabilities available within Ko Awatea. The Library is making significant progress in moving away from an old-fashioned, reactive model, to being a greater enabler for knowledge management and dissemination across the organisation. At the same time, three key new capabilities within the Health Intelligence and Informatics (HII) team will help to advance toward our aim of being a learning organisation.

The wider HII team have been reconfigured to focus on an end-to-end pathway, starting from a new idea (generated, for example, by data mining or data discovery), to scoping and design of a research or evaluation project, right through to formal dissemination of findings. Underpinning all of this are the tools we can leverage to tie it all together. This is the job of the Knowledge Manager, who has already achieved the following:

- Development of a collaboration platform based on SharePoint, to enable and facilitate knowledge sharing, project oriented document management, brainstorming ideas, FAQ's, etc.
- Development of a new platform for managing, monitoring and facilitating the process of requests for information and reports to the analyst team. This can be viewed at any time by anyone in the organisation.
- Development of a new platform for the Patient Safety department that provides a comprehensive solution for the Point of Care Measurement for Safety. This significantly reduces the manual workload of this team, and facilitates much higher data integrity – as well as the ability to produce interactive reports.

All of this has been achieved with existing resources, and readily demonstrates the value of being able to focus on identifying and practically mitigating real-world problems – and having the ubiquitous software and tools available to implement a solution. With greater access to such tools, even more could be achieved with no additional capital.

The Ko Awatea Research and Evaluation Office was set up after a consultation process in late 2014. This team features seven individuals who have a mandate to engage in primary research and evaluation activity across the organisation. This forms a key part of the knowledge management pathway by enabling us to engage in health services research and, more importantly, to make sure that local improvement initiatives are evaluated in a robust manner and we can publicise these results. This team has already completed evaluations for CMH on the Medical Assessment Unit, pilot of Physician Assistants, and has around 25 current pieces of work and is at the same time engaged in two external funding bids to generate revenue.

Finally, the engagement of a professional academic writer is explicitly about increasing our dissemination across the organisation and focusing on how to ensure both that our work is recognised, and that others can learn from it. In the space of one year, the Writer has been pivotal in completion of health system improvement guides, preparation of scientific posters for APAC, publication of several journal articles, improvement case reports, development of promotional material and has worked hard to improves our capability and processes around dissemination.

4.0 Compliance

4.1 There are no major compliance issues this month. The latest Health & Safety Audit, which was reported to ELT, is included below for info.

<u>Management of Hazardous Substances</u>

The independent audit of the CMH Hazardous Substance Management System including the storage of Hazardous Substances was concluded in January 2015.

A draft written report of this work, which was Phase 1 of 2 has been submitted and tabled for discussion and feedback with key stakeholders and the auditors on the 11th February 2015.

A copy of the Executive Summary of the audit provided by the Auditors is available for reference and will provide additional background to this paper and summary.

In summary:

1. The management of hazardous substances remains a risk to the organisation and remains on the risk register
2. A paper has been submitted to the appropriate members of the Executive Leadership Team (copy attached as Appendix 2) outlining next steps and approximate cost impact that are to be undertaken in order for CMH to achieve and maintain compliance especially once the new Health and Safety legislation is implemented. (The costs indicated are approximate and will be confirmed once the next steps are agreed by the Executive Leadership Team and Board, as appropriate.) CAPEX and OPEX arrangements are to be considered in the 15/16 Budget Planning processes.
3. An immediate action item is the confirmation that the next steps as defined by the audit report can be progressed.
4. It is also recommended that a strategic approach is implemented to manage Hazardous Substances in the future within CMH. As a result of the changing Health and Safety legislation, the focus on Hazard Substances must be reviewed to ensure that CMH does not repeat the non-compliance and non-certification challenges we have had to reactively remedy in recent months. A dedicated resource and skilled team should be considered as a stand-alone function to ensure dedicated and consistent risk management and ongoing compliance in the future.
5. There is the possibility that other District Health Boards will have the same issue in relation to the management of Hazardous Substances and this could present the opportunity for CMH to leverage the work and cost, if appropriate.
6. The initial high risk issues have ongoing remedial activities in place and is progressing according to plan.

HASNO Audit – Initial High Risk Remedial Activities Update

<table>
<tr><th>Main Issue(s)</th><th>Plan</th><th>Progress</th><th>Current State</th><th>What still needs to be done</th></tr>
<tr><td colspan="5">Botany Maternity: Main Gas store and manifold</td></tr>
<tr><td rowspan="4">LPG cylinder located in medical gas store.</td><td>Immediate removal of LPG Cylinder</td><td>Completed</td><td rowspan="4">Compliant</td><td rowspan="4">- Full review to be undertaken and completed by NCS
- Findings and outcomes to be communicated to all key stakeholders
- Implementation of corrective action
- Note: An additional issue relating to the fire rating of the store has also been identified and will be addressed in the final report</td></tr>
<tr><td>Incident Investigation undertaken and completed by Non Clinical Support (NSC) with BOC</td><td>Under Way</td></tr>
<tr><td>Agree and approve corrective action</td><td>To be undertaken</td></tr>
<tr><td>Commencement and completion of required work</td><td>To be undertaken</td></tr>
<tr><td colspan="5">AT&R: Main Gas store and manifold</td></tr>
<tr><td rowspan="3">Separation distance/Fire rating of current location /facility storing and using medical gas class 5 substances deemed unsuitable
Update:
Further review of regulations and facility by engineering and HSNO certifier has determined:
• Regulations remain questionable to interpretation.
• Raising queries with WORKSAFE not</td><td>Determine operational requirements (remove gas if possible – relocate to compliant store)</td><td>Operationally feedback confirms a store is required and no removal of gasses is planned (Complete)</td><td rowspan="3">Compliant</td><td rowspan="3">- Following completion of remedial work to the Galbraith and MSC stores further consultation to be undertaken to determine whether CMH raise regulatory interpretation.</td></tr>
<tr><td>Further assessment of the store/manifold location is required to determine how the required modification to achieve fire rating is achieved.
Refer to update</td><td>Complete</td></tr>
<tr><td>Complete work/modifications</td><td>Complete</td></tr>
</table>

recommended at this time Reasonable to consider store as compliant and not require additional mitigation.	Consider further consultation with WORKSAFE regarding interpretation of regulations and required controls.	To be determined		
Main Issue(s)	**Plan**	**Progress**	**Current State**	**What still needs to be done**
Galbraith: Main Gas store and manifold				
1. Fire rating/separation of class 5 substances deemed high risk	Further review of the store is required to determine operational requirements in the future	Complete	Non-Compliant until further work is undertaken	- *Note: Interim measures have not mitigated the requirement for a fire rating.* - Complete review of reticulation system and mitigation plan - Obtain approval and budget allocation - Commence and complete work required
	Confirmed store does not require capacity originally determined. Mitigation plan includes modification of existing CSB pipeline with Galbraith store utilisation to maintain gas system pressure (plan now requires minimal number of cylinders)	Complete		
	Complete reticulated gas system review and mitigation proposal.	Underway		
	Obtain approval for the above work proposal which will meet the separation/fire rating requirements	Underway		
	Complete required work to achieve separation, fire rating and risk mitigation	To be confirmed		
2. Store has no location test certificate – regulatory risk	Store confirmed to only require a capacity well under 200m3, therefore no future requirement to remain a certified store.	Refer to above plan for progress	Compliant	- No further action

Main Issue(s)	Plan	Progress	Current State	What still needs to be done
MSC				
1. Store has no adequate separation of class 5 substances/fire rating deemed high risk	Further review of the store is required to determine operational requirements in the future	Complete	Non-Compliant until further work is undertaken	- *Note: Interim measures have not mitigated the requirement for a fire rating.* - Complete review of the store and site mitigation plan - Obtain approval and budget allocation - Commence and complete work required
	Confirmation store is required. Suitable options to mitigate issues are to be consulted upon.	Underway		
	Complete review and mitigation proposal	Underway		
	Obtain approval for the above work proposal which will meet the separation/fire rating requirements	Underway		
	Complete required work to achieve separation, fire rating and risk mitigation	To be commenced		
2. Store has no location test certificate – regulatory risk	Store confirmed to require a capacity of greater than 200m3. Remedial work to be carried out as described above. Interim measures to remain in place until work completed and certificate obtained.	Refer to above plan for progress	Interim Compliance (*gas volume reduced no location test certification required at this time*)	- Obtain location test certificate once all work completed (only if store/manifold to exceed volume above 200m3 – will be determined by above plan)

Values Refresh

Staff Surveys and Graffiti Boards

- **Online**:
  - www.surveymonkey.com/r/CMDHBvaluesStaff (link via SouthNET homepage)
  - Kiosk
  - CM Health Facebook page

- **Hard copies** available at the blue Values stands in:
  - Wishbone Café, Ko Awatea
  - Outside Everest Café, Middlemore Hospital
  - Outside staff canteen, Manukau Super*Clinic*
  - Main reception desk at Lambie Drive
  - Download from SouthNET or email Monica.Diaz@middlemore.co.nz

- 760 responses
- Survey closes 8 May

Types of Session

- **In Our Shoes**

❖ This session is for <u>all</u> staff to attend and provide feedback on their experiences working at CM Health, to help us understand how we can increase the good days and learn from and improve on the bad experiences. We need 100 staff to attend each *In Our Shoes* session. **Staff are only expected to attend <u>one</u> of the five sessions.**

- **In Your Shoes**

❖ This session is for patients to attend and share the good and bad experiences of the care they received while at CM Health. We need staff to assist in this session in two ways: 1) Be a listener

2) Be a facilitator

Staff can attend multiple sessions.

- **Leading with Values**

❖ This session is for those with leadership roles to build skills to role model and manage values, attitude and behaviours. **Staff are only expected to attend <u>one</u> of the two sessions.**

Values Week
28 April- 4 May

	Tuesday 28 April	
	Session	Room
9.00-10.00	*Powhiri*- ELT	Onsite MMH Marae
10.00-10.30	*Briefing*- ELT	Room 103, Ko Awatea
12.00-2.30	*Facilitator Training*	Room 103, Ko Awatea
2.30-4.00	*In Our Shoes:* Staff	Room 103, Ko Awatea

	Wednesday 29 April	
	Session	Room
9.00-10.30	*Leading with Values:* Leaders	Room 103, Ko Awatea
12.00-2.30	*In Your Shoes:* Pacific Patients	Papakura Pacific Island Presbyterian Church- 153 Dominion Rd, Papakura
3.30-5.00	*In Our Shoes:* Staff	Room 1, Manukau Super*Clinic*

	Thursday 30 April	
	Session	Room
8.30-10.00	*In Our Shoes:* Staff	Main Lecture Theatre, Ko Awatea
10.30-12.00	*In Our Shoes:* Staff	Main Lecture Theatre, Ko Awatea
12.15-1.00	SMO Grand Round TBC	Lecture Theatre
2.30-5.00	*In Your Shoes:* Patients	Room 1, Manukau *SuperClinic*

	Friday 1 May	
	Session	Room
8.30-10.00	*In Our Shoes:* Staff	Main Lecture Theatre, Ko Awatea
10.30-12.00	*Leading with Values:* Leaders	Main Lecture Theatre, Ko Awatea
12.00-1.00	*Coffee with CEO*	Main Lecture Theatre, Ko Awatea
1.30-4.00	*In Your Shoes:* Asian Patients	Main Lecture Theatre, Ko Awatea

	Monday 4 May	
	Session	Room
8.30-11.30	*In Your Shoes:* Maaori Patients	Papakura Marae 29 Hunua Rd, Papukura
12.00-2.30	*In Your Shoes:* Patients	Main Lecture Theatre, Ko Awatea
3:00	*Feedback session:* ELT	Main Lecture Theatre, Ko Awatea

To register contact Adeline Cumings - Adeline.Cumings@middlemore.co.nz - ext. 9650 or Monica Diaz - Monica.Diaz@middlemore.co.nz - ext. 2884 by **Friday 17 April.**

Counties Manukau Health
2014/15 Summary Quarter 2 Report

Recommendations

It is recommended that Board **note** that this report was tabled at the 24 February ELT meeting.

Prepared and submitted by: Dawn Kelly, Planning Advisor on behalf of Margie Apa, Director Strategic Development

1. Purpose

To provide a summary picture of how well we are progressing against our planned commitments outlined in the 2014/15 CM Health Annual Plan.

2. Progress Highlights

Overall, we are on track to meet the commitments outlined in our Annual Plan for Quarter 2. In summary:

- Improved handover processes from GPs to LMCs and WCTO providers are being tested via PDSA cycle.
- A root cause analysis of each confirmed rheumatic fever case is being undertaken and learnings shared with all providers.
- We have implemented the National Child Protection Alert System;
- An action plan to address waitlists for children in state care continued through the Gateway programme has been completed.
- Mental Health SDP - community support services (agreement) active for older adults with all FTEs in place and working well; home based treatment teams working across the community mental health teams which is having a positive effect on inpatient services with no waiting times for acute inpatient beds over the last quarter.

Significant achievements in Quarter 2 include:

- Primary Smoking – ranked 3rd nationally
- CVD Health Target – ranked 2nd nationally

3. Key Issues

- Key challenges experienced in Quarter 2 relate to the new cancer target of patients receiving treatment/management within 62 days of being referred with a high suspicion of cancer and need to be seen within two weeks. As a new target there remain fluctuations in eligible patients under the 62 day target. Close communications continue with our colleagues at the Ministry around this target. Despite this, CM Health is performing well compared with Northern Region DHBs and are one of many DHBs not achieving this target.

Attachment 1: CM Health 2014/15 Quarter 2 Health Target Report – Publication Draft

Note that this is a working draft subject to confirmation on receipt of Ministry of Health's media package.

COUNTIES MANUKAU HEALTH	Shorter stays in Emergency Departments	Improved access to Elective Surgery	Shorter waits for Cancer Treatment	Increased Immunisation	Better help for Smokers to Quit Secondary	Better help for Smokers to Quit Primary	More Heart and Diabetes Checks
Quarter 3, 2013/14	95%	113%	100%	92%	95%	77%	86%
Quarter 4, 2013/14	96%	112%	100%	92%	96%	99%	91%
Achieved	✓	✓	✓	✓	✓	✓	✓
National goal	95%	100%	100%	90%	95%	90%	90%
Quarter 1, 2014/15	95%	111%	100%	94%	95%	98%	91%
Quarter 2, 2014/15	96%	111%	63%*	94%	95%	95%	91%
Achieved	✓	✓			✓	✓	✓
National goal	95%	100%	85%*	95%	95%	90%	90%

* The national cancer target has changed in Quarter 2. The target has changed from *'100% of all patients ready-for-treatment, will wait less than four weeks for radiotherapy or chemotherapy'* to a new target '*working towards 85% (by July 2016) of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks*'.

Quarter 2 Results

Shorter Stays in Emergency Departments – 96% (achieved target)
Target: 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

- 96% of patients seen in ED this quarter were admitted, discharged or transferred from ED within 6 hours.

Improved Access to Elective Surgery – 111% (achieved target)
Target: The volume of elective surgery will be increased by at least 4,000 discharges per year

- The target was to have performed 8,384 elective discharges by this quarter. We have exceeded this by 918 discharges, performing 9,302 elective discharges this quarter.

Faster Cancer Treatment (new target) – 63% (not achieved)
Target: Working towards 85 percent (by July 2016) of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks

- 63% of patients received their first treatment (or other management) within the 62 days of being referred with a high suspicion of cancer in the faster cancer treatment target.

Increased Immunisation – 94% (not achieved)
Target: 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time by December 2014

- 94% of eight-month-olds had their primary course of immunisation at six weeks, three months and five months on time this quarter. This result places the DHB in a good position to achieve the increased end target of 95% of eight month olds fully immunised by April 2015.
    - Maaori coverage 91%
    - Pacific coverage 97%

Better Help for Smokers to Quit –Secondary Care – 95% (achieved target)
Target: 95 percent of patients who smoke and are seen by a health practitioner in public hospitals, are offered brief advice and support to quit smoking

- 95% of patients who smoke and who were seen by a health practitioner in secondary care were offered brief advice and support to quit smoking

Better Help for Smokers to Quit – Primary Care – 95.5% (achieved target)
Target: 90 percent of enrolled patients who smoke and are seen by a health practitioner in primary care will be offered with advice and help to quit

- 95.5% of enrolled patients who smoke and were seen by a health practitioner in primary care were offered brief advice and support to quit

More Heart and Diabetes Checks – 91% (achieved target)
Target: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years

- 91% of the eligible CM Health adult population have had their cardiovascular disease (CVD) risk assessed in the past five years

Attachment 2: CM Health 2014/15 Quarter 2 Summary Progress Report – including MOH RATINGS

The following table is intended for internal review only and aims to provide CM Health leadership with a combined 2014/15 non-financial commitments performance and progress summary; with further detail provided through the Ministry of Health statutory reporting templates (Annual and Maaori Health Plans) and additional CM Health priorities. The comments are intended for internal consultation/query management.

How well is our health system….	Commentary
Protecting longer term population health through early detection and improved prevention support	Our immunisation rate sits just below the target however we exceeded the target for both Pacific and Asian populations. Support to quit smoking in primary care has seen a dip but still meets the national target; practices are concentrating call centre activity to address this.
Improving population health equity and individual health through early detection and management of common conditions	Our breast screening rates have seen an upward trend meeting the national target in our total and Pacific populations; our Maaori population result eludes us by 0.2%. Our CVD rates remains similar to last quarter, just not making the target for Maaori; at the same time diabetes management remains stable.
Improving support for people and families with mental health and addictions issues	Access to non-urgent mental health services exceeds targets except in the youth (0-19 year olds) group, noting 12-19 age group is above target; high acuity cases delay routine appointments; teams have been reorganised with an expectation to see improvement in coming months.
Providing the best value for health funding through efficient and effective service delivery	We have met our readmission rate as well as ALOS. The cancer target has not been met however an audit has shown a reduced number of eligible patients under the 62-target this quarter. Cancer registrations appear lower than target, some late records to be added will increase this to above the required 15%.

Table 1 Extract from CM Health Performance Measurement Framework (2014/15 Annual Plan)

Note 1: The System Level Measures (SLMs) form part of the Annual Plan Performance Measurement Framework but are reported separately through Ko Awatea so not duplicated in the following indicator summary; with the exception of the SLMs that are health targets.
Note 2: We have sought here available key performance indicators by ethnicity to raise the visibility of health gain needs and achievements. The reality is that ethnicity stratified data by ethnicity is not routinely available for the majority of indicators. Further input will be sought around which indicators that are most useful to pursue by ethnicity.

Dashboard Key			
Green = Target Achieved	Orange = Partially Achieved	Red = Not Achieved	Grey = Data not available

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2014/15 Quarter 2					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
National Health Targets										
2.1.3	**Cancer**	Percentage of patients receiving their first cancer treatment (or other management within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	Quarterly	**85% by July 2016**	62.7%					*As a new target there remain fluctuations in eligible patients under the 62 day target. A 'subtarget' of 15% of expected cancer registrations reported makes up part of the health target – CMH met 11.1%. With some late reports yet to be submitted this may improve our result.*
2.1.6	**CVD and Diabetes**	Percentage of the eligible population who have had their cardiovascular risk assessed in the last five years	Quarterly	**90%**	91%	86.5%	91%	92.5%		*Results remain stable from Q1.*
2.1.2	**Elective Surgery**	Volume of elective surgery will increase by at least 4000 discharges per year	Quarterly	**Increase of 4,000 discharges per year**	111%					
2.1.1	**Emergency Department Care**	Percentage of patients admitted, discharged, or transferred from an ED within six hours	Quarterly	**95%**	96%					
2.1.4	**Immunisation**	Percentage of eight months olds who have had their primary course of immunisation on time	Quarterly	**95%**	94%	91%	97%	93%	97%	
2.1.5	**Smoking (hospital)**	Percentage of hospitalised patients who smoke and were seen by a health practitioner in public hospitals and were offered brief advice and support to quit smoking	Quarterly	**95%**	95%	95.6%	94.8%			
2.1.5	**Smoking (primary)**	Percentage of enrolled patients who smoke and were seen by a health practitioner in general practice and were offered brief advice and support to quit smoking	Quarterly	**90%**	95.5%					
2.1.5	**Smoking (maternity)**	Percentage of pregnant women who identify as smokers, at the time of	Quarterly	**Progress towards**	97%	98%				*Results represent approximately 80% of pregnancies nationally. Ranked 8th nationally.*

AP Ref.	Priority	Indicator		Frequency of reporting	Current Target	Performance – 2014/15 Quarter 2					Commentary / Interpretation
						Total	Maaori	Pacific	Other	Asian	
		confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered advice and support to quit smoking			**90%**						
MOH Quarterly Reporting Performance Indicators											
2.3.7	**Mental Health**	PP6: Improving the health status of people with severe mental illness through improved access		Six monthly							
2.3.7		PP7: Improving mental health services using transition (discharge) planning and employment	Long terms clients	Six monthly							
			Child and Youth	Six monthly	**95%**						
2.3.7		PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds - Mental Health Provider Arm	3 weeks	Six monthly	**80%**	69.5%					*Large volumes of high acuity referrals is delaying access. An improvement is expected in coming months.*
			8 weeks	Six monthly	**95%**	91.7%					
2.3.7		PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds Addiction (Provider Arm and NGOs)	3 weeks	Six monthly	**80%**						
			8 weeks	Six monthly	**95%**						
2.3.8		PP18: The percentage of older people who have received long-term home-support in the last three months who have a Comprehensive Clinical Assessment and a completed individual care plan		Quarterly	**95%**	75%					

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2014/15 Quarter 2					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
2.3.2	***Long Term Conditions***	PP20: Long term conditions/DCIP	Quarterly							
2.3.2		PP20: Diabetes - Improved management (HbA1c)								
2.3.4		PP20 Acute Coronary Syndrome - Percentage of high-risk patients who receive an angiogram within 3 days of admission ('day of admission' being 'Day 0')	Quarterly	**70%**	86.9%					
2.3.4		PP20 Acute Coronary Syndrome - Percentage of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	Quarterly	**95%**	78.2%					*A new process is in place to complete ANZACS and CAth/PCI data collection.*
2.3.3		PP20: Stroke - Percentage of potentially eligible stroke patients thrombolysed	Quarterly	**6%**	2.6%					*Numbers of eligible patients continues to be audited, (numbers are small). No patients with a stroke able to be treated by thrombolysis were missed this quarter.*
		PP20: Stroke - Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Quarterly	**80%**	75%					
2.1.4	**Immunisation**	PP21: Percentage of two year olds who are fully immunised	Quarterly	**95%**	96%	93%	97%		99%	
2.3	**System integration**	PP22: Improving system integration	Quarterly							

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2014/15 Quarter 2					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
2.3.8	**Health of Older People**	PP23: Improving Wrap Around Services - Health of Older People	Quarterly							*Overall this measure was achieved.*
2.1.3	**Cancer**	PP24: Improving Waiting Times – Cancer Multidisciplinary Meetings	Quarterly							
2.2.2	**Mental Health**	PP25: Prime Minister's Youth Mental Health Project	Quarterly							
2.3.7		PP26: The Mental Health and Addiction Service Development Plan	Quarterly							
2.2.3	**Child Health**	PP27: Delivery of the Children's Action Plan	Quarterly							
2.2.1	**Rheumatic Fever**	PP28: Hospitalisation rates (per 100,000 total population) for acute rheumatic	Quarterly	**7.9 per 100,000 (Total)** **16.3 per 100,000 (Maaori)**						
2.3.5	**Improving waiting times for diagnostic services**	PP29a: Coronary angiography – within 3 months (90 days)	Monthly	**90%**	100%					*Overall MOH provided an ACHIEVED rating for PP29*
2.3.5		PP29b: CT –within than 6 weeks (42 days)	Monthly	**90%**	72.5%					
2.3.5		PP29c: MRI – within 6 weeks (42 days)	Monthly	**80%**	65%					
2.3.5		PP29d: Urgent diagnostic colonoscopy – within two weeks (14 days)	Monthly	**75%**	82%					
2.3.5		PP29e: Diagnostic colonoscopy – within six weeks (42 days)	Monthly	**60%**	30%					*5% increase from previous quarter. Outsourcing to private has not enabled waiting lists to reduce sufficiently. Modelling demonstrates more facilities (currently being developed) and further outsourcing*

AP Ref.	Priority	Indicator		Frequency of reporting	Current Target	Performance – 2014/15 Quarter 2					Commentary / Interpretation
						Total	Maaori	Pacific	Other	Asian	
											required. Regional workstreams addressing various aspects of these issues.
2.3.5		PP29f: Surveillance colonoscopy - within twelve weeks (84 days) beyond the planned date		Monthly	**60%**	97%					
2.1.3	**Faster Cancer Treatment**	PP30a: FCT - Length of time taken for patients to receive their first treatment (or other management) for cancer from date to decision-to-treat		Quarterly		89%					
		PP30b: All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy from decision to treat		Quarterly							
2.3.1	**Ambulatory Sensitive Hospital Admissions**	SI1: ASH		Six-monthly							*0-74 trending downwards but still not meeting target; all other targets remain unmet. Maaori & Pacific very high although slightly improved.*
2.1.2	**Inpatient length of stay**	OS3: Inpatient length of stay	Elective LOS	Quarterly	**3.3 days**	3.41 days					
3.3.3			Acute LOS	Quarterly	**3.88 days**	4.15 days					
3.3.3	**Acute readmissions**	OS8: Reducing acute readmissions to hospital	Total Population	Quarterly	**<=7.4% standardised**	7.5%					
			75+ years	Quarterly	**<=10.1% standardised**	10.9%					
7.1.2	**Data Quality**	OS10: NHI and data submitted to National Collections		Quarterly							
7.1.2		National Collections		Quarterly							*Continuing improvement seen, just under the achieved rating. Anticipated to 'achieve' next quarter.*
7.1.2		PRIMHD File Success Rate		Quarterly							

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2014/15 Quarter 2					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
2.1.2	**Electives**	SI4: Elective services standardised intervention rates *(major joints, cataracts, cardiac surgery, percutaneous revascularisation & coronary angiography)*	Quarterly							*Meeting cardiac surgery and angioplasty. Actions to support improved access to angiography in place. We are currently meeting population demand.*
7.1.4	**Mental Health**	OP1: Mental health output delivery against plan	Quarterly							
2.5	**Patient Experience**	DV4: Improving patient experience - Proportion of patients who have rated CMH overall experience of care and treatment as 'Very Good' or 'Excellent'	Quarterly							
	CFA	**DSS Funding**								
	CFA	**Well Child Tamariki Ora Services**								
	CFA	**Green Prescription**								
	CFA	**Immunisation Coordination Service**								*Immunisation Coordination Proposal outstanding.*
	CFA	**National Immunisation Register Ongoing administration Services**								
	CFA	**Oral Business Case for Investment in Child And Adolescent Oral Health Services**								
	CFA	**Rapid Response Sore Throat Primary and Community Services**								
	CFA	**Youth Forensic Community FTE**								

Attachment 3: Northern Regional Health Plan Quarter 2 Top 10 Commitments

The table below shows progress against the top 10 commitments

● On track	▲ Some concerns regarding progress to target	◆ Not achieved or declining performance

	Commitment	Status	Notes
1	Achieve and maintain the Minister's health targets	●	Good progress on targets (refer Appendix A)
2	Reduction in falls causing major harm to a rate less than 0.07 per 1,000 bed days in the acute sector	▲	0.12 in Q2. As per previous quarters, the rate of falls with major harm continues to remain at a low rate, demonstrating normal variation. Despite the static rate of major harm there continues to be a decrease in the overall harm rate from falls.
3	86% of Well Child Tamariki Ora checks in first year all completed by December 2014 (rising to 95% by June 2016)	▲	ADHB 78% CMDHB 66% NDHB 68% WDHB 76% These indicators from MoH supplied statistics (6 monthly in arrears; Jan 2014 to June 2014). Plunket data only. DHB WCTO data not included. Overall value for Northern Region not available.
4	% of ARRC residents with completed InterRAI assessment and associated care plan	●	Actual for 12 months (to end Sept 2014) = 25% Baseline = 19% (12 months 13/14 year)
5	80% of patients who have a stroke are treated on a stroke unit	▲	69% (This is expected to approve now that NDHB has approval for extra beds)
6	80% of patients presenting with ST elevation myocardial infarction (STEMI) referred to percutaneous coronary intervention (PCI) will be treated within 120 minutes	●	The Northern Region STEMI result at 81.4% has met and exceeded the MOH target. All three metropolitan DHBs have exceeded the target. The lower result from NDHB is in part due to on-going difficulty with data entry and geographical distribution of patients. The data issue is in the process of being resolved. (NDHB were one of the last hospitals to implement ANZACS-QI and are currently receiving greater support).
7	Improvement in the % of patients referred urgently with a high suspicion of cancer receiving their first cancer treatment (or other management) within 62 days from date of referral (achievement of the 85% Health Target by July 2016)	Baseline	Q2 (baseline) = 52.5% All DHBs are focused on improving this percentage as it transitions into a health target, and are working locally and regionally to understand and resolve issues.
8	1.25% of young people aged between 12 and 19 years old are accessing specialist Alcohol and Other Drug (AOD) services	●	Rate of access for young persons aged between 12-19 years old has increased, with 78% of the full year target being achieved by Oct 2014.
9	37,000 patients undergo retinal screening	▲	Regional total (YTD) = 15,707 which is 8% below the expectation for Q2 (assuming equal phasing of screening activity by quarter). Catch-up activity is occurring to achieve annual target. Results are still awaited from ADHB Auckland Eye Clinic for Q2 (delayed due to staff shortages). While WDHB data is currently only collected from the new PMS OptoMize. Non OptoMize data (screened prior to switch over) for Q1&2 is being analysed and will be added to Q3 results.
10	A 20% increase in the 2013/14 end of year ACP conversations documented by each of the four DHBs	●	Target for 2014/15 = 7,843 2014/15 YTD = 4,803 Q1 = 2,733, Q2 = 2,070

Attachment 4: Northern Region Alliance Workstream Progress Summary Quarter 2

Our Priority Goals

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
First, Do No Harm				• Successful regional Medication Safety Collaborative Learning Session held. • Training, coaching and mentoring with teams progresses. • Ongoing work on engagement with aged care sector. Good engagement from Northland aged care sector - reaching 75% target for data reporting. • Development of a strong partnership with the Opioid collaborative team.	• The collection, analysis and reporting of falls and pressure injuries data from some residential aged care facilities continues to be a challenge. Discussion is ongoing regarding how to obtain and report outcomes measures for residential aged care and find a regional data capture and reporting solution. • Varying degrees of engagement with residential aged care sector. • Ensuring key people in organisations are identified and messages are communicated.

Child Health				**Rheumatic Fever:**
				• DHB activity continues with delivery of school based programmes and primary care deliver rapid response clinics
				• Technical Advisory Group meets monthly to review evidence for decision making. This supports regional consistency.
				SUDI:
				• 5 December Safe Sleep Day promoted regionally with DHBs and primary care services engaging in promotional activities. Partnership approach with Whakawhetu.
				• Maternity Services Audit of primary care birthing units completed in draft, and endorsed by the Child Health Network. To be implemented regionally.
				• All DHBs in the region are establishing safe sleep enabler programmes for high risk populations. Workforce development continues regionally. Regional SUDI action plan implementation group meets monthly.
				• Discussion in Q2 with Janine Ryland from MoH, Professor Ed Mitchell (SUDI researcher) and selected interested parties from primary care and DHB to have early discussion about integrating a risk assessment tool into the 6 week check primary care tool for WCTO.
					• Issues remain regarding the ability to report progress against the four key patient outcome measures in a timely manner.
					• Work is underway to ensure reporting arrangements are better understood; including consideration of:
					  ◦ The acceptability of a lag in ability to report on measures.
					  ◦ Alternative measures for the 2015/16 plan.
					• Ensuring clear responsibilities and accountabilities for interrelated activity undertaken across: the region; DHBs; and at local levels. A regional forum is planned for January 2015 to refine planning and to further clarify actions and responsibilities.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
				• Regional group established to develop an agreed regional process to inform primary care when an infant or child has died. Conversations underway with MoH, Births Deaths and Marriages and Coroner to consider national and regional process improvement. **Unintentional Injury:** • 13 October Child Health Network Meeting had theme of unintentional Injury. Auckland Council presented the Guiding Coalition for injury prevention priority areas. Auckland Council distributed a Council Report called "I am Council. An Auckland Wide Strategic Action Plan for Children and Young People: Stage 1". **Skin Infections** • Regional discussion held in November to consider increasing the visibility of skin infection pathways in primary care. Paper written to support DHB Nurse Leaders (CMDHB &WDHB) in primary care promote the static pathway and engage nurse champions in primary care. **Respiratory Tract Conditions:** • Primary Care Pathway published on Healthpoint. Implementation presently in static pathway. • Paper presented to the Child Health Network on implementing chronic asthma pathway. Agreement to publish this pathway as a dynamic pathway in the future.	
Inequalities	●	●	●	**Models of care and service:** • Work has continued to agree source data for the regional Maori health dashboard and to finalise the reporting format/structure. **Workforce (growing capacity and capability):** • Regional Workforce Ethnicity Report developed. • This quarter, 73 additional Maori people interested in a health study pathway/career were registered in Kia Ora Hauora. • Work continued on regional and local initiatives to 'grow our own', including: o Ko Awatea, Pacific Mentoring, Health Science Academies have included a regional tertiary mentoring programme (as the second part of the pacific workforce development programme alongside the Pacific Health Science Academy) which saw the introduction of mentoring programme for pacific tertiary students studying health. AUT hosted an event on 16 October to match mentors to	• There remain challenges with ethnicity data availability for some of the dashboard measures these are being worked through with the Regional Decision Support Team. A phased implementation will be applied.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
				mentees. 56 students and eight mentors attended. o The Rangatahi Programme (run by ADHB) has been developed for Maori and Pacific senior secondary school students to facilitate Maori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce. This involves an introduction day, work experience week, and cadetships (10 per annum for over 10 weeks). WDHB fund an additional five cadetships. Also, the 2014/15 Rangatahi Programme cohort includes the first graduates of the Health Science Academy at Hato Petera College, which is a joint initiative with WDHB. The ADHB and WDHB Maori Health and Pacific Health Workforce Development Consultants are working collaboratively with the team at ADHB to establish the Rangatahi Programme for WDHB by 2015/16.	
Health of older people	●	●	●	**Key achievements include:** • Further dementia education has been provided to primary & community care • Agreement reached, with the other three regions, to jointly develop national education materials (dementia education for GPs and practice nurses). **Cognitive Impairment (CI):** • The regional CI Pathway proof of concept is still being tested in ten GP practices. Feedback from GPs has resulted in minor technical changes to the "look and feel" of the application making it more intuitive to use. • A further two dementia education symposia were held on 11/12 November. The evening and breakfast meetings were attended by approx. 100 health professionals of which approx. 40 were GPs. The opportunity to have Professor Steven Lliffe as keynote speaker (the first professor of primary care in the UK and a world authority on dementia in the community), was opportune given he was attending the NZ Alzheimers Conference. A post-evaluation survey completed by 58% of attendees was in the main, very positive – the quality of the webinar audio was the key area for improvement in future. • The two new regional Psycho-Geriatric (PG) protocols are being forwarded to DHBs and ARRC providers for sign-off prior to testing.	• Implementation of recommendations arising from the Psycho-Geriatric (PG) Review has been delayed slightly (due to prolonged staff sick leave). • The preparation of a business case to roll-out the Quality Care for Older People portal to all ARRC providers has been put on hold due to the difficulty in making an economic case for it. Alternative strategies continue to be identified to increase participation of ARRC providers in regional quality initiatives. • The ARRC content pertaining to the Community Acquired Pneumonia Pathway has been difficult to agree. This slow progress led to the decision to drop the pathway from the list to convert to dynamic, and replace with a pathway of higher priority. Meanwhile, content will be agreed and static pathway completed by Q4.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
				A set of guidelines on Dementia Unit Design (also pertinent to PG Units) is undergoing first review. **Quality & Safety (ARRC):** • ARRC providers participating in the regional Falls/Pressure Injury Programme has slightly increased to 32% (Q1=27%). This increase has been achieved solely through the effort of NDHB who now have 75% of providers engaged. It should be noted however, that this metric only reflects those participating in the regional programme – in fact, the majority are engaged at a local level in falls reduction efforts. • A letter and certificate recognising participation in the regional programme has been sent to ARRC providers meeting the criteria. **Falls initiative:** • The joint pilot with St John Ambulance to refer people to a DHB falls clinic for assessments (who fall in the community but are not transported to hospital/A&M) has been evaluated following the 3 month pilot. While the numbers were lower than expected, it was found that most people were known to the DHB, were appropriately referred and approx. half required further assessment. The pilot has been extended till June. • The Hip Fracture Registry Pilot has kicked off, with CMDHB the first to commence on 15 Dec – the remaining DHBs will be staggered over the next couple of months. **InterRAI initiative:** • Lacey Langlois (from the national interRAI project team), delivered a very good presentation to the HOP network which highlighted the clinical improvement capabilities of the system. • 25% of ARRC residents now have a LTCF interRAI assessment for the 12 months ending Sep 2014 (previously 19% for Q1). • Performance to the 65% YE target for long term HBSS clients receiving an interRAI assessment within 12 months, is steadily increasing and is now 60% for Q2 (Q1=58%).	
Cancer	●	●	●	• The Faster Cancer Treatment projects are underway, both at DHB and regional levels. The sector is responding positively to the range of initiatives in progress. Oversight is provided by the Cancer Governance Board. • Dr Roberts oversees regional colonoscopy activity as the CEO/CMO representative. Regional process is expedited across a range of projects including utilization/ demand/ capacity modelling,	• The new FCT 62 day health target is confirmed at 85%, to commence measurement 1 October 2014, and target implementation 1 July 2016. The Regional FCT group work continues, with each DHB sharing initiatives, for example tools tracking individual patients from high suspicion to treatment, to assist with clinician engagement. A bowel cancer audit has been

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
				understanding detection rates, outsourcing, standardizing referral processes and surveillance. We await the outcome of the Ministry RFP. • The first draft Regional Plan for Cancer in the Northern Region has commenced consultation. • The region supports the NEQUIP team, with substantive engagement across endoscopy units. • There is regional engagement with the Bowel Screening Pilot, with network attendance at the Steering Group, and engagement to understand potential national rollout implications for the region.	completed to determine an accurate denominator for both 31 and 62 days. This shows that the expected cohort is being identified and that the numbers are low consistent with the correct application of national definitions. The Cancer Governance Board is considering potentially broadening their interest across a wider patient cohort.
CVD	●	●	●	• STEMI Regional guidelines have been updated and circulated. • Inter-hospital transfer pathway completed. • Regional ECHO guidelines competed and circulated. • AF static pathway completed and dynamic pathway underway.	• Size of ECHO waiting list and strategies for reduction. • Particular workforce capacity issues relating to: o EP Staffing resources; highly specialised staff and rosters not sustainable in long term o Primary PCI on call arrangements. A revised approach is currently being planned .
Diabetes	●	●	●	• Nurse Led Clinics document issued for final sign off. • Stocktakes initiated for both Podiatry and Nurse forum. • Regional podiatry group established. • Refocus of network goals and objectives to ensure regional approach. • Progress has been made regarding access to TestSafe data.	• Meeting retinal screening volumes across the region (process is in place to create visibility and to generate support in reaching this target).
Major Trauma	●		●	• Trauma data collection is underway in all 4 DHBs. • Stock take of current guidelines done and work started on developing a regionally consistent set of guidelines for the region. • Approval process for the regional registry continuing with current effort to secure funding. • Clinical leadership is being strengthened through greater CMO input and greater engagement from senior clinicians.	• Regional trauma registry progress delayed because of funding approval process through each DHB.
Mental Health		● ●		**AOD services for Adolescents and Youth:** • Rate of access for young persons aged between 12-19 years old has increased, with 78% of the full year target being achieved during Sept-Oct 2014. **Adult Forensic Psychiatry:**	

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
		●	●	• 100% of admissions to Mason Clinic have met the admission wait time targets.	
		●	▲	**Eating Disorders Services:** • Supra-regional agreement on a revised hub and spoke Service Delivery Model with a broadened clinical focus. • Supra-regional agreement on an IDF arrangement for 2015/16. • An agreed supra-regional funding position on transition from CFA top-slice to PBF funding arrangement.	**Eating Disorders Services:** • A funding gap of $1.2m for ADHB hub services due to redistribution of funds to the supra-regional DHBs under a PBFF arrangement.
	● ●		▲	**Services for people with high and/or complex needs:** • Resourcing for the five beds for people with high and/or complex needs at the Mason Clinic has been confirmed. The first three beds will be commissioned during the 15/16 year.	**Services for people with high and/or complex needs:** • Work continues to achieve a shared view on feasible, sustainable and acceptable options for addressing service gaps locally and regionally.
				Youth Forensic services: • Allocation of the 5.54 FTE was agreed in October 2014, recruitment is underway.	
				Perinatal and Infant Maternal Mental Health Acute services: • Mother and baby inpatient service operational with high utilisation to date. • NDHB services in place and functioning well. • Delivery of training to support workforce development underway. • 87% of clinical positions filled. • Development of increased respite/packages of care capacity, and provider for further respite/packages of care identified.	**Perinatal and Infant Maternal Mental Health Acute services:** • Delay in implementation of the full model of care due to recruitment/workforce availability.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
Stroke	●	●	●	• Performance to KPI targets continues to be a key focus for reporting and discussion at the network meetings. The Northern Region Dashboard was reviewed at the last meeting and is close to being rolled out, which will give a good overview of services provided, across the DHBs. • The Q2 result for thrombolysis remains at 5.7% again this quarter. The number of patients thrombolysed was in the higher range at 30, however there was an unprecedented number of people who were admitted with acute stroke for Jul-Sep. All DHBs have adopted the new thrombolysis register and look forward to benchmarking nationally next year. • Admission of patients with stroke to a dedicated stroke bed has fallen to an all-time low of 69% against the target of 80% (Q1=76%), despite two DHBs meeting or exceeding target. NDHB continues to decline with only 39% of patients able to be placed in a designated stroke bed. The DHB has received approval to increase the number of beds from 4-6 which will make a substantial improvement. Understanding the ethnic composition of patients is a focus for Q3 particularly for Maori and Pacific Island who have a higher incidence of stroke which should be reflected in the occupancy of stroke beds. • We are pleased to advise that the KPI: *'Proportion of people with acute stroke who are transferred within 10 days of acute stroke admission',* has exceeded the 60% target and in Q2 is at 65%. This is a considerable improvement from the previous quarter (Q1=57%). • The fourth KPI: *'Proportion of people with acute stroke who are transferred to inpatient rehabilitation services',* result for Q2 is 23% (Q1=26%). • Work continues on updating the TIA clinical pathway. • Northern region representatives continue to participate in national discussions and various working subgroups, and are well engaged in planning for stroke nursing, TIA management, training/education, and stroke rehabilitation. The NRA is considering the national request to report KPIs on behalf of the other three regions.	• The rate of thrombolysis continues to be a major focus with a number of strategies being used to increase the rate, such as; encouraging earlier presentation of patients by GPs & St John, further relationship building with ED & analysing door-to-needle times. A recent review of data fields confirmed we are adhering to the national definitions. • Continue to increase stroke unit admission. For example; NDHB has reviewed their stroke beds and have submitted a business case to increase the number and we are seeking to understand ethnicity of patients admitted to stroke units.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
Advance Care Planning	●	●	●	• Interest in, and demand for, Level 2 courses across the region remains high. • HWNZ advertised the RFP for the evaluation of the ACP L2 training programme (results due Feb 2015). This contract has been awarded to Deloitte and the evaluation commenced in September 2014. • Two Northern Region staff continue their ACP Level 3 Facilitator training (both from ADHB). • CMDHB appointed a 0.5 FTE ACP Facilitator. • Northland appointed a part-time Project Support Administrator for ACP in October.	• Waitemata have limited ACP project support and are seeking to employ a new staff member for this. • Lack of an electronic system to record and report on ACP activity continues to present challenges, particularly with regard to consistent ACP conversation recording across the region. This issue is linked to IT software CCMS rollout across the Metro region and is also impacted by IS/IT prioritisation and funding allocation.
Youth Health	●	●	●	• Draft DHB Feedback and Summary Document for Schools Health Service survey compiled. Final versions to be issued to DHBs and schools in January. • 4 KPIs have been developed and draft reports produced.	• Gaining clinical representation and balanced engagement across the four DHBs.

Clinical Services

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
Laboratory				• Transition of Anatomic Pathology services to ADHB management completed with minimal service impacts and positive feedback from key stakeholders. • Community referred laboratory services KPIs met contract requirements with the exception of the Anatomic Pathology KPIs in the first month post AP transition. • Detailed planning for the colocation of community Anatomic Pathology services and the transition of NCSP cytology contract to ADHB is on track for Quarter 3 transition. • Building consent issued and contracts let for building works at Community Anatomic Pathology Services Mt Wellington. • Building consent issued and contracts let for building works at LabPLUS Fourth Floor with work initiated in late December. • Reporting on non-schedule tests provided to DHBs to support analysis of test ordering and management of demand. • Laboratory Joint Advisory Group (JAG) progressing work on mislabelled specimens and Business Continuity Plan. • Specimen tracking requirements definition and business case development is progressing in parallel with evaluation of potential providers. • IS systems transitioned smoothly in line with contract changes. • Implementation recommendations for AP Scientific and Technical Workforce endorsed.	• Managing the transition of anatomical pathology and the risks associated with this. • Demand growth is substantive primarily due to increased CVD risk assessment and rheumatic fever testing. • Analysis is being undertaken of the potential implications of the release of the new guidelines for diabetes testing in pregnancy.
Radiology				• Revised regional prices for Radiology procedures for DHB inter-provider invoicing have been agreed and supported by the National Costing Team. A request to support implementation and next steps has gone through to the National Counting Group. • Regional Radiology IS Group has a program manager role approved and is now recruiting. Reporting structure has also been clarified. • Nuclear Medicine and Neuroradiology working groups established to progress regional service planning. • Obstetric Imaging QA group has agreement around focus areas and is working with private providers to facilitate copies of maternity scan reports coming into éclair. Cross sector current state activity and provision completed and areas for QA improvements identified.	• Our region currently holds the Chair and project management role for the National Radiology Advisory Group, and was expecting to handover to the Midland region. However this is not progressing as that region has not been able to find a clinical lead.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
				Linkages with national maternity groups and NSU established. • First cohort of the sonographer trainees have completed their start up course and formal review is underway.	
Elective Services	● (green)		▲ (amber)	**Models of care and Service:** • Significant effort has been devoted to achieving the ESPI 2 and ESPI 5 targets by end 2014. At end December the Northern Region DHBs achieved both targets with 100% compliance. • Work has continued on implementation of the national prioritisation tools relating to ORL and Bariatric. The region is aligned to National work on these tools. Some issues remain with regard to acceptance of the plastics prioritisation tool. Other, locally adopted, prioritisation tools are also in use. **Workforce:** • The tool for identification of elective workforce constraints has been developed and is expected to be applied during Q3. **IS:** • Implementation of the cardiac pathway for chest pain and angiography eReferrals inter and intra DHB pilot remains affected by the IS proof of concept showing the initially preferred solution would not meet business needs. The regional CareConnect eReferrals Steering Committee met on 19 December and approved a range of integrated workstreams including in relation to the delivery of Phase 2.3 – Intra and Inter Hospital Referrals. A Statement of Work and solution design for this Phase has now been finalised with the vendor. In addition a detailed proposal for delivery of eRequests (referrals for diagnostic procedures/investigations has been presented). Impacts on milestones will be confirmed following completion of the procurement and contracting process.	• On-going sustainability of ESPI target achievement is still expected to be challenging for some of our DHBs in Jan and Feb 2015, with at least one of our DHBs signalling possible issues in this period which should be resolved by March. This remains a focus for on-going planning. While the Cardiac workflow and process requirement has been fully described and agreed, the IS component of the solution remains behind schedule.
Pharmacy	● (green)	● (green)	● (green)	• The overall programme of work is on track and meeting initiative targets	• CCMS version 4 is not yet released by MoH, which impacts on some regional initiative timeframes. • Affordability and funding issues may impact on initiative 4 ('green bag'). This has been implemented in hospitals; funding agreements impact on wider pilot, eg via St Johns Ambulance Service). • Current variance in level of engagement of clinicians involved in discharge processes could impact on Q3 achievement of the implementation plan Item 5 [to actively refer patients to Pharmacy Home for LTC

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
					Service (LTC), CPAMS and/ or Medicines Utilisation Review Services (MURs)].
Long term service for chronic health conditions	●	●	●	• 19 Clients with a service package of $80k pa or over have been reviewed and monitored by the Regional Review Panel in this Quarter. • A regional rehabilitation model has been agreed to by the Regional Rehabilitation Project Group that includes LTS CHC rehab clients. • Ongoing regional support is provided through the LTS CHC Regional Review Panel, Peer and NASC review groups. • The MoH will generate LTS CHC ARRC Inter District Flow clients (IDFs) with data agreed to and submitted by the Regions.	• 7 clients with unclear funding streams between LTS CHC and DSS in this Quarter. • 0 clients for shared funding resolution between LTS CHC and Mental Health in this Quarter. • Ongoing support of the National LTS CHC and DSS Resolution Panel to address the lack of consistent methodology for dual funding, duplicating client assessments and defining Advanced Personal Care and Personal Caregiver tasks to better determine client funding eligibility requirements.
Other Service Developments	●		●	• Acute spinal cord impairment service commenced at CMH in August, with roll out for wider supra region still in progress. • Rehabilitation service review has been completed with no additional services identified for delivery from a centralised location. • Sexual Health review extended to include Counties Manukau. Revised service specifications have been agreed for the Auckland Regional Sexual Health Service specifications. The milestones and consultation process required to implement the service specifications in 2015/16 has also been approved • The Service Development Work plan has been endorsed by CEOs/CMOs.	• Priorities for progressing work differ between DHBs but this is being worked through as part of the phasing and resourcing for the regional service development plan.

Enablers

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
Workforce				Refer full report available if required	
IS				Refer full report available if required	
Procurement and Supply Chain	● (green)		● (green)	**Procurement** • At 30 November (YTD FY14/15), $3.37m of projected[1] and implemented[2] budgetary benefits have been achieved for the Northern region DHBs • At this point, it appears that the budgetary benefits targets for each of the Northern DHBs will be reached. It is estimated that, by year end FY14/15, budgetary benefits will be about $10m vs a target of $8m. • In addition, it is estimated that, by year end FY14/15, $7.57m of projected[1] and implemented[2] non-budgetary benefits (predominantly Capex cost reduction and cost avoidance) will have been achieved. This will continue to grow for the remainder of the financial year. • Planning for FY15/16 is well advanced as a desk top exercise. The next step is to take the draft plans to each DHB for review and validation in preparation for the re-forecast due for submission in early 2015. The agreed forecast activity will represent the Procurement Plan for each DHB and will be an essential component of the FY15/16 Annual Operating Plans • Quarterly meetings were completed for all DHBs. hA attendees were the General Manager Procurement, National Procurement Manager and the Regional Relationship Manager. All conversations were positive and, while there was concern about reaching the benefits targets, there was also empathy for the challenge. A key learning is the extent of the differences between DHBs and their very different needs, priorities and risk appetites. • The Annual Operating Plan with Northland DHB has been signed. [1] "Projected Benefits" mean benefits arising from contracts that have been signed but not yet provided to or implemented by the DHBs. [2] "Implemented Benefits" means that the DHBs have confirmed that implementation is complete	**Procurement** • Last quarter it was reported that, "Finalisation of Annual Operating Plans is slow due to conflicting priorities at DHBs". This is still the case with ADHB, WDHB and CMDHB. • The team is dealing with 1015 expired contracts under which purchasing continues to be done and 1079 (at last count) contracts that will expire in calendar year 2015. Note: these figures are national. This volume of "maintenance" activity was not anticipated at the outset of the National Procurement Service and only came to light as the contracts received from the DHBs were entered into a register and analysed.

Workstream	Found-ation	Patient outcome results	Process results	Achievements	Challenges
Procurement and Supply Chain	●	●	●	**Supply Chain** • A positive second quarter, as the service responds very well to all challenges, and continues on track to our business plan. Milestone achieved in publishing financial benefits achieved through the service, which will be socialised and refined through the remainder of the year. We are on track to achieve the annual benefit total. • hA have taken a leading role in taking the management of the project for the national data hub development and the management of suppliers with GS1 to create a national catalogue. • Preliminary work on a solution to implement national distribution centres earlier than the HBL replan exercise, bringing sector benefits forward has commenced and aligning the northern region process up nationally.	**Supply Chain** • Maintain services with cost pressure due to regional growth of requirements. • Continue Northern region development of processes with national pressures.

Capital and Assets	●		●	Work has continued in relation to those areas of focus for 14/15 identified in the Regional Capital Plan, particularly regarding:
				• Meeting the capital planning requirements of the Ministry of Health and the Treasury; including commencement of the 2015/16 capital planning cycle.
				• Progressing regional oversight, review and endorsement of DHB capital development plans by the Regional Capital Group, including:
				  ◦ Regional IT Plan (draft Q1 2014-15)
				  ◦ WDHB: Histology Specimen Tracking (Regional Project – for info only)
				  ◦ ADHB: Replacement Fluoroscopy Unit
				  ◦ ADHB: Bulk Instruments – Perioperative Fleet Instruments
				  ◦ WDHB: Replacement of inpatient beds over 5 years.
				and noting various progress updates on the business case relating to CMDHB : Acute Mental Health – Inpatient Unit.
				• Enhancing the consistency of capital planning processes and practice across our region; with the organising and scheduling of Better Business Case 'Foundation' training for 90 Northern Region DHB staff (held during December 2014).
					• Affordability issues continue to impact on the prioritisation of capital projects.
					• The complexity of IT/IS planning requirements continues to be a key focus for our Region.

Counties Manukau District Health Board
Patient Information Strategy & Plan 2015

Recommendation

It is recommended that the Board note the attached Patient Information Strategy & Plan 2015.

Prepared and submitted by Phillip Balmer, Director Hospital Services

Patient Information Strategy and Plan

2015

Prepared By:

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Acknowledgments

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DOCUMENT ACCEPTANCE and RELEASE NOTICE

This is version 1 of the **Patient Information Strategy and Plan (2015)**.

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Please submit all requests for changes to the owner/author of this document.

PREPARED BY: Phillip Balmer, DATE:___/___/___
(for acceptance)

ACCEPTED BY: Peter Gow DATE:___/___/___
(for release)

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1 EXECUTIVE SUMMARY

The purpose of this strategy is to create a consistent and quality response, taking responsibility for the provision of Health Information for Counties Health. This will be underpinned by existing strategies particularly those concerned with patient or community information, and education and training.

There has been a growing awareness among health professionals and consumer advocates that comprehensive information in a format the patient can understand needs to be provided to manage care at home. These formats can include verbal and written information, audio, video, follow-up phone calls, E-mail communication with their doctor, and websites to access further information. These delivery formats contrast with the provision of verbal information only at the time of discharge, which is an approach that leaves knowledge and authority in the hands of health professionals. It also has the potential to disempower patients, as they are unable to refer to information after discharge or may not remember what they have been told (Linke, 1996). It has been demonstrated in several qualitative studies that providing written information to patients on discharge is an important strategy which has the potential to improve the confidence of patients (or significant others) to manage care and seek appropriate follow-up care (Johnson, 1999), decrease recovery time (Johnston and Vogele, 1993;Devine and Westlake, 1995), improve satisfaction with services provided whilst in hospital (Larson, 1996), decrease stress and anxiety (National Health and Medical Research Council, 2000), reduce hospital readmissions (Mamon, 1992; Fries, 1998), and improve adherence to hospital aftercare regimes (Mazzuca, 1982;Gibbs 1989; Frith 1991).

2 BACKGROUND

Manaaki Hauora, Supporting Wellness Campaign through Ko Awatea is leading a DHB-wide quality improvement programme that aims to improve the patient experience and achieve greater efficiency and value from health delivery systems by improving the design and coordination of care for all. Counties currently has the goal to provide self management support for 50,000 people living with ***long term conditions*** across Counties Manukau by 1 December 2016. At present there are the following numbers of known patients with the following conditions:

- 38,860 with Diabetes
- 16,600 with Cardiovascular Disease (CVD)
- 5,750 with Chronic Obstructive Pulmonary Disease (COPD)
- 4,590 with Coronary Heart Failure (CHF)
- 18,440 with Gout
- 4,720 with Asthma

Goals

- *Whaanau inspired, enabled, resourced to be in control of their health*
- *Inspiring* people to learn more about their condition and to take an active role in their health care
- Providing support, information, tools and techniques that *enable* people to manage their health on a day-to-day basis.
- Coordinating *resources* – services, people, partnerships

Manaaki Hauora supporting Wellness Campaign , aims to promote greater reliance on patient and community self-management through more effective support and education. In commencing this work, it has been identified that a patient information strategy did not exist for the organisation and that to deliver benefit tied to the organisation objectives, and set future direction for information, this was required.

In order to establish the scope of this strategy it is important to define what we mean by 'patient information.' 'Patient information' is information '…about conditions, treatments, procedures, examinations, surgery and services. It covers information provided for patients. It does not cover information about patients or their individual care. Formats of patient information include printed patient information leaflets, printed leaflets in alternative script such as Large Print and Easy Read, websites, audio and other multi-media mechanisms.

Health literacy requirements should be taken into consideration as research into health literacy undertaken in New Zealand shows that overall; "the majority of New Zealanders are limited in their ability to obtain, process and understand basic health information and services, in order to make informed and appropriate health decisions."

3 OBJECTIVES OF THE STRATEGY

The aims of the Strategy are:

- To set a framework for more informed health decisions
- The provision of information to empower and facilitate self-care for patients with long-term conditions
- To increase awareness of health issues and signpost appropriately to services
- To provide a holistic approach to patient information at each patient 'touch-point'

The strategy is graphically represented below:

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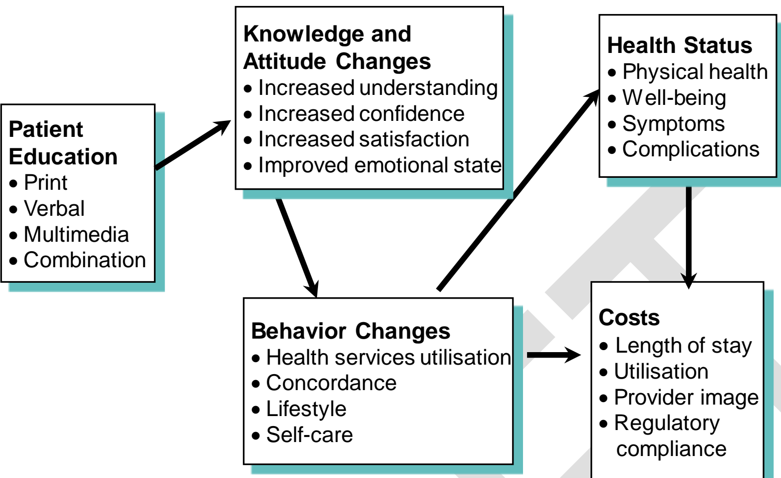
Patient Education Rationale



Research as shown below demonstrates that patient engagement is key to improving health outcomes.

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The level of health literacy as shown below follows a continuum from knowledge to full and active participation in health care decisions.

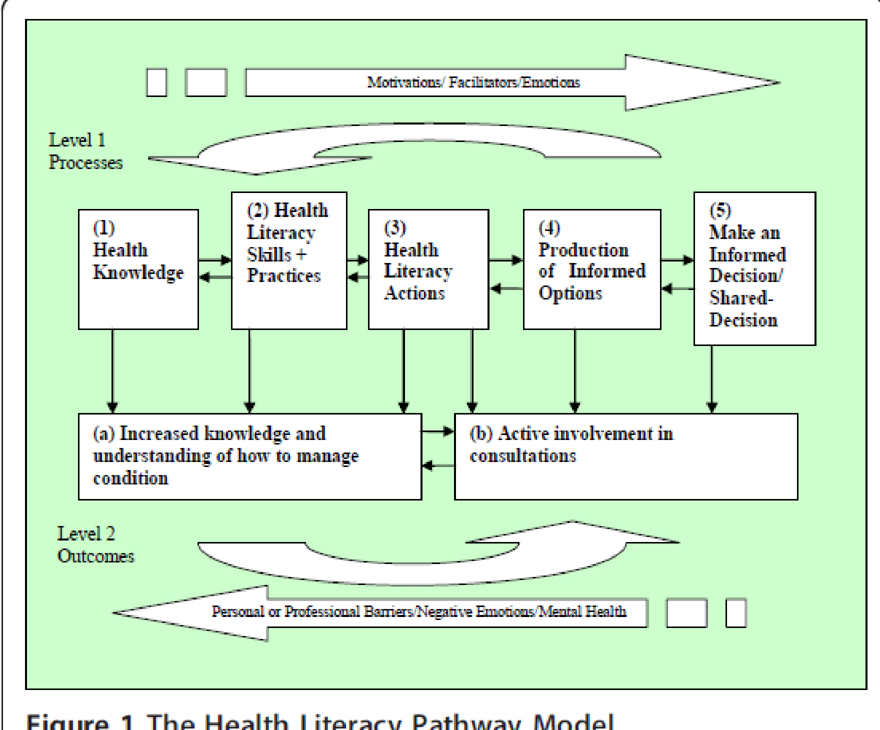

Figure 1 The Health Literacy Pathway Model.

Themes	Sub themes	Categories
1. Health knowledge	Knowledge of health in general and own health concerns	Knowledge of science and health
		Knowledge of condition
		Knowledge of health service
		Knowledge of patients' rights
2. Self management skills	Managing medication	Organising medications and managing a medication regime (self-injecting, taking pills)
	Self-monitoring	Self monitoring blood sugar/coagulation
	Managing a diet	Managing diabetes with diet
3. Active information seeking and use	Engaging with written materials	Reading medical reference books, dictionaries, leaflets, newspaper reports
	Accessing online information	Health-related websites, health organisations
	Using social media	Posting messages on discussion boards, web chat with other patients, using video sharing websites to view procedures
	Engaging with research	Reading research papers
	Critical appraisal of information and considering it within context	Assessing the reliability and quality of information and the source of information, assessing relevance of the information in context of own concerns
4. Actively communicating with health professionals	Preparation	Keeping a record of symptoms, preparing questions to ask in consultations
	Exchanging information	Bringing information to a consultation, discussing results, medications
	Expressing needs and concerns	Asking to change a medication, talking about problems, communicating preferences, asking for a referral to another service, asking for monitoring devices, asking to see results
	Conveying information	Reiterating health information given by one health professional to another
	Managing communication	Managing communication with multiple health professionals

5. Seeking and negotiating treatment options	Seeking treatment options	Seeking alternative treatment options online
	Negotiating medication or treatment	Asking doctor to try a new medication or alternative treatment method
6. Decision making	Desire for involvement	Making informed decisions about treatment preferences
	Opportunities for involvement	Taking part in shared decision making
7. Influences on health literacy	Negative influences (personal and professional barriers)	**Patients:** poor acceptance, compliance, reliance on health professionals for information, emotional barriers (shock fear, anxiety), avoidance of information
		Health professionals: poor communication styles, conflicting information
	Positive influences (personal and professional motivators, facilitators)	**Patients:** manage emotions (reducing fear), make sense of symptoms
		Friends and family: distributed health literacy skills
		Health professionals: GP support information seeking, pharmacy support with understanding of medications, nurse support with self-management, access to services and mediate communications with doctors
8. Health literacy outcomes	Develop knowledge, skills, understanding and coping	
	Active involvement in consultations	

The objectives:

- To involve the public, patients, partners and professionals in the co-design and presentation of health information
- To develop evidence based key messages
- To create central 'quality assured' resources
- To link to the services and activities of all Counties Health providers via Care Connect, and Health Navigator website
- To promote and provide training in the use of patient information tools
- To design, co-ordinate and deliver patient information across a full suite of multimedia platforms

This strategy has a number of interlinked aims:

- To improve the quality, timeliness and accessibility of information given to patients at different stages of their care.
- To improve our knowledge of patients' information and communication needs, including their access requirements.
- To investigate ways of continually improving the DHB's patient information provision.
- To develop ways of providing staff with improved support and guidance on their responsibilities around patient information.
- To raise awareness of the importance of patient information and the role it plays in empowering patients.

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- To be open to developing other aims, as a result of public, patient and stakeholder involvement during the lifetime of the Strategy.
- To translate all aims stated above into SMART (specific, measurable, achievable, relevant, and time-limited) plans of action.

4 HEALTH INFORMATION

Health Information can be defined as the information that individuals need to make decisions about their health and lifestyle. To help ensure that our patients do not become disengaged or feel disenfranchised, they need to feel they're part of the system, understand what is being said, understand their condition and what the options are so that they can play an active role in their own healthcare. For the purposes of this strategy, patient information is information that is about discrete conditions and generic. It does not include any identifying information for example, patient's names. Patient information should mirror the patient journey: from the community (GP visits, pre-treatment education), into hospital (outpatients, day stay or longer-term inpatient) and back into the community (GPs, Allied Health and other support). Different information is required at each touch-point. The patient must be provided with the information that will enable them to understand what is being said, understand their condition and what options there are, so that they can play an active role in their own healthcare. The best medical advice in the world won't do patients much good if they can't understand it.

Effective information will need to be:

- relevant
- consistent
- attractive / appealing
- easy to access
- available in a variety of formats and languages

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5 CONTEXT

The strategy will be developed and implemented within a whole of system partnership approach. This will be essential in order to achieve comprehensive coverage and ownership of consistent messages. The structure will encourage clinical and patient involvement. Active links will be made with existing and potential projects, in particular Project Swift, PWCC and regional pathways. The central element of the patient information will be a digital knowledge base. This will be supported by a range of other media and approaches.

6 DELIVERY

The knowledge base in the form of a website will form the basis of the patient information service. It will aim primarily to provide a signposting service for information required by Counties Health professionals and will be accessible to community groups and members of the public. To support the knowledge base locality based information points will be identified and relationships developed with systems such as the Ko Awatea Library Service, and community health practices through the PHO's.

7 RISK

As part of the planning process a risk assessment needs to be carried out to identify areas of risk that may impact on the successful delivery and impact of the strategy. This will be undertaken by the Ko Awatea Team in collaboration with PWCC.

8 MONITORING AND EVALUATION

A formal review of this Strategy will be completed in June 2015.

9 DELIVERY PLAN

1. To identify and implement systems to support the promotion of patient information in a hospital and community setting primarily using Intranet, Web and other forms of written communication.
2. To develop an effective partnership with the Ko Awatea Library services and PHO's for cohesive patient information across the DHB
3. To support a programme of continuing review and development related to patient information
4. To design and implement a programme of training to support the development of patient information
5. To further develop the patient information available through community, primary and hospital systems

Work area 1:

- Improve our knowledge of the impact of information on patients and the public and use this knowledge to develop services and resources
- Monitor feedback given to the DHB concerning patient information through all available channels: patient surveys, patient advisors and liaison group, complaints and focus groups

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- Systematically gather data on the subjects and issues raised in patient information research
- Develop services and resources in response to findings gathered through research

Work area 2:

- Improve our knowledge of the information and communication needs of 'seldom heard' patient groups and develop services and resources to meet these needs.
- Use the data gathered on patients' ethnicity, language and accessibility requirements to develop services and resources.
- Ensure that patient information is an integral part of the PWCC and DHS and DHPH&CS work plans.

Work area 3:

- Provide a comprehensive suite of patient information that can be accessed across the continuum of care including the use of existing resources and identification of additional resources that are fit for purpose
- Improve the capacity of staff in clinical and non-clinical settings to provide information to patients effectively and efficiently.
- Integrate patient information into pathways, Intranet development and website content work to reduce the time currently spent searching for patient information or dealing with problems resulting from a lack of information.
- Integrate patient information into the new discharge templates (being developed), which should result in patients having a more positive experience of discharge and being more informed when they leave hospital.
- Promote patient information through the DHB's online presence as a resource that can be used by staff, as well as patients.
- Promote resources on the Intranet and Health Navigator that can be used by all staff to obtain DHB approved patient information and support the production of new materials.
- Raise awareness of the processes for obtaining and producing patient information across localities, hospital and pathway groups, including advice and support available from communications and digital.

Work area 4:

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- Develop collaborative working practices between all DHB health care providers in the production of patient information.
- Promote Health Navigator as the lead group in external patient information, sharing resources and processes to make best use of the combined resources.
- Develop mechanisms to ensure consistent branding of internally produced information.
- Facilitate the integration of community services patient information, including internally produced information and information obtained from external sources.
- Develop a plan to support community services patient information.

Work area 5:

- It is recognised by the DHB that staff require access to expertise, support and advice to enable them to provide patient information and to ensure a standardised approach across the DHB.
- The Communications Manager and Manaaki Hauora Delivery Manager are responsible for advising staff on the availability of appropriate sources of information and on the process required to approve patient information for use within the DHB.
- The Communications Manager is responsible for maintaining a central database of approved patient information, accessible through the Intranet, Health Navigator and DHB website so that all DHB staff can retrieve patient information.
- The Communications Manager and Delivery Manager are responsible for maintaining and developing guidance for DHB staff on patient information, and for making this guidance accessible through the Intranet.

Work area 6:

- A Patient Information Policy to be developed to ensure more robust accountability at Executive level for patient information work.
- Provide patients and the public with a Health Collection of books, multimedia materials and DHB approved leaflets, and hosts information events on topics of relevance to public health, for example Smoking Cessation, in collaboration with the Ko Awatea librarian services.
- The communication team manages the DHB's external website and central resources for providing information for patients.

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- The Patient Information Strategy should seek to monitor and learn from existing work and extend good practice across the DHB.

Work area 7:

- Patients and the public will be kept informed of developments, and opportunities for involvement, through DHB publications, wherever possible and through the DHB's website.
- DHB staff will be kept informed of developments, and opportunities for further involvement.
- The Communications Manager is responsible for the drafting, monitoring and reporting on the annual implementation plan, for leading implementation of areas specifically identified and for supporting managers and staff as required.
- The Communications Manager, supported by the Program Manager, is responsible for keeping this strategy under review and for establishing ways in which its impact can be assessed.
- It is noted that the development and integration of patient information may have resource implications for the strategy that are unknown at the time of writing.
- The strategy will be reviewed and updated every 12 months and will be agreed by the Executive Team after widespread consultation with all relevant parties.

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Counties Manukau Health Board Meeting
Resolution to Exclude the Public

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

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

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Minutes of 11 February 2015	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)]	**Confirmation of Minutes** For reasons given in the previous meeting.
2. Action Items	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)]	For reasons given in the previous meeting.
3. Appointment to CPHAC 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. [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)]
4. Health & Safety Quarterly Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [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)]
5. Otahuhu Boundary Change	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	**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.

	9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	[Official Information Act 1982 S9(2)(i)]
6. Northern Region Electronic Health Record Project & Regional Information Strategy Refresh	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)]
7. Project Swift Update	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)]
8. IS Strategic Projects Update	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)]
9. Health Targets 2014/15 Quarter 1 Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [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)]
10. APAC Update	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)]
11. Planning 2015/16	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	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to

	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)]	carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]