## Counties Manukau District Health Board
### Board Meeting Agenda

**Wednesday, 27 July 2016 at 1.30 – 4.30pm, Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tbody>
<tr>
<td>1.00 – 1.30pm</td>
<td>Board Only Session</td>
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<tr>
<td>1.30 – 1.35pm</td>
<td>2. Governance</td>
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<tr>
<td>1.35 – 1.45pm</td>
<td>3. Strategy</td>
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<tr>
<td>1.45 – 1.55pm</td>
<td>4. General Business</td>
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<tr>
<td>1.55 – 2.00pm</td>
<td>5. Resolution to Exclude the Public</td>
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<tr>
<td>2.00 – 2.05pm</td>
<td>6. Confidential</td>
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<tr>
<td>2.05 – 2.10pm</td>
<td>6.1. Confirmation of Confidential Minutes – 15 June 2016</td>
</tr>
<tr>
<td>2.10 – 2.25pm</td>
<td>6.2. Action Items Register</td>
</tr>
<tr>
<td>2.25 – 2.40pm</td>
<td>6.3. Investor Confidence Rating (Ron Pearson/Louise Zacest)</td>
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<tr>
<td>2.40 – 2.50pm</td>
<td>6.4. APAC Strategy 2017-2019 (Jonathon Gray/Katie Latimer)</td>
</tr>
<tr>
<td>2.50 – 3.00pm</td>
<td>6.5. Healthy Together 2020 - Technology Update (Sarah Thirlwall)</td>
</tr>
<tr>
<td>3.00 – 3.05pm</td>
<td>6.6. Healthy Together 2020 – Technology – e-Prescribing &amp; e-Pharmacy Business Cases (Sarah Thirlwall)</td>
</tr>
<tr>
<td>3.10 – 3.30pm</td>
<td>6.7. IS Projects Update (Leanne Elder)</td>
</tr>
<tr>
<td>3.30 – 3.40pm</td>
<td>6.8. Living Well Centre - Verbal Update (Louise Zacest)</td>
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<tr>
<td>3.40 – 3.50pm</td>
<td>6.9. Integrated Pharmacist Services (Benedict Hefford/Trevor Lloyd)</td>
</tr>
<tr>
<td>3.50 – 4.00pm</td>
<td>6.10. Health Research Strategy 2015-2018 (Geraint Martin/John Hanson)</td>
</tr>
<tr>
<td>4.00 – 4.05pm</td>
<td>6.11. Acute Mental Health Unit Tender (Ron Pearson)</td>
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<td></td>
<td>6.12. Proposal for new hA Director (Lee Mathias)</td>
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**Afternoon Tea Break**

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<tr>
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<tbody>
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</table>

**Next Meeting: 7 September 2016**

**Room 107, Ko Awatea, Middlemore Hospital, Otahuhu**
### Board Member Attendance Schedule 2016

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>10 Feb</th>
<th>23 Mar</th>
<th>4 May</th>
<th>15 June</th>
<th>27 July</th>
<th>7 Sept</th>
<th>19 Oct</th>
<th>30 Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lee Mathias (Chair)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Wendy Lai (Deputy Chair)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
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</tr>
<tr>
<td>Arthur Anae</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Colleen Brown</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Sandra Alofivae</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
</tr>
<tr>
<td>Lyn Murphy</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>David Collings</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>Kathy Maxwell</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>George Ngatai</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dianne Glenn</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Reece Autagavaia</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>

* Attended part meeting only

* No Meeting
### BOARD MEMBERS’ DISCLOSURE OF INTERESTS
**July 2016**

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Dr Lee Mathias, Chair   | • Chair, Health Promotion Agency  
                          • Chairman, Unitec  
                          • Deputy Chair, Auckland District Health Board  
                          • Acting Chair, New Zealand Health Innovation Hub  
                          • Director, healthAlliance NZ Ltd  
                          • Director, New Zealand Health Partners Ltd  
                          • External Advisor, National Health Committee  
                          • Director, Pictor Limited  
                          • Director, John Seabrook Holdings Limited  
                          • MD, Lee Mathias Limited  
                          • Trustee, Lee Mathias Family Trust  
                          • Trustee, Awamoana Family Trust  
                          • Trustee, Mathias Martin Family Trust |
| Wendy Lai, Deputy Chair | • Partner, Deloitte  
                          • Board Member Te Papa Tongarewa, the Museum of New Zealand  
                          • Chair, Ziera Shoes  
                          • Board Member, Avanti Finance |
| Arthur Anae             | • Councillor, Auckland Council  
                          • Member, The John Walker ‘Find Your Field of Dreams’ |
| Colleen Brown           | • Chair, Disability Connect (Auckland Metropolitan Area)  
                          • Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
                          • Member, NZ Down Syndrome Association  
                          • Husband, Determination Referee for Department of Building and Housing  
                          • Chair, IIMuch Trust  
                          • Director, Charlie Starling Production Ltd  
                          • Member, Auckland Council Disability Advisory Panel  
                          • Member, NZ Disability Strategy Reference Group |
<table>
<thead>
<tr>
<th>Name</th>
<th>Roles and Positions</th>
</tr>
</thead>
</table>
| Dr Lyn Murphy   | • Member, ACT NZ  
• Director, Bizness Synergy Training Ltd  
• Director, Synergex Holdings Ltd  
• Trustee, Synergex Trust  
• Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
• Member, New Zealand Association of Clinical Research (NZACRes)  
• Member, Franklin Local Board  
• Senior Lecturer, AUT University School of Inter professional Health Studies  
• Member, Public Health Association of New Zealand |
| Sandra Alofivae | • Member, Fonua Ola Board  
• Director, Housing New Zealand  
• Member, Ministerial Advisory Council for Pacific Island Affairs  
• Member, Social Housing Reference Group |
| 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  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Vice President, National Council of Women of New Zealand  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group |
| George Ngatai   | • 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  
• Transitioning out Aotearoa provides services and back office support to Huakina Development Trust and also provide GP Services to their people  
• Chair, Restorative Practices NZ |
| --- | --- |
| 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  
• Trustee, Epiphany Pacific Trust |
### BOARD MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

**Specific disclosures (to be regarded as having a specific interest in the following transactions) as at July 2016**

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Collings</td>
<td>Innovation Hub</td>
<td>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.</td>
<td>5 October 2011</td>
<td>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.</td>
</tr>
<tr>
<td>David Collings</td>
<td>Potential Botany Land Development</td>
<td>Mr Collings declared a specific interest in relation to the Potential Botany Land Development, being a member of the Howick Local Board.</td>
<td>4 September 2013</td>
<td>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.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>HBL – Food &amp; Laundry &amp; FPSC Programme</td>
<td>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.</td>
<td>12 February 2014</td>
<td>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.</td>
</tr>
<tr>
<td>George Ngatai</td>
<td>Community Services Pharmacy Funding Policy</td>
<td>Mr Ngatai declared a specific interest in terms of their GP Service being like to use a local Pharmacy.</td>
<td>13 August 2014</td>
<td>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.</td>
</tr>
<tr>
<td>Name</td>
<td>Case/Project</td>
<td>Declaration</td>
<td>Date</td>
<td>Note</td>
</tr>
<tr>
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</tr>
<tr>
<td>Wendy Lai</td>
<td>HBL Business Cases</td>
<td>Ms Lai declared a specific interest in regard to Deloitte’s involvement with HBL on this work.</td>
<td>13 August 2014</td>
<td>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.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>Ko Awatea Panel Advisory Services</td>
<td>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</td>
<td>5 November 2014</td>
<td>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.</td>
</tr>
<tr>
<td>Lee Mathias</td>
<td>Otahuhu Boundary Change</td>
<td>The Chair noted her Specific Conflict of Interest, being Deputy Chair at ADHB.</td>
<td>25 March 2015</td>
<td>That Dr Mathias’ specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Lee Mathias</td>
<td>Northern Region Electronic Health Record (NEHR) Project &amp; Regional Information Strategy (RIS 10-20) Refresh</td>
<td>The Chair declared her specific interest as a Director of HealthAlliance.</td>
<td>25 March 2015</td>
<td>That Dr Mathias’ specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>FPSC</td>
<td>Ms Lai advised that Deloitte is involved with FPSC, but confirmed that she personally does not have any involvement.</td>
<td>6 May 2015</td>
<td>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.</td>
</tr>
<tr>
<td>Wendy Lai</td>
<td>EPIC</td>
<td>Ms Lai noted that a Deloitte colleague worked with EPIC in the US. Mr Pearson and Mrs Zacest have met with him for his independent expertise on EPIC.</td>
<td>6 May 2015</td>
<td>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.</td>
</tr>
<tr>
<td>Name</td>
<td>Topic</td>
<td>Details</td>
<td>Date</td>
<td>Notes</td>
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<tr>
<td>Wendy Lai</td>
<td>Botany Land Discussions</td>
<td>Ms Lai advised that Deloitte has been appointed by the three parties involved in the Botany Land discussions (CMDHB, BUPA &amp; East Health). She is not personally involved in this work.</td>
<td>17 June 2015</td>
<td>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.</td>
</tr>
<tr>
<td>David Collings</td>
<td>Fencing of Swimming Pools Legislation</td>
<td>Mr Collings advised that he is the Chair of the Howick Local Advisory Board Swimming Pool Fencing Exemption Committee.</td>
<td>9 September 2015</td>
<td>That Mr Collings’ 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.</td>
</tr>
<tr>
<td>Lyn Murphy</td>
<td>Fencing of Swimming Pools Legislation</td>
<td>Mrs Murphy advised that she is the Deputy Chair of the Swimming Pool Fencing Exemption Committee for Franklin Local Board.</td>
<td>9 September 2015</td>
<td>That Mrs Murphy’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
</tr>
<tr>
<td>Lyn Murphy</td>
<td>MIT Nursing Programme Report</td>
<td>Mrs Murphy is a Lecturer in the Faculty of Business &amp; Information Technology at MIT.</td>
<td>9 September 2015</td>
<td>That Mrs Murphy’s specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.</td>
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</table>
Minutes of Counties Manukau District Health Board
Held on Wednesday, 15 June 2016 at 1.30 – 4.30pm Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

Present: Dr Lee Mathias (Chair), Mrs Dianne Glenn, Mrs Sandra Alofivae, Mrs Kathy Maxwell, Mrs Colleen Brown, Anae Arthur Anae, Apulu Reece Autagavaia, Mr David Collings

In attendance: Mr Geraint Martin (Chief Executive), Mr Ron Pearson (Deputy CEO), Mrs Lyn Butler (Board Secretary)

Apologies: Ms Wendy Lai, Mr George Ngatai, Dr Lyn Murphy

1. Welcome
The Chair welcomed everyone to the meeting.

2. Governance
   2.1 Attendance & Apologies
       Noted.

   2.2 Conflicts of Interest/Specific Interests
       Noted.

       Mrs Alofivae advised an update to the Disclosure of Interests Register.

   2.3 Confirmation of Public Minutes – 4 May 2016
       Resolution
       That the public Minutes of the Board Meeting held on Wednesday, 4 May 2016, were taken as read and confirmed as a true and correct record.
       Moved: Sandra Alofivae    Seconded: Dianne Glenn    Carried: Unanimously

   2.4 Action Items Register
       Noted.

       Patient Care, Experience & Professional Standards – the review has now been completed, with feedback currently being reviewed. The Terms of Reference have been added to the Diligent Resource Centre.

3. Strategy
   3.1 Chair’s Report - verbal update (Lee Mathias)
       The Chair advised that regional collaboration is progressing well.
3.2 **Chief Executive’s Report (Geraint Martin)**

The report was taken as read, and Mr Martin provided the following summary:

Mr David Lenihan officially starts tomorrow, but has been working remotely prior. His Powhiri is being held next week.

Patient and professional standards of care have areas of excellence, but there are too many variations, so work is underway to raise standards across the organisation.

Last month’s Deep Dive focussed on Population Health, with June relating to Localities, which will see a redesign of patient care, particularly through the ARI project.

The Chair advised that hA are undertaking a lot of work with Care Connect, with major changes being made to the platform.

**Resolution**

That the Chief Executive’s Report be **received**.

**Moved:** Lee Mathias  **Seconded:** Reece Autagavaia  **Carried:** Unanimously

3.2.1 **Health & Safety Quarterly Report (Bev Stone/Beth Bundy)**

The report was taken as read.

Mrs Maxwell asked about visitors on site. Mrs Stone confirmed that staff are currently looking at this, in terms of managing unidentified ‘risk’. The Chair noted that contractor management is easier, due to the contractors on site being known. Mrs Stone confirmed that Facilities and Contractors are being managed well.

The Chair advised Mrs Bundy that MBIE have standard wording that can be included in Contracts.

**Resolution**

That the Board **receive** the Health and Safety quarterly report.

**Moved:** Lee Mathias  **Seconded:** Reece Autagavaia  **Carried:** Unanimously

4. **General Business**

None.

5. **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 & Disability Act 2000, that the public now be excluded from the meeting as detailed in the above paper.

**Moved:** Reece Autagavaia  **Seconded:** Colleen Brown  **Carried:** Unanimously
The meeting was re-opened to the public.

The meeting closed at 5.10pm. The next meeting of the Board will be Wednesday, 27 July 2016 at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board of 15 June 2016 are approved.

Signed as a true and correct record on 27 July 2016.

Chair  ........................................
       Dr Lee Mathias (Chair)
### Counties Manukau District Health Board
#### Action Items Register (Public)

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 May</td>
<td>CE Report</td>
<td>The management of Patient Care, Experience and Professional standards is being reviewed to ensure we are fit for purpose with the Transformation Strategy. The Terms of Reference will be added to the Diligent Resource Centre when available.</td>
<td>July</td>
<td>Geraint Martin/ Lyn Butler</td>
<td></td>
<td>✓</td>
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Counts Manukau District Health Board Agenda
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 2016/17.
- **Operational** – including the reports from the Director of Strategic Development, Director of Corporate & Business Services and Director of Ko Awatea.
- **Compliance** – included is an update on Health & Safety.

2.0 Strategic

2.1 There are four key strategic issues I would like to brief the Board on this month, namely:

- The DHB’s Research Strategy
- The establishment of a Social Investment Board
- Next steps regarding Healthy Together 2020
- Progress on the Investor Confidence Ratings Programme

However, before doing so, I am sure you would want to join with me in congratulating Dr Mataroria Lyndon and Ko Awatea for being awarded the Prime Minister’s Award for Excellence in Public Service as Young Professional of the Year at the Deloitte IPANZ Awards. The award was for his work on System Level Measures and Equity that we discussed at the last Board Meeting. Indeed, the shortlist for Young Professional of the Year was remarkable for being an all CMH/Ko Awatea affair, as the runner up was Alex Nicholas for her work for ‘Handle the Jandal’. We were shortlisted in several categories and were the only health sector winners on the night. Congratulations to all concerned.

2.2 DHB’s Research Strategy

It has long been a strategic goal for the DHB to become a Centre for Research & Development. Over the years, we have built up and expanded the capability for R&D as a key, business as usual, part of our work. There are many reasons for doing so, but leading ones are:

- Developing and evaluating innovative solutions in both clinical research and health systems research.
- Strengthening the role of South Auckland Medical School, and our place as a go to organisation for training.
- Creating a strong Research & Development culture will enable us to attract and retain top quality clinicians.

- Ensuring we have opportunities to commercialise innovation through current partnerships, such as Middlemore Trials, G2G and through Ko Awatea.

In the past, we have grown our academic base by investing in Chairs and other academic appointments in several specialities. We have also steadily and significantly grown our research base over the last few years.

Last year, I asked Professor Andrew Hill and Dr Gloria Johnson to review our R&D Strategy, and recommend the way forward to take the DHB forward as a substantive Research Centre and embed R&D as ‘business as usual’.

To achieve this, we have budgeted $2Mp.a. (or 0.18% of our turnover) partially made possible by income generation from Ko Awatea. Whilst a modest sum, this will be a step change for R&D, and the Strategy will be presented to the Board for endorsement. (By way of context, CMH has been working with the Health Research Council, MoH & MBIE in reviewing the role of R&D in the DHB sector and especially how to ensure it is centre state for DHBs. Our Research Strategy has been highlighted as an exemplar in New Zealand).

2.3 Place Based Social Investment
I have included an update on the Social Investment Board – refer Appendix A, with Recommendation for approval.

2.4 Healthy Together 2020
With the arrival of David Lenihan, we are now well into the detailed planning of our Transformation Programme. The first draft of this will be presented to ELT by David on 29 July, after which, we will present it to the Board for approval and subsequent launch in September. An important part of the launch will be a SMO Engagement Workshop. The Transformation Programme will be our route map for delivery up until 2020, and therefore:

- Will focus on disciplined planning and delivery. Part of this will be to upgrade our Investor Confidence Rating to become best in class.

- Embed Ko Awatea Change Management Capacity.

- Accelerate the implementation of a new service models that underpin our strategy to ensure CMH has a high performing, high quality and sustainable and equitable health system by 2020.

2.5 Investor Confidence Ratings Programme
This month CM Health has been finalising the various components of the Investor Confidence Rating for Treasury’s review and subsequent moderation of scores across all Tranche 2 DHBs. This has included provision of data showing asset performance, change management, benefit realisation and project delivery performance over the past two years as well as
completion of our Long Term Investment Plan. This complements independent evaluations commissioned by Treasury of our asset management maturity and portfolio programme, and project management maturity.

The Long Term Investment Plan outlines strategic investments required over the next 10 years to enable us to deliver our **Healthy Together** strategy. We have been complimented by Treasury on the content and approach we have taken to preparing our Long Term Investment Plan which includes exploration of a range of investment options.

While indications are that we have scored well in the independent evaluations, we are aiming to continue to improve our performance over the coming 18-24 months. Both our Executive Leadership Team and the Audit Risk and Finance Committee of the Board have recently endorsed an improvement plan to achieve this. We will be monitoring our progress against this plan on a quarterly basis.

We expect to receive our final Investor Confidence Rating scores in August 2016 for review prior to the scores being submitted to Cabinet in September 2016. Treasury has advised that scores are expected to be made public in December 2016.

### 3.0 Operational

3.1 CMH finished the 2015-16 year very strongly in its financial, service and clinical quality delivery. Although a tight and challenging year, I am extremely proud of how the team at Counties has continued to significantly improve each year and continues to set higher standards and set the pace for the sector as a whole.

We are currently collating the end of year results and once confirmed, I will present to the Board in September a Performance Report for the DHB detailing our progress across the year. A particular focus for this will be the third of my Deep Dives, reviewing achievements and challenges for the Hospital Arm.

<table>
<thead>
<tr>
<th>Health Target Summary</th>
</tr>
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<tbody>
<tr>
<td><strong>Target</strong></td>
</tr>
<tr>
<td><strong>Emergency Departments</strong></td>
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<tr>
<td><strong>Elective Surgery</strong></td>
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<td>Category</td>
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<tr>
<td><strong>ESPI 2:</strong></td>
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<tr>
<td><strong>ESPI 5:</strong></td>
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<tr>
<td><strong>ACTION:</strong></td>
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<tr>
<td><strong>Faster Cancer Treatment</strong></td>
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<tr>
<td><strong>Immunisation</strong></td>
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<tr>
<td><strong>Heart &amp; Diabetes Checks</strong></td>
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<tr>
<td><strong>Tobacco</strong></td>
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<tr>
<td><strong>Maternity</strong></td>
</tr>
</tbody>
</table>
smokers, at the time of confirmation of pregnancy in general practice or booking with a LMC is offered advice and support to quit smoking

**March result:** 100%

Health target data for Maternity is not expected in until 18 July.

**ACTION:** Focus on smokefree incentives programme, Te Hapu (training) programme, quality improvements and networking. The Smokefree service received 161 referrals for pregnant women in Q4 – an increase of 30 women compared to the previous quarter.

**ACHIEVE:**
- Already meeting target / will meet target by 30 June 2016.
- **ON COURSE:** Includes actions to meet target; expected to meet target by 30 June 2016.

*PHOs concentrate on quarterly reporting resulting in lower, inaccurate mid-quarter results. For this reason quarterly results are only provided.

### 4.0 Strategic Development

**Deep Dive – Population Health and Social Investments Directorate**

The Healthy Together 2020 Delivery document describes three key front line Directorates that will each and collectively undergo varying degrees of change to align with strategy (diagram below). Population Health refers to the health outcomes of a group of individuals – groups, families and communities, including the distribution of such outcomes within the group. In a New Zealand context, population health approaches refers to ‘taking account of all the influences on health (the determinants of health) and how they can be tackled to reduce inequalities and improve the overall health of the population’ (Winnard, Crampton et al 2008).

This deep dive addresses the formation of the final Directorate – Population Health and Social Investments to achieve this purpose to complement the expansion of the Primary and Integrated Care Directorate and the focus of the Hospital Directorate on specialist services.
Population health is an important feature of Healthy Together 2020 as it acknowledges that the same rate of health improvement is not the same for all population groups or subgroups due largely to socio-economic determinants of health that vary by factors including but not limited to locality. Healthy Together also acknowledges that variation in those health outcomes are impacted by a range of determinants many of which are not within the control of the healthcare system but that CMH expects to strengthen its capability and capacity to influence those factors, particularly the broader social sector.

The purpose of establishing a Population Health and Social Investments Directorate is to consolidate a capacity and capability that has at its core a population health approach, alongside an emphasis on population health outcomes. A capacity and capability that ensures ‘investment’ decisions are supported by robust evidence and analysis of impact on population groups or subgroups including defined cohorts are more likely to have a positive impact on the reduction of health inequities for those groups to complement broader system focus on the effective treatment, rehabilitation and re-enablement of individuals and national/regional public health promotion and protection efforts. A population health approach aids more impactful investment decision making through the sophisticated use of analytics and processing of information to inform a more targeted approach to cohorts of...
populations. The features of a population health approach that would be visible from an effective Directorate encompasses:

- Champion and promotion of a **culture** across the healthcare system that places the same emphasis on promoting health and preventing disease as on treating illness;
- **Investment** in activities that influence the determinants of health
- enabling and supporting operational commitment to **reducing inequalities**
- **Intersectoral and Intrasectoral** collaboration on local initiatives so that there are working partnerships and alliances with a range of community groups
- genuine **community participation**
- support for sustainable **community development**
- **Data collection and analytics** that is comprehensive and considers ethnicity, deprivation and outcomes
- and **workforce development** to support this wider population health approach.

It is not intended that the Directorate undergoes a name change without a full review of the capability and focus of functions that are currently within the existing Strategic Development Directorate and supporting the wider healthcare system to ensure alignment with population health approaches. Recent appointments and structural changes reflect this emphasis (lead). A capability review and implementation of its actions will be complete by 31 December 2016:

- Appointment of GM Corporate Affairs (Sarah Baddeley ex MBIE, Tsy and corporate affairs private sector) and Head of Digital (Jason Ranston) to reflect the expansion of digital channels that enable more rapid and sophistication engagement with communities and segments of populations and a deeper understanding of broader social and economic policy impacts on engagement with communities;
- Maaori Health Development (Riki NiaNia) and Pacific Health Development (Elizabeth Powell) structural changes to focus on whaanau/families at risk of poor health outcomes due to the complexity of health AND social issues and improve whole of system experience for those whaanau/families;
- Strategic approach to risk management (Kerry Bakkerus) to ensure an internal and critical assessment of those issues that may inhibit our ability to achieve our ultimate population health improvement goals over the life of strategy;
- Planning and organisation performance measurement (Marianne Scott) that assures ELT, Board and informs Transformation on whether the business is aligned and delivering against our national, regional and local commitments;
- Enabled by an expert Population Health and Analytics team (Dr Doone Winnard) who are resourced to provide ongoing health needs analysis, critique of interventions and surveillance of population health outcomes;
- A soon to be formed ‘Social Investment Board’ Unit will complete the Directorate led by a team of analysts and project managers to provide secretariat to the SIB and ensure implementation of its investment decisions.
Directorate Highlights to 30 June 2016

There are 7 teams that provide ‘corporate services’ and two direct patient support services (Maaori and Pacific cultural support) in the Strategic Development Directorate. Risk Management is reported through the Finance and Audit Committee and will be added as a regular monthly update from July 2016. The table below summarises Directorate highlights as at end May.

<table>
<thead>
<tr>
<th>Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Planning</strong></td>
</tr>
<tr>
<td>• 16/17 Annual Plan and Maaori Health Plan are currently with MoH for formal notification of approval.</td>
</tr>
<tr>
<td>• The annual de-brief of the 16/17 planning process will commence to inform the 17/18 cycle.</td>
</tr>
<tr>
<td>• Q4 and Annual Report on 15/16 is work in progress.</td>
</tr>
<tr>
<td><strong>Maaori Health Development</strong></td>
</tr>
<tr>
<td>• Healthy Together 2020 Implementation: Two teams in the Maaori Health Development groups have completed their review and are now in recruitment of key leadership roles – Maaori Health Workforce Development Manager and replacement of existing Te Kaahui Ora staff to increase the clinical capacity to progress its translation to a Whaanau Ora service.</td>
</tr>
<tr>
<td>• Integrated Service Agreement (ISA) contracts for the 16/17 year is currently in consultation with providers. A significant change in the agreements is the removal of self referral in anticipation that a direct and automated process for vulnerable whaanau will be prioritised by the DHB.</td>
</tr>
<tr>
<td><strong>Pacific Health Development</strong></td>
</tr>
<tr>
<td>• 2016/17 Pacific Health Plan – the plan has been approved and is now in implementation.</td>
</tr>
<tr>
<td>• Regional Pacific: Samoa highlight is the launch of Telehealth linking Samoa to more specialist consultations. The details of implementation (scheduling clinical time and appropriate rostering) is currently work in progress.</td>
</tr>
<tr>
<td>• Healthy Together 2020 Implementation: The Fanau Ola team is currently in recruitment to replace existing staff with more clinical capacity to manage more complex families. The AH+ ISA agreement will undergo an analysis of year 1 of implementation during July-Sept to assess whether the appropriate referrals for high need families have been achieved.</td>
</tr>
<tr>
<td><strong>Communications</strong> Highlights of campaigns in progress:</td>
</tr>
<tr>
<td>• Consultation on use of Manukau land closes on 5 August. To date more than 30 submissions have been received with more than 75% supporting its sale</td>
</tr>
<tr>
<td>• New recruitment of Head of Digital will progress planning for intranet replacement during Q1 of 16/17. New GM, Corporate Affairs and Communications begins from 1 August 2016.</td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
</tr>
<tr>
<td>• Ongoing analysis of acute demand growth, bed modelling, diabetes, GDM and pre-diabetes prevalences, preparation of life expectancy healthy life years &amp; amenable mortality for publication.</td>
</tr>
</tbody>
</table>

5.0 Finance

**Key issues (June) 2016:**

1. We have now finalised the interim unaudited result for June and year end June 2016. The most important aspect being that we have very slightly exceeded the financial budget and forecast targets through a superhuman effort by all parts of the organisation, while still achieving virtually all clinical targets. Against the targeted $2.702m surplus [inclusive of the $2.7m pass through] we have posted a surplus of $2.884m.
2. The result was after huge swings in critical areas such as unfavourable, but validated IDF wash ups with ADHB, offset by an equally large favourable [but clinically unacceptable] under delivery in Dental/ARDs by WDHB. Because of the financial materiality to each DHB, the final amounts will be subject to ongoing negotiation but are included at believed correct values.

3. Within the final June result we have absorbed a huge unbudgeted SMO provision cost built up throughout the year as well as taking a firm but objective and compliant stance around treatment of SWIFT/Healthy Tomorrow investment costs, capital vs operating expense i.e., where costs do not meet capital standards we have expensed, despite the original Board approvals assuming full capitalisation given we could never have afforded at that time to expense related costs, and still achieve break even.

4. When the results are considered, both at individual divisional and consolidated level after the above, the financial landing is extremely satisfying given the multiple clinical and financial pressures throughout the year, but has required very strong instruction/action to achieve in June. As a result, the challenge for the next financial year is now even greater.

Key Issues (May) 2016:
1. Monthly result posted a slight negative variance to budget of $126k, but we remain ahead of budget overall $544k. The level of ‘one off’ benefits remains very high relative to the underlying operational performance. Late in June there was huge but expected volatility arising in many of the traditional year-end areas – IDF, ARDS, Actuarial, Revaluations, NZHP, Electives and other normal year end ‘wash-up’ that require very close managing to achieve budget.

2. Key operational issues remain primarily hospital based. Despite a very mild entry towards winter, hospital attendances remain at all-time highs for this time of the year with multiple ‘Dot’ (i.e. well in excess of 100% bed capacity) days continuing. Being well managed by the team but causing increasing stress as this continues. Elective WIES numbers remain behind budget despite being well over discharge budget levels. Phillip Balmer presented the recovery plan to the last Audit Risk & Finance Committee (ARF) reflecting the agreed plan to correct this by year end. Note nearly 40% of the shortfall was generated by the national change in WIES calculation, which has been accepted by MoH. The balance however, will be recovered primarily through third party provisions contracts now being enacted but also increased theatre utilisation. We are confident these targets will be achieved.

3. As above, the forecast year end position is reaffirmed at the budget level. While it has been stated previously many times, the operating position remains extremely tight requiring intense management on all fronts. This tightening position is well reflected already in the worsening health sector position, particularly the hospital arms, which suggest an underlying structural funding problem.

4. As advised earlier, we achieved break even on the Annual Plan/Budget 16/17, but this has required a received enormous organisation wide commitment. Additional funding announced in the June Budget has been allocated to the DHBs’ with
$6.6m allocated to CMDHB. MoH has advised that $1.8m should pass straight through to the bottom line which would make the surplus required by MoH to be $4.5m. Management in discussion with ARF and the Board recommends that the whole $6.6m be applied to fully fund the absolutely minimum level of priority initiatives required in regard to Healthy Together.

5. The current year capital budget is still being finalised. Still outstanding is finalising regional discussion/resolution of hA IT capital funding, both in terms of core infrastructure replacement/upgrade and new investment. While still to be landed/approved, this requires a $38m Infrastructure investment by hA in 16/17 (after rigorous challenging) of which almost $37m would be funded by the full hA depreciation and over $1m more from the region. However, these numbers exclude all application requests, both carry over and new, which would double the amount sought hence the extended regional discussions occurring. The additional challenge is the consequential related higher depreciation and operating costs against continuing under investment and the consequences of such.

6. Huge effort and resource continues to be put into the Treasury Investor Confidence Rating (ICR) process and Louise will update Board on the current status/rating assessments. Although clearly not at desired levels yet, significant groundwork is occurring to relatively quickly lift these upward. We have recently received feedback from Treasury on the LTIP (long Term Investment Plan) which has been extraordinarily positive and unofficially seen as the ‘exemplar for the health sector and one of the best seen in the public sector at this stage of the process’. From discussions directly with Treasury, it is seen as a quality document that is professional, (almost) complete, objective and (interestingly) honest. Apparently it is the only one that has looked hard at a variety of agreed options no matter how unpalatable they might be. The financial sections continue to be refined based on sensitivity scenarios, but the overall trend remains as previously, a position well acknowledged by Treasury.
## Statement of Performance by Operating Arm (interim result)

<table>
<thead>
<tr>
<th>Month</th>
<th>Net Interim Result</th>
<th>Full Year 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td></td>
</tr>
<tr>
<td><strong>ACT</strong></td>
<td><strong>Bud</strong></td>
<td><strong>Var.</strong></td>
</tr>
<tr>
<td>June 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,061</td>
<td>1,129</td>
<td>(68)</td>
</tr>
<tr>
<td>(2,049)</td>
<td>(2,002)</td>
<td>(46)</td>
</tr>
<tr>
<td>(726)</td>
<td>(1,259)</td>
<td>532</td>
</tr>
<tr>
<td>(1,714)</td>
<td>(2,132)</td>
<td>418</td>
</tr>
<tr>
<td>2,395</td>
<td>3,717</td>
<td>(1,322)</td>
</tr>
<tr>
<td>564</td>
<td>19</td>
<td>544</td>
</tr>
<tr>
<td><strong>1,244</strong></td>
<td><strong>1,605</strong></td>
<td><strong>(360)</strong></td>
</tr>
</tbody>
</table>

**Hospital Provider**

$26,890 \quad 27,366 \quad (476)$

**Integrated Care**

$(24,346) \quad (24,620) \quad 274$

**Ko Awatea**

$(14,494) \quad (15,157) \quad 663$

**Provider**

$(11,951) \quad (12,411) \quad 461$

**Funder**

$15,227 \quad 14,883 \quad 344$

**Governance**

$(393) \quad 230 \quad (623)$

**Surplus (deficit)**

$2,884 \quad 2,702 \quad 182$

## Statement of Performance by Operating Arm (May 2016)

<table>
<thead>
<tr>
<th>Month</th>
<th>Net Result</th>
<th>YTD May 2016</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>Last year</td>
</tr>
<tr>
<td><strong>Act</strong></td>
<td><strong>$000</strong></td>
<td><strong>Var.</strong></td>
<td></td>
</tr>
<tr>
<td>May 2016</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>981</td>
<td>980</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(2,221)</td>
<td>(2,003)</td>
<td>(218)</td>
<td></td>
</tr>
<tr>
<td>(1,413)</td>
<td>(1,275)</td>
<td>(138)</td>
<td></td>
</tr>
<tr>
<td>(2,653)</td>
<td>(2,298)</td>
<td>(355)</td>
<td></td>
</tr>
<tr>
<td>1,240</td>
<td>1,015</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>20</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>(1,389)</td>
<td>(1,263)</td>
<td>(126)</td>
<td></td>
</tr>
</tbody>
</table>

**Hospital Provider**

$25,828 \quad 26,233 \quad (405) \quad 14,541 \quad 10,744 \quad 10,744$

**Integrated Care**

$(22,297) \quad (22,618) \quad 321 \quad (8,306) \quad (9,665) \quad (9,665)$

**Ko Awatea**

$(13,767) \quad (13,899) \quad 132 \quad (11,951) \quad (13,500) \quad (13,500)$

**Provider**

$(10,236) \quad (10,284) \quad 48 \quad (5,716) \quad (12,421) \quad (12,421)$

**Funder**

$12,832 \quad 11,170 \quad 1,662 \quad 9,413 \quad 14,893 \quad 15,593$

**Governance**

$(956) \quad 210 \quad (1,166) \quad (2,857) \quad 230 \quad (470)$

**Surplus (deficit)**

$1,640 \quad 1,096 \quad 544 \quad 840 \quad 2,702 \quad 2,702$
6.0 Ko Awatea

**Purpose**
Ko Awatea is updating its internal reporting processes and transitioning to a balanced scorecard approach. It aims to improve the articulation of its specific products and services (and thus relevant expectations, measures and targets) for Counties Manukau Health and wider, nationally and internationally.

Coverage across Ko Awatea’s functions will be selective, with the aim of bringing relevant highlights and issues to the Board’s attention. As such, not all functions will be covered in each report. As the service lifts its maturity across these aspects, it welcomes the Board’s feedback on the information provided or any requests for more information if required.

**Supporting improvement and transformational change**
Utilisation/deployment of resources: **100% deployed until December 2016**.

*Includes external cross-sector contracts such as Early Learning with the Ministry of Education.
*Also accounts for the Equity Campaign which is in the planning stages.

<table>
<thead>
<tr>
<th>Improvement Focus</th>
<th>FTE</th>
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<tbody>
<tr>
<td>Service Improvements</td>
<td>4</td>
</tr>
<tr>
<td>Campaigns</td>
<td>11</td>
</tr>
<tr>
<td>Community Organising</td>
<td>3</td>
</tr>
<tr>
<td>Technology Implementation</td>
<td>1</td>
</tr>
<tr>
<td>Teaching &amp; Coaching for improvement</td>
<td>2.5</td>
</tr>
<tr>
<td>Change Management</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

**Highlights:**

- **Service improvements across secondary care** with sustained improvements in June for **Faster Cancer Treatment**. Performance has remained at around 80% (% patients treated within 62 days) for the last 3 months. Efforts continue to reach the target of 85%.
  - Participants on the programme are working on common challenges across the health system, resulting in significant sharing of ideas and lessons.
- **Learning Sessions** for multiple campaigns during June. Manaaki Hauora/Supporting Wellness is now in its final phase with teams moving from testing change ideas into implementation and looking to collaborate and spread successful change.
- **Cross-sector work with the Ministry of Education** - strong uptake from Early Learning centres to participate in Phase 2 of the programme – focus on increasing enrolments and attendance and oral language acquisition.
- **The Improvement Advisor Programme** is being delivered for the second year to 22 staff from DHBs and PHOs around the country.
  - 100% of participants say they would recommend the programme to others.
Highlights:

- Ko Awatea staff Alexandra Nicholas and Mataroria Lyndon nominated for the Deloitte Institute of Public Administration New Zealand (IPANZ) young person of the year award. Mataroria won the award for Ko Awatea’s work in developing System Level Measures (SLMs), now used as a model for the national health sector SLMs. Alexandra was recognised for her Leadership in the area of Pacific Youth with the Handle the Jandal campaign.

Current issue:
The high level of new requests for improvement projects that will need to be prioritised against existing and planned improvement projects and programmes e.g. Advance Care Planning utilisation in ED; MRI MoH targets; Theatre scheduling and utilisation; Public Health Nursing processes.

Mitigation:
Increased proactive communication with Phillip Balmer and Benedict Hefford to review current and planned/requested improvement work to prioritise best deployment of effort and resources.

Capability Building

<table>
<thead>
<tr>
<th>LEADERSHIP AT CMDHB</th>
<th>Total Enrolments</th>
<th>Patient Safety Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGING LEADERS</td>
<td>44</td>
<td>July 2015 - March 2016</td>
</tr>
<tr>
<td>DR’S AS LEADERS</td>
<td>24</td>
<td>1757</td>
</tr>
<tr>
<td>BOLD CONVERSATIONS</td>
<td>40</td>
<td>Online</td>
</tr>
<tr>
<td>SPIRITED LEADERS</td>
<td>91</td>
<td>1832</td>
</tr>
<tr>
<td>LEADING QUALITY CARE</td>
<td>STARTING FY 16-17</td>
<td>F2F</td>
</tr>
</tbody>
</table>

- People Strategy launched - visit SouthNet.
- Development of e-portfolio (PDRP) – started.

Highlights (Leadership):

- Emerging leaders programme capstone project presentations delivered, including:
  - Community partnership using social media to connect with local māori youth around health information
  - Review in cardiology to reduce the number of outpatient appointments and to support the reduction of waiting lists for Echo procedures
  - The content was well received by ELT members.

Highlights (building capability through improvement):

- Radiology: Following a recent emergency event at Building 58 (Radiology), Ko Awatea’s Clinical Training and Education team completed a process simulation exercise with key staff to safely review areas of difficulty and identify improvements in the way teams respond and operate during emergency situations in this environment.
  - This drives improvement and builds capability in situ and across the multi-disciplinary team.
The exercise recived 100% positive feedback across the categories Value added, Insight gained, Timeliness and Making changes.

**Capability building for innovation thinking and practice**

**Highlights**

- Commissioned to run **creativity and innovation** session for the **NZ Pharmacy Guild** (Board members and Pharmacy owners) - focus on increasing consumer input to service provisions within pharmacy retail businesses.
- Commissioned to run a Health and Care Radical session for the **Ministry of Health’s Cancer Nurse Coordination Forum** – focus for cancer nurses to become leaders of improvement.
- Ongoing innovation support for the **Agency for Clinical Innovation**, Sydney and **Western Health**, Melbourne.

7.0 **Compliance**

7.1 There are no major compliance issues to report. The Health & Safety update is included below.

7.1.1 **Health & Safety**

Priority has been assigned to health and safety risk management at CM Health with the aim of aligning and improving practices. Where necessary, updated processes are being considered for relevance and possible adoption. This includes alignment with the organisational Risk Management methodology, Quality Management practices, Safety 2 which is being facilitated by Dr Carl Horsley, Intensivist – Critical Care Complex and industry ‘best’ practice. The purpose will be to redefine risk management as an embedded approach to daily operations and not only to meet compliance requirements. This work will continue in the future.

Currently operational health and safety risk management is continuing as a deep dive review for community health workers safety. This also encompasses moving and handling, occupational health risks and components of the wellness strategy as separate work streams.

CM Health is on track with preparations to meet the obligations of the ACC Partnership Program Audit scheduled for October 2016. An audit scheduled by the Regional Internal Audit team is being scoped for later in the year with initial planning to focus on Contractor Management, Moving and Handling and Safety Leadership.

The Wellness Strategy has been presented to relevant stakeholder groups and has been met with positive feedback.
Appendix A

Counties Manukau District Health Board
Social Investment Board (SIB)

Recommendation

It is recommended that the Board:

Receive the update on the establishment and implementation of the Social Investment Board (SIB refers);

Note that State Services Commission officials have confirmed that Cabinet agreed:
- the establishment of an SIB with collective accountability through an independent Chair to the lead Minister;
- funding for a 2 year work programme of $1.5m in 16/17 and $2m in 17/18;
- an indicative Social Investment Plan that will focus on an estimated 1,480 at risk 0-5 year old children and their families in Mangere; and the result areas to be targeted are:
  - reducing the number of children experiencing substantiated physical abuse;
  - increasing the number of children participating in early childhood education before they start school;
  - reducing the number of preventable child hospitalisations for illnesses

Approve the Chief Executive Officer agree a contract directly with the State Services Commission for funding to establish the SIB Unit (16/17 $1.5m; 17/18 $2m) and its disbursement as directed by the SIB Chair on the condition that CMH own financial and operational delivery targets are enhanced not compromised by providing support to the SIB;

Note that an SIB Unit will be established in the soon to be renamed ‘Population Health and Social Investments Directorate’ currently the ‘Strategic Development Directorate’ and led by Margie Apa, Director.

Prepared and submitted by Geraint Martin, Chief Executive Officer

Glossary

SIB  Social Investment Board
SSC  State Services Commission
RED  Regional Economic Development programmes (MBIE)
MBIE  Ministry of Business, Immigration and Economic Development
MoSS  Minister of State Services
MSD  Ministry of Social Development
MoE  Ministry of Education
SIU  Social Investment Unit
Executive Summary
Cabinet agreed the establishment of a SIB to be funded by the State Services Commission at its 11 July meeting. The SIB’s initial focus will be on an estimated 1,480 at risk 0-5 year old children and their families in Mangere in its first year. The CEO will establish the Social Investment Board Unit with funding of $1.5m in 16/17 and $2m in 17/18 from the State Services Commission.

Purpose
This paper advises the Board that Cabinet has endorsed the establishment of an SIB, funding for its work and the appointment of an independent Chair reporting directly to the Minister of State Services. That Chair is Sandra Alofivae. This paper also seeks endorsement by the Board of the arrangements in place to establish the Social Investment Board Unit within the CMH organisation.

Background
The Board was last updated at its 18 April meeting and endorsed that CM Health proceed with the establishment of an SIB for South Auckland. Cabinet has now approved that the SIB proceed at its 11 July meeting.

Healthy Together Strategy Alignment: The establishment of the SIB is relevant to the Board because it is a significant strategic action signalled in the Healthy Together 2020 Strategy (pg 8). It also contributes to achieving the strategic goal by enabling social sector agencies to address the social determinants of health and wellbeing in a systematic way. That strategic goal being:

“Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020.”

Healthy Communities – “Together, we will help make healthy options easy options for everyone”

and the key system wide actions that will translate this strategic objective into reality by 2020....

Prevent ill health
“working in partnership to catalyse a new model of health and social service integration to strengthen resilience, health and wellbeing of high needs communities – starting in Mangere”

Healthy neighbourhoods
“working in partnership with health and social sector to co-ordinate local services better through Localities”.

Government policy on Place Based initiatives: The SIB is one of three place based initiatives supported by the Government. The other two ‘places’ are Tairawhiti and Northland. All three place-based initiatives (PBIs) are seeking to improve the outcomes of the most at-risk populations in each area by establishing new approaches to collaboration and decision-making at the local level. The three initiatives are aiming
for similar end structures but each region has started with a different local leadership model:

• a Cabinet endorsed Social Investment Board in South Auckland,
• an existing inter-agency Social Wellbeing Governance Group in Te Tai Tokerau, and
• the creation of a new single governance group in Tairawhiti.

All three groups will take a social investment approach that:

• draws on data and analytics to better understand the outcomes and resourcing required in the target population in the locality; and
• uses this alongside local intelligence and engagement to make evidence-based investment decisions about services and interventions that deliver better outcomes for the target population and that manage long term costs to individuals and government.

The place-based initiatives are complementary to the Regional Economic Development (RED) programme being led by the Ministry of Business, Innovation and Employment, which aims to improve skills, training, and employment outcomes in the regions. The place-based initiatives and the RED programme are working on defining their relationship and sharing information to support the government in achieving its goals. The place-based initiatives are also complementary to the Whānau Ora initiative led by Te Puni Kökiri. Nationally, a connection between the place-based initiatives, the new children’s entity including Children’s Teams and the Whānau Ora Partnership Group will assist the government to achieve long-term beneficial outcomes for these target populations.

Proposal

The SIB Chair reports directly to the Minister of State Services and CMH will be funded through a contract with the SSC to support the SIB. The Board is being asked to endorse this arrangement because it is unusual for DHBs to be contracted for activities accountable to Ministers other than the Minister of Health to whom the DHB is responsible. The unusual circumstances of this activity and the degree of scrutiny will require regular reporting to the MoSS through the Chair while assuring the Minister of Health that this is enhancing delivery of his health priorities, not taking away.

An SIB Unit will be formed under the Strategic Development Directorate under the accountability of Margie Apa. The Strategic Development Directorate is undergoing a name and function changes to better align it to the Healthy Together 2020 Delivery document. It will be renamed ‘Population Health and Social Investments’ to reflect that it is one of the ‘three field marshal’ functions alongside ‘Primary and Community’ and ‘Hospital’ Directorates that must move forward together to achieve our strategy. This is complemented by further investment in population heath priorities – i.e. MoH awarded a further $1.2m for tobacco control and stop smoking services; ELT have prioritised $990,000 in the 16/17 year for alcohol harm minimisation initiatives.

The funding for the SIB Unit is appropriated from Vote: State Services. Further funding for the SIB will be sought as part of the Budget 2018 process. This means that if the SIB is effective and able to build an evidence base for effectiveness this may be submitted as part of the Budget 2018 process.
South Auckland Social Investment Board

<table>
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<tr>
<th></th>
<th>16/17 (000)</th>
<th>17/18 (000)</th>
<th>18/19 (000)</th>
<th>19/20 (000)</th>
<th>20/21 &amp; outyears (000)</th>
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<tr>
<td>1.500</td>
<td></td>
<td>2.000</td>
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**Discussion**

The early potential for benefits that impact on wellbeing include but are not limited to:

- ensuring vulnerable children and their families access the full range of universal and core services currently available across the whole social sector;
- streamline access to both social and health services that are targeted at vulnerable people;
- identify those decision rights, policies and programme design features that prevent the ‘right thing to be the easy thing’ to be done for families at the front line by any agency;
- provide an authorising environment for information to be shared between agencies where it enables improved outcomes for vulnerable children and their families; and
- enable a more sophisticated approach to analytics between social sector agencies that help a more systematic approach to identifying cohorts of people who may benefit from an innovative investment opportunity across social sector agencies.

There are a number of factors that, if managed poorly will hamper successful implementation:

- **challenge to current decision rights**: the SIB may uncover deficiencies in agencies design or policy settings that challenge national policy settings or design features and create tension. Ministers however expect tension and a challenge to decision rights that will lead to a better experience for vulnerable families even if it means that changes are required nationally. The Government expects an improvement in evidence based decision making through the use of analytics;
- **complexity of stakeholder engagement**: keeping a broader ‘church’ of stakeholders engaged at the right time when it matters requires significant co-ordination. Significant agency stakeholders include but are not limited to MSD (Income Support, Community Investment, Child Youth and Family), MoE, NZPolice, Court, Corrections, Auckland Council, Social Investment Unit, Housing NZ. This also requires engaging stakeholders at both a national level (policy units) as well as local leaders (operational delivery). Stakeholder engagement among Mangere communities and locally based providers, NGOs and opinion leaders will also be necessary to support local buy in improvements;
- **measurement and monitoring impact on outcomes**: Ministers have set a high expectation of impact on outcomes. Cabinet have prioritised that result areas will focus on the following outcomes:
  - reducing the number of children experiencing substantiated physical abuse;
  - increasing the number of children participating in early childhood education before they start school;
  - reducing the number of preventable child hospitalisations for illnesses.
Determining the indicators, contributory measures and interventions that will improve these outcomes clearly requires a whole of social sector approach to ensuring that the right investment choices are made. This will be a priority for the SIB.

The priority actions for the SIB are:

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<tr>
<th>Priority Actions</th>
<th>Purpose</th>
<th>Output</th>
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| **Priority Action One** | Analytics for Investment, Action and Social Impact | • Outcomes and measures that will be reported to Ministers for accountability purposes.  
• Analysis and evaluation to inform investment choices and opportunities. |
| **Priority Action Two** | Information Sharing for Effective Integration | • Agreement on mechanisms for enabling information sharing at local level between agencies and front line practitioners for purposes of improving service planning, and service and life experiences of vulnerable populations. |
| **Priority Action Three** | Interventions | • Advice on the application of evidence to Māngere, interventions required and implications for existing service models where change is recommended. This may include nationally defined programmes to ensure better responsiveness to local needs.  
• Implementation of investment decisions that improve the reach and value of existing investments and development of new initiatives where needed. |
| **Priority Action Four** | Workforce Capability and Capacity Development | • Provider and workforce development programme to expand tools for collaborative working, spread of improvement science methods and tools to activate community organising. |
| **Priority Action Five** | Community and Stakeholder Engagement | • Scheduled engagement forums for providers, community leaders and feedback from stakeholders on issues, risks and effectiveness. |
Resolution:
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

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

<table>
<thead>
<tr>
<th>General Subject of Items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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</table>
| 1. Minutes of 15 June 2016               | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Confirmation of Minutes  
For reasons given in the previous meeting. |
|                                           | [NZPH&D Act 2000 Schedule 3, S32(a)]                          |                                                      |
| 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. | For reasons given in the previous meeting. |
|                                           | [NZPH&D Act 2000 Schedule 3, S32(a)]                          |                                                      |
| 3. Investor Confidence Rating             | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |
| 4. APAC Strategy 2017-2019               | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. |
| 5. Healthy Together 2020 – Technology 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. | 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. |
|                                           | [NZPH&D Act 2000 Schedule 3, S32(a)]                          |                                                      |
| 6. Healthy Together 2020 – Technology – e-Prescribing & e-Pharmacy Business Cases | 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. IS 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)] |
| 8. Living Well Centre | 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. Integrated Pharmacist Services | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | Commercial Activities  
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)] |
| 10. Health Research Strategy 2015-2018 | 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. Acute Mental Health Unit Tender | 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)] |
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<th>12. Proposal for New hA Director</th>
<th>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.</th>
<th>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.</th>
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