Counties Manukau District Health Board
Board Meeting Agenda

Wednesday, 11 February 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 2.2. Conflicts of Interest/Specific Interests 2.3. Confirmation of Public Minutes – 3 December 2014 2.4. Action Items Register
1.35 – 1.45pm 1.45 – 1.55pm	3. **Strategy** 3.1. Chair's Report (Verbal Update) 3.2. Chief Executive's Report
	4. **Presentations**
	5. **General Business**
1.55 - 2.00pm	6. **Resolution to Exclude the Public**
2.00 – 2.30pm 2.30 – 2.35pm 2.35 – 2.40pm 2.40 – 2.45pm 2.45 – 3.00pm	7. **Confidential** 7.1. Maternity External Review – Prof Ron Paterson, Prof Lesley McCowan, Maggie O'Brien, Margie Apa 7.2. Confirmation of Confidential Minutes – 3 December 2014 7.3. Action Items Register 7.4. Minister's Letter of Expectations (Lee Mathias) 7.5. Funding 15/16 Advice - Presentation (Ron Pearson)
	Afternoon Tea Break
3.00 – 3.30pm 3.30 – 3.45pm 3.45 – 4.00pm 4.00 – 4.15pm 4.15 – 4.20pm	7.6. Project Swift Update (Sarah Thirlwall) 7.7. Project Swift Governance (Sarah Thirlwall) 7.8. IS Strategic Projects Update (Sarah Thirlwall) 7.9. Acute Mental Health Final Draft Detailed Business Case (Tess Ahern) 7.10. Resolution in Lieu of AGM – HealthAlliance (Ron Pearson)

Next Meeting: 25 March 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 December 2014

Member	Disclosure of Interest
Dr Lee Mathias, Chair	• MD Lee Mathias Limited • Trustee, Lee Mathias Family Trust • Trustee, Awamoana Family Trust • 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
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 • Board Member Phobic Trust • Member The John Walker 'Find Your Field of Dreams' • Chairman, NZ Good Samaritan Heart Mission to Samoa Trust
Colleen Brown	• Chair Parent and Family Resource Centre Board (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, Early Childhood Education Taskforce for COMET • Chair ECE Implementation Team Auckland South • 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	• Chair of the Auckland South Community Response Forum (MSD appointment) • 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 • President – National Council of Women Papakura/Franklin Branch • 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

Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Member, Auckland Council Pacific People's Advisory Panel • Board Member, United Otara Market • Member, Tangata o le Moana Steering Group

BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 3 December 2014

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, 3 December 2014 at 1.30pm at Ko Awatea, Middlemore Hospital, Otahuhu, Auckland.

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, Ms Sandra Alofivae
In attendance:	Mr Geraint Martin (Chief Executive), Mr Ron Pearson (Deputy CEO), Ms Rebecca Ellis (Acting Board Secretary)
Apologies:	Anae Arthur Anae (for lateness), Mr David Collings

1. Welcome

The Chair welcomed members to the meeting and noted it was a year since the new Board Members started. Dates have been set for next year's meetings.

2. Governance

2.1 Attendance & Apologies

Noted.

2.2 Conflicts of Interest/Specific Interests

Noted. Ms Lai advised Deloitte did have a conflict of interest regarding Ko Awatea, however Deloitte had not been shortlisted at this stage. Deloitte has now been selected to work with the Ko Awatea team to improve commercial awareness and increase income levels.

2.3 Confirmation of Minutes – 1 October 2014

Resolution

That the Public Minutes of the Board Meeting held on Wednesday 5 November 2014, were taken as read and confirmed as a true and correct record.

Moved: Wendy Lai **Seconded**: Reece Autagavaia **Carried:** Unanimously

2.4 Action Items Register

Noted.

Dr Jackie Cumming is confirmed to facilitate a workshop session on Wednesday 10 December at Ko Awatea. The Board have been invited to attend the afternoon session between 1 - 4.00pm.

Mr David Moore from Sapere Research Group is confirmed to undertake specific work around the localities and economic model for the localities hub.

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 2015.

Mr Collings provided his apologies to the Chair for non-attendance at the Board Meeting and advised he had reviewed the Health & Safety Report prior to it being signed off at ELT. Mr Collings was given the opportunity to provide his input and feedback into the report, however, he did not feel it was his place to change the report prior to it coming to the Board. The Chair advised it was an operational report and was happy to receive the report in this format, with a view to aggregate or cull the report over-time as necessary.

The Chair advised she had given her commitment to the Health & Safety Manager to join the monthly safety audits that are carried out at the various sites. The Chair will take a more pro-active approach to obtain a wider understanding of the specific issues and look at the extent of risk under health and safety, as this is an area that requires more focus.

1. Monthly Reports

3.1 Chair's Report (Verbal)

The Chair advised her main report was around the Health Benefits Limited (HBL)/ healthAlliance (hA) transition. A Transition Group has been established and is meeting on 12 December at the Regional Governance Group. The Chairman of due diligence for the Transition Group project, has gone to the Honours and Appointment Committee, this will go to Cabinet on Friday. Advice should be received early next week.

Mr Pearson advised hA Finance Procurement & Supply Chain (FPSC), the Northern Region, need to remove themselves of the ownership at some stage so liabilities are not incurred through HBL or other areas, as a very large risk. The Chair responded that was an issue for the Transition Review Group.

Nettie Knetsch was invited to the meeting and was presented with a bouquet of flowers to mark her 30 years working with CMDHB. Ms Knetsch started her career in 1983 at Mangere Hospital. Her main highlight has been Kidz First and the Meningococcal campaign.

3.2 Chief Executive's Report

The paper was taken as read.

Mr Martin congratulated Mr Martin Chadwick and his team on receiving the Health Excellence Bronze award which is a remarkable achievement for best practice. Ten organisations within New Zealand have received the award.

Mr Chadwick advised this was an international award and not specific to New Zealand and will be displayed in a prominent position. The report has highlighted some areas of improvement requiring further focus.

Mr Martin advised the highlight is page 19 of the social media report – the report has shown further work has yet to be completed. Mr Paul Patton is leading the work on this in terms of how to engage our younger population.

The Chair advised Mr Martin to contact Mr Vaughn Davis (Author of Tweet this Book) to discuss further and that it would be beneficial for Mr Davis to spend an hour with Prof Jonathon Gray on TEDx (Mr Davis has the TEDx Licence for New Zealand and he is on the Unitec Board).

Ms Lai advised Mr Martin to update all using Social Media and its Policy in terms of the using Facebook, YouTube, Twitter etc., and appropriate use at the Board Meeting of 11 February 2015.

The Chair referred to page 15 of the report on healthy people in Whanau Ora and advised the report requires being more specific around 'what being healthy looks like'. The community tend to look towards Counties Manukau Health as a health organisation for clarity, therefore a clear message needs to be stated specific to all cultures. Further discussion ensured around healthy peoples.

Mr Anae joined the meeting

2014/15 Quarter 1 Report
The report was taken as read. Mr Martin advised 90% of targets are on track, focus will be on those lagging behind to bring back to target.

Ms Brown referred to page 40 personnel costs – Mr Pearson noted this is a rolling 12 month average of gross salaries on a rolling month period.

Rheumatic Fever Programme, early days as yet in terms of looking at evidence, but results so far are promising. Further discussion ensued regarding renal dialysis and obesity.

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.

2017/15 Quarter 1 Maaori Health Report
The report was taken as read. Mr Martin advised the report highlights some important initiatives and is pleased with the effort to date; however there are a couple of areas that require more focus. Mr Nia Nia has made very good progress with the level of performance.

Resolution
That the Chief Executive's Report be received.
Moved: Lyn Murphy **Seconded:** George Ngatai **Carried:** Unanimously.

4. Presentations
No presentations this month.

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: Lyn Murphy **Seconded:** George Ngatai **Carried:** Unanimously

The meeting closed at 4.45pm. The next meeting of the Board will be Wednesday, 11 February 2015 at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board of 3 December 2014 are approved.

Signed as a true and correct record on Wednesday 11 February 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 ✓
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	Chief Executive's Report	The Chair advised Mr Martin to contact Mr Vaughn Davis (Author of Tweet this Book) to discuss further and that it would be beneficial for Mr Davis to spend an hour with Prof Jonathon Gray on TEDx (Mr Davis has the TEDx Licence for New Zealand and he is on the Unitec Board).	February	G Martin	This has been done as part of APAC 2015 planning.	✓
		Ms Lai advised Mr Martin to update all using Social Media and its Policy in terms of the using Facebook, YouTube, Twitter etc., and appropriate use at the Board Meeting of 11 February 2015.	February	G Martin	Circulated updated Social Media Policy. A formal review is planned for mid 2015. Comments on improvement to Beth Bundy, GM HR.	✓
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 2015.	February	L Mathias/ G Martin	Discussed at CPHAC. Population Health team have been tasked to produce an options paper for April.	

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
1 October	Otara Locality Development	Following discussions around the suburb of Otahuhu, and patients coming to Middlemore for treatment, rather than Auckland Hospital, Mr Anae advised that Otahuhu is in the Manukau Ward of Auckland Council. The Chair said that she would bring this issue up at the Regional Chairs' Meeting.		L Mathias	Lee Mathias to provide an update at the December meeting. Refer – Population Based Funding Changes above.	
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 early next year.	March	G Martin/ B Hefford		

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.** I shall focus on the next steps following the Board Planning Day. In addition, I shall outline the process by which we shall undertake planning for 2015-16 now that funding advice is available.

- **Operational.** Including the reports from the Director Strategic Development, Director Corporate & Business Services and Director Ko Awatea.

- **Compliance.** I shall brief the Board on action following a Health & Safety Audit. This issue has already been reported (with action taken), to the Finance & Audit Committee.

2.0 **Strategic**

2.1 **Strategy & Values Refresh**

Following on from the Board Workshop in December 2014, the process for a refresh of the organisation's strategy and values are to be launched the week beginning 9 February. The purpose of running the two processes together is to ensure that, by July, we align strategy ***(what we do)*** with our values ***(how we do it)***. We will refresh both our CM Health values and strategy in a way that clearly builds on the completion of our 'Best by December 2015' strategy.

Our values are now almost 14 years old and it is timely to revisit whether they are fit for purpose in an integrated healthcare, whole of system context. Within this context, we will join up capital, workforce development and service development priorities (including Hospital and Localities development) in a cohesive joined up plan and actions.

I am particularly excited about the values refresh process. We know that values-led approaches drive positive staff, patient, whaanau and family experience. Tim Keogh of April Strategy has been contracted to support the team who supported ADHB and WDHB's values refresh process. I shall circulate separately to the Board the slides that informed ELT's workshop for Board's information. I am looking forward to the opportunities to hear directly from our staff what a 'good

day at work' looks like in their shoes and how we support making these repeatable experiences. Equally it is important that we hear from staff what a 'bad day at work' looks like and reflect on how we reduce these experiences. The values work will draw on patients and whaanau experiences during March and culminate in a Values week beginning 27 April where there will be many forums and opportunities for staff to write/tell us what they think. A schedule will be forwarded to Board if you are interested to participate and/or hear the feedback from the forums. The table below summarises the activity towards July Board sign off.

	January – March 2015 **Prepare, Question & Understand**	March – June 2015 **Design, Distil & Refine**	July onwards **Set Up & Implement**
CM Health Strategy Refresh Lead: Marianne Scott	▪ What we know now – building on achievements and commitments ▪ **Clarify what we know now** - next 5 year big opportunities? - clear success picture by 2020? - key activities to achieve this, and clear links	▪ Co-design to develop and test key strategic actions over 5 years (Jan 2016 – Dec 2020) ▪ Distil plan and align with other key programmes and plans, e.g. ICT, Workforce, Infrastructure ▪ Alignment with service plans	▪ Design structures ▪ Align with 'Best by 2015' outcomes ▪ Implement
CM Health Values Refresh Lead: Beth Bundy	▪ What we know now – analysing existing data and information ▪ Engage key governance groups ▪ Values week starting April 27 'In Your Shoes' event design, engagement pack development	▪ Facilitated codesign sessions and multiple media to support input from range of perspectives ▪ Values week starting 27 April ▪ Develop and test values for review and approvals	▪ Ongoing activity to support living and leading within our values
Communication Lead: Paul Patton	Combine communications across both the Strategy and Value refresh workstreams using multiple media and tools. This aims to provide clear messages that leaders can use with their teams, provides context of how this work fits in with other work underway, how work is progressing and what it means.		
Governance Sponsor: Margie Apa	Engaging key governance groups for advice and support on the project approach and input	Late May Whole of System Strategy Board (ELT & PHO) review and endorsement of draft Strategy. 9 June ELT approve Board submission	**29 July Board Strategic Plan approval**

2.2 Project SWIFT

Significant activity has been initiated since the Board approval at the December meeting to proceed with the next stage of SWIFT. Program oversight has been reviewed and is presented to the Board this month for consideration. Combined project teams have been formed and are underway; in the case of Model of Care work the team includes PHOs. An expression of interest to clinical staff has generated more than 60 responses from people keen to engage actively in projects. We also have co-opted a consumer representative from the Patient & Whaanau Centred Care group who will act as a key liaison point with our communities.

In addition to project activity, Statements and Work have either been signed or are in the final stages of finalisation, in accordance with the approval and delegation given by the Board at the December meeting. We are also working closely with regional colleagues on development of an integrated regional IS strategy and plan, including SWIFT.

2.3 **Planning for 2015-16**

The financial envelope for 2015-16, along with the Letter of Expectations, was received during the Summer break. Consequently, our Annual Planning round has begun in earnest. Undoubtedly, there will be a number of key decisions to be made regarding our financial and service strategy, especially as financial growth for the DHB has slowed.

Following the January ELT, we have decided to follow the same principles and process as last year.

The key principles guiding our planning will be:

- Delivering the Letter of Expectations within budget.
- Maintain our strategic shape through the Triple Aim.
- Focus on the re-design of the system to be fit for purpose:- 'as quality & effectiveness increase, costs go down'.

The process to be followed will be:

- Annual Planning team led by Strategic Development.
- Financial & Service Sustainability Project Group will progress detailed planning. The core team is the CFO, Director of Hospital Services, Director of Primary & Community Care & Director of Strategic Development.
- Progress will be reported to the ELT, then through to the Board for advice during plan development, then for approval.

As part of this process, it is important that we have a clear picture as to how the re-designed health system is developing. To this end, I have asked Benedict Hefford and Phillip Balmer to produce a joint paper for the next Board identifying how the several initiatives, reforms and changes are:

- Developing into a modernised 'fit for purpose' health system.
- How each component (e.g At Risk Individuals, Localities, Mental Health Capital) is contributing to the change.
- Identify key metrics that will map progress.

It is important for us to do this for three principal reasons:

- Stocktake change.
- Positively critique progress.
- To develop a Communications Strategy for staff and stakeholders.
- Integrate change with our strategic refresh.

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 It is important to draw the Board's attention to three issues:

- The DHB achieved full compliance with the Elective Targets for December 2014. A major achievement that the surgical teams should be congratulated upon.
- The Provider financial position continues to tighten. Whilst budgets remain on track, I and the Director of Finance, have met with the Director Hospital Services team to underline delivery to targets and ensure our financial strategy remains robust.

- Pauline Hanna has been tasked to lead a Project Team ensuring improvement in these target areas (such as Diagnostics & Cervical Screening), where the DHB is below green status, with the objective of ensuring there are no red status targets and the maximum number of green status by year end (N.B. those targets are additional to the six main National targets).

4.0 **Compliance**

4.1 **Health & Safety Action Plan**

Following a review of Health & Safety, improvements have been identified for gas storage. A detailed review has been submitted to the Finance & Audit Committee and a strategy for remedial action agreed with Workplace NZ and put in place to ensure CMH is compliant with standards by an acceptable deadline.

Strategic Development

Highlights

There are 7 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 January 2015. The table also highlights risks that are of organisation concern.

Team	Highlights	Risks
Strategic Planning	Strategy and Values Refresh process preparation to launch week of 9 February underway. 15/16 DAP first draft of Schedule 2 that specifies actions to progress the Government's priority initiatives is under consultation among staff.	Channels for staff engagement and feedback on values and strategy do not provide opportunities for all staff groups to contribute. A comprehensive campaign utilising multiple channels is in place.
Population Health	Census 2013 population demography analysis resulted in a reduction of 12,000 people estimated as resident in CMH. This has impacted on CMH's PBFF share calculations for 15/16.	The Census 2013 results impact on CMH's future PBFF share calculations for 16/17 outyears. Dialogue with MoH is underway to consider alternative methods of estimating population and/or influencing formulae in future PBFF policy development.
Maaori Health Development	The first ever Hui with CMH Maaori staff was implemented in December 2014. The hui was entitled Hui Kaikookiri Paeora (C*hampions for healthy Maaori futures*). Model of care review for Te Kaahui Ora (inpatient support team) is out for consultation with staff (both Maaori and non-Maaori) and providers. MHAC and Maaori Health providers were advised of the changes and invited to comment. A whaanau ora inpatient support service will complement whaanau ora service developments in parallel in localities.	Maaori specific: NHC agreement for the management of Integrated Services is likely to be reviewed and specific contract management tasks to be repatriated to the DHB. This follows concerns that NHC's capacity and capability has suffered from turnover of significant staff Cervical screening indicator performance improvement will require approaches specifically targeted at Maaori and Pacific in addition to current approaches. AWHI service has requested greater input from Pacific and Maaori cultural support services. This presents some issues regarding role clarity and available capacity. This is to be considered further in January.
Pacific Health Development	130 additional primary clients were registered in the Fanau Ola service with an additional 426 whaanau members as part of the engagement. Based on the past 12 months of data, it appears that a ratio of primary client/whaanau engagement is 1:3. This has implications for the skills of Fanau Ola support workers in engaging with a wider group of people. Regional Pacific – Niue and Kiribas agreement expired in Dec 14 and was renewed with MFAT. A renewal with Cook Islands is under negotiation. Current agreements in place with Samoa and Fiji.	
SPMO	Daptiv is the project management application of choice and is in early stages of implementation. Daptiv is designed to provide the organisation with a tool to ensure the alignment and track progress of significant projects, programmes and alignment across portfolio of work.	n/a

Communications	Refreshed Connect+ magazine was distributed in December on the stands. 2015 will see a bi-monthly production of Connect+ with a reformatted "look" to enhance its attractiveness to staff as a channel for information and profiling our people.	n/a
Human Resources	Annual, sick leave and turnover are within acceptable limits. The Health and Safety Action Plan had as one of its priority actions the completion of a HASNO audit. The audit was completed in December 2014 and has resulted in immediate action being undertaken to ensure certification and compliance of existing gas storage sites at Galbraith and Manukau Super Clinic. Short term reallocations to reduce the amount of gas is likely to ensure compliance while longer term solutions are being scoped to ensure the storage location meet fire rating standards.	Gastroentorology claim for backpay on job sizing was referred to Court for decision by Employment Relations Authority. The risks are that the outcome of this decision will set a precedent for other groups who wish to undertake job sizing.

Deep Dive – Te Rapunga Paeora Model of Care Review

This section will take a "deep dive" or focus in depth on activities in the work programme. This month we focus on the Te Rapunga Paeora: Establishing a Whaanau Ora Model of Care in CMH.

The purpose of this project is to develop a robust Model of Care for Whaanau Ora services that will accelerate Maaori health gain and better health outcomes for Maaori. The key objective is to establish a new model of care for patient and whaanau care services currently provided by Te Kaahui Ora Services at Middlemore Hospital. Ultimately, the new model of care will be a catalyst to join up and ensure a consistent approach to providing whaanau centred care to Maaori across the organiation and in community based services.

Of the 85,000 estimated Maaori population in the CM District:

- Approximately 50% of Māori patients are admitted via ED
- ALOS is 3 days
- Rates of potentially avoidable admission for Māori are higher compared to non-Māori.

A 2014 study analysing 5,000 people with the highest health care cost in Counties Manukau Health in 2010 and 2012 was undertaken to assess the potential for interventions in this group to reduce health care cost. This study (yet to be published) identifies that, after adjusting for age structure and population numbers, Māori had the highest age standardised prevalence of the 5,000 people with the highest health care cost in 2010 in CMDHB.

The current model provides on demand cultural support to patients whom request, services whom refer and/or those identified as high risk through daily concerto reporting from Monday to Friday 0800 - 1700. Staff are allocated to wards and services. The project has reviewed hospital utilisation by Maaori, population health need of Maaori and existing practices across other DHBs who have inpatient Maaori cultural support services.

An Expert Advisory Group comprising secondary and primary care clinicians and health professionals and Maaori consumers represented met fortnightly in November/December to advise on the following key issues:

- The target inpatient population that would most benefit from a Maaori cultural and whaanau support
- Triaging the level of support a patient and their whaanau may require (i.e. brief vs more longer term support including transitions to primary/community based provision)
- The process of engagement, assessment and care co-ordination appropriate for each Maaori including interface with existing programmes (e.g. ARI, VHIU).

The proposed model aims to target the needs of:

- Mama, pepi, tamariki (including antenatal/maternal care) and whaanau
- Rangatahi (young people) to Kaumatua with high health needs including whaanau with members living with a disability.

The proposed model that will be open for consultation from 9 February comprises the following changes:

- Extended hours from 0800 – 2000 Monday to Friday, on call weekends
- Redesigned criteria and assessment processes to assess need and level of intervention including holistic assessment of whaanau needs
- Staff are allocated based on needs of patient and whaanau
- Improved engagement with primary and community based provision – particularly Maaori providers.

The model will be open for consultation from staff from 9 February 2015. The model was presented to Maaori providers and MHAC for comment during January 2015.

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.

This month we would like to focus on our partners and collaborators.

Ko Awatea has been strengthening relationships with a range of health systems, public and private organisations, teams and individuals, regionally, nationally and internationally.
The Northern region DHBs especially in the areas of:

1. Safety – Do No Harm;
2. Increasingly in Patient Experience led by Lynne Maher with a focus on Patient Experience Week March 23; and a joined up focus for ChangeDay, 2015, March 11.
3. APAC with both Waitemata, Canterbury and Auckland DHBs running all day sessions on the first day of the Forum, September 23.
4. Regional QI forums rotating between the DHBs

Nationally

1. NZ Health Quality Safety Commission. Ko Awatea has always had a close working relationship with the Health Quality and Safety Commission since its inception. The nature of that relationship is maturing and developing in accordance with our respective roles and

expertise. Our flagship national programme to eliminate central line infections, our work in patient experience, the courses we offer and our annual APAC Forum have provided areas of common interest. Geraint Martin and Dr David Galler have been members of the Commission's Board.

2. Victoria University. Professor Jonathon Gray, the Director of Ko Awatea is the Stevenson Professor of Health Innovation and Improvement at Victoria, University. We have close working relationships with their Health Services Research Centre.
3. University of Auckland. Through Professor Andrew Hill, Ko Awatea has maintained working relationships with the University at a post graduate and research level and we are exploring a close working relationship with the NZ Institute of Leadership.
4. Government Ministries – Ko Awatea is developing its working relationships with the Ministry of Health and Ministry of Education
5. The Association of Salaried Medical Specialists
6. Otago – Prof Jonathon Gray, the Director of Ko Awatea, has a close academic relation with University of Otago; sharing research fellows exploring the development of system level measures

International partnerships

1. The Institute of Healthcare Improvement – Although the nature of our relationship has changed Ko Awatea has maintained close ties with the Institute for Health Improvement (IHI).
2. Oxford Centre for Healthcare Transformation – Ko Awatea has contractual working relationships with this group led by Professor Sir Muir Gray. He remains a close advisor to Ko Awatea as well as a co- author on an increasing number of important publications highlighting cutting edge thinking in healthcare and adding enormous value to our thinking, practice and reputation.
3. Public Health Wales. Ko Awatea has a contractual relationship with Public Health Wales another organisation that is at the forefront of healthcare innovation.
4. The Health Foundation in the UK. Ko Awatea has close links with the Foundation and their work.
5. We are developing a significant relationship with The Royal Salford Foundation Trust and its Chief Executive, Sir David Dalton; and with Haelo and its Director Professor Maxine Power. Salford is one of the best performing Trusts in the UK and its Haelo akin to our Ko Awatea. The primary purpose of Haelo is to identify, adopt and spread innovation and best practice for population health benefit, focusing on improving outcomes to address inequalities and optimise public resource.
6. Tang Tok Seng Hospital, Changi General Hospital; the clinical service lead for the new Woodhills Hospital in north Singapore; and the Singapore Health Improvement Network – SHINe. These organisations have supported past APAC Forums with their attendance and with presentations. We expect those relationships to extend into working collaborations in the near future.
7. Joint Commission international – JCI. This arm of the American Joint Commission is responsible for hospital accreditation and had has extensive networks into Asia, notably Singapore, Malaysia, China, Taipei, Japan, Korea, India and elsewhere. JCI presented a session at our third APAC Forum and likely will have an influence at our fourth. Our discussions about mutual opportunity are continuing.
8. Qatar – Ko Awatea has been asked by the Qatari government to assist them with a major healthcare redesign process and is likely to strengthen our relationships there and more broadly in the Middle East.
9. Australia – Ko Awatea has established a range of relationships with healthcare organisations in Australia as a result of the planning in the run up to the success of our third APAC Forum in Melbourne. They include: The Federal Commission for Quality and Safety; the federal Chief Medical Officer at the Ministry of Health, Professor Chris Baggoley; the Victorian Ministry of Health; Quality and Safety Professor Dorothy Jones from Curtin University and her staff; the Alfred Hospital in Melbourne; The Eastern and Northern Victorian health systems and others. In New South Wales we have established working relationships with the Clinical Excellence

Commission; the Agency for Clinical Innovation; the Australian Healthcare and Hospitals' Association; and others.

Ko Awatea is developing a reputation as a world leader in innovation and improvement and as such attracting attention from a wide range of organisations both directly and indirectly associated with the provision of health services.

FINANCIAL POSITION at December 2014

Summary:

While it may only seem a marginal dollar worsening of the surplus over recent months, there is no question that each month's operating performance particularly within the Provider Arm has become much more challenging in meeting budget.

The main drivers of the pressure remain primarily delays in achieving external (HBL) and internal (hA) "procurement savings" where we are exerting maximum effort - timing remains, a problem. While the Nursing initiatives in being implemented, this is much slower than anticipated or needed and further urgent focus is being directed here. A comprehensive update is being prepared for the February HAC meeting.

Month / Year to date

The consolidated result for the month was a favourable variance of $97k. The actual result was actual $(76)k v's budget $(173)k deficit, with the year to date result a favourable variance of $114k, actual $718k v's budget $604k surplus.

The Funder Arm was $547k favourable to budget and year to date $1,481k favourable. 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 $4k and year to date a favourable $39k. The Hospital side of the provider arm was favourable for the month by $51k and year to date $83k favourable. High volumes continue in Emergency Care (9,175 discharges vs budget 8,761)4.73% increase in December. Inpatient volumes were up 4.8% on the same time last year, however case weight volumes increased by 1.9% against last year.

Governance was unfavourable for the month of $(454)k and year to date $(1,406)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.

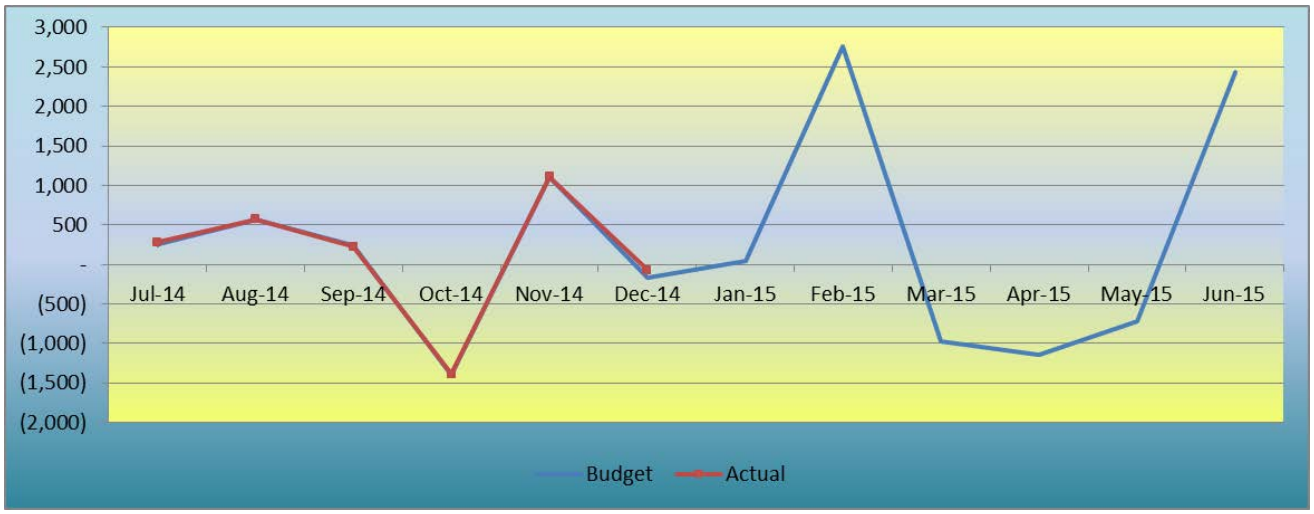
Forecast:

The high level forecast (based on September results) shows the organisation 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. Savings are monitored and reported using a comparative of actuals to target baselines for procurement initiatives, and actual cost vs. budget for all other initiatives. These savings plans are reported in more detail in the Practising Sustainable Healthcare (PSHC) monthly report. Further delays and reductions in HBL initiatives rollouts such as Food and 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 December			Net Result	YTD December				Full year	
Act	$000	Var.	$000	Act	Bud	Var.	Last year	Bud	Forecast
1,332	1,281	51	*Hospital Provider*	9,062	8,979	83	7,577	16,713	17,931
(798)	(805)	7	*Integrated Care*	(4,397)	(4,830)	433	(2,628)	(9,590)	(9,626)
(1,132)	(1,165)	33	*Ko Awatea*	(6,589)	(6,808)	219	(6,455)	(13,413)	(13,490)
(152)	(65)	(87)	*HBL*	(931)	(235)	(696)	(572)	(714)	(1,738)
(750)	(754)	4	*Provider*	(2,855)	(2,894)	39	(2,078)	(7,004)	(6,923)
1,129	582	547	*Funder*	4,979	3,498	1,481	4,342	6,996	7,644
(455)	(1)	(454)	*Governance*	(1,406)	-	(1,406)	(351)	1	(724)
-	-	-	Gain on Sale	-	-	-		3,007	3,007
(76)	**(173)**	**97**	***Surplus (deficit)***	**718**	**604**	**114**	**1,913**	**3,000**	**3,004**

Monthly Result (not cumulative)



Volume Summary (December 2014)

Total WIES

Month						Year to date				
Act	Bud	Var.	%	Last. Yr.		Act	Bud	Var.	%	Last. Yr.
4,864	4,857	7	0.14%	4,793	*Acute*	31,682	31,149	533	1.71%	31,104
1,360	1,234	126	10.21%	1,315	*Elective*	9,123	9,107	16	0.18%	9,158
6,224	**6,091**	**133**	2.18%	**6,108**	***Total***	**40,805**	**40,256**	**549**	1.36%	40,262

Discharges

Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
5,867	5,610	257	4.6%	*Acute*	36,988	36,309	679	1.87%
1,121	1,061	60	5.7%	*Elective*	8,759	8,580	179	2.09%
6,988	**6,671**	317	4.8%	*Total*	**45,747**	**44,889**	**858**	1.91%
0.89	**0.92**	0.02	2.7%	***Ratio WIES to discharges***	**0.89**	**0.90**	**0.01**	0.54%

Volumes Other

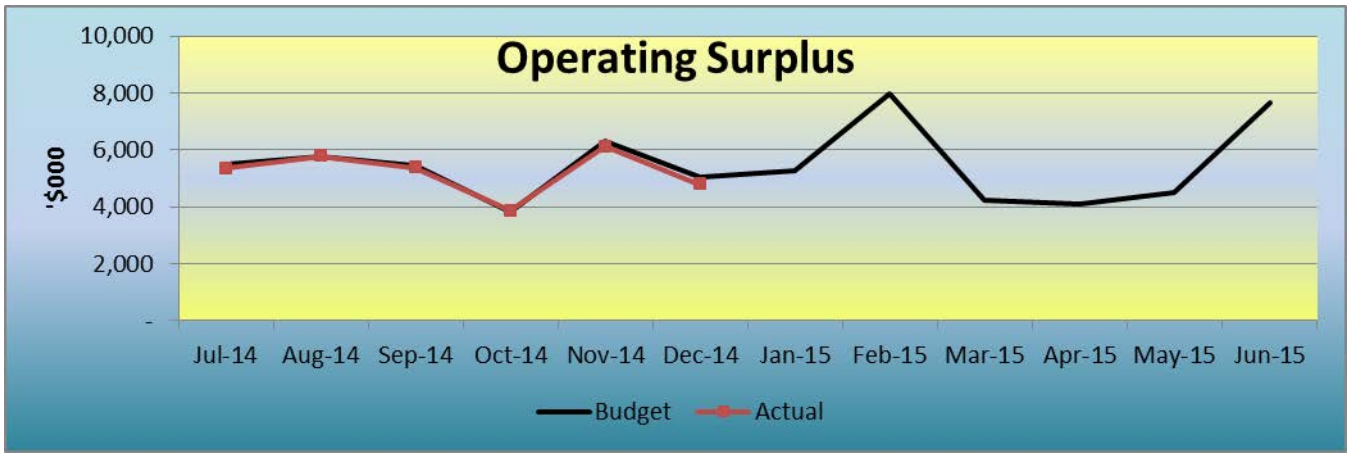
Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
642	619	23	3.72%	*Birth Numbers*	3,705	3,680	25	0.68%
9,175	8,761	414	4.73%	*ED Volumes*	55,815	53,617	2,198	4.10%
4,782	4,213	569	13.51%	*Renal Dialysis*	27,676	25,923	1,753	6.76%
26,760	27,249	(489)	(1.8)%	*Outpatient Summary*	181,902	189,541	(7,639)	(4.0)%
2.5	2.5	-	-	*ALOS*	2.5	2.5	-	-

Renal growth is now growing at an average of 6.76% along with ED volumes at 4.1%.

Statement of Performance

Month				Year to Date				Full Year	
Act	**Bud**	**Var.**	*$000*	**Act**	**Bud**	**Var.**	**Last year**	**Bud**	**Forecast**
			Revenue						
121,253	121,156	97	*Crown*	724,773	728,253	(3,480)	702,023	1,456,397	1,455,400
3,220	2,713	507	*Other*	19,046	16,772	2,274	19,260	32,246	32,597
124,473	**123,869**	**604**	***Total Revenue***	**743,819**	**745,025**	**(1,206)**	**721,283**	**1,488,643**	**1,487,996**
			Expenses						
46,244	46,362	118	*Personnel*	269,797	272,715	2,918	262,389	556,961	541,174
5,480	4,684	(796)	*Outsourced*	32,338	28,495	(3,843)	32,711	46,607	59,503
53,247	54,855	1,608	*Funder Provider payments*	322,787	329,124	6,337	315,784	657,917	653,550
9,038	7,410	(1,628)	*Clinical Sup.*	53,357	48,534	(4,823)	49,732	97,038	104,019
5,690	5,508	(182)	*Infrastructure*	34,303	34,225	(78)	33,631	67,471	67,307
119,699	**118,819**	**(880)**	***Operating Exp***	**712,582**	**713,093**	**511**	**694,247**	1,425,994	1,425,553
4,774	**5,050**	**(276)**	***Surplus after operating Exp.***	**31,237**	**31,932**	**(695)**	**27,036**	62,649	62,443
2,508	2,848	340	*Depn.*	16,578	17,078	500	15,357	34,156	34,157
1,083	1,280	197	*Interest*	6,428	7,680	1,252	3,331	15,360	14,539
1,259	1,095	(164)	*Capital Chg.*	7,513	6,570	(943)	6,435	13,140	13,751
-	-	-	*Gain on Sale*	-	-	-		3,007	3,007
(76)	**(173)**	**97**	***Net Surplus***	**718**	**604**	**114**	**1,913**	**3,000**	**3,004**
Better than 5%	**Worse than 5%**								

Monthly Operating Result (not cumulative)



Revenue

Month				YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
69,083	67,398	1,685	*Provider*	409,769	406,198	3,571	778,434
117,144	117,287	(143)	*Funder*	700,560	703,724	(3,164)	1,363,247
(62,768)	(61,850)	(918)	*Elimination*	(372,794)	(371,102)	(1,692)	(715,366)
1,014	1,034	(20)	*Governance*	6,284	6,205	79	15,085
124,473	**123,869**	**604**	***Total***	**743,819**	**745,025**	**(1,206)**	**1,441,400**

Provider: favourable for the month of December. The main drivers for the current month's variance are:

- ***Government Revenue*** *$444k;* CTA Nursing timing of revenue to budget $96k, ACC additional revenue $172k; additional gastro and other clinical revenue $270k, breast services $(60)k, other $(34).
- ***Patient/Consumer Sourced*** *$(223)k;* There were no Tahitian burns patients that presented in December $(175)k, Non-resident billings for the month $(54)k (offset by bad debts); other $6k.
- ***Other Income*** *$608k;* Interest Received is $181k above budget for the month, donation revenue $(38)k; Pharmac rebate $250k; Respite revenue (ex Funder) $146; Bad debts $11k; additional billings to MIT for Training Course Fees $61k; other $(3)k.
- ***Funder Payments*** *$857k;* Variation in revenue phasing from Funder for contracts outside base funding ie: 20k days and localities $307k; $550k IDF inflow wash-up 2014/15.

Staff Costs

Month				YTD			Full Yr.
Act	**Bud**	**Var.**	**$000**	**Act**	**Bud**	**Var.**	**Bud**
45,332	45,689	357	Provider	265,264	268,670	3,406	519,227
912	673	(239)	Governance	4,533	4,045	(488)	9,898
46,244	**46,362**	**118**	**Total**	**269,797**	**272,715**	**2,918**	**529,125**
14,444	14,727	283	Medical	84,541	87,109	2,568	169,096
17,226	16,965	(261)	Nursing	101,548	99,910	(1,638)	197,975
6,642	6,936	294	Allied Health	39,002	40,244	1,242	77,878
2,159	2,086	(73)	Support Personnel	12,171	12,177	6	21,966
5,773	5,648	(125)	Management Admin	32,535	33,275	740	62,210
46,244	**46,362**	**118**		**269,797**	**272,715**	**2,918**	**529,125**

- **Provider:** reflects a deliberate strategy to balance overall 2014/15 budget expectations. Vacancies (220FTE in Dec14) across the organisation (representing 3.8% of budget FTE), have been part offset by internal bureau (48)FTE, overtime (39)FTE, casual staff (47)FTE, funded FTE (37)FTE. A level of outsourced personnel costs (26)FTE have been incurred to cover vacancies (primarily Medical, Surgical and Women's Health).

Nursing personnel costs for the month and YTD reflects the level of clinical demand within the hospital as well as a delay to deploy the agreed nursing strategies (now underway – refer DON report) which are critical to meet 2014/15 budget.

Reviews commenced in November that encompassed the following key themes (and will be on-going):

1. Skill-mix - continued management of recruitment strategy and approvals to ensure that opportunities to right size skill-mix are proactively aligned with nursing turnover. The commitment to increase our intake of nursing graduates is a key component of this strategy.
2. Review of Nursing Hours Per Patient Day (NHPPD) - review of NHPPD for all hospital ward areas to confirm right size for each area and across the 24 hour roster. This review will incorporate review of resourced beds; occupancy and acuity together with leave policy, and will feed into the McKesson deployment scheduled for early 2015. The review will also incorporate benchmarking with other like DHBs. This review will confirm the appropriate "hire to" and "roster to" FTE levels for each ward/division and will inform 14/15 forecast and 15/16 budget.
3. Protocol and Measurement - Review and Confirm Protocol (incl. responsibility and accountability) for use of additional non-standard resource (external bureau, overtime, watches etc). Work is already underway to confirm the most appropriate exception reporting for this area.

The Director of Nursing will provide a progress update to HAC in February.

Outsourced Services

Month				YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
735	460	(275)	*Medical*	3,893	2,777	(1,116)	4,860
213	37	(176)	*Nursing*	772	228	(544)	549
49	70	21	*Allied Health*	319	422	103	768
44	38	(6)	*Support*	248	227	(21)	444
295	163	(132)	*Management/Administration*	1,827	945	(882)	1,486
1,336	768	(568)	***Total Personnel***	7,059	4,599	(2,460)	8,107
2,656	2,547	(109)	*Corporate & Funder Services*	15,993	15,294	(699)	28,296
1,488	1,369	(119)	*Clinical Service*	9,286	8,602	(684)	18,864
5,480	**4,684**	**(796)**	***Total***	**32,338**	**28,495**	**(3,843)**	**55,267**

- **Provider:** unfavourable for December (includes personnel, clinical and other).

  Mental Health is the main contributor, $(182)k. The service employed locum medical staff due to a national shortage of psychiatrists (part offset by favourable personnel costs).

  Surgical services, $(125)k. Outsourced surgical procedures increased to deliver to the MOH ESPI 120 day target by 31 December 2014. Additional outsourcing has also been incurred to manage increased volumes during the month and planned theatre closures early 2015 (refurbishment of MSC). This variance is offset by a positive variance of $341k in Personnel costs.

  Medical & Clinical Support, $(187)k, Outsourced gastro colonoscopy procedures $(112)k (offset by MoH funding); outsourced nursing to cover leave $(46)k; other $(29)k.

  Kidz & Womens, $(77)k external personnel to cover existing vacancies and additional FTE for funded projects.

  National agreements with HBL and Pharmac have resulted in YTD cost increases against budget in December; HBL National Procurement Project $(85)k; HBL Food Service Regional Implementation YTD $(7)k, Pharmac Sector Funding $(18)k.

  Ko Awatea, $(7)k variance to budget is directly offset by personnel costs.

  Other Non-Clinical Outsourcing, $(124)k.

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

Month			Major Categories	YTD			Full Yr.
Act	Bud	Var.	$000	Act	Bud	Var.	Bud
			Personal Health				
21,024	20,857	(167)	*IDF Personal Health*	124,646	125,140	494	245,784
8,167	8,349	182	*Pharmaceuticals*	50,632	50,097	(535)	99,096
7,309	6,976	(333)	*Primary Practice Services – Capitated*	42,534	41,855	(679)	81,144
567	576	9	*Child and Youth*	3,531	3,454	(77)	5,767
468	465	(3)	*Adolescent Dental Benefit*	2,802	2,791	(11)	5,664
178	247	69	*Chronic Disease Management and Education*	1,324	1,481	157	5,772
375	361	(14)	*Palliative Care*	2,247	2,167	(80)	4,332
343	427	84	*General Medical Subsidy*	2,058	2,559	501	4,176
1,241	1,992	751	*Other*	9,654	11,953	2,299	16,603
39,672	**40,250**	**578**	***Total Personal Health***	**239,428**	**241,497**	**2,069**	**468,338**

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

			Mental Health				
1,226	1,225	(1)	*IDF Mental Health*	7,354	7,354	-	13,824
842	917	75	*Community Residential Beds & Services*	5,038	5,499	461	11,232
706	688	(18)	*Other Home Based Residential Support*	4,221	4,131	(90)	8,280
322	321	(1)	*Dual Diagnosis – Alcohol & Other Drugs*	1,901	1,923	22	3,636
274	272	(2)	*Crisis Respite*	1,631	1,631	-	3,267
357	327	(30)	*Child & Youth Mental Health Services*	2,134	1,963	(171)	3,561
176	164	(12)	*Kaupapa Maori Mental Health Services - Community*	1,046	984	(62)	1,975
157	185	28	*Mental Health Community Service*	918	1,111	193	1,785
255	740	485	*Other*	2,308	4,443	2,135	13,086
4,315	**4,839**	**524**	***Total Mental Health***	**26,551**	**29,039**	**2,488**	**60,646**

The traditional slow start for mental health shows in these small variances

			Disability Support Services				
4,080	4,341	261	*Residential Care: Hospitals*	20,910	21,704	794	49,707
1,708	2,035	327	*Residential Care: Rest Homes*	9,697	10,175	478	23,076
1,700	1,731	31	*Home Support*	8,664	8,654	(10)	20,116
1,534	1,422	(112)	*Other*	7,116	7,104	(12)	15,808
9,022	**9,529**	**507**	***Total Disability Support Services***	**46,387**	**47,637**	**1,250**	**108,707**

140	**115**	**(25)**	***Total Public Health***	**734**	**689**	**(45)**	**852**
98	**122**	**24**	***Total Maori Health***	**665**	**733**	**68**	**1,308**
53,247	**54,855**	**1,608**	***Funder***	**322,787**	**329,124**	**6,337**	**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				YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
3,524	3,031	(493)	*Treatment Disposables*	21,763	20,214	(1,549)	40,569
739	606	(133)	*Diagnostic Supplies & Other Clinical Supplies*	4,412	3,797	(615)	7,345
1,271	900	(371)	*Instruments & Equipment*	6,708	5,896	(812)	11,786
308	242	(66)	*Patient Appliances*	1,784	1,603	(181)	3,217
1,385	1,097	(288)	*Implants & Prostheses*	8,404	7,885	(519)	15,983
1,555	1,239	(316)	*Pharmaceuticals*	8,545	7,349	(1,196)	14,582
256	295	39	*Other Clinical Supplies*	1,741	1,790	49	3,558
9,038	7,410	(1,628)	***Total***	53,357	48,534	(4,823)	**97,040**
			Explained by:				
(197)		(197)	***Volume greater than budget***	(725)		(725)	
(58)		(58)	***Non Residents***	(518)		(518)	
(472)		(472)	***Saving targets***	(2,167)		(2,167)	
(167)		(167)	***PCT Revenue***	(2,004)		(2,004)	
8,144	7,410	(734)	***Operational costs***	47,943	47,534	(409)	

- **Provider:** unfavourable for the month.
  Delayed target procurement savings across the services of $(708)k are partially offset in other cost and revenue areas.
  Clinical Support is over budget by $(401)k explained by a drug overspend of $(210)k driven by demand across the organisation (offset by PCT revenue $167k). Laboratory testing kits higher than budget $(37)k due to volume increase. Blood overspends of $(31)k have been influenced by an increased demand for

platelets and patients presenting with complex conditions that required Intragram Albumex. Radiology shunts, stents and catheters continue with a steady increase above budget, driven by vascular surgery demand, $(125)k. Other cost increases $2k.

Surgical & Ambulatory, $(304)k unfavourable due to an increased workload of both acute and elective surgical volumes in December (compared to contract) and budget phasing for anticipated MSC theatre closures.

ARHOP, $(81)k unfavourable due to an overspend in community dressings costs $(60)k, other $(11)k.

Kidz First, $(82)k, an issue with the inventory set up for NICU caused the balance sheet inventory to be overstated. An investigation of the issue resulted in an expense adjustment being made of $(103)k.

Non-Clinical Patient transport and lodging agreement with NTA (MoH National Transport and Accommodation) is $(4)k unfavourable to budget reflecting an increase in the number of patients that require transport. Ambulance/Air Ambulances costs were favourable for the month $5k.

The above variance includes clinical supply costs incurred in delivering additional unbudgeted revenue: Pharmaceutical Cancer Treatment $50k and Non-Residents $0k (Calculated as 30% of additional Non-resident revenue). Spinal implants estimated at $60k for the month.

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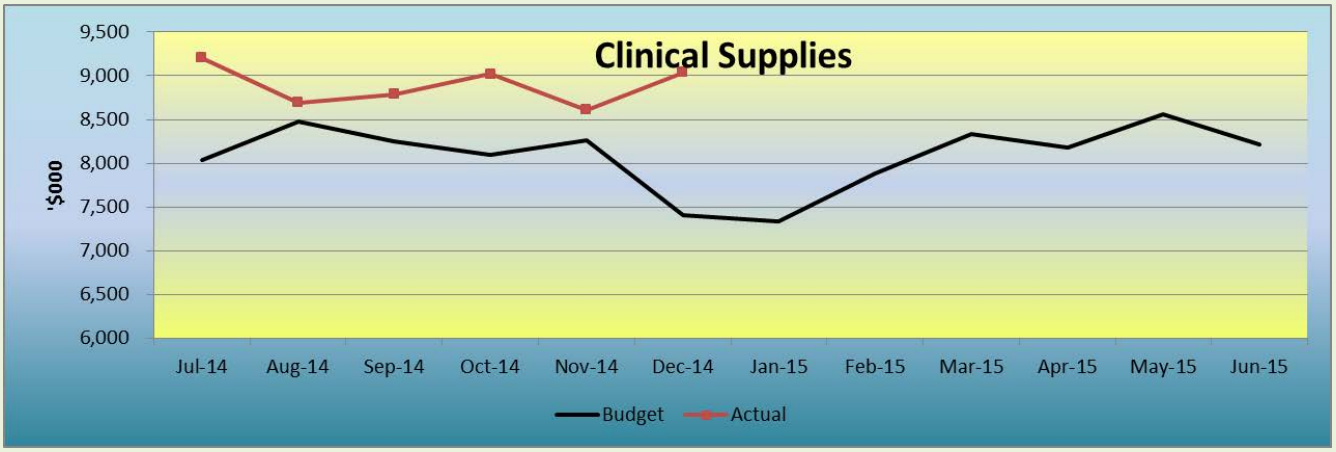


Non-Clinical / Infrastructure (excluding Interest and Capital Charge)

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
5,174	5,214	40	*Provider*	31,601	32,459	858	89,056
516	294	(222)	*Governance*	2,702	1,766	(936)	4,053
5,690	5,508	(182)	***Total***	34,303	34,225	(78)	**93,109**

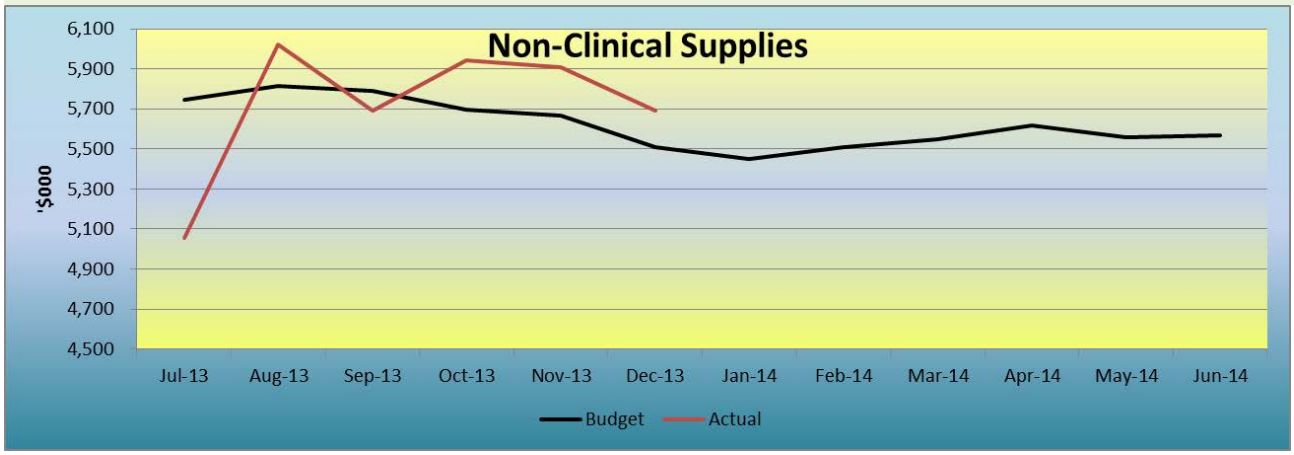
- **Provider:** The main expense drivers for the month are:

  Delayed target laundry procurement savings across the services of $(143)k;

  Integrated Care $129k. Expense recovery for Dec14 $118k attributable to revenue; other $11

  Facilities, $61k, savings achieved in patient meals $54k, utilities $75k offset by security $(36)k and R&M $(47)k, other $15k.

- **Governance**: Consultant fees , Swift, Planning and Funding, Maori



Interest and Capital Charge

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
281	100	181	*Interest - Received*	1,661	600	1,061	**1,200**
1,083	1,280	197	*Interest Paid - Debt*	6,428	7,680	1,252	13,450
802	**1,180**	**378**	***Net Interest Paid***	**4,767**	**7,080**	**2,313**	**12,250**
1,259	1,095	(164)	*Capital Charge*	7,513	6,570	(943)	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

	Dec 14	Nov 14	Oct 14	Sep 14	Aug 14	July 14	June 14
Medical	20.81	20.05	21.03	20.61	20.29	20.56	20.00
Nursing	24.89	24.66	25.32	24.43	24.17	24.93	24.03
Allied	9.61	9.33	9.59	9.56	9.36	9.66	9.05
Support	3.13	2.96	3.03	2.88	2.89	2.93	2.81
Management	7.18	6.60	6.95	7.04	6.76	7.20	6.44
Personnel	**65.62**	**63.60**	**65.92**	**64.52**	**63.47**	**65.28**	**62.34**
Outsourced Pers.	2.10	2.01	1.73	2.01	1.67	1.62	2.44
Total Personnel	**67.72**	**65.61**	**67.65**	**66.53**	**65.14**	**66.90**	**64.78**
Outsourced Clinical Services	2.15	2.21	2.70	2.11	2.37	2.05	2.76
Outsourced Corp (hA)	3.61	3.72	3.60	3.71	3.80	3.50	3.52
Clinical Supplies	**14.38**	**13.95**	**14.51**	**14.34**	**13.94**	**14.90**	**13.65**
Infrastructure	13.21	13.74	14.42	14.06	14.52	13.12	13.59
Total	**101.09**	**99.23**	**102.88**	**100.75**	**99.76**	**100.47**	**98.29**

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	24.7	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	7.0	6.8	7.2	7.8	7.7
Personnel	**64.7**	**65.2**	**66.3**	**65.2**	**64.0**
Outsourced Personnel	1.9	1.8	1.8	1.7	1.9
Total Personnel	**66.6**	**67.0**	**68.1**	**66.9**	**65.9**
Outsourced Clinical Supplies	2.3	2.7	2.9	2.8	3.4
Outsourced Corporate	3.7	3.7	3.4	3.3	2.4
Clinical supplies	14.3	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]	144,378	553	143,825	20,705	123,673
Trust	876	860	16	865	11
Prepayments	1,163	500	663	1,196	(33)
Debtors	35,142	42,000	(6,858)	32,887	2,255
Inventory	2,096	4,490	(2,394)	1,434	662
Assets Held for Sale	12,503	12,503	-	12,503	-
Total current Assets	**196,168**	**60,916**	**135,252**	**69,600**	**126,568**
Fixed Assets					
Land	110,020	62,430	47,590	110,020	-
Buildings & Plant	611,493	729,494	(118,001)	710,607	(99,114)
Investment Property	1,360	1,360	-	1,360	-
Information Technology	2,745	2,945	(200)	4,145	(1,400)
Information Software	323	730	(407)	4,391	(4,068)
Motor Vehicles	3,932	4,488	(556)	4,292	(360)
Total Cost	**729,873**	**801,447**	**(71,574)**	**834,815**	**(104,942)**
Accum. Depreciation	(137,346)	(214,364)	77,018	(195,671)	58,325
Net Cost	**592,527**	**587,083**	**5,444**	**639,144**	**(46,617)**
Work In-progress	4,998	10,000	(5,002)	1,851	3,147
Total Fixed Assets	**597,525**	110,020	62,430	47,590	110,020
Investments (hA IT / HBL)	29,349	27,000	2,349	27,127	2,222
Total Assets	**823,042**	**684,999**	**138,043**	**737,722**	**85,320**
Current Liabilities					
Creditors	90,812	95,930	(5,118)	91,817	(1,005)
Income in Advance [1]	127,579	1,300	126,279	3,192	124,387
GST and PAYE	7,950	5,000	2,950	6,761	1,189
Loans (Crown and HBL shared banking)	40,000	40,000	-	40,000	-
Payroll Accrual & Clearing	35,391	26,049	9,342	32,452	2,939
Employee Provisions	79,139	80,700	(1,561)	81,249	(2,110)
Total Current Liabilities	**380,871**	**248,979**	**131,892**	**255,471**	**125,400**
Working Capital	(184,703)	(188,063)	3,360	(185,871)	1,168
Net Funds Employed	**$442,171**	**$436,020**	**$6,151**	**$482,251**	**$(40,080)**
Non-Current Liabilities					
Term Loans	227,600	227,600	-	227,600	-
Employee Provisions (non-current)	16,836	15,300	1,536	16,984	(148)
Trust and Special Funds	872	860	12	864	8
Insurance Liability- Non Current	1,337	1,300	37	1,337	-
Total Non-Current Liabilities	**246,645**	**245,060**	**1,585**	**246,785**	**(140)**
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	(77,366)	(76,637)	(729)	(74,511)	(2,855)
	Retained Earnings – Govern.	(19,557)	(16,644)	(2,913)	(18,151)	(1,406)
	Retained Earnings - Funder	33,579	32,300	1,279	28,600	4,979
Total Crown Equity		**195,526**	**190,960**	**4,566**	**235,466**	**(39,940)**
Net Funds Employed		**$442,171**	**$436,020**	**$6,151**	**$482,251**	**$(40,080)**

Commentary

Net borrowings: Long and short term debt less bank balance is $143.8m lower 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 a stronger closing cash position, opening position $20.7m higher than budgeted and not drawing down on the final $30m facility for CSB.

Debtors: $6.8m lower than budget, $2.2m higher than June 14 due to timing of payments mainly by Crown organisations (MOH ACC and other DHB's).

MOH Debtors $000	**Total**	**Current**	**30 day +**
Invoiced	8,999	5,791	3,208
Accrued	352		
Total	**$ 9,351**		

Accounts payable: $5.9m lower than budget and $1.0m lower than June 2014.

Net Fixed Assets: This level is $0.4m higher 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	244,002	121,056	122,946	847,199	725,428	121,771
Other	2,939	2,445	494	17,385	14,676	2,709
Interest rec.	281	100	181	1,661	600	1,061
Expenses						
Suppliers	71,278	72,425	1,147	451,037	433,713	(17,324)
Employees	49,603	51,492	1,889	269,116	278,058	8,942
Interest paid	1,083	1,280	197	6,428	7,682	1,254
Capital charge	-		-	-		-
Net cash from Operations	**125,258**	**(1,596)**	**126,854**	**139,664**	**21,251**	**118,413**
Fixed Assets	(5,991)	(1,965)	(4,026)	(13,766)	(13,855)	89
Investments (hA & HBL)	(229)	(249)	20	(2,222)	(2,516)	294
Restricted & Trust Funds	0	(1)	1	8	1	7
Net cash from Investing	**(6,220)**	**(2,215)**	**(4,005)**	**(15,980)**	**(16,370)**	**390**
Debt	-	-	-	-	-	-
Other non-current liability	-	-	-	-	-	-
Net cash from Financing	-	-	-	-	-	-
Net increase / (decrease)	**119,038**	**(3,811)**	**122,849**	**123,684**	**4,881**	**118,803**
Opening cash	26,226	5,234	20,992	**21,580**	(3,458)	25,038
Closing cash	**145,264**	**1,423**	**143,841**	**145,264**	**1,423**	**143,841**

Summary	Month			YTD		
	Actual	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**
Opening cash	26,226	5,234	20,992	21,580	(3,458)	25,038
Operating	125,258	(1,596)	126,854	139,664	21,251	118,413
Investing	(6,220)	(2,215)	(4,005)	(15,980)	(16,370)	390
Financing	-	-	-	-	-	-
Closing cash	**145,264**	**1,423**	**143,841**	**145,264**	**1,423**	**143,841**

Commentary:

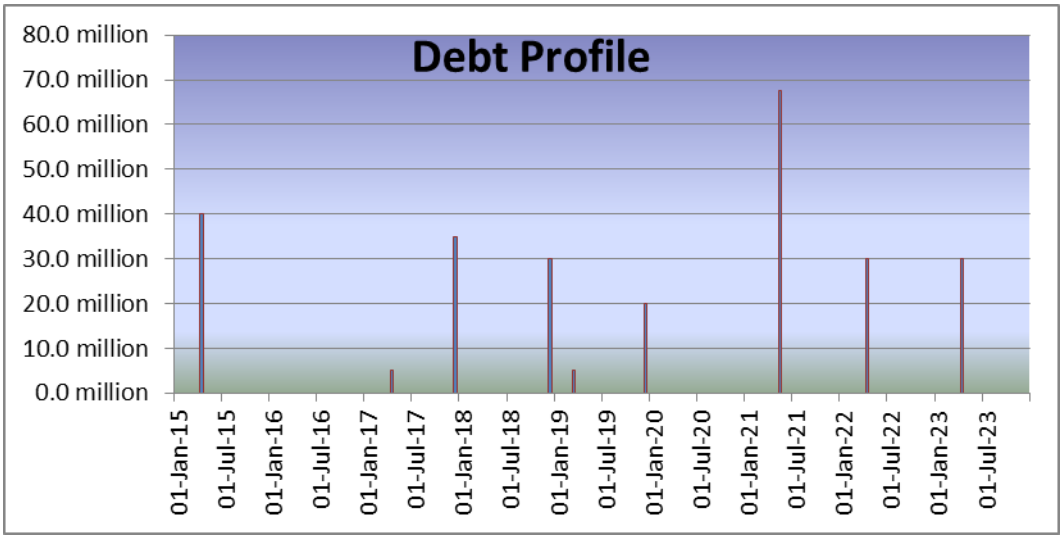
Funding: All DHB's received funding for January 15 ($120m) on the last day of December (this had not happened for 4 years). Therefore December saw two monthly funding deposits in the month.

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 - December 2014	Month			Year to date		
	Actual FTE	Variance FTE	Variance $000's	Actual FTE	Variance FTE	Variance $000's
Medical Personnel	802	(16) U	$321 F	772	19 F	$2,696 F
Nursing Personnel	2,541	(9) U	$(257) U	2,588	(39) U	$(1,623) U
Allied Health Personnel	1,081	54 F	$286 F	1,088	36 F	$1,192 F
Support Personnel	473	(4) U	$(73) U	477	(2) U	$6 F
Management/Administration Personnel	762	67 F	$80 F	778	50 F	$1,133 F
Total (before Outsourced Personnel)	**5,660**	**92 F**	**$357 F**	**5,704**	**65 F**	**$3,404 F**
Outsourced Medical	27	(11) U	$(297) U	23	(7) U	$(1,246) U
Outsourced Nursing	19	(16) U	$(176) U	11	(8) U	$(544) U
Outsourced Allied Health	4	2 F	$21 F	4	1 F	$102 F
Outsourced Support	8	(1) U	$(6) U	8	(1) U	$(21) U
Outsourced Mangement/Admin	51	(14) U	$(114) U	49	(13) U	$(618) U
Total Outsourced Personnel	**108**	**(40) U**	**$(573) U**	**96**	**(28) U**	**$(2,328) U**
Total Personnel	**5,768**	**53 F**	**$(216) U**	**5,799**	**37 F**	**$1,076 F**

FTE for the month are unfavourable by 92FTE favourable (excluding outsourced) (above) explained below:

- ***Medical personnel*** are unfavourable by (16)FTE, $321k. This represents vacancies 26FTE, of which Mental Health has 12 vacancies due to a national shortage of psychiatrists (covered by locums), and Surgical Services 6FTE. Stat days in lieu, study leave, sick leave and overtime/casuals/outsourced

- ***Nursing personnel*** are unfavourable by (9)FTE, $(257)k. This is attributable to 60FTE vacancies, primarily offset by overtime (24)FTE, internal bureau (48)FTE, external bureau (26)FTE and casuals (15)FTE, net annual leave 45FTE, sick/study leave (38)FTE, other 37FTE. Unbudgeted funded projects account for (13)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 54FTE, $286k. High levels of vacancies exist within Allied Health of 52FTE. These vacancies have been partially covered by overtime and casuals (10)FTE, net annual leave 12FTE, Other 18FTE. Additional Funded FTE accounts for (18)FTE.

- ***Support personnel*** are unfavourable by (4)FTE, $(73)k reflecting 35FTE vacancies, offset by use of casuals (17)FTE, overtime (8)FTE and net annual leave (14)FTE.

- ***Management and Administration personnel*** are favourable by 37FTE, $80k primarily reflecting existing vacancies across the organisation 48FTE, partially offset by casuals (9)FTE. Additional Funded FTE accounts for (5)FTE and other 3FTE.

Personnel Costs per FTE

(Rolling average)

	Dec 14	Nov 14	Oct 14	Sep 14	Aug 14	July 14	June 14	May 14
Medical	166,148	166,418	166,387	165,785	165,500	165,650	165,536	167,870
Nursing	76,853	77,041	77,028	76,879	76,537	76,674	76,560	76,363

Allied Health	70,790	70,538	70,320	70,283	70,062	70,088	70,141	69,779
Mgmt/Admin/Clerical	73,120	72,714	72,318	72,394	72,020	71,974	71,629	72,633
Support	50,570	50,259	50,206	50,369	50,207	50,346	50,369	50,210

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

Counties Manukau Only	**Dec 14**	**Nov 14**	**Oct 14**	**Sep 14**	**Aug 14**	**July 14**
Accrued FTE (as per MOH template)	818.8	854.5	817.0	846.2	839.1	827.4
Annual Leave loading	(75.8)	(75.6)	(75.7)	(77.0)	(76.7)	(76.0)
FTE's on holiday	98.8	61.0	99.5	81.6	89.8	92.8
Payroll FTE's	841.8	839.9	840.8	850.8	852.2	844.2
Contractors / Consultants (FTE equivalent)	11.0	11.0	11.0	11.0	11.0	11.0
Vacancy	14.7	16.6	15.7	5.7	4.3	12.3
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	-	-	-	-	-	-

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. Maternity External Review	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)]
2. Minutes of 3 December 2014	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.
3. 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.
4. Minister's Letter of Expectations	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. Funding 15/16 Advice	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. 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)]
7. Project Swift Governance	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. Acute Mental Health Final Draft Detailed Business Case	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** 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. Resolution in Lieu of AGM - healthAlliance	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)]