MEETING OF THE BOARD
29 March 2017

Venue: Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu Time: 9.45am

CMDHB BOARD MEMBERS	CMDHB MANAGEMENT
Lester Levy – Chair Rabin Rabindran – Deputy Chair Colleen Brown – CMDHB Board Member Catherine Abel-Pattinson – CMDHB Board Member Dianne Glenn – CMDHB Board Member Lyn Murphy – CMDHB Board Member Katrina Bungard – CMDHB Board Member Mark Darrow – CMDHB Board Member Ashraf Choudhary – CMDHB Board Member Reece Autagavaia – CMDHB Board Member George Ngatai – CMDHB Board Member	Geraint Martin - Chief Executive Ron Pearson – Deputy CEO/Director Corporate & Business Services Gloria Johnson – Chief Medical Officer Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer Lyn Butler - Board Secretary

APOLOGIES

REGISTER OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

PART 1 – Items to be considered in public meeting

AGENDA

9.45am	**1.**	**AGENDA ORDER AND TIMING**
	2.	**BOARD MINUTES**
9.50am	2.1	Confirmation of Minutes of the Meeting of the Board – 15 February 2017
	2.2	Circular Resolution – Proposed Amendment NZHP Constitution
	2.3	Actions arising from previous meeting
	3.	**EXECUTIVE REPORTS**
9.55am	3.1	Chief Executive Officer's Report (Geraint Martin)
10.05am	3.2	Health and Safety Report (Beth Bundy/Bev Stone)
10.15am	3.3	Communications Report (Margie Apa/Sarah Baddeley)
	4.	**DECISION ITEMS**
10.25am	4.1	Healthy Together 2020 Strategic Plan (Margie Apa)
10.35am	4.2	healthAlliance C Class Shares (Ron Pearson)
10.40am	4.3	Audit NZ Letter - Primary Health Organisations Audits (Ron Pearson)
		Morning Tea Break
	5.	**PERFORMANCE REPORT**
10.55am	5.1	Financial Performance (Ron Pearson)
	6.	**INFORMATION PAPERS**
11.05am	6.1	IS Operational Excellence (Leanne Elder)
11.10am	6.2	Socioeconomic Factors & Health Status – Implications for CMDHB Population (Margie Apa/Doone Winnard)
11.15am	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Board Member Attendance Schedule 2017

Name	Jan	15 Feb	29 Mar	10 May	21 June	2 Aug	13 Sept	25 Oct	6 Dec
Dr Lester Levy (Chair)	No Meeting	✓							
Rabin Rabindran (Deputy Chair)		✓							
Colleen Brown		✓							
Dr Lyn Murphy		✓							
Dianne Glenn		✓							
Reece Autagavaia		✓							
George Ngatai		×							
Catherine Abel-Pattinson		✓							
Katrina Bungard		✓							
Mark Darrow		✓							
Dr Ashraf Choudhary		✓							

*** Attended part meeting only**

BOARD MEMBERS' DISCLOSURE OF INTERESTS March 2017

Member	Disclosure of Interest
Dr Lester Levy, Chairman	• Chairman, Waitemata District Health Board (includes Trustee Well Foundation, ex-officio member). • Chairman, Auckland District Health Board • Chairman, Auckland Transport • Chairman, Health Research Council • Chairman, Regional Governance Group, Northern DHBs • Independent Chairman, Tonkin & Taylor • Adjunct Professor of Leadership, University of Auckland Business School • Lead Reviewer, State Services Commission, Performance Improvement Framework • Director & Sole Shareholder, Brilliant Solutions Ltd • Director & Shareholder – Mentum Ltd • Director & Shareholder – LLC Ltd • Trustee, Levy Family Trust • Trustee, Brilliant Street Trust
Rabin Rabindran, Deputy Chair	• Chairman, Bank of India (NZ) Ltd • Director, Auckland Transport • Director, Solid Energy NZ Ltd • Director, Swift Energy NZ Ltd • Director, Swift Energy NZ Holdings Ltd • Director, Kowhai Operating Ltd • Director, NZ Liaoning International Investment & Development Co Ltd • Singapore Chapter Chairman – ASEAN New Zealand Business Council
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
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) • Senior Lecturer, AUT University School of Inter professional Health Studies • Member, Public Health Association 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	• Director, Transitioning Out Aotearoa • Director, The Whanau Ora Community Clinic • Chair, Safer Aotearoa Family Violence Prevention Network • Board Member, Manurewa Marae • Huakina Development Trust (Partnership Clinic) • Community Organisation Grants Scheme (Auckland) • Lotteries Community (Auckland)
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Member, Tangata o le Moana Steering Group • Employed by Tamaki Legal • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board
Catherine Abel-Pattinson	• Board Member, Health Promotion Agency • National Party Policy Committee Northern Region • Member, NZNO • Member, Directors Institute • Husband (John Abel-Pattinson), Director, Blackstone Group Ltd

	• Husband, Director, Blackstone Partners Ltd • Husband, Director, Bspoke Ltd • Husband, Director, 540 Great South Ltd • Husband, Director, Barclay Suites • Husband, Chairman, Lifetime Design • Husband, Director, various single purpose property owning companies
Mark Darrow	• Chairman, Primary ITO • Independent Director, Motor Trade Association • Director, Dekra NZ Ltd (VTNZ) • Independent Director, Balle Bros Group • Chairman, Courier Solutions Ltd • Chairman, The Lines Company Ltd • Chairman, Armstrong Motor Group (Advisory Board) • Chairman, Signum Holdings Ltd (Trust Codes) • Chairman, Toloda Properties Ltd • Trustee, Tudor Park Trust • Shareholder & Director, Tudor Park Farm Ltd
Dr Ashraf Choudhary	• Board Member, Otara-Papatoetoe Local Board • Member, NZ Labour Party • Chairperson, Advisory Board Pearl of Island Foundation • Co-Patron, Bharatiya Samaj Charitable Trust
Katrina Bungard	• Chairperson MECOSS – Manukau East Council of Social Services. • Deputy Chair Howick Local Board • Member of Amputee Society • Member of Parafed disability sports • Member of NZ National Party

BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at March 2017

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
George Ngatai	Community Services Pharmacy Funding Policy	Mr Ngatai declared a specific interest in terms of their GP Service being likely 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.
Reece Autagavaia	RMO Industrial Action	Mr Autagavaia declared a specific interest in relation to this item, in that his brother is a Junior Doctor at Middlemore Hospital.	15 February 2017	That Mr Autagavaia's specific interest be noted.

Minutes of Counties Manukau District Health Board

Held on Wednesday, 15 February 2017 at 9.45 – 4.30pm Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

Present:	Dr Lester Levy (Board Chairman), Mr Rabin Rabindran (Deputy Chair), Mrs Dianne Glenn, Dr Lyn Murphy, Mrs Colleen Brown, Apulu Reece Autagavaia, Mr Mark Darrow, Dr Ashraf Choudhary, Mrs Catherine Abel-Pattinson, Mrs Katrina Bungard
In attendance:	Mr Geraint Martin (Chief Executive), Mr Ron Pearson (Deputy CEO), Dr Gloria Johnson (Chief Medical Officer), Ms Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer, Mrs Lyn Butler (Board Secretary)
Apologies:	Mr George Ngatai

1. Welcome

The Board Chair welcomed new and returning Board Members to their first meeting.

Dr Colin Thompson and a Manukau Courier Reporter were in attendance.

2. Governance

2.1 Attendance & Apologies

Noted.

2.2 Conflicts of Interest/Specific Interests

Mr Mark Darrow, Dr Lyn Murphy and Dr Ashraf Choudhary noted updates, which will be provided to the Board Secretary and the Register updated accordingly.

2.3 Confirmation of Public Minutes – 30 November 2016

Resolution

That the public Minutes of the Board Meeting held on **Wednesday, 30 November 2016**, were taken as read and confirmed as a true and correct record.

Moved: Dianne Glenn **Seconded:** Colleen Brown **Carried:** Unanimously

2.4 Action Items Register

None.

2.5 Power of Attorney & Deed of Delegation – Board Chair/CEO (Brigid Mills)

The Board Chair advised that it was his preference for documents to be put before the Board for consideration, rather than signed via Power of Attorney. This enables the Board to be engaged in decisions, particularly on long term commitments, such as leases, etc. The Board agreed.

3. Strategy

3.1 Health & Safety Update (Bev Stone/Beth Bundy)

The report was taken as read.

The Board Chair noted the significant responsibility Board Members have in regard to Health & Safety, and are expected to be involved in key decision making in this area. They will be taking a stronger involvement and may have a different perspective on what is being done currently. All Board Members will be involved, however, one Board member will take a lead role in this area.

Comments from the Board included:

- Has a full external audit been undertaken following the change in legislation last year? Response: Yes. What follow ups are planned?
- Has the Bowtie analysis been utilised. Response: Yes, as well as other methodologies.
- The paper lacks the depth and analysis required by the Board, and does not portray what has been updated as a result of work undertaken.
- Explain what has been done and where, plus identify any trends.
- Targets, benchmarking.
- Follow up audit, usually 18-24 months after first audit.
- Title of report – should it be titled 'Workplace Safety' or 'Health & Safety'.
- Staff visiting patients' homes/monitoring in localities.
- Prosecution cases should be reported in the Board report.

A copy of the external audit report, follow ups, any identified gaps and what action has taken place, will be provided to the Board Secretary for distribution to the Board.

Mrs Stone summarised the process to date, the engagement of services from Mr Gavin Johnson, staff engagement, ACC audits, risk management and framework, contractor management, etc. Mr Brent Sutton provided expertise as the risk expert, and Mrs Kerry Bakkerus has provided input as our Risk Manager.

Staff workshops are held, and feedback from staff is developed into a framework of thinking, to ensure that service delivery also addresses potential risks involved. A risk matrix has been developed for frontline staff. Staff inductions and refreshers are held.

The Board Chair requested information to be distributed via the Board Secretary on specific culture survey.

The Board Secretary will organise Health & Safety visits for the Board.

Resolution

That the Board:

Receive the Health and Safety quarterly report for the period ending 31 December 2016.

Moved: Katrina Bungard **Seconded:** Reece Autagavaia **Carried:** Unanimously

3.2 Board Chair's Report - verbal update (Dr Lester Levy)

The Board Chair stressed the importance to management of applying the collaboration and developing metro-Auckland lens. If this does not apply to particular work, the Board will need to know that it has been considered. This is important in regard to any mutual impact. Actions need to be clear, noting whether other parties have been involved, and whether there is agreement, if applicable.

The Board must be provided with options, to ensure that they have the ability to influence decisions.

3.3 Chief Executive's Report

The Chief Executive acknowledged the importance of having good synchronisation between Board and management, and welcomed feedback from the Board on papers, etc.

He acknowledged the excellent work of Dr Gloria Johnson and Mr Benedict Hefford on the Long Term Investment Planning (LTIP).

The report was taken as read, and the following areas were highlighted:

- ELT is focussed on key areas in delivering the Healthy Together 2020 Strategy. Four sub-Committees have been established to focus on specific areas:
    - Operations, Performance & Business Cases
    - Future design
    - Active leadership
    - Equity
- Dr Lance O'Sullivan, Ko Awatea and the Social Investment Board (SIB) are focussed on reducing inequity.
- A patient story will be incorporated into each meeting. Mrs Parr read out this month's story.

  'George's story' has identified that if a patient has three chronic diseases or more, the demand on the health system increases exponentially. There are 30,000+ people in Counties Manukau with three or more co-morbidities, which require proactive and planned care. 26,000 patients have been reviewed to date, and evidence shows that this has resulted in reduced demand and ED presentations. The Board Chair requested that any reference to 'evidence' should be included in future papers.
- Board relationship with Manawhenua, acknowledging Mr Ngatai's work in this area.

The Board Secretary is to circulate a copy of the Victoria University of Wellington's Localities Strategy Review.

Dr Johnson advised that this is being done belatedly, as a robust proactive way to evaluate what is being done. This would require a variety of different analyses to be meaningful. Prof Andrew Hill will lead a group of people from CMDHB/WDHB/ADHB, to establish what needs to be evaluated and what key questions need to be answered. The Board Chair, and other Board members, if required, will be asked to participate.

The Board Chair requested that the evaluation process have stage gates and off-ramps in place. The Board would like to be involved at the framing, rather than implementation, stage.

Mr Pearson summarised the Financial Statements to the Board. He advised that there has been a two month delay on the annual funding package from the Ministry of Health (MoH).

The report was received.

4. Information Papers

4.1 2017/18 Annual Planning Update (Marianne Scott)

The paper was taken as read.

Mrs Scott advised new members that the Annual Plan is an MoH accountability document and details how Counties Manukau serves its community. It is currently in consultation phase, which provides focus on areas to make the greatest gains, particularly in the areas of Maori, Pacific and Asian health.

The first draft of the Annual Plan, together with the draft Maori, Pacific and Asian Health Plans will be available by the 29 March.

The Board Chair outlined his expectation that the three Annual Plans have collaboration and a building system lens applied, with correlation between all three plans. No Plans will be signed off if this is not evident. Direction from the Board Chair and Board will be required.

Mrs Scott has been in discussion with regional colleagues since November, with information and data sharing taking place. The document will be socialised at the end of February, and will be discussed regionally thereafter.

CMDHB localities results should be compared with the work being undertaken by WDHB/ADHB.

The Minister no longer requires a separate Maori Health Plan, but all DHBs will continue to produce, submit and publish as usual. Definition is being sought around 'Asian' health.

The Board Secretary is to distribute WDHB/ADHB's Benchmarking Study on Asian Health Status.

Resolution

That the Board:

Receive this high level update of the 2017/18 annual planning process.

Note that 2017/18 financial planning is currently based on the Ministry of Health indicative funding signal of the same equivalent share of the sector allocation as 2016/17.

Note that the 2017/18 full funding envelope will be communicated on confirmation of Budget 2017.

Moved: Lyn Murphy **Seconded:** Catherine Abel-Pattinson **Carried:** Unanimously

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: Dianne Glenn **Seconded:** Katrina Bungard **Carried:** Unanimously

The meeting closed at 3.40pm. The next meeting of the Board will be **Wednesday, 29 March 2017** at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board of **15 February 2017** are approved.

Signed as a true and correct record on **29 March 2017.**

Board Chair ……..
Dr Lester Levy (Board Chairman)

CONFIDENTIAL
Counties Manukau District Health Board
Circulated Resolution 17 March 2017
Proposed Amendment to the Constitution of New Zealand Health Partnerships

Resolution Passed 17 March 2017:

That the Board approve an amendment to clause 9.3(b)(i) to the constitution of New Zealand Health Partnerships as follows:

That the paragraph found at the end of clause 9.3(b)(i) of the constitution, which reads:

"The notice of appointment of each director must be signed by each DHB Shareholder jointly appointing that Director. Each Director must be a Chair or Chief Executive of one of the DHB Shareholders appointing the Director. The DHBs will endeavour to ensure that the composition of DHB Directors includes a mix of DHB Chairs and DHB Chief Executives."

is altered by deleting the term "Chief Executive" and replacing it with the term "Deputy Chair", and deleting the last sentence of that paragraph so that the altered paragraph now reads:

"The notice of appointment of each director must be signed by each DHB Shareholder jointly appointing that Director. Each Director must be a Chair or Deputy Chair of one of the DHB Shareholders appointing the Director."

Prepared and submitted by: Lyn Butler, Board Secretary

The request to amend the constitution of New Zealand Health Partnerships following the most recent changes in DHB Board composition was considered and passed by circular resolution of the Board on 17 March 2017.

The matter was considered under urgency to provide Board endorsement at the New Zealand Health Partnerships shareholders meeting on 20 March 2017 (unanimous DHB approval of the resolution was required) and to allow full DHB representation at the NZ Health Partnerships meeting scheduled to occur on 30 March 2017.

The resolution is being submitted to the Board for endorsement.

Counties Manukau District Health Board
Action Items Register (Public)

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
15 February	Health & Safety Update	A copy of the external audit report, follow ups, any identified gaps and what action has taken place, will be provided to the Board Secretary for distribution to the Board.	March	Beth Bundy/ Bev Stone	Information was uploaded to Diligent on 10 March.	✓
		The Board Chair requested information to be distributed via the Board Secretary on specific culture surveys.			Information was uploaded to Diligent on 10 March.	✓
		The Board Secretary will organise Health & Safety visits for the Board.	April	Bev Stone/ Lyn Butler		
15 February	Chief Executive's Report	The Board Secretary is to circulate a copy of the Victoria University of Wellington's Localities Strategy Review.	March	Benedict Hefford	Information e-mailed to Board and uploaded to Diligent on 20 March.	✓
		The Board Chair requested that the evaluation process have stage gates in place. The Board would like to be involved at the framing, rather than implementation, stage.			Noted. These will be factored into the paper coming to the May Board Meeting.	
15 February	2017/18 Annual Planning Update (Marianne Scott)	CMDHB localities results should be compared with the work being undertaken by WDHB/ADHB.	March	Benedict Hefford	Noted. This will be included in the paper coming to the May Board Meeting.	
		The Board Secretary is to distribute WDHB/ADHB's Benchmarking Study on Asian Health Status.	March	Marianne Scott	Information was e-mailed to the Board and uploaded to Diligent on 10 March.	✓

SIX WEEKLY REPORTING						
Six Weekly	IS Projects Update	Standing Report to Board	Ongoing	Leanne Elder	Included in Meeting papers.	✓
Six Weekly	Health & Safety	Standing Report to Board.	Ongoing	Bev Stone	Included in Meeting papers.	✓

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 The Board will be aware that I have resigned from the post of Chief Executive Officer in order to take up the same role at Te Papa Tongarewa/Museum of New Zealand. I shall be starting there towards the end of May.

It has been a huge privilege to have led the DHB for eleven years, and over that time have seen it grow and develop into a high quality and leading health system. The rebuilding of Middlemore Hospital in particular marks a certain 'coming of age' for the organisation. Above all, it has been a collective team effort and I would like to acknowledge and thank all that I have had the pleasure of working with. I believe very strongly that linking the incredible, compassionate and determined culture of Counties with the focus on quality improvement, capacity building and innovation that Ko Awatea brings, has been critical to addressing many of the seemingly ineluctable problems facing healthcare such as the National CLAB initiative, 20,000 bed days and ED actions.

Above all, I believe the 'Grow your Own' programme with the Tindall Foundation's support, has the potential to change many lives and Whanau in South Auckland – indeed as one of many recent blogs highlighted, it already has.

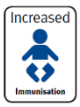
I have often reflected that as CEO of Counties, I have the best job in health, and so any future role would be in another sector. Many of you know of my interests in history, education and arts and culture, so when the opportunity at Te Papa came up, it was both a logical and exciting next move for me. Although given one of Te Papa's main objectives is to establish Te Papa North in Hayman's Park, I hope to be continuing to serve South Auckland in the future.

Finally, I would like to thank the various incarnations of the Board throughout my time. Having made the fateful error of appointing me, each Board has been hugely supportive and challenging, and each Board has been passionate about, and focused upon, ensuring the people of South Auckland get the best healthcare.

Counties has, is, and will always be, a very special part of my life, but to quote Sir Robert Naylor, regarded as the best CEO in the NHS over the last generation and a mentor and friend, 'never let your memories be greater than your dreams'. I have the huge fortune to be leaving one dream job for another.

I wish the Board all the best for the future. I believe the regional agenda to be positive and exciting if a demanding one to deliver. I look forward to witnessing the Board and staff at Counties, turning the future into the present.

2.0 Health Target Summary – 2016/17

Target	Current Results	Status by 30 June 2017
Emergency Departments	***95%** of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours* **January result: 95%**	**ACHIEVE**
Elective Surgery*	*Elective surgery will increase by an average of 4,000 discharges per year* **January result (indicative only)**: 106% **ESPI2:** 0 FSA breaches for YTD (target of 0) **ESPI5:** 31 FSA breaches for YTD (target of 0) **Note:** ESPI5 breaches relate to Resident Doctor Association strike losses. Recovery plan is in place and production plan has been adjusted. We are on track to deliver Counties and IDF volumes for 2016/17.	**ACHIEVE**
Faster Cancer Treatment	***85%** of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.* **February result (indicative only): 67%** 72% performance excluding patient choice related reasons for the year to date. **Note**: A performance improvement action plan is progressing incorporating: specific tumour stream FCT capacity buildings, service leave cover process, ongoing engagement with Auckland DHB FCT team to explore new areas for improvement and re-development of the FCT tracker role to be more active with tumour streams and provide active support to ensure pathway performance.	**AT RISK**
Immunisation 	***95%** of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Maaori and Pacific population groups).* **February result (indicative only):** 95% for total population • Maaori coverage:91% • Pacific coverage:97% **Note**: Performance against this target has improved for both total population and Maaori coverage rates since Q1 (Maaori coverage rates Q1:86%, Q2:89%, Q3 (Jan-Feb): 91%).	**ACHIEVE**
Raising Healthy Kids**	***95%** of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)* **Result (for 6 months to the end of December 2016, indicative only): 74%** • Percentage of obese Maaori children referred: 75% • Percentage of obese Pacific children referred: 81% **Note:** Trend shows continuous improvement in performance since quarter 1 (Q1:29%, Q2:62%, Q3 (Jan only):74%) as the results from the electronic referral process from B4SC to primary care operational since 30 September 2016 come through. We are on track to achieve the health target (100% acknowledgement should be reflected in reporting from Q4 2016/17 due to delay in reporting).	**NEW TARGET**

Tobacco	**Primary**	*90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months* **February result (indicative only)**: 87% total population (Maaori: 85%, Pacific: 87%)	**ON COURSE**
	Maternity	*90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking* **February result (indicative only)**: 78% total population (Maaori: 85%, Pacific: not reported) **Note:** The data issues that have been affecting performance results since Q1 are ongoing. There is an issue with interventions being reporting by self-employed midwives resulting in potential underreporting of brief interventions. The Smokefree maternity advisor is working with maternity service manager on possible solutions. The MOH is aware of the data coding issue which is affecting DHBs nationally.	**ON COURSE**

ACHIEVED: Already meeting target / will meet target by 30 June 2017.
ON COURSE: Includes actions to meet target; expected to meet target by 30 June 2017.
* Performance against the Elective Surgery target is reported one month in arrears.
** New health target for 2016/17 with data provided from the MOH quarterly (for previous 6 months)

3.0 Population Health, Strategy & Investments Directorate

The Population Health, Strategy and Investments Directorate has the following functional accountabilies:

- Maaori Health (including Living Smokefree, Alcohol Harm Minimisation)
- Pacific Health (including Regional Pacific Health MFAT funded services)
- Population Health Analytics and Insights
- Social Investment Board implementation
- Strategy and Planning
- Communications and Corporate Affairs
- Risk Management
- Intersectoral Programmes (including Housing).

Grow Our Own – Thank you Tindall Foundation

This section reports against an action point in the Board's register. In June 2016 the Board was advised that a significant milestone in the partnership between CM Health and Tindall Foundation was expected to be achieved at the end of the 2016 Academic year. The first 2 graduates of the Health Science Academy (HSA) programme from Tangaroa College were expected to pass State exams and be offered employment in the healthcare system.

Fono and Shayna both graduated successfully from degree studies (Manukau Institute of Technology), passed State exams and were recruited as nurses in CM Health and ADHB. Fono was profiled recently in a TV One news on 19 February (link below).

https://www.tvnz.co.nz/one-news/new-zealand/we-can-want-programme-helps-auckland-pacific-island-students-excel-science

A letter of thanks will be drafted from the Board Chair to Sir Stephen Tindall, Founder and Trustee, noting the milestone that has been achieved and expressing our thanks for this partnership. Fono and Shayna are going to write a personal letter to attach to this letter. A ceremony was deemed not appropriate and a likely opportunity for an event may occur at the end of the year when there are more HSA graduates due later who may be more comfortable celebrating as a group (e.g. we expect another 8 possible graduates). Fono and Shayna are both first time university graduates in their families.

There are now more than 300 Pacific and Maaori students in six secondary school-based Health Science Academies across the metro-Auckland region. Tangaroa College, James Cook, Alfriston (Maaori focused), De La Salle College, Onehunga High School and Waitakere College. The Principals meet 3 times a year with the three DHBs to discuss improvements, risks and challenges. A formal social investment approach to evaluation will be commissioned in the 17/18 year now that we will have a 2nd cohort of students graduate and enter employment.

Directorate Highlights

There are 5 teams that provide advice (Population Health and Insights, Social Investment Board, Strategic Planning, Corporate Affairs and Communications, Risk and Privacy) and 3 direct patient support services (Maaori Development, Pacific Development and Intersectoral) in the Population Health Strategy & Investments Directorate. The table below summarises Directorate highlights as at end February that are not reported elsewhere:

- Corporate Affairs and Communications - report to Board
- Risk and Privacy - report to Audit, Risk and Finance Committee
- Maori Health - report to MHAC

Highlights

Population Health Analytics and Insights - The Population Health team are the primary analytics and insights capability for the DHB and the SIB South Auckland. Below are highlights on key analyses and insights over the past month:

- **SIB South Auckland:** The team are the primary providers of analysis for the SIB South Auckland. This requires working closely with the national Social Investment Unit (SIU) to ensure alignment of national devleopments and approaches for social investment and its application 'place based initiatives'. The complexities of sharing data between agencies to better understand the experiences of at risk children and their families are flushing up a range of technical (e.g. common identifiers, data definitions) and legal (e.g. privacy) issues. These are all positive as they reflect the true challenges that need to be worked through if service design and investment decisions to be impactful.
- **Bowel Screening:** Implementation planning for the rollout of bowel screening is underway. The importance of design, however, are being considered to ensure that learnings and implications for population health are adopted. A significant challenge is ensuring that local implementation does not **increase** inequities between Maaori, Pacific, Asian and NZ European/Other populations.

  Equitable implementation is a significant priority for CM Health because of the age structure and absolute number of people in the targeted screening population 60-74yr olds. The bowel screening programme will need to be tailored to match the degree of diversity present in CM Health that may differ to other Districts e.g.WDHB (pilot site) and Hutt Valley/Southern DHB (next sites for rollout).

  - CM Health Maaori ***6,120*** people vs WDHB 4,200 vs Hutt Valley 1,920 vs Southern 2,460.
  - CM Health Pacific ***8,880*** people vs WDHB 3,360 vs Hutt Valley 1,000 vs Southern 440
  - CM Health Asian ***14,960*** vs WDHB 12,400 vs Hutt Valley 2,120 vs Southern 1,400
  - CM Health Euro/Other ***35,620*** vs WDHB 61,370 vs Hutt Valley 16,040 vs Southern 47,240.

  This diversity calls on very specific approaches to language, understanding of socioeconomic circumstances among other factors that impact on access.

- **Social Determinants of Health:** Attached in the Board papers Information section is a paper on the socioeconomic factors of health status and comparisons with other DHBs. The purpose of the paper is to offer more context for the information showing differences in outcomes such as life expectancy.

- **Population Funding:** CM Health provided policy and technical expertise to the MoH's PBFF review that was concluded end 2017. It is likely that this review will make an impact on 17/18 allocations which will be disappointing from a technical perspective. While the health system acknowledges the 'bluntness' of PBFF there are technical issues that could make a difference to the calculations underpinning PBFF decisions. One example being our preferred use of Health Tracker as a more helpful reference to the number of unique individuals who ***actually*** used publicly funded health services rather than population ***estimates*** released by Statistics New Zealand (2016 edition). There were 24,766 more people in CM Health who had used publicly funded health services compared to estimated population from Statistics New Zealand for the period in 2014/15.

Social Investment Board (SIB) South Auckland

CM Health hosts the implementation office on behalf of the SIB South Auckland. The SIB advises the Independent Chair who reports directly to the Deputy Prime Minister who is also Minister for State Services and is the lead agency for South Auckland.

- ***Update:*** The SIB South Auckland are reporting to Cabinet Sub-Committee for Social Policy (5 April) and will be represented by Sandra Alofivae as Independent Chair and Margie Apa as Director of the Implementation Office for SIB. A draft of the Cabinet paper is attached and confidential for the Board's information.
- ***Maangere Intervention Portfolio:*** the first of a suite of interventions has begun on the 15th March with the establishment of a Family Harm Intervention to streamline access for perpetrators and victims to immediate interventions within real time and comprehensive social support as follow up. The NZPolice estimate in 2015 700 of 1490 family violence related callouts exposed children under 5 to violence and trauma and missed opportunities to intervene with perpetrators/victims AND children to reduce likelihood of repeat offending. The SIB investment question is to understand how **actual** family violence demand in Maangere by NZPolice matches the **supply** of interventions actually funded by social sector agencies (MSD, Justice) in Maangere. In the first 3 days, 12 family harm callouts involving children under 5 were assessed and follow up established.

Strategic Planning

This team supports strategy formation, development of annual plans, performance reporting against those plans including National Health Targets, equity and System Level Measures.

- 2017/18 Annual Plan and Maaori Health Plan are submitted separately in these papers. The Pacific and Asian Health plans will be submitted to the next Board.
- Q2 reporting against 16/17 is attached as a separate report in this month's Board papers.
- ELT has established an executive sub-committee for ***Health Equity Taskforce*** that will focus on deep dives on indicators with persistent inequity in achievement for Maaori, Pacific and high need Asian populations. The Taskforce is chaired by Margie Apa and will invite membership from both internal executive team and external Maaori, Pacific and Asian health experts. The role of the Taskforce is to work with relevant sector partners to identify opportunities to improve or accelerate achievement against equity indicators, identify actions and accountability for those actions and monitor action against those actions.

Pacific Health

The Pacific Health Team delivers the following services – Fanau Ola service support and co-ordination for high risk Pacific families with repeat admissions to hospital due to complex medical and social need; workforce development initiatives that aim to increase the number of Pacific people in the workforce pipeline; purchase integrated Fanau Ola services from primary care for high risk Pacific fanau, Pacific community engagement to promote health and wellbeing (e.g. LotuMoui) and institutional linkages in the wider Pacific region across 7 countries.

- **Fanau Ola:** January saw a full Fanau Ola team commence with the 5 new Fanau Ola nurse case managers. Fanau Ola Social workers saw 33 referrals of high and complex need fanau for the month of January (12 Tongan, 15 Samoa, 5 Cook Island, 1 Niue). The most common reasons for families poorly managing their health are medication management related, housing and complex family circumstances that have completed care arrangements (e.g. overcrowded living conditions).
- **LotuMoui** team with DHB Child Health are working with Plunket and Taha to improve engaging with Pacific families. Pacific children have poorer access to full Well Child coverage when compared to non-Maaori and non-Pacific.
- **Regional Pacific** *Samoa* – an extension of the current Institutional Linkage Programme is under way to extend to June 2017 and 17/18 year. *Fiji* – A team of child health nurses were funded to work in Fiji during February to support ongoing implementation of paediatric initiatives in the hospital. Fiji has done extremely well in achieving the outcomes in the INFANTS Programme. *Niue* - Initial scoping and consultation visit for new ambulance completed to Niue by St John NZ and purchase of ambulance approved and underway. *Country Medical Treatment Scheme* – CM

Health are negotiating inception visits to begin in April for new programmes (funded by MFAT) with Kiribati, Vanuatu, Tonga, Fiji and Tuvalu. These visits aim to negotiate and assess the needs of those 5 countries and jointly (with those Governments) propose a work programme to MFAT for funding. This may include medical specialist visits, training and development programmes or expert advice in clinical services.

Intersectoral - The Intersectoral Team delivers 2 projects of work – Housing Initiatives that aim to house patients who are at risk of poor health outcomes if they are not supported into approiprate housing (e.g. adults being discharged form mental health) and PATHS supporting people on benefits back to work by facilitating access to healthcare.

- **Housing** Current housing intervention is in design phase funded by SIB aiming to reduce vulnerable tenancies for families with 0-5yr olds. An est. 25% of under 5s in Mangere change addresses within a year increasing risk of not receiving or accessing sustained Early Childhood Education and healthcare. Transience also increase risk of child neglect if at risk families are not able to be monitored by agencies. The Vulnerable Tenancy aims to intervene earlier with families who show signs of potentially losing their tenancy without support (e.g. rent arrers, multiple police intervention). This is a joint project sponsored by MSD and Housing New Zealand. It is aiming to start from 27th March.
- **PATHS:** The total number of Voluntary Participants Enrolled onto the PATHS Programme to date is 92. 80% of these have an activated health and wellness care plan. All participants deemed work read have been referred to an appropriate Supported Employment Service for assistance with obtaining sustainable/suitable employment.

4.0 Ko Awatea

Established in 2011, Ko Awatea has become an internationally recognised centre for education, healthcare system innovation and improvement. We are a department of Counties Manukau Health (CMH). Our purpose is to be a hub of education, improvement and innovation primarily supporting CMH, and other health systems and public services locally, nationally and internationally.

Ko Awatea comprises the Centre for Education and Innovation, and four business units which collectively provide support to CMH in healthcare system improvement, building workforce capability, research and evaluation and clinical data analysis. Wider business elements of Ko Awatea: Research & Development, APAC Healthcare Improvement Forum, Knowledge Management (including evidence-based practice support), Patient Experience in Co-design and communications and digital production.

Ko Awatea works together and collaborates with Auckland and Waitemata DHBs. Currently there are nearly 20 initiatives, programmes or projects where we are sharing, leading or following the DHBs to enhance population outcomes through Education and Capability Building; Digital Transformation; Library services/knowledge access; Research and evaluation; Care redesign; Innovation; Community engagement; and Health leadership.

HEALTH INTELLIGENCE

Health Intelligence & Informatics is currently **reviewing the metrics around locality reporting and leading the evaluation work** in this space:

- Revising the cross-over between community and hospital reporting with the aim to consolidate reporting and reduce duplication
- Supporting and compiling the regional system level measures with WDHB.
- The contributory measures or whole-of-system measures are due for release, which will allow better monitoring visibility and allow staff to refresh the report on a daily basis.
- Released a data cube in the last month allowing the end user to refresh data daily to show comparison of booked versus available theatre session time. This highlights available un-booked theatre time, making it easier for schedulers/managers to understand what is available for scheduling.

KNOWLEDGE ACCESS SUPPORTING EVIDENCE-BASED PRACTICE

- **New Library Resource – Nursing reference centre Plus**

As an evidence-based information resource, this is designed to **support nursing competencies, professional development and enhanced health literacy for Secondary, Primary and Community nurses across CMH.**

Nursing Reference Centre Plus covers:

- *Core measures*
- *Nursing care plans*
- *Nursing management and leadership*
- *Regulatory and risk management*
- *Nursing skills checklists*
- *Videos and images*
- *Continuing education modules*
- *Patient education handouts*
- *Nursing reference books*

A mobile app gives users instant access, both on and offline, to content on their smartphones and tablets. It can also be accessed by primary care, school and community nurses. Nurses working in primary care, aged and residential care, and schools in the Counties Manukau region who are not currently CMH employees are being invited to register for online access. In the first week there were 11 sign-ups from this group.

BUILDING CAPABILITY

- **Leading Quality Care programme**

The aptitude needed to successfully manage and lead wards and other teams continues to increase. Recently launched, this programme targets **frontline clinical leaders**, to further build leadership capability and strengthen performance on quality care and patient outcomes. Leading Quality Care is endorsed and supported by the Director of Patient Care; Director of Nursing; and the Director of Allied Health.

- **ePortfolios**

This project was developed to assist the development of an electronic system to host the Nursing Council compliant Professional Development and Recognition Programmes (PDRP) within CMH.

The ePortfolio system will also be deployed via the LEARN Learning Management System, meaning it will be available across CMH. The system will potentially be available across all member DHBs who use LEARN (11 currently), **securing access to a common ePortfolio system for all registered users**. This project is nursing-led and is accompanied by a process of cascade training and development to enhance user adoption across CMH.

- **NZ HR Awards**

The 2017 NZ HR **award for Learning and Development Capability in the Public Sector** was awarded to CMH's Building Capability team for Safe Practice and Effective Communication (SPEC). This training package was developed at CMH to improve the outcomes for people experiencing acute mental distress. The package is being viewed as a template for national application. Building Capability now provides train-the-trainer development for DHBs in the region and nationally.

PATIENT EXPERIENCE, CO-DESIGN

The Patient Experience Co-design function runs a variety of educational and experiential activity, currently spread across the district health boards of Counties Manukau, Auckland, Waitemata, Hutt Valley, Capital and Coast, Taranaki, Canterbury, Mid-Central, Waikato, West Coast and Northland.

- **Regional Participation and Engagement - Oncology Services**

All three Auckland region DHBs are working to review 'best place' for oncology services. Waitemata DHB and CMH are specifically looking at opportunities for some services to be undertaken in their respective organisations and are running focus groups of consumers and staff. The output will be shared across the region. CMH have four focus groups running in March.

RESEARCH & EVALUATION

- **Activity summary March update:**
  - Submitted response to MoH RFP to analyse sexual and reproductive health data in collaboration with AUT (in the final two, awaiting decision).
  - Presented proposal to ACC for a Kaupapa Maaori evaluation.
  - Upcoming submissions: CMH Consumer Council, Manaaki Hauora Campaign, SWIFT.

- Ongoing work: Localities evaluation, Bariatric surgery, Green prescription.
- Publication: to be submitted; article on reducing pressure ulcers at Middlemore.

SUPPORTING IMPROVEMENT AND TRANSFORMATIONAL CHANGE (D&D)

- **Project pipeline update for March**

Projects in the pipeline	Projects being initiated	Active Campaigns and Collaboratives
Flu vaccination – request from public health to address 12% gap in take up of vaccinations.	Now we're talking – national collaborative with MoE to increase oral language.	Health Equity Campaign
Dementia pathway – integrating the pathway into the Safety in Practice collaborative.	'Evolve' – collaborative in one Early Childhood service to reduce waste in their service.	Safety in practice collaborative across Auckland region primary care
Plastic surgery / Patient Experience – hearing the patients' experience in the waiting room (involving medical students at Manukau Super Clinic).	ERAS Society – collaborative to implement the Enhanced Recovery After Surgery programme in several Australian state hospitals.	Manaaki Hauora – self-management support campaign, finishing in June. Diabetes Care – primary care collaborative supporting people at risk with diabetes management, finishing in June.
Youth health redesign – embedding more Youth-friendly design for services in CMH.	HQSC mental health Improvement Facilitator training programme – 9month focus on building capability in improvement methodology.	Enhanced Primary Care – redesign of primary model of care covering 10 practices with plan to scale up across all 110 practices in CMH.
Southern Cross – aims to provide opportunity for Southern Cross members to improve their experience in cancer care pathways.	Social Investment Board – Early Childhood Education contract for 112 Mangere Early Childhood Centres, to improve educational quality.	Talking matters – community based collaborative in Otahuhu and Mangere to increase oral language.
Healthy Auckland Together – via project Auaha, align with work being done regionally on increasing healthy lifestyles and addressing obesity.	Renal Service – care redesign project for people on home dialysis.	
Multi-Disciplinary Team Mangere Locality - request from Primary care to scale up the MDTs across the locality.	Ophthalmology – service redesign to meet MoH targets for wait times.	
General medicine – request to help implement final stages of model of care with Doctor's rosters.	Children's team (cross sector team) – review of model of care to scale up across Counties Manukau.	
	Patient feedback process for CMH – process design to create process that captures/responds and learns from patient feedback.	
	Stroke – redesign of service delivery from acute to community rehabilitation (ARHOP).	
	Social Investment Board – providing improvement framework and support to 16 intervention areas identified across five sectors in Mangere.	
	Medical oncology pathway – designing a new service starting at Middlemore.	

Counties Manukau District Health Board
Occupational Health and Safety Report
Nov 2016 – Jan 2017

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period ending 31 January 2017.

Prepared and submitted by: Bev Stone, Manager Occupational Health & Safety Service

Executive Summary

This paper reports on 3 months rolling health and safety activity for the period November 2016 - January 2017.

Quarterly Report Highlights

Health and Safety Performance Overview

Lagging Indicators					
	Jan-17	Monthly Benchmarking Average	Performance Indicator	Trend data for 12 month period (Feb 2016 - Jan 2017)	Performance Commentary
Number of Reported Incidents	102	101	→		Incident notifications remain stable.
Number of Notifiable Events	1	1	→		See Notifiable Events
Lost Time Incidents	14	10	↑		There was an increase in the number of Lost Time Injuries attributed primarily to moving and handling.
Lost Time Injury Frequency Rate (LTIFR)	17.54	11.9	↑		The number of Lost Time injuries were slightly higher in January influencing the LTIFR
Cost of Injury Claims	$15,526.11	$32,335.75	↓		Injury claims costs fluctuate as claims roll over as additional interventions are required.
Lost Time Injury Severity Rate (LTISR)	77.66	133.4	↓		The number of Lost Time injuries increased in January, but the total time lost was relatively low and only influenced the severity rate minimally.
Predominant Incident Profile:					
Occupational Health Incidents (*Blood, Body, Fluid Exposure & Contact Tracing)	28	50.58	↓		
Musculoskeletal	21	19	↑		
Assault / Behavioural	16	20	↓		
Slip / Trip / Falls	16	11.8	↑		

Leading Indicators					
	Jan-17	Monthly Benchmarking Average	Performance Indicator	Trend data for 12 month period (Feb 2016 - Jan 2017)	Performance Commentary
Number of Pre-Employment Health Screening	119	133.9	↓		The decrease was due to the Christmas and New Year break over December. Many of the January new starters would have been screened in December in preparation of the break.
Fitness to work assessments completed	84	79.4	↑		The increase in the number of fitness to work assessments is attributed to post holiday needs and change in circumstance of employees.
Number of EAP visits	20	24.8	↓		EAP usage remain stable.
Immunisation Screening	144	127	↑		Includes vaccinations following pre-employment screening and recalls from November and December.

The above table provides a high level overview of Counties Manukau Health (CM Health) Health and Safety performance for this quarterly reporting period. Commentary is included in further detail in this report.

Quarterly Performance

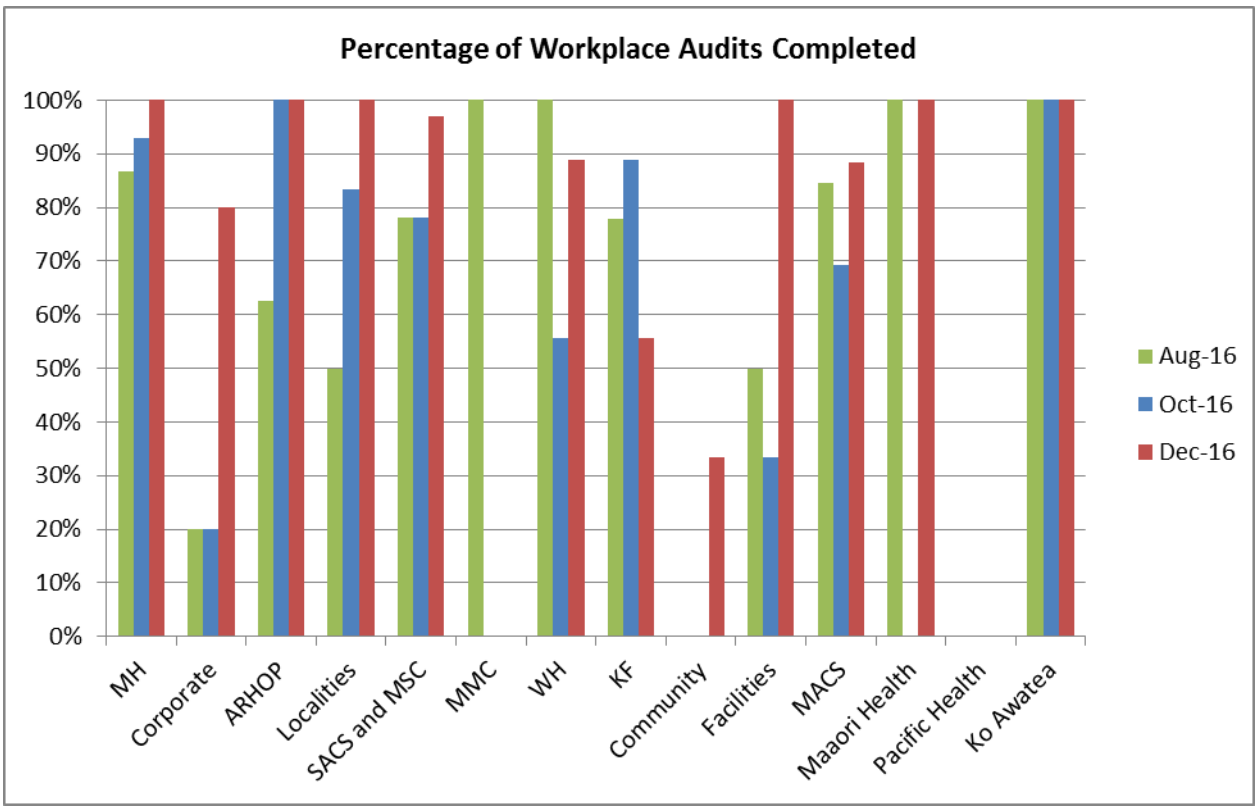
Notifiable Events

These injuries fulfill the criteria defined in the H&S Legislation and require external notification to WorkSafe NZ:

Division	Location	Injury	Details	Hazard/Process involved	Date
Mental Health	Core MH Adult Services	Fatality	Vehicle accident	Acts of others	Occurred 31/10/2016, notified 2/11/2016
Strategic Development	Te Kaahui Ora	Fractured ankle	Fractured ankle which required admission to hospital as an inpatient	Falls	25/11/2016
Central Clinical Services (Previously MACS)	Laboratory	Fractured elbow	Fractured elbow requiring admission to hospital as an inpatient.	Wet/Slippery surface	5/12/2016
Auckland Regional Dental Service	Pukekohe Intermediate Dental Clinic	Notifiable Incident	Possible exposure of patients to contaminated water during dental procedures	Still under investigation	January 2017

- CM Health has received a formal response from WorkSafe indicating no further action or investigation is required for the two fracture incidents
- CM Health is awaiting response from WorkSafe on the remaining incident
- WorkSafe have not notified CM Health of any further activity for the fatality incident that occurred in October 2016.
- All incidents have been investigated to identify hazards and risks. Mitigation activities have been followed up

Work Place Inspections

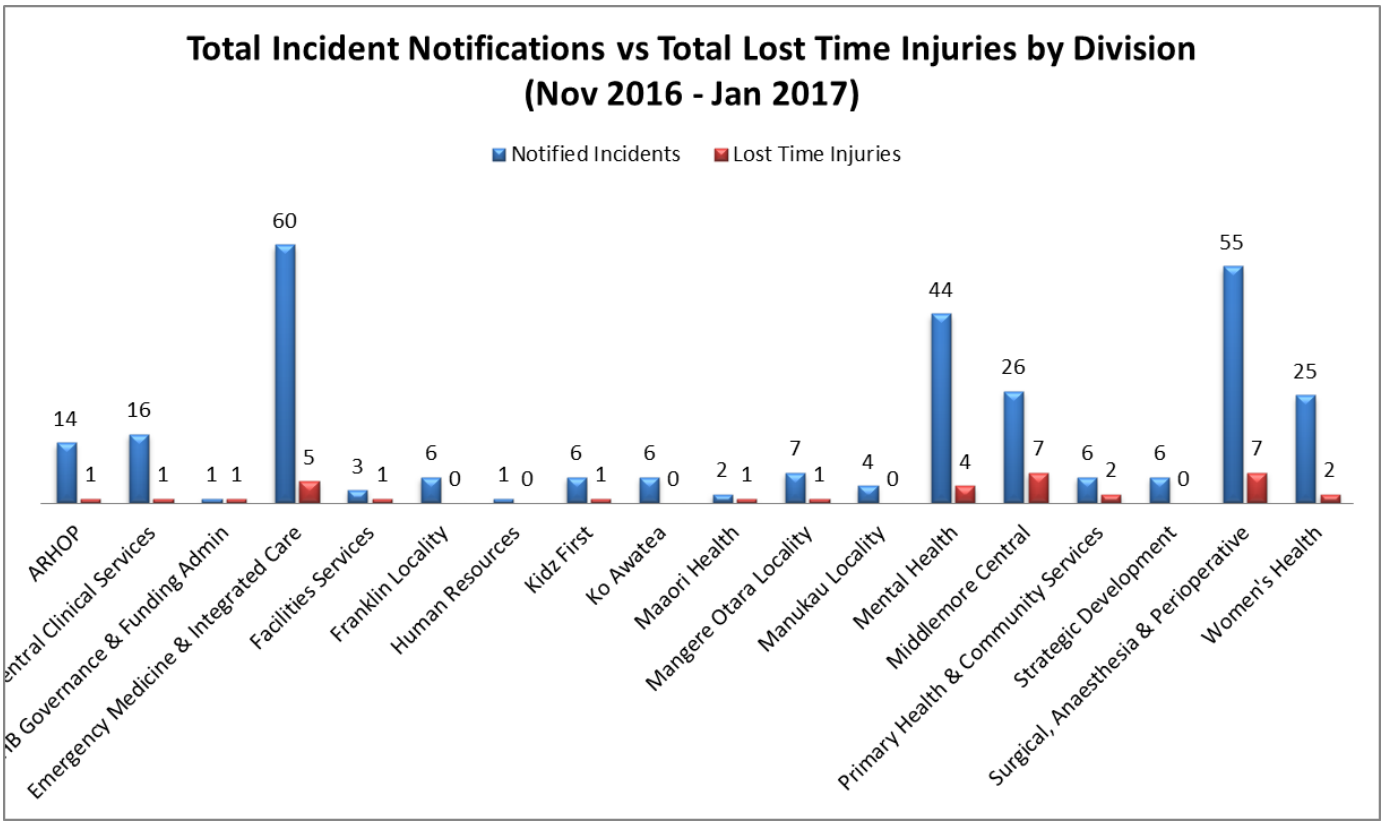


- One cycle of work place inspections was completed in December 2016 with a 91% return rate which is an improvement on the previous cycle in October (which returned 73%).
- The completion outcomes are driven by increased engagement from the OHS Service, continuing to encourage completion of the inspections.
- The inspection tool has been reviewed and with functionality being developed for reporting to the ELT and board, capture of new hazards and feed back into the CM Health risk register.
- The next inspection cycles will be undertaken in February and April 2017.

Injuries and Impact

Incident Notifications

- The incident profile remains consistent with other reporting periods and predominantly feature the following:
  - BBFE
  - Moving and Handling
  - Assaults
- The frequency of these injuries has resulted in their inclusion in the H&S Critical Risk Profile, which ensures ongoing review of causation and organisational mitigation processes, which will remain ongoing due to the complexity of human factors.

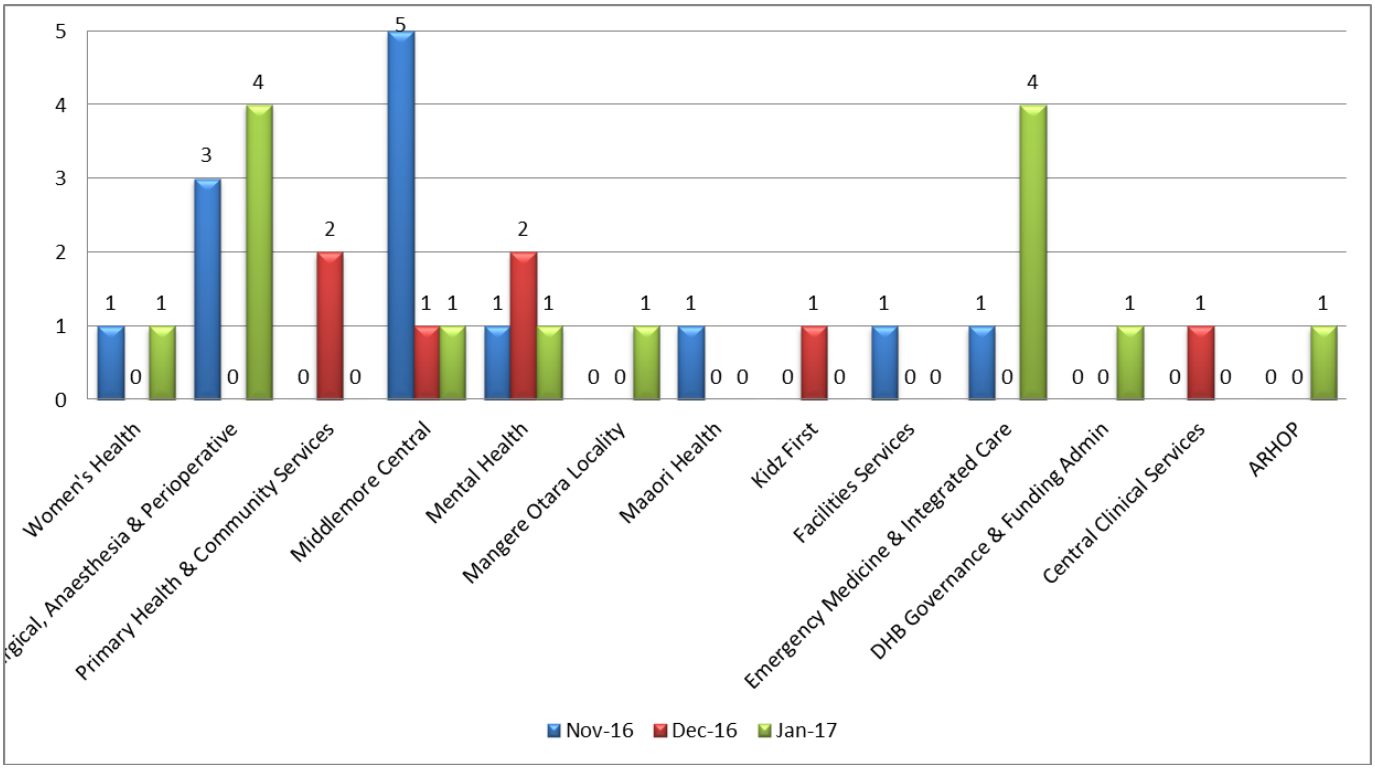


Incident Notifications - count of incidents with incident date occurring Nov 16 – Jan 17.

Lost Time Injuries (LTI's) - count of workplace injuries with injury date occurring Nov 16 – Jan 17.
* Not all Divisions are shown here so the total may be higher than the consolidated divisional data. Data is accurate as at time of reporting and may change month on month for some measures

- A total of 102 incidents were notified via the Incident Reporting System (IRS) in January.
  This remains consistent with monthly reporting trends for the past 12 months.
- All incidents have been reviewed and where appropriate referred for operational investigation and intervention based on the severity of the incident.

Number of Lost Time Injuries by Division per month



There was an increase in lost time injuries, with 34 people requiring active injury and rehabilitation management compared to 18 for the previous three months.

CM Health Lost Time Injury Frequency Rate (LTIFR) and Lost Time Injury Severity Rate (LTISR)

Frequency and Severity Rates for the quarter increased as the number of injuries were higher than the previous three months and also resulted in an increase in lost time.

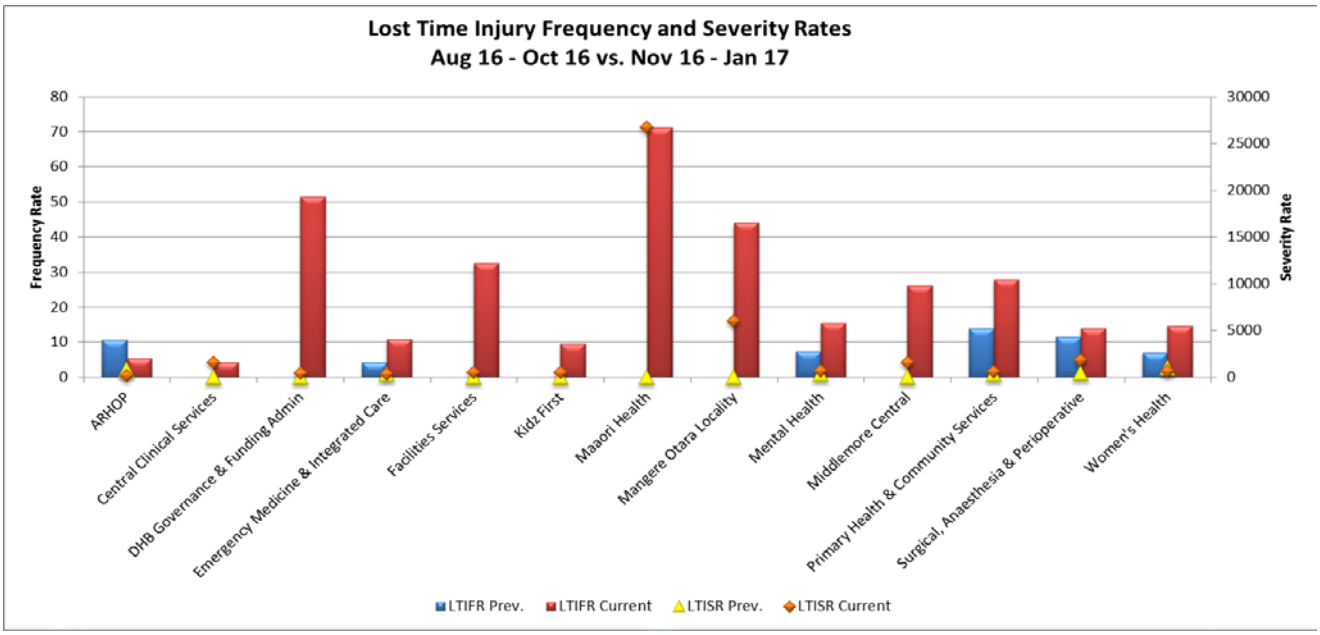
	LTIFR	LTISR
Aug 2016 - Oct 2016	6.58	334.04
Nov 2016 - Jan 2017	13.69	1095.90

LTIFR (Lost Time Injury Frequency Rate) = (# of Lost Time Injuries / Hours Worked) x 1,000,000.
LTISR (Lost Time Injury Severity Rate) = (# of Lost Hours / Hours Worked) x 1,000,000.

The main causes for the increase in the severity rate were particularly due to the following 3 injuries:

- Open wound of the scalp resulting in 68 days off work occurring in Surgical, Anaesthetics and Perioperative Care. Causation: Medical
- Fracture of medial malleolus resulting in 47 days occurring in Maaori Health. Causation: Slip/ Trip/ Fall This particular injury caused that the severity rate was negatively impacted as the hours worked in the unit are small by comparison to other work areas.
- Fracture of radius and ulna resulting in 44 days lost time occurring in Central Clinic Services (MACS). Causation: Slip/ Trip/ Fall

Lost Time Injury Frequency and Severity Rates

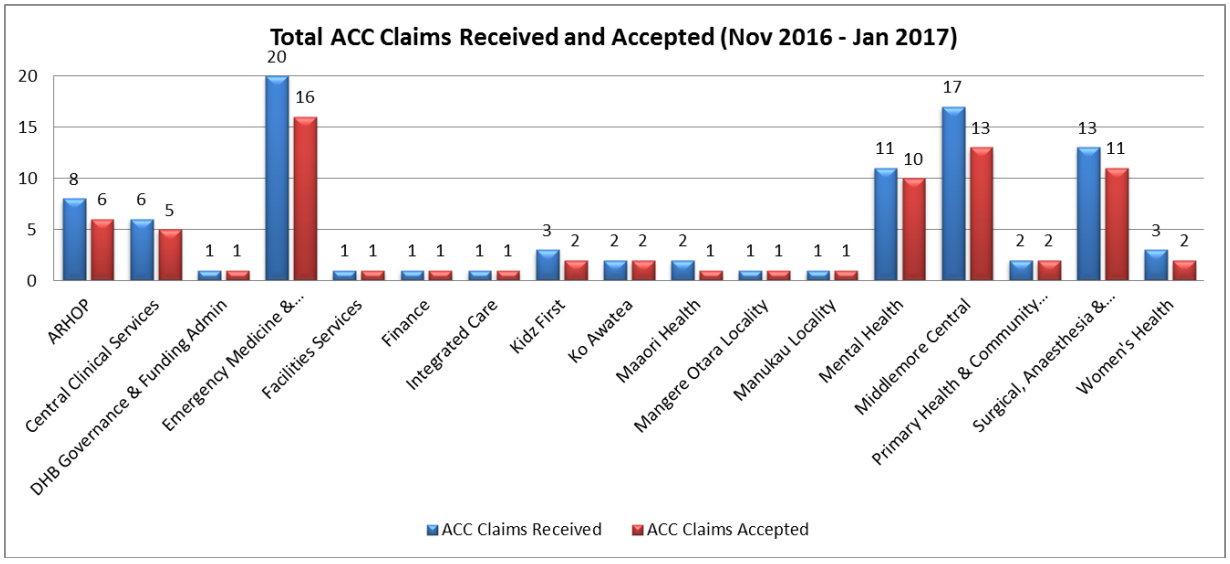


LTIFR (Lost Time Injury Frequency Rate) = (# of Lost Time Injuries / Hours Worked) x 1,000,000.
LTISR (Lost Time Injury Severity Rate) = (# of Lost Hours / Hours Worked) x 1,000,000.

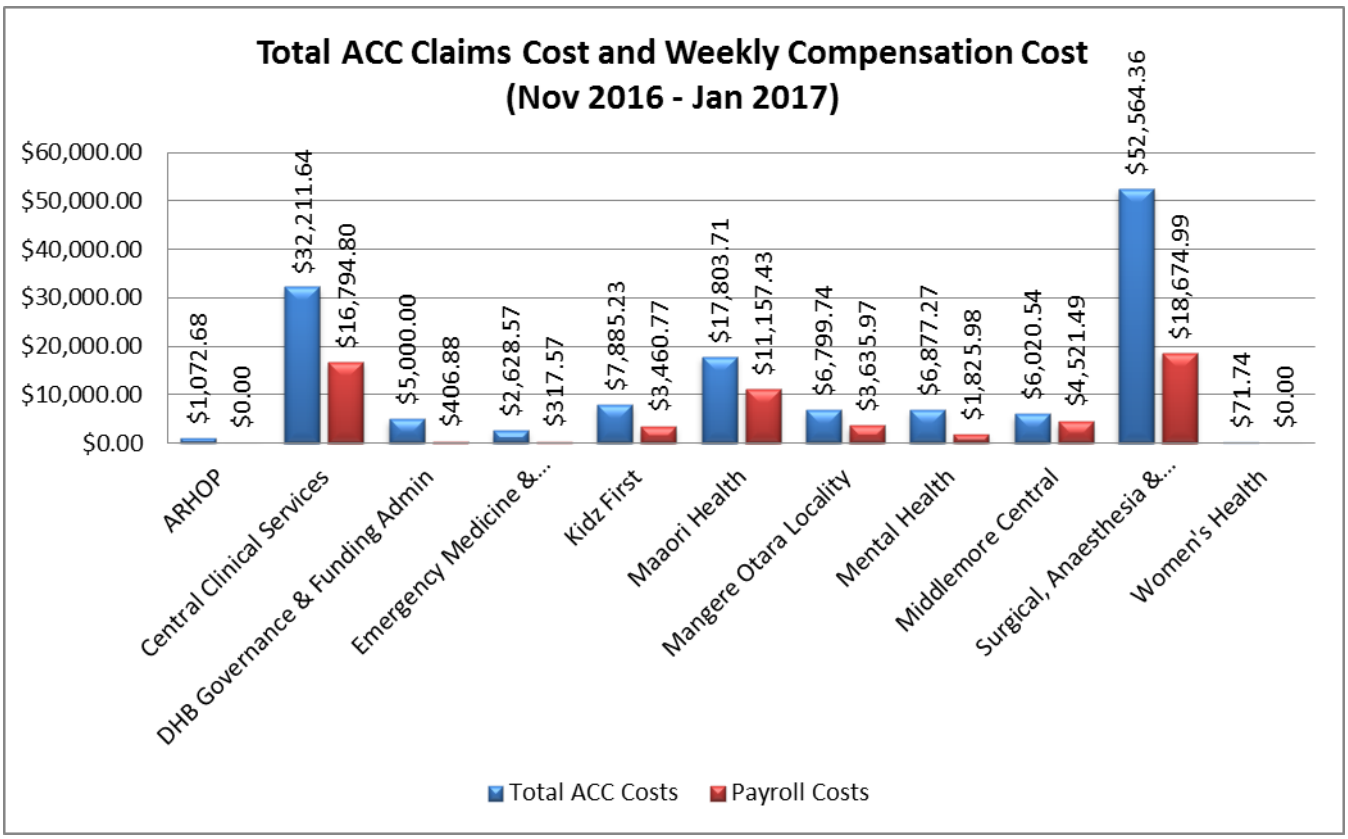
Note:

- The increased frequency rate in Maaori Health, Mangere Otara Locality and DHB Governance and Funding were all due to Slips/Trips/Falls incidents causing Sprain and Fracture injuries and time off work.
- The injury in DHB Governance and Funding had 5 lost days, causing the severity rate to be negatively impacted as the hours worked in the unit are small by comparison to other work areas.
- The injury in Mangere Otara Locality had 17 lost days, causing the severity rate t negatively impacted as the hours worked in the unit are small by comparison to other work areas.

Injury Impact – Claims Overview



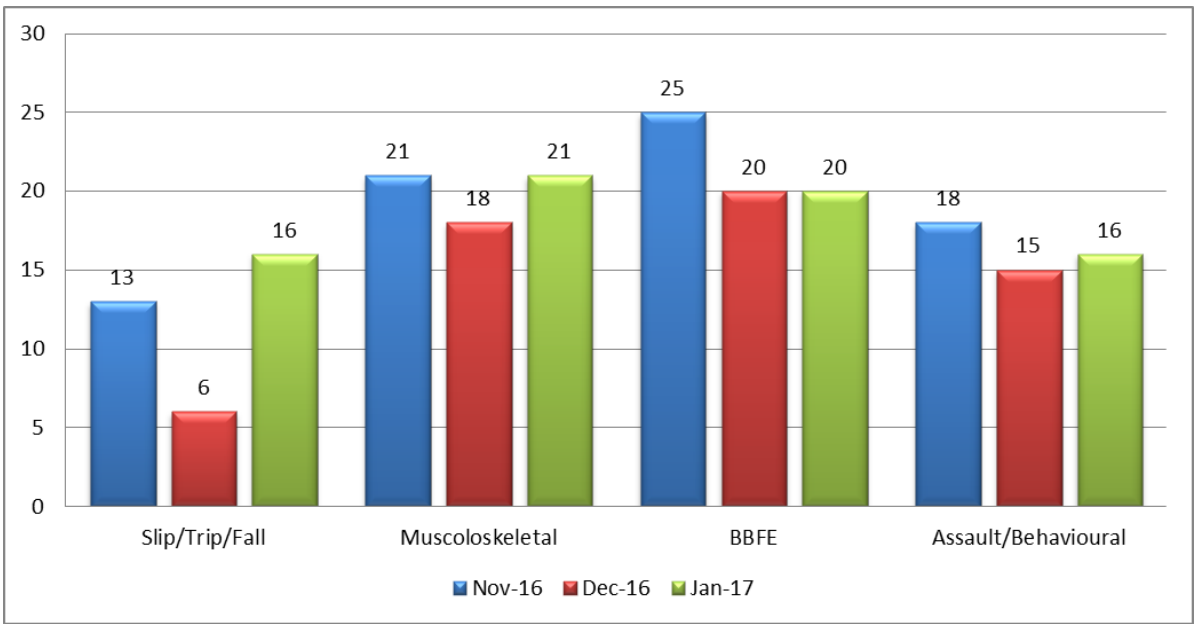
- A total of 93 work related ACC claims were received for the period, which was less than the 62 received for the previous period. 76 Claims were accepted, with 13 still pending at the time of reporting.
- 6 Claims were declined following investigation ensuring CM Health did not incur unnecessary and ongoing claims liabilities and costs.
- Injuries resulting in ACC Claims continue to be predominantly caused by sprains and musculoskeletal injuries resulting from Moving and Handling and Slips/Trips/Falls



* The total ACC claims costs include medical costs, social costs, vocational rehabilitation and weekly payroll compensation costs. The medical costs are a combination of actual and predicted cost impact. Though the weekly compensation costs are included in the total claims cost, it is important to report them separately as they are attributed to payroll.

- The total claims cost for the period is $139 433.59. The total annual spend was $388 578.48, with an average monthly spend of $32 381.51.
- The total weekly compensation cost for the period is $63 345.24. The total annual spend was $200 020.65, with an average monthly spend of $18 183.70.

Injury Trends



- There was an increase in the number of Blood, Body, Fluid Exposure (BBFE) incidents resulting in Occupational Health follow up and screening. BBFE incidents are reflected in the risk profile.
- The trends indicate that the injury profile remains unchanged.
- All incidents have been investigated and managed.

Health and Safety Management Framework - Update

The Health and Safety Management Framework is underpinned by the Health and Safety Management Framework. This framework forms the basis for the Health and Safety Planning and work continued against the Action Plan 2015/2016 until December 2016.

The Framework has been reviewed to include the legal requirements of Risk Management and as such, the Health and Safety Action Plan 2017/2018 was finalised in January 2017 and is *attached in Appendix A.*

The plan continues to have an ongoing focus on meeting the objectives of the overall Health and Safety Management Framework with an additional priority focus on managing the risks attributed specifically to Compliance, Occupational Health and Safety and Wellness as subsets. This approach aligns and has incorporated the organizational risk methodologies.

All Occupational Health and Safety reporting will incorporate the risk approach.

Hazard and Risk Management

- Reviewing of the OHSS critical risk profile against the CM Health Risk Assessment criteria has commenced.
- Moving and handling remains an uncoordinated organisational risk during this quarter.
- The sub-committee of the Clinical Governance Group regrouped. Work is continuing to align expectations with this strategic group of stakeholders. Meetings will be ongoing indefinitely.
- Refer to appendix A

Incident Management and Injury Prevention

- The information related to Occupational Health and Safety incident reports is validated by telephone contact of every H&S incident notification, injury management and manual data capture and analysis. The current organisational Incident Reporting System does not have the capability to capture close off and corrective activities attributed to investigations. Follow up does currently require a lengthy manual process to facilitate reporting in a consolidated format. Preliminary discussions are being held with appropriate internal stakeholders about other organisational software options as the basis for scoping a future project that encompasses all incidents reporting including those that relate to patients and staff.
- Occupational Health and Safety Incident data analysis and findings are continually assimilated into the risk management framework to ensure ongoing review of the risk profile.
- Due to an increase of slips, trips and falls occurring at the Middlemore Train Station from the tactile paving, a collaboration discussion with Auckland Transport to manage this risk has resulted in CM Health receiving a formal improvement notification that the issue is being prioritised in the effected high risk areas.

Contractor Management

- Contractor Management has been identified as an ongoing organisational risk and as such an audit, gap analysis and framework development has been confirmed.

  A Contractor Management Risk Management Framework audit on has been confirmed and will be commenced in April 2017. The audit outcome will be undertaken in 3 phases:
  - Phase 1: "Development of Contractor Management and Safe Systems of Work Framework" for the following six areas:
    1. Voluntary, Work Experience, labour hire or temporary labour workers
    2. Contractors performing scheduled and planned repairs, maintenance, servicing and cleaning
    3. Contractors performing one off/one time work or work relating to unscheduled, unplanned or emergency work
    4. Contractors commissioning, installation, modifications or decommissioning of plant or structures
    5. Contractors occupying or sharing shared facilities
    6. Community funding arrangements
  - Phase 2: Pilot and trial the new Framework with single interest group stakeholders, update on the progress of the pilot and amend the framework as mutually agreed
  - Phase 3: Roll out the Framework and includes:
    1. Develop implementation, communication and training plan.
    2. Develop user guide.
    3. Develop train the trainer material.
    4. Train the trainers (5 x ½ day modules)

- OHSS continues to engage and collaborate with the appropriate project management teams on the various capital works ongoing on the CM Health site, including:
  - Ko Awatea 2
  - Tiaho Mai
  - Dental Clinic
  - Extension on the Gastro ward

Training

- The review of the CM Health training framework has commenced with consideration of all relevant H&S training requirements and current modules available across service providers, including Ko Awatea. The aim is to ensure these requirements are imbedded into the organisational frameworks, which ensures an effortless experience.

- The Health and Safety at Work Act 2015 requires Health and Safety (H&S) Representatives (Reps) to be elected at the request of workers, if the Persons undertaking a Business Undertaking (PCBU) employs 20 or more workers.

  CM Health is obliged to provide training for H&S Representatives to the standard of AS 29315, "Describe the Role and Functions of the Health & Safety Representative in a New Zealand Workplace" in order to allow compliance with the Act.

  The New Zealand health care industry has been identified by WorkSafe as a high risk industry but currently the unit standard on offer in New Zealand does not address the specifics of the health care industry. The current course has a focus on the manufacturing industry.

  CM Health identified an opportunity to design and develop a specific health care industry focused training course which will meet the unit standard requirements whilst simultaneously providing CM Health to be innovative and providing an opportunity to share the course to other health care providers in New Zealand, all of whom are currently also attempting to address this issue.

  As such the development of a specific health care focused H&S Representative training module for CM Health has commenced and will provide an additional level of training to staff who have an interest in supporting Health and Safety in their work areas but who don't necessarily want to be trained as a H&S Rep. This training module will provide a robust understanding of health and safety practices in CM Health. Elected H&S Representatives will then continue with an additional training day, to provide the required NZQA unit standard for H&S Reps. The only difference being the H&S Reps can issue Provisional Improvement Notices (PIN). The aim would be that CM Health's Worker Participation practices will ensure engagement and avoid such activity to take place.

- The Occupational Health and Safety Orientation Module has recently been incorporated into the organisational "Welcome Day" managed by Building Capability and is presented to all CM Health new starters

Employee (Worker) Participation

- The finalisation of the Regional Worker Participation Agreement has been delayed due to a Union raising concerns outside the scope of this agreement. The issue relates to the expectation that DHB's will assume the responsibility of health and safety training for other PCBU employees while on site. The Regional DHBs are preparing and presenting a response to the Union, which will include options for consideration that will resolve the issues which were raised.
- CM Health forums, meetings and Joint Consultative Committee Meetings are utilized as a conduit and opportunity to embed health and safety into operational activities and discussions for participation and engagement. The Health and Safety Advisors provide support to Managers, H&S Reps and employees in a business partnering approach. This has been very well received with constructive feedback.
- The Health and Safety Recognition Awards ceremony was hosted with nominees, their managers and colleagues in November 2016 with 4 main category winners. Geraint Martin presented the awards as an opportunity to showcase visible engagement and leadership.

Wellness

- The Wellness Strategy has been included in the Target Operating Model as a component of the "People" layer.
- Current focus is to identify and consolidate what is already available for staff within CM Health and to review the feasibility of rebranding these under the strategy - this work remains ongoing.

January 2017 Board Meeting Action Items:

1. Governance Health and Safety Responsibility Assessment – 2017

   Has been scheduled and will be undertaken by Gavin Johnson, as a follow up to the audit undertaken in 2014 has been confirmed to take place in April 2017. This had originally been scheduled for 2016 but was postponed due to budget constraints.

2. The Risk Bowtie Analysis

   This risk methodology has been utilized as one of the various approaches to the CM Health Critical OHS risk assessment process. These assessments have, at the Board's request, been separated from the overall work and are attached independently. Please see Appendix B

3. Community Health Work

   A summary of the activities that commenced in February 2016 are as follows:
   - Safe Home Visiting Workshops were conducted to gain personal feedback from Community Health Workers to facilitate the identification of issues, hazards and risks that were prevalent in this work area.
   - The Safe Home Visiting Risk Assessment Steering Group was established as a working group as part of the change management process for the Community Health Teams.
   - Work began to identify and confirm CM Health policies, practices, processes and gaps. Where appropriate these have been reviewed and updated or removed.
   - Risk Assessment tools were designed with alignment to Health and Safety Risk tools (based on organisational risk methods) to encompass a simple approach to Patient Safety / Staff Safety and Service Delivery risk assessments and mitigations.
   - A training module was developed with the initial focus on the new Community Health Assistants.
   - After the initial training was delivered, an evaluation was completed 6 weeks after the training and the feedback indicated a change in practice including:
     - Parking selectively and more attentively /cautiously
     - Increased awareness of environmental factors e.g. dogs / people
     - Increased risk assessments of the physical environment and people prior to entering the home.
   - A Train-the-trainer program was developed to build the capacity to deliver the above-mentioned training.
   - A completely revised Community H&S Orientation Manual has been developed and is in final stages of consultation and feedback.
   - "Safe Home Visiting" training will commence for all existing staff in late March and is scheduled to provide training over 20 days to 400 staff. This training incorporates the fundamentals of AI2DET, which is a communication tool, as an additional mitigation consideration and which additionally supports health literacy. Future planning will include an inclusion and focus on family violence.
   - Training includes the development of the workforce by involving them as co-facilitators in the training to enable them to take more knowledge, skills and attitudes back to the physical working environment.
   - Currently Mental Health has one full day of Personal Safety and Awareness training, which includes "Safe Home Visiting and Break-aways". This training is not new but the new training module described earlier will be included, as appropriate as it's roll out will be across all CM Health Community Health work areas
   - The "Safe Home Visiting" training will become an ongoing training requirement for all working in the Community Health environment.

Next Steps:
The following activities are now planned:

- Strategic escalation of discussion to redefine the remit and organisational engagement and dissemination of the work
- Initial design of the Community Health Team Home Visiting Guideline
- Scoping of a business case defining fleet usage.
- Collaborative discussions have been confirmed with Auckland DHB who have indicated interest in this work with the aim of sharing and gaining information and knowledge

Appendix A – 2017/2018 H&S Workplan

H&S Work Plan												
Risk	Primary Driver	Actions	Status	2017				2018		Comments	
				Q3	Q4	Q1	Q2	Q3	Q4	Work Completed	Next Planned Activity
Compliance Risks											
Contractor Management	• Risk profile to be clarified • Legislative requirements need to be understood in a DHB context • Management System of Contractors need to be aligned	Phase 1 - Develop	Planning	x						Meeting with external consultant and key CM Health stakeholders took place to define project plan	Meetings with the six identified contracting work streams to commence to identify needs, present framework and agree on the solution
		Phase 2 - Pilot	Scoping	x	x						
New Build Projects	Assimilating into new build projects from conception phase	Facilitate robust communication and consultation process with project Managers (CM Health, main contractors & sub-contractors) on the implementation of the established system.	Consulting and Engaging	x	x	x	x	x	x	Initial communication with the relevant stakeholder groups have begun	Involvement to continue as required while the scope of Contractor Management throughout CM Health is being developed
OHSS Framework Delivery	The culture and values, leadership direction and operational engagement supports the delivery of the OHSS Management System to minimise harm impact to our people	Responsibility, Commitment and Legal Obligations	Finalizing	x	x	x	x	x	x	Annual review of the HSMS was undertaking, ensuring that the Risk Framework priorities are incorporated and the plans updated to reflect accordingly.	The update of the HSMS to be communicated to the relevant stakeholders and ELT for information and agreement
		H&S Information, Document Management & Comms	Consulting and Engaging	x	x	x	x	x	x	H&S Advisor Business Partnering with Divisions have been established.	Identify and communicate with the relevant Division/Service stakeholders to ensure that H&S needs are met
		Operational and Maintenance H&S	Scoping	x	x					Current available H&S Documentation is being reviewed to identify additional tools and templates which may be required by the organisation	Documentation, tool and template development investigations will continue and activities planned accordingly
		Incident Management (For staff, volunteers and contractors)	Consulting and Engaging	x	x	x	x	x	x	Incident reporting and investigation continues.	Scoping of the process of incorporating incident data into the hazard/risk registers to commence
		Hazard and Risk Management	Consulting and Engaging	x	x	x	x	x	x	OHSS completed a H&S Critical Risk Review in order to establish the H&S Critical Risk Register. Alignment with the HSMS, Organisational Generic Risk Registers and up- and downstream reporting opportunities have begun	OHSS will continue review of approach across all strategic and operational activities to ensure alignment with the Critical Risk Framework
		Audit and Performance Measurement (OH&S Service specific audits)	Planning	x	x	x	x	x	x	All Audit and Workplace Inspection Tools are being reviewed to align with the Risk Framework	Reporting methods and strategies of Audit/Inspection feedback will be considered
Occupational Health	Identification and preparation for the emerging health risks	Develop procedure to ensure sub-optimal results are addressed	Embedding	x	x	x				Current Occupational Health reviews are being embedded in the organisation	Commence review to identify gaps
	Regulatory guidelines	A process is in place to meet regulatory requirements relating to medical issues and reporting in the workplace.	Finalizing	x	x					OHSS is finalizing the reporting methods and requirements	Formal processes to be implemented
Worker Participation	Robust and credible processes to participate and engage with our workers are identified and leveraged	Strengthen HS Reps & optimise their participation in departmental H&S management	Planning	x	x	x	x			Identification of areas without H&S representation (Champion or Representative) has begun	Continue to partner with the services to identify and elect the appropriate H&S representation for the area
		Strengthen forums, worker participation & optimise their effectiveness in ensuring a safe workplace	Planning	x	x	x	x	x	x	H&S Forums and engagement opportunities were considered for future improvement opportunities	Identify and outline the information or reporting requirements for the various forums to ensure a fit for purpose, but consistent in context, approach
		Rollout the implementation of CM Health's WP Structure Guideline	Consulting and Engaging	x	x	x				Current focus remains on incorporating feedback from stakeholders into the current guideline	Following the finalisation of the H&S Training framework for H&S Champions and Representatives, the document will be reviewed to ensure alignment
H&S Training Framework	The development of the OHS training framework reflects an integrated systems approach to organisational training opportunities	Develop and communicate annual H&S Training Programme	Finalizing	x	x					The training programme has been confirmed for the core H&S training requirements of H&S representation, manager training, accident/ incident and risk management.	Additional requirements will be addressed as they are identified throughout the year.
		H&S Role Specific Training Framework (Managers and H&S Champions & Reps)	Consulting and Engaging	x	x	x	x	x		EMA has scoped the work and gathered evidence based on discussions with OHSS.	The learning resources will be developed in March.
		H&S Forum training and improvement opportunities to be identified and leveraged	Planning	x	x	x				The H&S Forum training is in the first stage of planning. An online audit inspection tool is being developed for use throughout CM Health.	OHSS will engage with the JCCs and other H&S Forums to complete a needs assessment which will provide clarity on additional training requirements The audit tool will move from the final stages of design to testing.
		Generic H&S Organisational Training Opportunities	Implementing	x	x	x	x			Welcome day inductions have been implemented. The online induction tool has been completed and is now available on line.	Induction resources will continue to develop as service specific needs are identified. Effective roll out and communication of the online induction to be established.
		H&S Role Specific skills and training	Scoping	x	x	x	x	x	x	H&S role specific skills and training requirements are being identified through discussions with service areas, review of the CM Health risk profile and risk register.	H&S role specific skills and training requirements will be an ongoing discussion organisation wide throughout the year to meet additional needs as they arise.

Occupational Health and Safety Risks											
Slips, Trips and Falls	Understanding the causation of these incidents due to the high impact to both people and cost	Analyse incident trends and scoping the STF high risk areas	Scoping	x	x	x				Engaged with the organisation on a high risk STF area to start the process of understanding and defining the hazards involved	Communication with the organisation will continue.
Aggression and Violence	Whole of system approach with the aim of establishing an organisational strategic management plan	Ensure that physical locations offer staff appropriate levels of protection	Planning		x	x				A CM Health security checklist has been developed.	The security checklist will be incorporated into the online audit tool. Information will be fed back to OHSS and disseminated across the organisation to the relevant service areas for action. It is expected that testing of this tool will commence in April.
Community Health Work	Establish an integrated risk management approach to patient care, service delivery and employee harm prevention	Risk Register Review and update of control methods to mitigate risks	Consulting and Engaging	x	x					A review of the risk register review and incidents is underway	Findings from the review will be analysed to assess whether current controls are sufficient.
		Review of training offered to all community health workers.	Consulting and Engaging	x	x	x	x	x	x	Training has been reviewed with Train the Trainer occurring in March for new training programme.	Roll out of the training will occur throughout the year.
Moving and Handling	Clinical Governance Group sub-committee developing Whole of System/across organisation strategic management plan and key performance indicators for the design, delivery and sustainability of the safe moving and manual handling program at CM Health.	Participation in Clinical Governance sub-committee	Planning	x	x	x	x	x	x	OHSS participation in sub-committee with take away actions to be delivered back to the committee in March.	To be determined by committee governance.
		Identify high risk, high frequency moving and handling hazards.	Planning	x	x					Analysis is currently being performed on IRS and WelINZ data to identify high frequency and high hazard risks.	This data, plus a literature review will be presented to the sub-committee in March for further consideration.
	Alignment to current Health and Safety legislation, human resource policy and procedures, clinical service delivery and workforce capability. Includes Quality and Safety Initiatives, Patient and Family Centre Care co-design, current fiscal and procurement policies, processes and procedures, and the resolution of issues relating to patient/staff health and safety.	Development of campaigns and awareness from ward/ dept level up through organisation.	Scoping		x	x				OHSS work on data analysis and literature review to continue in March, with the information from other service areas to be collected during Q4. This will provide relevant information to the sub-committee from which decisions on development of awareness and campaigns can be made.	To be determined by committee governance.
Health Impact on Work	Robust and credible processes to participate and engage with our workers are identified and leveraged	Tasks are identified that require a person's fitness to work are assessed prior to starting a new or changed job.	Finalizing	x	x					Fitness to work assessment procedures were reviewed	Safety Critical Role Matrix to be scoped for development
		Controls are in place to ensure a person's disability or incapacity due to a workplace injury will not compromise the safety and wellbeing of the employee.	Embedding	x						CM Health has an established health monitoring system in place.	Review of system to be undertaken, to identify areas for continuous improvement opportunities
Wellness Risks											
Wellness	• Providing the frameworks for setting and reviewing our performance • Understanding any consequential accidents, injuries and illnesses • Identifying the organisational impact due to deficits of wellness in our workforce • Undertaking a range of activities that will support the improvement of our health, safety and wellness culture • Maintaining and increasingly developing the management of the health, safety and wellness strategies to improve our approach to personal and organisational risks and ensuring improvement in standards and performance outputs	Confirm leadership engagement and commitment	Finalizing	x						Continual engagement with stakeholders remain ongoing	Update to be provided to the Workforce Education Committee (WEC)
		Confirm draft framework	Consulting and Engaging	x	x					Strategy and framework reviewed	Strategy and framework to be socialised within WEC and HR

KEY
To be confirmed
Scoping
Planning
Participation
Consulting and Engaging
Finalizing
Implementing
Embedding
OVERDUE

Detailed Risk Analysis : Worker Participation

Risk ID : 1

Directorate / Division : Health & Safety

Last Updated On : 14/03/2017

RISK OWNER

Bev Stone

CAUSES

Robust structures for worker participation and engagement with communication, consultation and coordination are inconsistent and require further definition to comply with new regulations.

Unique risk factors considered: Unknown future WorkSafe prosecution approach

RISK EVENT

Break down of worker participation practices in CM Health

CONSEQUENCES

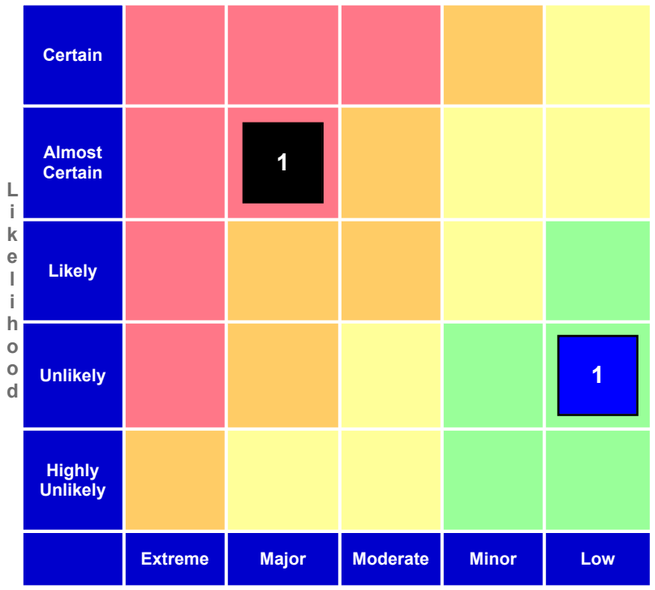
- Internal serious event review conducted using external agency/personnel to assist.
- Substantial adverse publicity resulting in mid-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Significant breach of legislation and/or regulatory standards with substantial financial liability risk for which insurance cover is unlikely
- Severe breach of and/or inability to meet contractual agreement.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Regional "Employee Participation Agreement" in place, pending sign off	
Reporting	
Worker Participation guideline developed	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
A process is in place to enable participation, consultation and engagement with staff in the development of systems, processes and procedures for health and safety at work.		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Health and Safety Training Framework

Risk ID : 2

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

The current training framework does not reflect the new legislative requirements that focuses on risk and Worker Participation.

RISK EVENT

CM Health does not have adequate H&S training opportunities in place to meet compliance and equip our workers to stay healthy and safe while at work.

CONSEQUENCES

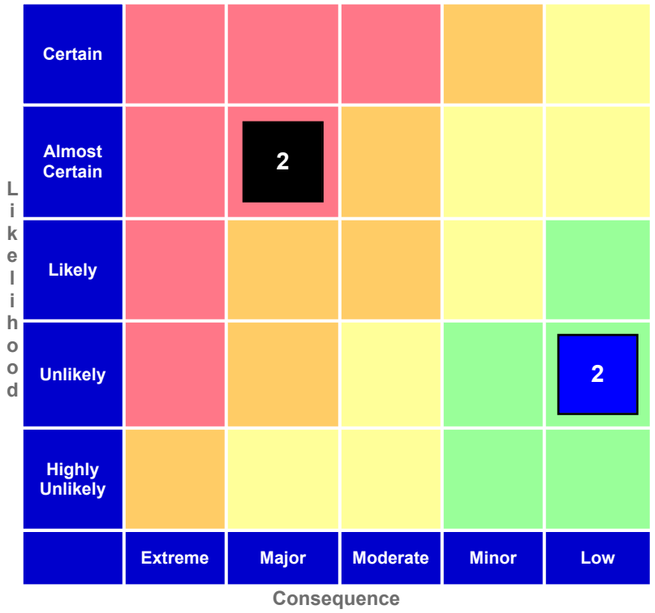
- Significant breach of legislation and/or regulatory standards with substantial financial liability risk for which insurance cover is unlikely
- Severe breach of and/or inability to meet contractual agreement.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Engage external consultants to scope and design healthcare specific unit standard to align with comp	
Investigating opportunities for accreditation as training provider for health related OHS training	
OHS Training Framework encompassing compliance, leadership, information and skills opportunities	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities, Natural event
Changing socio-economic circumstances, Culture
Lack of engagement, Management support
Resourcing (time and costs)

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
A Framework covering compliance requirements, leadership & participation competencies, focusing on risk & responsibility. Communication, including a process for delivering of H&S awareness that highlights risks, policies, HSMS, Operating Procedures & Hazard Standards. Staff will have the required H&S competency or adequate supervision will be implemented.		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Contractor Management

Risk ID : 3

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

The management of contractors is misaligned and misunderstood and does not consistently comply with the new legislative requirements with unidentified risks impacting people safety

RISK EVENT

Harm caused to CM Health Workers, visitors or patients due to the inadequate H&S measures in place from on-site contactors

CONSEQUENCES

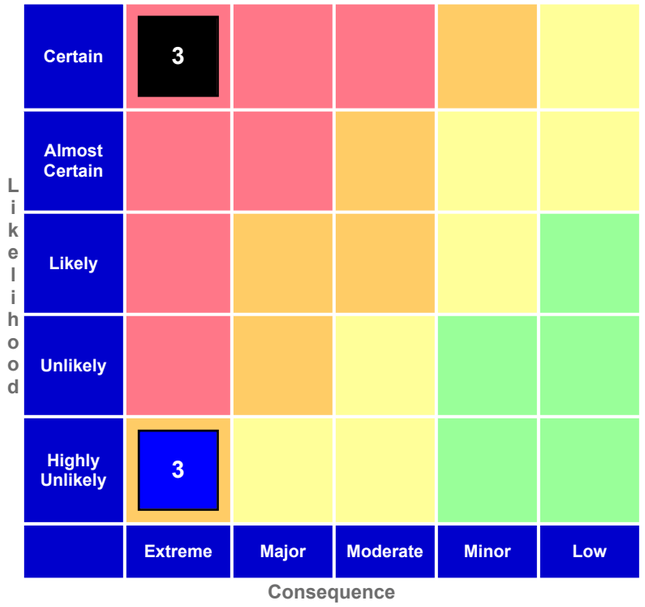
- Fatality and/or multiple casualties.
- Significant breach of and/or inability to comply with legislation and/or regulatory standards with potential DHB Board/ELT, and/or staff personal liability risk and any liability risk unlikely to be covered by insurance.
- Internal serious event review conducted using external agency/personnel to assist.
- Substantial adverse publicity resulting in mid-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Small scale irreversible or large scale but reversible significant environmental/ecological impacts requiring significant resource.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
A process is in place for the evaluation and selection of contractors	
Clinical access and service agreements in place to include health and safety clause	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities, Natural event
Changing socio-economic circumstances, Culture
Lack of engagement
Informal and inconsistent processes and Unknown contracting arrangements

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Initial assurance audit to identify gaps • Scope and plan revised Contractor Management System • Pilot the system in selected areas, roll out the system to the organisation		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Occupational Health

Risk ID : 4

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

Health related safety hazards and risks i.e. the likelihood of personal health issues impacting on safe work is undefined and the new legislation is placing an increased focus on prevention of harm.

RISK EVENT

Failure to identify and prepare for emerging health risks

CONSEQUENCES

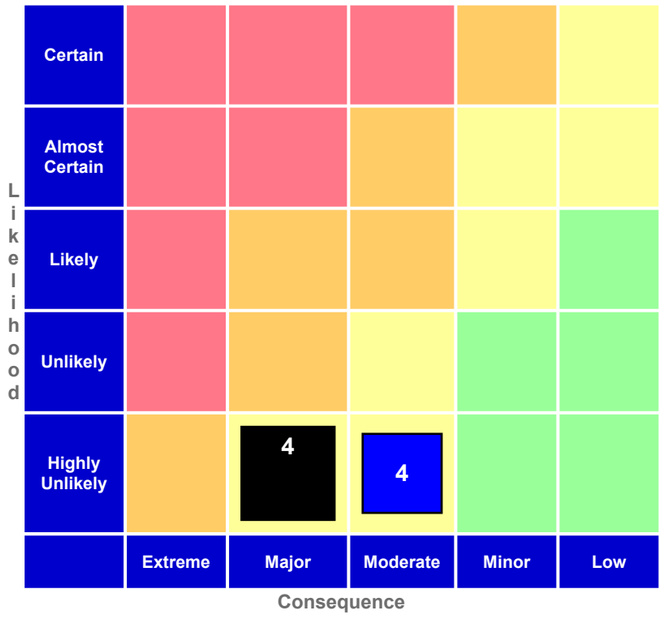
- Permanent major or temporary severe loss of function that is related to the process of health care and differs from the expected outcome of that care.
- Internal serious event review conducted at an organisational level.
- Substantial adverse publicity resulting in short-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Medical treatment injury resulting in lost time 1-7 days (excluding day of injury).
- Temporary loss of function <7 days.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Biological screening	
Ministry of Health - Health Promotion events and campaigns	
Occupational Physician Assessments	
Personalised consultation for individual health factors	
Pre-Employment Health Screening	
Specialised Occupational Health Nurses	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities, Natural event
Changing socio-economic circumstances, Culture
Lack of engagement
Conflicting priorities

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Operational risk management process in place • Worker engagement and participation in the prevention of hazards and risks relating to work-related disease • Increase awareness of work-related health • Encourage reporting of work-related harm to health		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : New Construction Builds

Risk ID : 5

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

Construction has been identified as a high risk industry and has increased compliance requirements. CM Health has a number of new build projects planned.

RISK EVENT

Harm caused to CM Health Workers due to the inadequate H&S controls during a new construction build

CONSEQUENCES

- Internal serious event review conducted using external agency/personnel to assist.
- Substantial adverse publicity resulting in mid-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Fatality and/or multiple casualties.
- Extensive damage to property - disruption to services >8 hours.
- Complete loss of utility service(s) >8 hours.
- Inability to replace clinical equipment.
- Unable to supply critical equipment or resources.
- Permanent or large scale irreversible severe environmental/ecological impacts requiring significant/ongoing resource.
- Significant breach of and/or inability to comply with legislation and/or regulatory standards with potential DHB Board/ELT, and/or staff personal liability risk and any liability risk unlikely to be covered by insurance.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Active monitoring the safe work practices	
Focussed engagement with capital work contractor site managers and project managers	

DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities, Natural event
Changing socio-economic circumstances, Culture
Lack of engagement and Conflicting stakeholders
H&S not included in contracting arrangements

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
Due diligence process prior to engagement with provider through the procurement process resulting in clear contractual specification of services & performance monitoring system of service providers through specified KPIs. Risk management process included in the scope of each project, showing defined escalation pathways for issues & resolution		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

COUNTIES MANUKAU HEALTH

Detailed Risk Analysis : OHSS Framework Delivery

Risk ID : 6

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

Lack of culture, leadership direction and operational engagement

RISK EVENT

Failure to deliver the expectations and objectives of the OHSS Framework

CONSEQUENCES

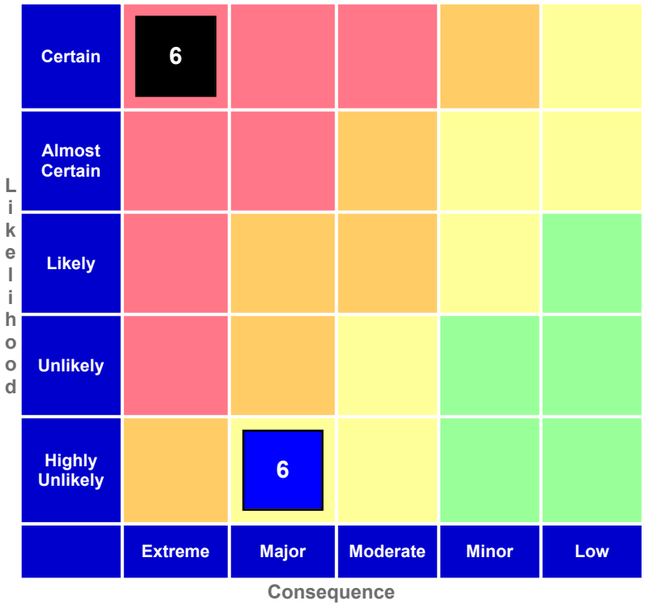
- Major inquiry by external agency.
- Substantial adverse publicity resulting in long term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Fatality and/or multiple casualties.
- Significant breach of and/or inability to comply with legislation and/or regulatory standards with potential DHB Board/ELT, and/or staff personal liability risk and any liability risk unlikely to be covered by insurance.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Annual ACC Partnership Program Audit at Tertiary Level for Injury Management and Rehabilitation	
Bi-Annual ACC Partnership Program Audit at Tertiary Level for Health and Safety	
Initial OHS Gap Analysis and annual self assessment	
Leadership work area visits	
Policy, Management System, Risk Profile, Occupational Health and Reporting in place	
Work place inspections	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities
Natural event
Changing socio-economic circumstances, Culture
Lack of engagement
Unplanned, reactive work

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Upstream and downstream management of the framework. • Develop, design and delivery of systems and processes • Benchmarking and performance measurement		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Moving and Handling

Risk ID : 7

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

This is a high consequence activity due to the high level of exposure and likelihood of harm. This is a known and ongoing musculoskeletal injury risk to our people.

RISK EVENT

Harm caused to CM Health Workers, visitors or patients due to inadequate practices of moving and handling throughout the organisation

CONSEQUENCES

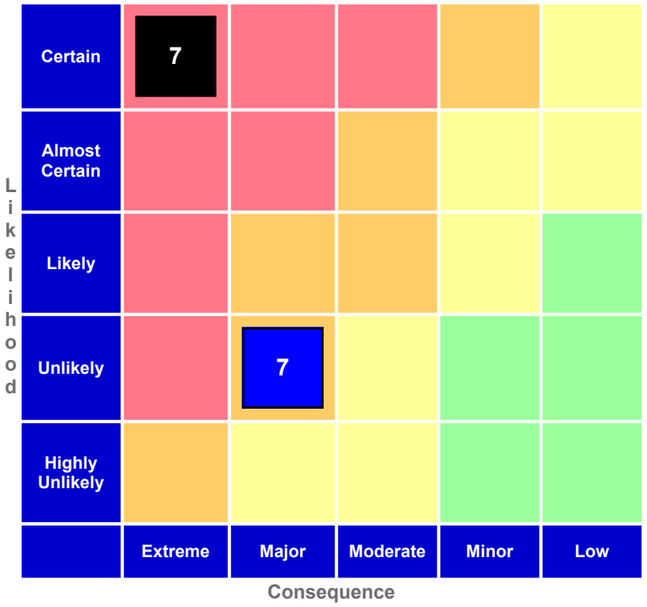
- Major inquiry by external agency.
- Substantial adverse publicity resulting in long term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Permanent disability
- Severe loss of function.
- Requires major medical or surgical intervention.
- Medical treatment injury resulting in lost time >7 days.
- Significant breach of legislation and/or regulatory standards with substantial financial liability risk for which insurance cover is unlikely

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Alignment to current legislation, policy/procedures and service delivery	
Clinical Governance Group sub-committee developing Whole of System strategic management plan	
Includes Quality and Safety Initiatives, Patient and Family Centre Care co-design	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities
Changing socio-economic circumstances, Culture
Lack of engagement
Full scope of risk is not clearly identified and understood
Inappropriate stakeholder involvement (i.e. too many opinions)

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Develop and implement an organisational wide strategic safe moving and handling management system (to be lead by sub-committee of the Clinical Governance Group with OHSS support)		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Aggression and Violence

Risk ID : 8

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

This is a high consequence activity due to the high level of exposure and likelihood of harm.
This is a known injury risk for CM Health workers who engage with the public and patients on a daily basis, especially given the changing socio-economic demographics in our community.

RISK EVENT

Harm caused to CM Health Workers, visitors or patients due to inadequate processes for risk identification and prevention throughout the organisation

CONSEQUENCES

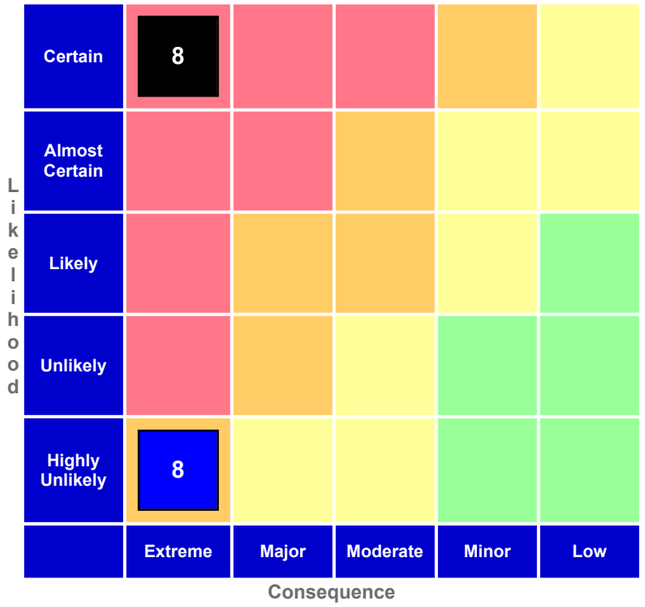
- Major inquiry by external agency.
- Substantial adverse publicity resulting in long term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Fatality and/or multiple casualties.
- Significant breach of and/or inability to comply with legislation and/or regulatory standards with potential DHB Board/ELT, and/or staff personal liability risk and any liability risk unlikely to be covered by insurance.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Incident analysis being undertaken	
Initial discussions with external service providers to clarify current approach to a 'shared' risk	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Natural event
Changing socio-economic circumstances, Culture
Lack of engagement
Full scope of risk is not clearly identified and understood

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Include risk assessments in models of patient care and expand risk mitigation process • Rigorous safety programme of improvement and align with service delivery • Shared information channels with appropriate external stakeholders and services to be defined • Causation profiling of incidents		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Health Impact of Work (Biological and Environmental Exposures)

Risk ID : 9

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

Work related safety hazards and risks i.e. the likelihood and consequence of safety risks impacting on the health and safety of work is immature or incomplete and the new legislation is placing an increased focus on prevention of harm.

RISK EVENT

Failure to identify new and robustly mitigate current safety risks.

CONSEQUENCES

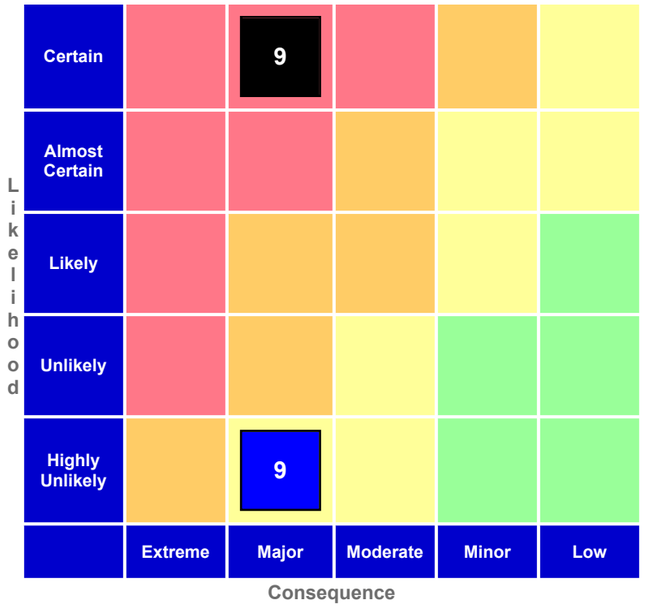
- Internal serious event review conducted using external agency/personnel to assist.
- Substantial adverse publicity resulting in mid-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Permanent disability or severe loss of function.
- Requires major medical or surgical intervention.
- Medical treatment injury resulting in lost time >7 days.
- Significant breach of legislation and/or regulatory standards with substantial financial liability risk for which insurance cover is unlikely
- Severe breach of and/or inability to meet contractual agreement.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Biological health monitoring and Contact Tracing	
Environmental exposure screening	
Ergonomic assessments	
Immunity and Vaccination program including the annual Flu campaign	
Management of work related conditions and disease states	
Occupational Health Physicians and Specialised Occupational Health Nurses	
Training e.g. Bullying and Harassment, Inductions, Information sessions	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities
Changing socio-economic circumstances, Culture
Lack of engagement, Conflicting priorities

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
Formal accepted and owned occupational health screening risk framework and strategy under the leadership and direction with regular and active review, monitoring and responding through all levels of the organisation Task-based risk assessments		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Community Health Work

Risk ID : 10

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

This is a known and ongoing severe injury risk to our staff who work in the community due to the unknown factors from the changing socio-economic environment our staff work in.

RISK EVENT

Failure to identify new safety risks within a changing community health scope of work

CONSEQUENCES

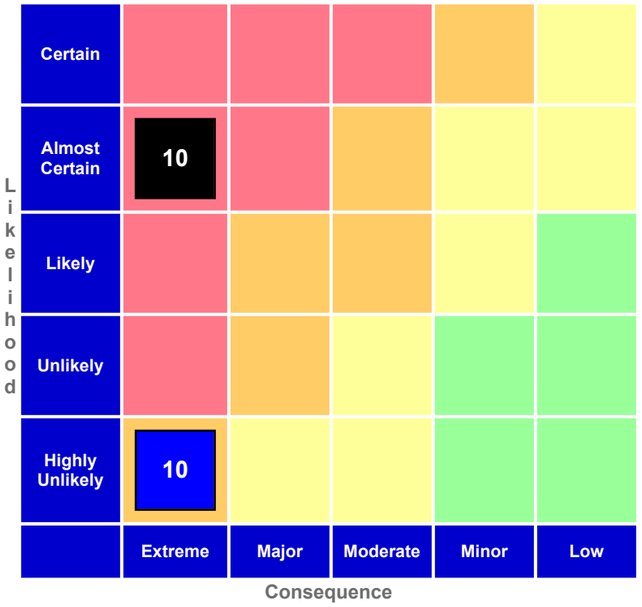
- Major inquiry by external agency.
- Substantial adverse publicity resulting in long term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Fatality and/or multiple casualties
- Significant breach of and/or inability to comply with legislation and/or regulatory standards with potential DHB Board/ELT, and/or staff personal liability risk and any liability risk unlikely to be covered by insurance.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Alignment of risk assessment methodology to patient care, service delivery and employee safety	
Identification of inconsistencies and gaps in safe practices	
Localities lead joint working group with unions to review current policies, practices and training	
Wider worker participation and engagement	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities
Natural event
Changing socio-economic circumstances
Culture
Lack of engagement

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Deep dive risk review of the system and process of work as a worker in the community, to identify gaps and risks • Continuous monitoring of high risk areas, inspections plans • Prioritisation of key areas/service delivery components - concentrate on areas with high risk of likelihood		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Slips, Trips, Falls

Risk ID : 11

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

This is a high consequence activity due to the high level of exposure and likelihood of harm. Causation is not fully understood.

RISK EVENT

Harm caused to CM Health Workers, visitors or patients due to inadequate understanding of high risk slip, trip, fall incidents throughout the organisation

CONSEQUENCES

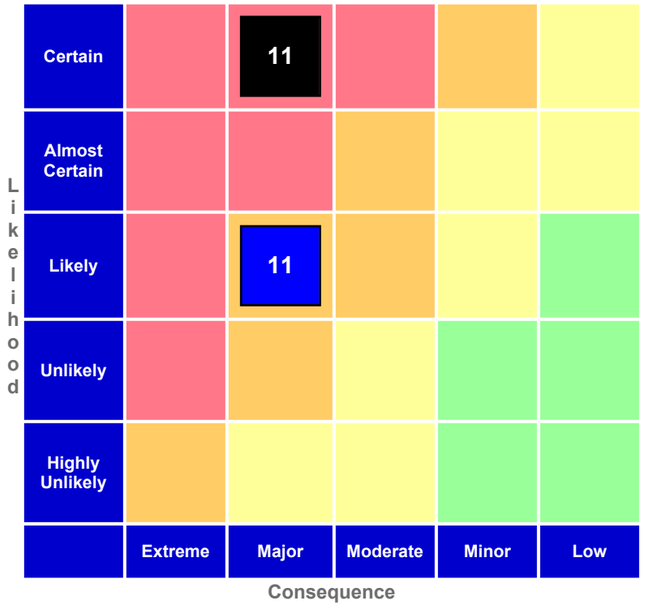
- Internal serious event review conducted using external agency/personnel to assist.
- Substantial adverse publicity resulting in mid-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Permanent disability or severe loss of function.
- Requires major medical or surgical intervention.
- Medical treatment injury resulting in lost time >7 days.

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Incident analysis being undertaken	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative or Funding arrangement changes
Facilities
Natural event
Changing socio-economic circumstances, Culture
Lack of engagement
Full scope of risk is not clearly identified and understood
Inappropriate stakeholder involvement (i.e. too many opinions)

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Continuous monitoring of high risk work areas and consequence profiling • Defined safety programme of awareness, improvement and expanded risk mitigation process		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Detailed Risk Analysis : Wellness

Risk ID : 12

Directorate / Division : Health & Safety

Last Updated On : 15/03/2017

RISK OWNER

Bev Stone

CAUSES

A diverse workforce has multiple personal factors that influence individual and organisational 'wellness' that could potentially impact patient outcomes. These factors are often undefined

RISK EVENT

Sub-optimal patient outcomes due to an unwell workforce

CONSEQUENCES

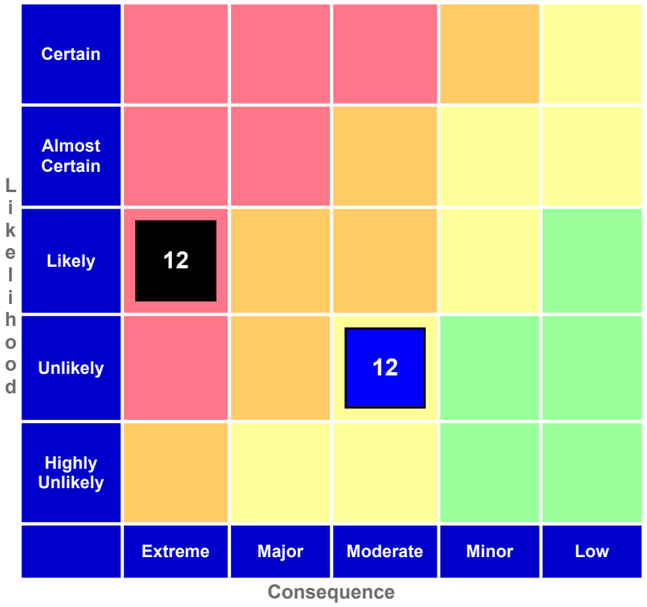
- Internal serious event review conducted using external agency/personnel to assist.
- Substantial adverse publicity resulting in mid-term term public loss of trust and confidence in the quality and safety of care received at CM Health.
- Industrial action resulting in >1hr loss of patient facing staff.
- Non delivery of an essential service due to shortage of workforce supply.
- Medical treatment injury resulting in lost time 1-7 days (excluding day of injury).
- Significant breach of legislation and/or regulatory standards with substantial financial liability risk for which insurance cover is unlikely

PREVENTATIVE CONTROLS

(how do we stop the risk from materialising?)

Controls that are currently in place:

CONTROL NAME	OWNER
Consolidation of current initiatives being undertaken to avoid duplication of effort	
Wellness issues incorporated into the critical OHS risk profile	
Wellness Strategy developed and designed with alignment to Healthy Together and the People Strategy	



DETECTIVE CONTROLS

(what do we do if the risk has materialised?)

Controls that are currently in place:

CONTROL NAME	OWNER
Analysis of trends through deep dives	
Exception reporting	
Hazard identification and assessment	
Incident Management	
Inclusion of H&S in the scoping of new projects	
Review of hazard and risk register	

RISK INTERDEPENDENCIES

Legislative and Funding arrangement changes
Facilities
Natural event
Changing socio-economic circumstances, Culture
Lack of engagement and unclear direction of strategic alignment

Risk Matrix Legend:

- Inherent Risk - Current Risk - Target Risk

TREATMENT PLANS (future actions)

PLANS	OWNER	DUE DATE
• Upgrading networks and opportunities to improve engagement • Leadership and direction that is unified and not siloed • Measurement of effectiveness, decision-making, ownership and successful culture changes • Communication strategy, actively managing regular reassessment, confirmation of operational culture and values		

ISSUES WE ARE CURRENTLY FACING

Report Produced On: **Wednesday, 15 March 2017**

Counties Manukau District Health Board
Corporate Affairs & Communications Report
Month ending 15 March 2017

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report.

Prepared and submitted by: Sarah Baddeley, General Manager Corporate Affairs and Communications and Margie Apa, Director Population Health, Strategy & Investments Directorate.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the month ending 15 March 2017. This paper also provides context for the role of the Corporate Affairs and Communications Team and an approach to regional working.

Major issues or events

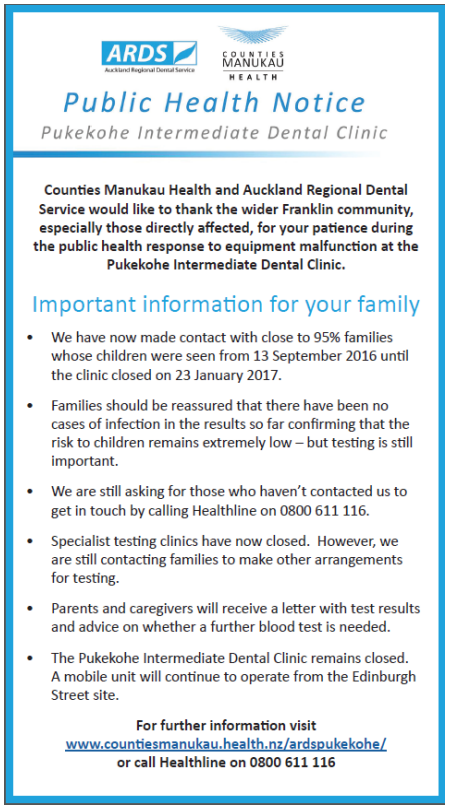
Pukekohe Intermediate Dental Clinic Public Health Response

The public health response to the contamination that occurred at Pukekohe Intermediate Dental Clinic has continued but is phasing down as the EOC is completing the screening and follow up work. The number of families who have yet to be contacted is now 5 out of more than 2,100. The learning from this phase of work has highlighted that Friday evenings are the most useful time to call families who have been more challenging to contact. This is a significant achievement for the wider response team including nurses within the Counties Manukau School Health Network. There have been no positive results from testing undertaken to date.

Community sentiment continues to be monitored locally and through social and traditional media. Stakeholders have been invited to participate in local debrief and a full emergency response review is planned. A paid advertisement ran in the local newspaper.

At the time of writing this report, the following issues were 'in flight' for media management also:

- Public petition seeking DHB review of parking fees for public and staff.
- Mental Health Foundation sponsored report on underfunding in mental health.



ARDS Auckland Regional Dental Service

COUNTIES MANUKAU HEALTH

Public Health Notice

Pukekohe Intermediate Dental Clinic

Counties Manukau Health and Auckland Regional Dental Service would like to thank the wider Franklin community, especially those directly affected, for your patience during the public health response to equipment malfunction at the Pukekohe Intermediate Dental Clinic.

Important information for your family

- We have now made contact with close to 95% families whose children were seen from 13 September 2016 until the clinic closed on 23 January 2017.
- Families should be reassured that there have been no cases of infection in the results so far confirming that the risk to children remains extremely low – but testing is still important.
- We are still asking for those who haven't contacted us to get in touch by calling Healthline on 0800 611 116.
- Specialist testing clinics have now closed. However, we are still contacting families to make other arrangements for testing.
- Parents and caregivers will receive a letter with test results and advice on whether a further blood test is needed.
- The Pukekohe Intermediate Dental Clinic remains closed. A mobile unit will continue to operate from the Edinburgh Street site.

For further information visit
www.countiesmanukau.health.nz/ardspukekohe/
or call Healthline on 0800 611 116

Figure 1 Public Notice placed in public print newspapers

Media and email enquiries

Media enquires through the period remain impacted by media interest in the Pukekohe Intermediate Dental Clinic public health response. Approximately 127 enquires were received through the period of which over 30% related to patient condition updates.

The Corporate Affairs and Communications team manage a generic communications email box responding to all emails and connecting people to departments. For this period 91 emails were received. 62 were not related to communications issues and, where appropriate, were referred to other departments and services at the CM Health.

Routine Sector Communications

There are 2 regular e-newsletters that update on operational issues (e.g. referral pathways) and highlight issues and/or developments relevant to specific segments of the local healthcare sector:

- ***E-Update for Primary Care*** targeting PHOs, GPs and other primary care health practitioners is issued fortnightly. The Update currently has 915 subscribers and an average open rate of 27% (consistent with industry standards).

- ***E-Update for Maternity Care*** is issued monthly and has 604 subscribers and an average open rate of 22.4%. The *Our Maternity Monthly* is electronically distributed amongst CM Health staff, Independent Midwives and the wider paediatric community. A community midwife was profiled in the last issue to support the CM Health priority recruitment drive for this and hospital midwife roles.

Figure 2 Header for fortnightly e-Update for Primary Care

& Work has continued across the CM Health integrated care programme to deliver strategic communications advice, activities to staff, stakeholders and the community on Enhanced Primary Care (EPC), Community Central (CC), Reablement, Planned Proactive Care (PPC, previously ARI) and Mental Health Addictions (MHA).

Internal communications

There are 5 core centrally managed channels of internal communications. Some channels also reach an external audience (e.g. blogs). In this period the following channels and key content with reach are:

- ***Daily Dose*** an all staff email distributed three times a week with average reach of 2,500 per email.
- ***CEO Blog*** (produced weekly) to support the Chief Executive to communicate to staff and the wider health system. Reach rates vary and over this period the most popular blog had over 1000 views. Our analytics show us that while readership is lower, overall engagement is higher (with more comments on blogs).
- ***Team Counties*** blog which is produced 1-2 times a month showcases the work of an individual or team at CM Health. This month's focus was on patient experience with the introduction of Jenny Parr, the new Director of Patient Care, Chief Nurse and Allied Health Professions Officer.
- ***Connect Magazine***: A February issue was published leading on the opening of Pataka Place, the new retail precinct. Reach for this is difficult to measure as the 1000 copies produced are targeted at non-computer based workers and are positioned in staff rooms. We think there is opportunity to review the effectiveness and value of this staff magazine and to undertake this work in the middle of the year once a new digital platform is in place. Our early view is that a less polished more frequent physical newsletter may be of more use.

- ***Southnet*** is the current intranet platform. This is an outdated platform now running on unreliable technology which is undergoing a review (see below).
- ***Staff Forum*** is a face to face exchange between the CEO and staff. This occurs at least one a quarter and provides staff with direct conversations with the CEO. The last forum was held this week on Wednesday 15 March at which the CEO shared key developments including his resignation.

Campaigns in development

- ***Access 365*** campaign is in design stage, this was formerly known as the Winter campaign. The objective of this campaign is to create a platform for access based communication at peak period of demand throughout the year including the winter period. Work includes concept development, design refresh, a video component, a usage and stocktake audit of last year's resources and a community stakeholder research exercise to test the effectiveness of the ***Access 365*** messages with members of the public.

  Historically a Winter communications campaign comprised a proactive social and media push to encourage the public to 'prepare' for winter (flu vax, medication management) and during winter promote the appropriate use of help ranging from self care to emergency (see graphic below). Data on acute presentations suggests that acute presentations that might have been regarded as winter volumes are now occurring throughout the year outside season. The difference this year will be to extend a structured communications approach that is able to offering a more consistent messages during the year i.e. 365 days. Monitoring of data on reach of messaging is embedded to evaluate the value of each channel during campaigns.

Figure 3 Communications Collateral produced for 2016 Winter Campaign that will be modified for 2017 Access 365 Campaign

- ***Transformation of patient experience*** lead by Director, Patient Care at Counties Manukau Health. The Director of Patient Care has responsibility for 60% of our workforce. The aim of the campaign is to promote among staff ways of engaging patients in their care experience.

- ***Staff flu immunisation campaign*** which will run from 18 April to late May. The aim of the campaign is to promote flu vaccination among staff to reach and exceed the target coverage rate is 70%. Last year the immunisation rate was 66% and varied across services and employment type.

- The team are also working with the ***Maternity Strategic Group*** to assess messaging and appropriate channels to encourage Normal Childbirth and Promoting Early Engagement in maternity care. This will be informed by insights from the Maternity Consumer Network.

Digital Channels
This section reports on utilisation and/or access to digital channels comprising intranet, external website, social media – CM Health and Healthy Together Facebook, Twitter and LinkedIn.

Intranet: CM Health is upgrading its intranet from FrontPage (SouthNet) to a new site developed on the regional platform, SharePoint 2013. The vision of the CM Health intranet is to enable the creation, management, and sharing of knowledge assets in a business-driven environment. Our aim is that this also enables collaboration across the whole organization. The literature on organisations that foster collaborative cultures suggests digital networks are critical to help people form communities and networks of interest that are not constrained by structures or hierarchy.

Content migration from the outdated platform is a slow task due to the volume of information with 14% of services and content migrated. Significant consultation has occurred with staff – particularly clinical audiences and a group has been established to provide oversight and ensure user responsiveness.

Website www.countiesmanukau.health.nz. Our site has maintained statistics that are consistent with the last 12 months, with slight improvements (<5%) across all areas. This is with the exception of new sessions (people who have never visited our site before) that have dropped by 1%. While desktop use still makes up half of our usage (54.57%), mobile is still increasing slightly month on month at 2%. Organic search makes up 66% of our acquisition, with direct (bookmarks) and referrals (web links) second and third respectively. Socially driven acquisition drove 1099 sessions on the site, with these sessions lasting over 2 minutes each.

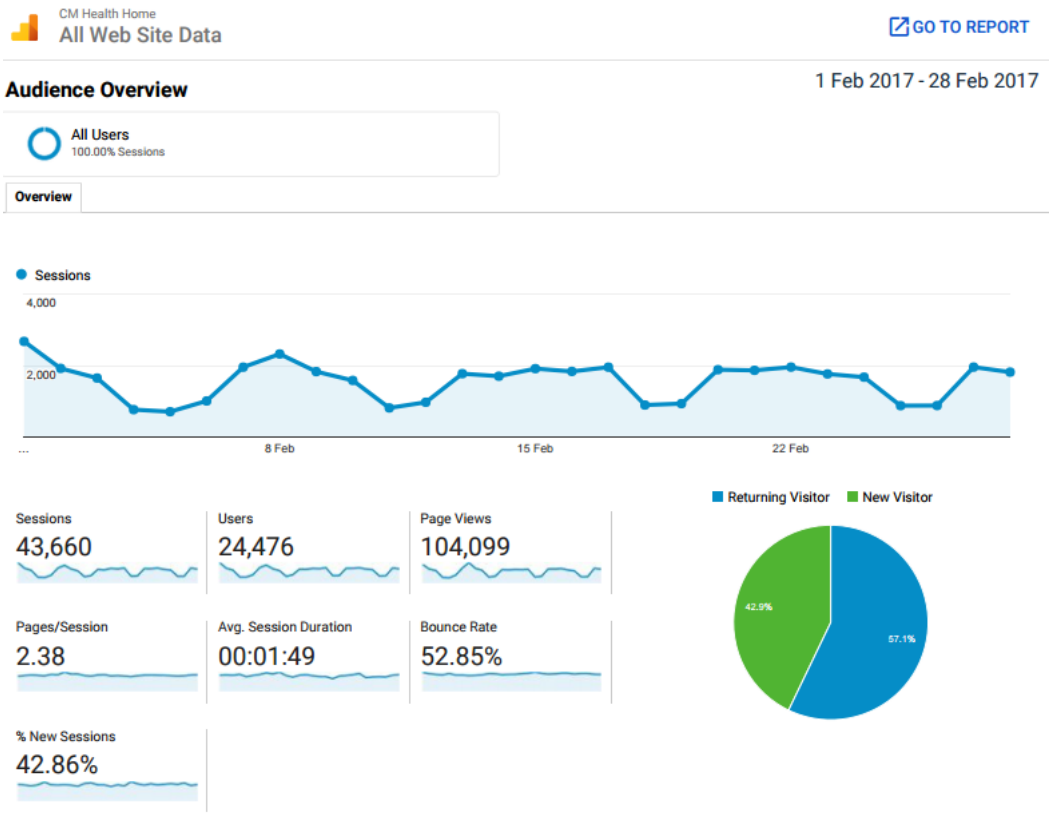


Figure 4 Web Site Data Metrics from Google Analytics

Social Media

CM Health has 2 Facebook sites – CM Health and Healthy Together. We see the audiences of these as quite distinct. Our assumption is that some messaging that is aligned to strategy (e.g. healthy lifestyles, vibrant stories on community life) but is targeted to community networks may have greater reach if they were not seen as part of a 'corporate' or 'institutional' link. The following graphs also show the top 3-4 posts by channel. The common trend is that people like to hear and read about real people ranging from colleagues, local heroes or stories about events in their own backyard.

CM Health Facebook - Our target audience for the CM Health Facebook page are those working in healthcare and/or are associated with the healthcare system in the District. The number of posts we sent increased by 13.3%, with 68 posts sent over the month. Our total impressions increased by 16.5%, with a total of 168,521 impressions overall - one third of which were viral. Total Engagements increased by 52.9% since previous month, with 1817 reactions, 160 comments and 304 Shares.

	Total Followers	Follower increase	Messages Sent	Impressions	Impressions per Post	Impressions per Post	Engagements per Post	Link Clicks
CM Health Facebook	3,163	1.67%	68	168,521	2,478	2,281	33.5	903
Healthy Together Facebook	7,926	-0.19%	18	16,483	916	245	13.6	141
CM Health Twitter	2,268	1.11%	147	25,882	176	244	1.7	43
CM Health LinkedIn	4,027	1.49%	29	82,443	2,843	919	31.7	507

Figure 5 Summary of Reach and Engagement Metrics for each Social Media Channel

Audience Growth Metrics:

	Totals	Change	
Total Fans	17,384	+0.7%	**Total fans increased by 0.7% since previous month**
New Facebook Fans	37	+8.8%	
New Twitter Followers	25	-	
New LinkedIn Followers	59	-1.7%	
Total Fans Gained	121	+29.7	

Figure 6 Audience Growth Overview by social media channel

Top Posts by Reactions:

Post	Reactions	Comments	Engagement	Reach
Counties Manukau Health Congratulations to Drs Yousr Al-Sheibani and Simone Freundlich for being selected as House Officers of the Month for January! Dr Al-Sheibani, senior staff highlighted that: 'From the moment Yousr arrived to our ward (33 East) and introduced herself to us all, she has made a big impact on our ward. Yousr is always friendly and approachable and willing to help anyway she can – be it with staff, colleagues, visitors, patients and their whaanau.' Dr Simone Freundlich, colleagues highlighted that: 'She works very hard in her clinical role, eager to learn and actively promotes good practise', she is an 'excellent team player' and that 'She has excellent relationships with service users and their family/whaanau.' CM Health thanks Drs Yousr Al-Sheibani and Simone Freundlich for their outstanding contribution. CM Health also acknowledges nominees Fouad Nahab, Rebecca Teague, Young Eun Koo, Finau Tutone, Tevake Tonga, Laurell King and Penina Taimaglelagi for their hard work and deserves special mention. (Post) February 08, 2017 2:19 pm	316	56	12.8%	10,974
Counties Manukau Health Midwives bring life into our community and play an important role in our organisation. We are looking for midwives who want the opportunity to make a difference. Click here if you want to learn more about our team's stories: http://www.countiesmanukau.health.nz/careers/our-jobs/hot-jobs/midwives/ (Post) February 11, 2017 11:30 am	284	31	11.7%	8,799
Counties Manukau Health Paataka Place is now open for business at Middlemore Hospital. This amazing retail space offers a wider choice of shops, beverages and healthy food options. There's also plenty of comfortable seating and lounge areas. Welcome to all of our tenants! (Post) February 07, 2017 12:05 pm	233	26	10.8%	5,794

Figure 7 Top 3 CM Health Facebook Posts by Reactions

Healthy Together Facebook - Our target audience for Healthy Together Facebook is local District population, with a particular focus on Maaori and Pacific. We are also aware that women between the ages of 35-44 have the highest potential to see our content and visit our page. As they are often health related decision makers in their households – we target our communications to a "Mums and Aunties" cohort. We are not currently satisfied with our performance through this channel and have a strategy in place to improve it in coming months.

While the number of posts we sent decreased by 30.8%, the total number of engagements increased by 14.5% with 99 Shares of our content for the month. While our total impressions decreased we still managed 12,720 organic impressions with another 3,763 viral impressions.

Top 4 Posts by Reactions:

Post	Reactions	Comments	Engagement	Reach
Healthy Together - Counties Manukau It's awesome to see some of our South Auckland students excelling in Science as part of our Health Science Academy, supported by **The Tindall Foundation**. Around 300 students take part in the Academy as part of our Grow Our Own workforce programme to help get more Pacific health workers into our communities, just like Fonoifafo Mcfarland-Seumanu. Fonoifafo was one of the first students to be a part of the Academy at Tangaroa College and is now making a difference as a community nurse. http://ow.ly/4Alo3099pL0 'We can be what we want to be' - programme helps Auckland Pacific Island... (Post) February 20, 2017 9:50 am	32	–	5.5%	1,833
Healthy Together - Counties Manukau Our thoughts are with the Tongan community today on the passing of Queen Halaevalu Mata'aho Ahome'e. May she rest in peace. http://ow.ly/JdXx3099pZG Tongan queen mother dies, aged 90 - National - NZ Herald News (Post) February 20, 2017 2:20 pm	26	1	4.1%	1,460
Healthy Together - Counties Manukau South Auckland is full of talented people that need to be supported and celebrated. Check out some of our inspiring entrepreneurs below. http://ow.ly/yRtn3099pWg Insight: Unleashing the Potential of South Auckland (Post) February 21, 2017 7:25 pm	24	1	4.1%	1,426
Healthy Together - Counties Manukau Kia ora whanau - Did you know that more than half the country's rheumatic fever cases are in Auckland? If you or your child has a sore throat, don't delay, seek advice from your GP. Let whaanau and friends know about how they can prevent rheumatic fever. Click here for more info: http://rheumaticfever.health.govt.nz/ Rheumatic fever (Post) February 14, 2017 6:45 pm	19	–	4.2%	740

Figure 8 Top 4 Healthy Together Top 4 Posts by Reaction

CM Health Twitter - Our total followers increased by 1.1% since previous month with 64 new follower alerts generated. The number of messages we sent increased by 11.4% and subsequently the number of messages we received increased by 57.1% since previous month.

The number of engagements we had increased by 221.1%, with the number of impressions per Tweet increasing by 155.6%. Our Tweeting behaviour was 9:1 updates vs conversations, with 71% of our conversations with existing contacts. We are not currently prioritising twitter as its market share is declining globally.

Tweet	Reach	Responses	Clicks	Retweets
cmdhb This week marked the first meeting of our new **@CMDHB** Board. 2017 is off to a great start **@CEO_CMH** https://t.co/vaAdJP5cN0 (Tweet) February 16, 2017 1:01 pm	5,532	4	–	4
cmdhb Paataka Place opens its doors https://t.co/Mt8115dyHb https://t.co/AXyNaRLvGV (Tweet) February 09, 2017 1:20 pm	2,943	3	–	1
cmdhb Sonographers looking to work at CM Health, We are one of the most successful teaching hospitals in NZ. Apply-https://t.co/GtOjg7YxAo https://t.co/0ZLxe5XIUT (Tweet) February 28, 2017 2:33 pm	4,985	2	–	2
cmdhb Thanks for **#following** cmdhb, https://t.co/qJZCnDd4lQ (Tweet) February 21, 2017 2:16 pm	10,211	1	–	1
cmdhb The Five Ways to Wellbeing, Ētahi ara e rima ki te ngākau ora, help people stay mentally well. https://t.co/lVvu08Pb4A (Tweet) February 20, 2017 6:05 pm	2,454	1	–	1

Figure 9 Top 5 Tweets by reaction

CM Health LinkedIn - LinkedIn is a business and employment-oriented social networking service. Our target audience is staff, alumni and potential future employees. It is a strong low cost channel for recruitment and to showcase our corporate strengths, performance measures and things that may impact a decision to join CM Health. This is a channel most used by recruitment to create networks and global reach of opportunities for work and maintain a sense of a 'alumni' of people interested in CM Health if not now, perhaps in the future.

Total impressions where up 8.7% with almost 3000 a day, along with an impressive 32,161 users reached. Publishing volumes where the same as last month, at an average of 1 post per day – this is part of our strategy to focus on quality rather than quantity of engagement. Our engagement levels where down 5% overall, but this did not affect our audience growth metrics as we still managed to improve 1.5% on last month.

Top 3 Posts by Engagement:

Post	Impressions	Engagement ▾	Clicks	Likes
Counties Manukau Health Ko Awatea Training Fellowship (Health Leadership Development)- Ko Awatea is the Centre for Health System Innovation and Improvement for the Counties Manukau Health. The aim of Ko Awatea is to be a hub of education, improvement and innovation to support health systems and public services – foremost to Counties Manukau Health, but also locally, nationally and internationally. We are currently recruiting for a Training Fellowship (Health Leadership Development) and is certainly a unique role you will not find elsewhere! Read more at http://ow.ly/vXzP309c435 (Update) February 21, 2017 4:14 pm	3,417	1.84%	40	19
Counties Manukau Health CM Health receives A-rating from Treasury following a report which shows high confidence in Metro Auckland DHBs investment practices. http://ow.ly/bl61309cdKc (Update) February 21, 2017 6:33 pm	3,508	1.82%	42	19
Counties Manukau Health Are you a Senior Mental Health Clinician looking for a leadership role? If you have both clinical and community experience, this could be exactly what you have been looking for! To find out more about this position, please visit the job advertisement at http://ow.ly/LRN5308PnD0 (Update) February 09, 2017 3:56 pm	2,266	1.77%	27	10

Figure 10 LinkedIn Top 3 Posts by engagement

Role of Corporate Affairs and Communications
In 2016 a review of the work programme of Communications in strategy implementation was undertaken and came to the following conclusions:

Strategic context - Healthy Together 2020 provides a strategic action of greater social and health sector collaboration to improve the health and wellbeing outcomes of our most vulnerable populations. This is particularly focused on those populations that experience poorer health outcomes and drive a disproportionate growth of demand on the healthcare system.

If we are successful in increasing the diversity of our workforce to match our community, this same demographic challenge will be reflected internally in how we communicate with employed staff and those who partner with us in delivery (e.g. primary and community care workforce).

Deployment model for communications in CM Health has changed - The deployment model to support Healthy Together 2020 locally also relies on a much higher level of community based engagement and feedback into service delivery and design at the population health, primary and integrated care level than previously anticipated. This means shifting **from**:

- a largely 'hospital' and 'risk management' focus with transactional internal communications.

to:

- offering a more diverse 'menu' of options to support a more sophisticated match between message, specific audience segment and more effective and low cost channels contextualised for strategy.

Expansion of options in digital channels and social media has widened the possibilities that are a better fit for a highly digitally savvy CM Health population. Many of these new channels also offer greater transparency in performance metrics to understand how far messages have gone (reach) and reactions or response to those messages.

We would like to get more sophisticated in stretching that to understand whether it led to a change in 'intervention seeking behaviour' - are messages reflected in increased access or utilisation of services? or change in lifestyle choices.

This shift anticipates a communications function focused on broader channels for community impact, expanded use of social media and digital channels for engagement and the step change in our internal communication channels (including the intranet) to enable more efficient, timely and engaging communication with our workforce. Some of this work is commissioned from external expertise for specialist areas (e.g. social media reach, ethnic specific media). A broader approach encompassing 'Corporate Affairs' was added to the functions of the team to reflect this expanded scope.

Regional Opportunities - We will promote a discussion with regional colleagues on identifying the areas where regional collaboration would accelerate the goals of all three Boards. This may include:

- Areas where brand and reputation risk may be better managed by delivering together (i.e. matters to the public perception and reputation of the metro-Auckland healthcare system as whole and to three DHBs as collective)
- Clarify what is best led locally because of segmentation of local groups requires tailored approaches to messaging and operational delivery of information relevant to that District workforce and community sector.

There is significant opportunity to broker a regional approach that gets the best of all worlds while also being relevant and resonating with local communities.

Counties Manukau District Health Board
Healthy Together 2020 Strategic Plan

Recommendation

It is recommended that the Board:

Receive the paper on the Healthy Together 2020 Strategic Plan refresh or review.

Endorse a 'refresh' update of the Healthy Together 2020 Strategic Plan to reflect changes since its endorsement in 2015; **or**

Endorse a 'review' of the Healthy Together 2020 Strategic Plan to reflect the current Board's priorities and guidance.

Prepared and submitted by: Margie Apa, Population Health Strategy & Investments

Healthy Together Strategy Refresh or Review?

CM Health's current Healthy Together 2020 Strategy (HT2020) is attached for your information. The HT2020 was finalised and signed off by the previous Board in June 2015. Since then, variations of implementation have been actioned through existing programmes of work. The establishment of a Healthy Together Transformation Director and his portfolio of work aims to accelerate that implementation by reviewing the organisation's operating model.

It is logical and appropriate for a new Board to revisit whether the Strategy reflects your priorities and brief.

The Board has an opportunity to consider whether you accept the Strategy in its current form with some ***'refresh'*** to update parts that are no longer current (ie) Foreword, preparation for CEO transition.

Or, alternatively, the Board may wish to ***'review'*** some or all of its contents.

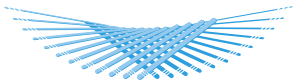
The assumptions and analysis underpinning the HT2020 Strategy will be shared through the 'Information section' of the Board papers. Board will find a paper setting the population demographic context for CM Health. The final Strategy does not fairly reflect the analysis, staff and partner contributions that informed it. It is also written in language that aims to be accessible to public (including being blind of brands and labeling of current initiatives) and may require some deep dives to assure Board of their contribution to improvement health outcomes.

If the Board requires a more substantive session this can be arranged.

Healthy Together

Strategic Plan

2015-2020



COUNTIES MANUKAU HEALTH

Our approach

'Healthy Together' outlines what we want to achieve for the people of Counties Manukau and how we will measure that achievement over the next 5 years. This strategy builds on our past successes and strong performance to:

- **Provide high quality and high performing** modern specialist and hospital based services;
- **Strengthen primary and community based services** to reduce the burden of disease and prevent ill health; and
- **Achieve health improvement for all** – with targeted support for our most vulnerable people and communities.

Dr Lee Mathias
Board Chair

We have a special relationship with Mana Whenua i Tamaki Makaurau as stewards to ensure Maaori health gains are accelerated. This plan represents a whole of system view – all parts of our health system working together.

Counties Manukau Health is a partnership across District Health Board, primary healthcare and community based NGOs working together with our colleagues in social services and other sectors. We are a regional partner as part of the Northern Region DHBs and work collaboratively with national health agencies.

Importantly, we have high aspirations for the people living in Counties Manukau. This district has many vibrant, diverse and dynamic communities.

We will play our part to ensure that the health system enables our communities to stay well, recover and live healthy lives – together.

Our actions

Counties Manukau Health's strategy to be the best healthcare system in Australasia by December 2015 has achieved many positive changes thanks to the hard work of everyone involved. This has been possible through the alliance with primary health providers to collaboratively build a greater range and scope of services available in the community and commitment of our people to excellent, high quality, safe and effective services. We have done this by codesigning service improvements in collaboration with patients and whaanau.

We can be proud of our performance in national health targets and living within our budgets, while at the same time investing in quality and safety improvements and services redesign innovations.

We will build on the many innovations and learnings generated over the last 5 years from across our health system. We will sharpen our focus on excellent system-wide e-services and growing the range and scope of community based services.

To help people to truly be healthy together, we will make it significantly easier to access information through smarter systems and technology when and where people need it. This includes patients, whaanau and family.

Geraint Martin
Chief Executive Officer

Who we are

Our strategic goal

We care about achieving health equity for our community.

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.

We will measure the impact we have on healthy life years every year. This is our commitment to act and be deliberate in our choices and priorities.

This means that people will live longer healthier lives in the community.

Healthy Together

Our values

We aspire to live and breathe our values every day as the foundation of our strategic actions:

Valuing everyone
Make everyone feel welcome and valued

Kind
Care for other people's wellbeing

Together
Include everyone as part of the team

Excellent
Safe, professional, always improving

Who we serve

Over the next 5 years, the population of people living in Counties Manukau is growing at 1-2% each year and is changing, both youthful and ageing, and is estimated to reach over 560,000 people by 2020. Our population is ethnically diverse and by 2020 is estimated to be 15% Maaori, 22% Pacific and 26% Asian people.

Our older population will increase by approximately 22% with an estimated 70,000 people aged 65 years and over by 2020. At the same time, we have the largest population of children of any District Health Board, with an estimated 54,000 out of almost 121,000 children living in poverty. Just over a third of our residents live in areas of high socioeconomic deprivation and if this situation continues, this could be as many as 202,150 people in 2020.

Our communities are different across Counties Manukau and this means we need to fit our services to best support the whole population.

The estimated resident population of Counties Manukau based on the 2013 Census tells a story about our diverse communities.

Otara & Mangere Locality

Of the 100,000 plus people living in this locality in 2013, almost 59,000 are Pacific (our largest Pacific community) and 17,500 Maaori. Nearly 30% of residents are aged under 15 years. About 77% of people are living in areas of high socioeconomic hardship.

Eastern Locality

Our second largest locality with over 146,000 residents in 2013. This includes more than 51,000 people of Asian ethnicities and over 18,000 people aged 65 years and over.

Franklin Locality

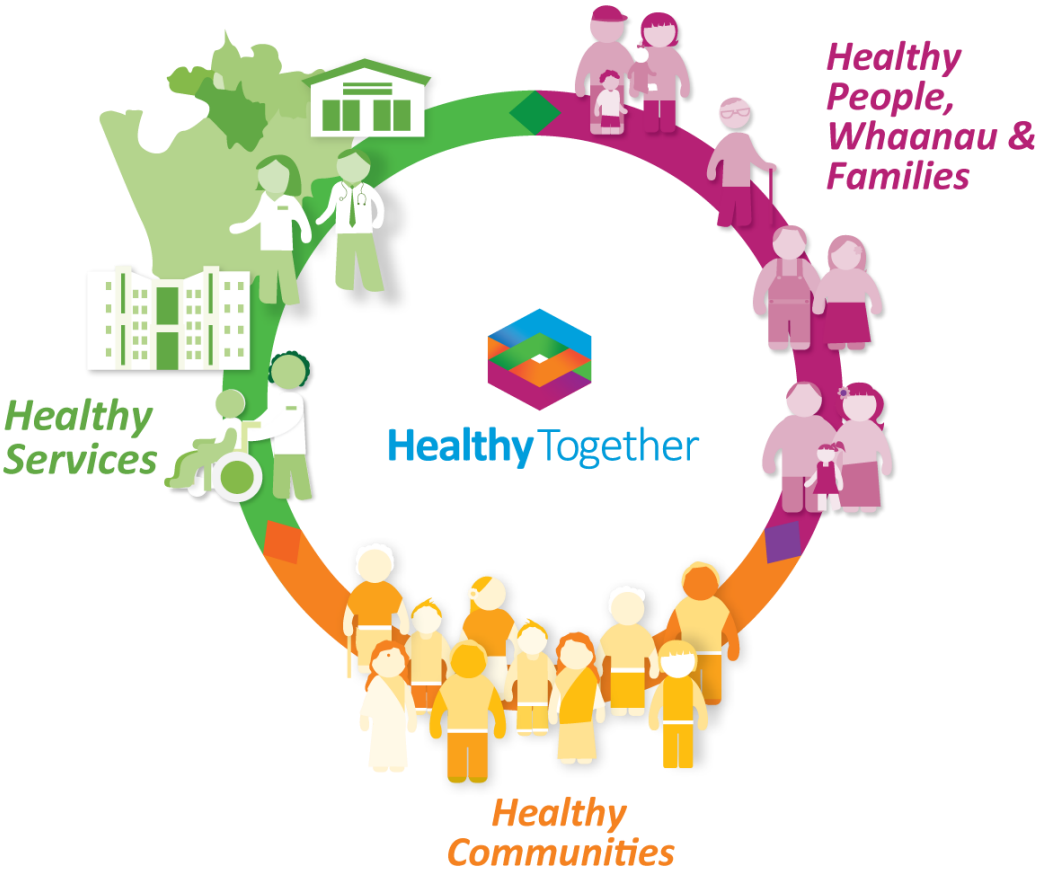
Our most rural locality with over 67,000 residents in 2013. Approximately 13% of people are aged 65 years and over, with a significant Maaori population, making up about 17% of the residents living in Franklin.

Manukau Locality

Our largest locality of over 181,000 residents in 2013. This includes almost 40,000 Pacific people, 42,000 Maaori people and 41,000 people of Asian ethnicities. A quarter of the population are aged under 15 years. About 50% of people are living in areas of high socioeconomic hardship.

Our strategic objectives and actions

To help us work together to achieve this, we will organise our actions around three strategic objectives. Together means collaboration and partnership with people, whaanau, families, communities, health and other providers.



"Together we will help make healthy options easy options for everyone."

Why does it matter?

If you grow up and live in a neighbourhood with a good school, it is safe, you can walk and play outside, your home is dry and warm, you have regular and accessible healthcare, access to good food, a satisfying work life and are surrounded by people who affirm and support you, you are more likely to live a long and healthy life.

What does this mean for us as a health system?

Many of the determinants of ill health are outside the control of the healthcare system. We can, however, exert our leadership role to support our communities in those issues that matter most to them; with a particular expertise in population health. By locating more healthcare services that are connected and integrated in community settings, we make it easier for communities to access care and support.

What do we do and how will we know we've achieved our objective?

We will add healthy life years to our community by working in partnership with local heroes to advocate for healthier settings that make healthy choices easy choices. These settings can lead to reduced tobacco use, minimise harm from alcohol and other drugs, increase likelihood of being physically active and provide our community with trusted advice on healthy nutrition. We will also add healthy life years by providing healthcare closer to homes that is better co-ordinated and integrated, reducing hospital readmissions, length of stay, residential care demand and acute presentations.

The following key system wide actions will translate this strategic objective into reality by 2020:

Prevent ill health

Means:

- 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
- protecting the health of our children by achieving our national health target for immunisation against common childhood diseases that cause harm
- finding cancer and treating people early by achieving our national health targets for cancer – breast, cervical and soon bowel cancer screening
- embrace diversity by making it easy for people and communities to be health literate through accessible and health information in languages and context that everyone understands
- provided free insulation for over 2,000 homes for families in need of help

Healthy neighbourhoods

Means:

- working in partnership with health and social sector to co-ordinate local services better through Localities
- advancing integration of healthcare for children and young people in schools as an important point of access for children and young people
- mental health care is an integrated part of the primary and community frontline healthcare team

Help make healthy choices easy choices

Means:

- mental health is seen as a normal part of building resilience in communities through collaborative health and wellbeing promotion
- achieving tobacco control goal of 12% smoking by 2018 and be on track to achieve 5% smoking by 2025 through increased access to help to quit
- working with Healthy Families New Zealand to promote healthy lifestyle choices in Mangere/Otara and Papakura/Manurewa
- reducing harm from obesity by working with communities and other health and social agencies to increase the likelihood of people being physically active and eat healthily
- working with health and other sectors to reduce harm from alcohol through advocacy and evidence based advice to local government decision makers

"Together we will involve people, whaanau and families as an active part of their health team."

Why do Healthy People, Whaanau and Families matter?

Our personal sense of health and wellbeing is influenced by our whaanau, families and the network of people that matter most to us. They influence our decision making and choices that help us to live well, recover and rehabilitate - including taking medications.

What does this mean for us as a health system?

Counties Manukau Health has recognised and actioned initiatives to enable patients, whaanau and family involvement in their healthcare. The chief co-ordinator of care may not be, and does not always need to be, a healthcare professional. Where patients agree, whaanau and families need to be part of our planning, conversations about what is possible and required to support people at home. It matters that healthcare is more holistic, that our staff and services listen, understand and are most responsive to the physical, mental, spiritual, and psychological needs.

How will we know we've achieved our objective?

Healthy years are added to people's lives. We expect to see reduced acute (unplanned) presentations for healthcare, increased use of primary and community services including technology that enables self-management. Patients, whaanau, family and health professionals report improved experiences due to more connected and co-ordinated care.

The following key system wide actions will translate this strategic objective into reality by 2020:

Improve patient, whaanau and family experience	**Means:** • more than 100,000 people with complex needs will have a care plan and care co-ordination within primary care and related social agencies • high patient, whaanau and family satisfaction and engagement in their care across hospital to community based care
Advance on being a health literate system	**Means:** • increasing access to information and resources that are relevant to patients, whaanau and their families • more than 2/3rds of health professionals have accessed health literacy training
Work better with whaanau and families	**Means:** • protecting our future generations through early engagement of pregnant mums in maternity services and seamless connection to early childhood and infant health services • more than 20,000 of our most high need whaanau/fanau and families receive more co-ordinated health and social services support and care so they can be better supported to live well at home
People managing well at home	**Means:** • more than 50,000 people with chronic health conditions receive self-management support • make it easy for people, whaanau and families to access their own health information and be central in their health and wellbeing

"Together we will provide excellent services that are well-supported to treat those who need us safely, with compassion and in a timely manner"

Why does it matter?

People are at the heart of healthcare services. Safe, quality healthcare services are provided by professionals whom are well trained, knowledgeable and come to work because they want to do their best for patients, users of services and our communities.

What does this mean for us as a health system?

We must invest to provide our frontline staff and partner organisations in primary and community settings with safe and well equipped working environments, information at their fingertips required for timely decision making, access to the best available diagnostics and treatment options we can afford. We must also continue to make values-led investments in people to attract and retain the best and educate and upskill our staff so they are fit for purpose for a changing healthcare environment. We know that we need to continue to innovate and be agile to make effective changes when we need to.

What do we do and how will we know we've achieved our objective?

We will add healthy years of life by providing excellent, collaborative, high quality, compassionate and safe healthcare. We will add healthy life years by ensuring access and utilisation of services that best reflects need and invest in infrastructure that adds capacity. This includes excelling on national health performance measures.

The following key system wide actions will translate this strategic objective into reality by 2020:

Excellent, kind, high quality experience for everyone

Means:

- quality and safety is consistent across care delivery every day
- reducing clinical variation for a more reliable experience
- enhancing patient survival, recovery, function and quality of life
- optimising care delivery through timely, safe, co-ordinated and effective care
- more integrated healthcare in schools

System wide information and communication technologies

Means:

- more reliable, accessible, virtual (e.g. Telehealth) and timely heath, business and population health information where and when it is needed
- foster continuous innovation and improvement to further enhance patient care and effectiveness
- progress towards a regional electronic health record
- more patients accessing Patient Portals and their own online healthcare records

Infrastructure investment that adds capacity

Means:

- six locality based Community Hubs supported by Community Central to co-ordinate people and services
- Hospital service expansion and shared infrastructure for acute mental health, medical oncology, radiology, laboratory, urology, gastroenterology and cardiology
- further develop Manukau site elective surgery, rehabilitation, ambulatory and diagnostic services to provide more proactive care and keep people well at home

People and culture investment

Means:

- values-led investment in workforce culture, across recruitment and retention and development of people
- continuous investment in educating and developing people to enable greater team collaboration across organisation and discipline boundaries
- building on our leadership talent across the whole district to ensure we are fit for the future
- getting the best out of our ethnic and culturally diverse workforce by enabling and recognising the value of bilingual practitioners in the workplace

Healthcare Home

Means:

- local GP practices have access to a greater range of support that provide their enrolled patients with more services that enable self-management
- establishing Community Central to improve the flow of information between hospital and primary settings to better coordinate community based care
- through Restorative Home and Community services, people are able to rehabilitate and maintain physical function, positive mental health and independence through locally based support

Contact

Email: communications@middlemore.co.nz

Address:
Middlemore Hospital,
Private Bag 93311,
Otahuhu, Auckland 1640

For more information visit:
http://www.countiesmanukau.health.nz

Counties Manukau District Health Board

Issue of healthAlliance C class Shares relating to the Wash-up of 15/16 capital.

Recommendation

The Audit Risk And Finance Committee recommends to the CMDHB Board the approval of the payment/purchase of new C class shares in hA relating solely to spend in excess of the hA depreciation levels and is the "wash up " of the previously approved 2015/16 hA capital budget "

Prepared by: Gordon Herdman: healthAlliance
Peter Tod: CMDHB
Endorsed by: Ron Pearson CMDHB

Background:

By paragraph 8.1 (b) of the Shareholders Agreement it was agreed that the power to issue any shares in the Company was to be exercised by the Shareholders unanimously. The Board of Directors of the Company have resolved to approve the issue of a further tranche of C Shares to cover regional IS costs in the 2015-16 year as outlined below, subject to the approval of the Shareholders.

RESOLVED BY RESOLUTION IN WRITING:

To approve the issue of a tranche of C shares for the wash-up of 2015/16 the regional IS Capital costs, in accordance with the following table:

a. CMDHB - 336,357 'C' shares
b. WDHB - 1,538,193 'C' shares
c. NDHB - 443,954 'C' shares

TOTAL 2,318,504 'C' shares
Note: ADHB over paid in 2015/16 $1,415,400

1. **Purpose**

To approve the issue of 2,318,504 class C shares to fund the wash-up of 2015 16 regional capital spend over and above depreciation charged to DHBs in 2015 16.

2. **Background: Shareholders Agreement, Asset Transfer Agreement and Memorandum of Understanding ("MOU")**

2.1 It is clear from the 2012 Asset Transfer Agreement and MOU between DHB shareholders and healthAlliance (NZ) Limited that it was agreed that in order to have a coordinated, integrated approach to standardise shared services and IT infrastructure the DHB shareholders decided that healthAlliance needed to have control over certain assets. Control was to be transferred by way of healthAlliance purchasing from the DHBs the assets described in the Asset Transfer Agreement in consideration of healthAlliance issuing a new class of non-voting 'C' shares to each DHB.

2.2 In addition, and in the context of healthAlliance's management of the initial assets transferred and the shared services to be provided by healthAlliance, the DHBs acknowledged and accepted that additional strategic investment in capital and operating costs would be required by the DHBs, particularly in respect to information services (IS). As it is stated in the MOU "*On agreement of the capex plan the DHBs must provide sufficient funding for hA to supplement or replace the assets, or to purchase new assets as set out in the approved plan*." (MOU clause 3)

2.3 It was agreed that healthAlliance would prepare a capital plan (which was subject to Regional Capital Investment Committee and National Capital Investment Committee requirements) to be agreed by the DHB shareholders as set out in clause 13.4 of the Shareholders Agreement. For the avoidance of doubt, the DHBs acknowledged that on agreement by the shareholders of the capex plan (the DHBs agreeing not to unreasonably withhold their consent to such plan) each would provide funding for healthAlliance to replace the initial assets as set out in such approved plan.

3. Further Tranche of initial $20.3m C shares

3.1 hA NZ spent $49.2m in 2015 16 related to regional capital spend. This was mostly funded by depreciation charged on a monthly basis to the shareholder DHBs – totaling $28.9m for the year.

This means that there is a cash requirement for hA NZ of $20.3m related to the 2015 16 year – to be funded by the further issue of class C shares. $18.3m shares have already been allocated leaving a wash-up of 2.3m shares to be allocated.

4. Funding Source

4.1 CMDHB had earlier included within its 15/16 capital plan [and then carried forward] full allowance for our share of the agreed Capital spend in excess of the hA depreciation levels on existing IT equipment. Our cashflow forecasting anticipates this uplift in regard to these shares. The ongoing value /asset backing to the non-voting C class shares is reflected by the underlying investment by hA in such assets and the assumption that depreciation on those assets will be re invested in the future for the sole purpose of replacing them. Our valuation is totally dependent on hA ensuring continuing replacement and not utilising for non replacement purposes. That is the role of our representative on the hA board".

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Counties Manukau District Health Board
Audit NZ Letter for PHO Audits

Recommendation

It is recommended that the Board:

Note the need for Audit NZ to audit DHB non-financial performance measures that rely on information from third party health providers, which will enable them determine if the qualification on non-financial performance information should remain or be removed for 2016/17;

Note that the audits will be completed jointly for all three metro-Auckland DHBs;

Approve that Regional Internal Audit provides direct and appropriate assistance to Audit NZ;

Approve that the Board Chair, on behalf of the Board, signs the attached Audit NZ letter on this audit.

Prepared and submitted by Ron Pearson, Deputy CEO/Chief Financial Officer

Purpose
The Board is being asked to approve the Audit NZ letter attached, which will enable audit non-financial performance information provided by third parties that is used in the DHB's Annual Reports.

Overview
Counties Manukau DHB's non-financial performance information has been qualified by Audit NZ (per below):

Qualified opinion on the performance information because of limited controls on information from third-party health providers

Some significant performance measures of the Health Board and group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board and group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

It has been agreed that it is more efficient and cost effective for Audit NZ to complete the audit for the three Auckland Metro DHBs at the same time and with assistance from Regional Internal Audit. An overview of the audit is provided in the Audit NZ letter attached. The Board is asked to approve the letter which should be signed by the Board Chair. A similar letter has been sent to the CMDHB CE.

13 February 2017

Level 6
280 Queen Street
PO Box 1165, Auckland 1140
www.auditnz.govt.nz
Fax: 09 366 0215

Dr Lester Levy
Chairman
Counties Manukau District Health Board
Private Bag 94052
Manukau
Auckland 2241

Dear Lester

Audit of performance data provided by primary health organisations for Counties Manukau District Health Board for the year ending 30 June 2017

This letter is to advise that we intend to use resources provided by Regional Internal Audit (RIA) to undertake some audit work on our behalf, as described below.

Auditing Standard requirements

When using internal auditors to provide direct assistance with our audit of Counties Manukau District Health Board's (CMDHB) financial statements and/or performance information, we are required to follow the requirements of International Standard on Auditing (New Zealand) 610: Using the Work of Internal Auditors (ISA (NZ) 610).

Direct assistance is described in the standard as being the use of internal auditors to perform audit procedures under the direction, supervision and review of the external auditor.

Paragraph 31 of ISA (NZ) 610 requires us to communicate with those charged with governance, the nature and extent of the planned use of internal auditors to provide direct assistance and to reach a mutual understanding that such use is not excessive in the circumstances of CMDHB's audit.

I would appreciate it if you could sign this letter as acceptance of RIA providing direct assistance and agreement that their use is not excessive (see last page of this letter).

As required by paragraph 33 of ISA (NZ) 610, we are also writing to your Chief Executive Officer to seek agreement prior to the work being undertaken, that RIA will be allowed to follow our instructions, and that CMDHB will not intervene in the work RIA performs on our behalf.

Scope of work to be performed by RIA

RIA will provide direct assistance to Audit New Zealand and perform the following work in respect of the audit of performance information for the year ending 30 June 2017:

- Reviews of the control environment at ProCare Networks Limited, East Health Trust and Total Healthcare Charitable Trust in respect of the collection, processing and

analysis of data used for monitoring performance against the National Health Targets for:

- Increased immunisation.
- Better help for smokers to quit.

- Confirming that data submitted to Primary Health Organisations (PHO) is accurate and complete for a randomly selected sample of GP practices.
- Preparation of work-papers documenting the work performed on our behalf, for inclusion on our audit file.

Steve Murray: Finance Manager – Funding from CMDHB and Tim Wood: Deputy Director Funding from Waitemata District Health Board are liaising with the PHOs to arrange the timing of RIA's visit to each location selected for review. We require RIA to complete their work by Wednesday 5 April 2017.

We do not anticipate using RIA to provide direct assistance for any other aspect of this year's audit.

Audit New Zealand's responsibilities in respect of work to be performed

Audit New Zealand will be responsible for determining the scope of work to be performed, providing direction to RIA staff performing that work, and reviewing all work produced by RIA staff.

We expect RIA to draw initial conclusions from the work performed. However Audit New Zealand will be responsible for assessing (a) whether sufficient and appropriate audit evidence has been obtained to support those conclusions and (b) how that work impacts upon the audit opinion we intend to issue in respect of performance information.

Regional approach for the audit

We are planning to use RIA to provide direct assistance for the audit of third party performance information for the Northern DHBs. This will help ensure that wherever possible, we can achieve efficiencies in our audit approach; in particular:

- where a PHO is responsible for GP practices across more than one DHB, we will only need to review its systems once. Note the random sample of GP practices will still be selected separately for each DHB; and
- the same staff from RIA and Audit New Zealand will be completing the work for all four DHBs.

Our audit opinion on performance information

We are completing work at the PHOs and GP practices with the intention of obtaining sufficient audit assurance to enable us to remove the qualification in your annual report about performance information. This assumes that no other matters come to our attention and we unable to obtain the necessary level of assurance to issue a clear opinion.

There is still no practical means of verifying the performance information for the 2015/16 financial year. We will therefore issue a qualified opinion on the performance information for

the 2015/16 comparatives because of limited controls over information from third-party health providers for that year.

This is consistent with last year where the eight DHBs who were issued with a clear opinion in respect of 2015/16 performance information, were still qualified in respect of the 2014/15 comparatives.

Please return the signed copy of this letter to suzanne.merriott@auditnz.govt.nz by Wednesday 22 February 2017. If you have any questions please contact me directly on 021 222 8211 or Suzanne Merriott on 021 222 8482.

Yours sincerely

Athol Graham
Director

I confirm my agreement to RIA providing direct assistance to Audit New Zealand for the 2016/17 audit of performance information provided by third parties.

I also confirm my understanding that the level of direct assistance provided by RIA is not excessive having regard to the overall size and complexity of our audit of CMDHB's financial and performance statements.

Signed:

Name (printed): Dr Lester Levy

Position: Chairman

Date:

CONFIDENTIAL
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Receive the Finance and Corporate Business report covering, Sector update Year to Date December 2016 and the report for January 2017.

Prepared and submitted by: Ron Pearson

Key Issues (January 2017):

- Year to date (YTD) financial performance is tracking to budget however operating performance remains tight as in previous months, as anticipated in the setting of the Annual Plan. Small but continuing positive variances have been posted in recent months, with January closing with a $15K favourable result, and YTD being $171K favourable to budget. This result has been sustained by the release of forecast and budgeted one off items; these items are due to terminate in June 17. Despite the last four months being at budget levels the underlying long term sustainability is not there. This is reinforced by the initial draft of the annual plan 2017-18.

- Very slight favourable Provider Arm result reflects additional ACC revenue accruing from the ACC Arrears initiative, supplemented by the favourable effect of net vacancies delays for a number of key initiatives; these have been offset specifically, opening of the retail pharmacy, procurement, and projects to reduce clinical costs associated with diagnostic and pharmacy user groups. Actions are underway to ensure that key initiatives fully deliver as planned over the balance of the year. The Summer Plan was implemented over the Christmas and New Year Break with a nominated number of beds closing through to early January, with in some cases extended closures. Non-essential staff were encouraged to take extended leave during the holiday period resulting in realised benefits for the month.

- Primary, Community and Healthy Together initiatives as a whole are on budget YTD. Mental Health NGO services spend is under budget as services are under review and up for retendering. This favourable variance reduced somewhat by Funder savings plan under performing and greater PHO capitation payments due to General Practice enrolments higher budget.

Challenges going forward (repeated for ongoing relevance)

In no priority order and common in many instances to other metro regional DHBs:

- Ongoing lack of material benefit from NZ Health Partnerships Limited (NZHPL).
- High unsustainable and unaffordable capital requirements particular around new investments.
- No reserves to offset fluctuations in operating activity.
- Significant transformation investment required (Healthy Together 2020) without hump funding. Many of these investments will be characterised by a delayed return. The return may not directly accrue to Health.
- hA capital requirements equally large and sustainable at indicated levels with no (as yet) consistent / common regional IT strategy/plan.
- Change of Treasury equity (mid- February 2017) structure likely to:

1. Detrimentally impact on cost of future capital;
2. Lessen or eliminate benefits of DHB sweep.

- Upcoming total hospital wage settlements likely to be well in excess of funded levels.
- Significant dependencies on one-offs (to date) – all new extinguished.
- Significant financial pressures associated with alignment of inter-regional flows. Despite best efforts.
- Unresolved Auckland Regional Dental Service (ARDS) recovery recognised in 2015/16 accounts ($2.5M) and similar issue for 16/17.
- Huge fire service levy exposure for whole of the health sector ($20-40 pa mil) over next few years, which also has potential negative impact on collective insurance benefits.

SECTOR FINANCIAL POSITION AT DECEMBER 2016

The Sector Forecast Year end position continues to deteriorate as the Year to date result slips particularly in Provider arms. Note the rate of deterioration in the Provider Arms is now significantly greater than the offsetting Funder under spending.

Sector Loss Statement $m	Actual	Sector Budget	Var	%Var
Total Revenue	**7,729**	**7,713**	**16**	**0.2%**
Personnel	2,902	2,917	15	0.5%
Outsourced Personnel	103	60	(43)	(71.6)%
Total Personnel	**3,005**	**2,977**	**(28)**	**(0.9)%**
Outsourced Services	228	220	(8)	(3.6)%
Clinical Supplies	690	672	(18)	(2.7)%
Infrastructure/ Other Suppliers	715	718	3	0.4%
Total Operating Costs	**4,638**	**4,587**	**(51)**	**(1.1)%**
Personal Health	2,124	2,123	(1)	-
Mental Health	221	232	11	4.9%
Public Health	15	14	(1)	(5.0)%
Disability Support Services	752	762	10	1.4%
Maori Health	23	23	-	2.0%
Total Payments to Other Providers	**3,134**	**3,155**	**20**	**0.6%**
Total Expenditure	**7,772**	**7,742**	**(31)**	**(0.4)%**
Net Result	**(43)**	**(29)**	**(14)**	**(50.9)%**

1. Total Personnel	Var. $m YTD Dec	Var. $m YTD Nov	Change	2. Clinical Supplies	Var. $m YTD Dec	Var. $m YTD Nov	Change
Canterbury	(9.7)	(7.5)	(2.2)	Auckland	(4.0)	(2.8)	(1.2)
Waikato	(9.6)	(10.1)	0.5	Counties	(2.4)	(1.8)	(0.6)
				Hawkes Bay	(2.8)	(2.9)	0.1

Sector Performance By DHB	YTD			Full Year		
December 2016	Actual	Budget	Variance	Forecast at Dec	Variance to budget	Budget
Auckland DHB	756	6,765	(6,010)	4,537	37	4,500
Counties Manukau DHB	3,823	3,667	156	4,514	14	4,500
Northland DHB	(847)	(919)	72	2,000	-	2,000
Waitemata DHB	1,484	1,408	76	4,664	164	4,500
Northern Region Total	**5,215**	**10,921**	**(5,705)**	**15,715**	**215**	**15,500**
Bay of Plenty DHB	(826)	(898)	72	3,101	-	3,101
Lakes DHB	(1,795)	(106)	(1,689)	(1,281)	(2,935)	1,654
Tairawhiti DHB	(1,436)	538	(1,974)	(3,666)	(4,532)	866
Taranaki DHB	31	(1,531)	1,562	(2,000)	-	(2,000)
Waikato DHB	3,932	8,666	(4,734)	-	(4,500)	4,500
Midland Region Total	**(94)**	**6,670**	**(6,764)**	**(3,846)**	**(11,967)**	**8,121**
Capital & Coast DHB	(11,686)	(9,342)	(2,343)	(17,918)	(1,958)	(15,960)
Hawke's Bay DHB	(275)	50	(324)	5,000	-	5,000
Hutt Valley DHB	(2,425)	(2,615)	190	(3,377)	(835)	(2,542)
MidCentral DHB	(1,526)	(513)	(1,013)	-	(1,488)	1,488
Wairarapa DHB	(1,455)	(1,138)	(318)	(1,817)	(256)	(1,561)
Whanganui DHB	(701)	(503)	(198)	(1,008)	1	(1,009)
Central Region Total	**(18,067)**	**(14,061)**	**(4,006)**	**(19,120)**	**(4,536)**	**(14,584)**
Canterbury DHB	(18,929)	(19,542)	613	(37,551)	4,436	(41,987)
Nelson Marlborough DHB	921	1,079	(158)	3,200	(800)	4,000
South Canterbury DHB	269	513	(244)	1,322	-	1,322
Southern DHB	(11,484)	(13,346)	1,862	(21,983)	17	(22,000)
West Coast DHB	(814)	(713)	(102)	(557)	(3)	(554)
Southern Region Total	**(30,038)**	**(32,009)**	**1,971**	**(55,569)**	**3,650**	**(59,219)**
All DHBs	**(42,983)**	**(28,479)**	**(14,504)**	**(62,820)**	**(12,638)**	**(50,182)**

Funder / Provider Split Performance	Funder			Provider		
	Actual	Plan	Variance	Actual	Plan	Variance
Auckland DHB	10,575	2,242	8,332	(9,662)	4,524	(14,186)
Counties Manukau DHB	13,846	13,451	395	(8,442)	(8,541)	99
Northland DHB	404	(801)	1,204	(1,293)	(209)	(1,084)
Waitemata DHB	7,292	2,253	5,039	(5,840)	(845)	(4,995)
Northern Region Total	**32,116**	**17,146**	**14,971**	**(25,237)**	**(5,071)**	**(20,167)**
Bay of Plenty DHB	4,170	1,996	2,174	(5,845)	(4,154)	(1,691)
Lakes DHB	543	249	294	(2,152)	(293)	(1,859)
Tairawhiti DHB	1,408	1,433	(25)	(2,939)	(881)	(2,058)
Taranaki DHB	9,208	5,598	3,610	(9,227)	(7,117)	(2,110)
Waikato DHB	21,316	13,398	7,918	(16,958)	(4,292)	(12,666)
Midland Region Total	**36,645**	**22,674**	**13,971**	**(37,120)**	**(16,737)**	**(20,384)**
Capital & Coast DHB	(5,110)	(7,007)	1,897	(6,576)	(2,335)	(4,241)
Hawke's Bay DHB	(4,252)	(3,883)	(368)	3,778	3,933	(155)
Hutt Valley DHB	(358)	(635)	277	(1,958)	(2,070)	112
MidCentral DHB	(871)	(2,400)	1,529	(2,096)	1,945	(4,041)
Wairarapa DHB	(670)	35	(705)	(702)	(1,173)	471
Whanganui DHB	196	(237)	433	(847)	(228)	(619)
Central Region Total	**(11,066)**	**(14,128)**	**3,062**	**(8,401)**	**72**	**(8,472)**
Canterbury DHB	3,207	(5,688)	8,895	(21,008)	(13,854)	(7,154)
Nelson Marlborough DHB	1,090	(615)	1,704	(151)	1,764	(1,915)
South Canterbury DHB	2,658	2,169	489	(2,488)	(1,686)	(802)
Southern DHB	(3,384)	(3,856)	472	(8,426)	(9,402)	976
West Coast DHB	2,957	2,041	917	(3,771)	(2,753)	(1,018)
Southern Region Total	**6,528**	**(5,949)**	**12,477**	**(35,844)**	**(25,931)**	**(9,913)**
All DHBs	**64,224**	**19,743**	**44,481**	**(106,602)**	**(47,667)**	**(58,935)**

FINANCIAL POSITION AT FEBRUARY 2017

Statement of Performance by Operating Arm

Month Feb 2017			Net Result	YTD Feb 2017				Full year	
Act	$000	Var.	$000	Act	Bud	Var.	Last year	Bud	Forecast
6,696	6,698	(2)	*Hospital Provider*	32,092	32,273	(181)	26,875	41,140	45,189
(3,608)	(3,598)	(10)	*Integrated Care*	(29,008)	(29,051)	43	(20,047)	(43,592)	(43,519)
(1,351)	(1,356)	5	*Ko Awatea*	(11,344)	(11,583)	239	(9,666)	(17,453)	(17,218)
1,737	1,744	(7)	*Provider*	(8,260)	(8,361)	101	(2,838)	(19,905)	(15,548)
2,219	2,240	(21)	*Funder*	18,030	17,932	98	8,908	26,900	22,608
(139)	(208)	69	*Governance*	(1,645)	(1,658)	13	(611)	(2,495)	(2,546)
3,817	**3,776**	**41**	***Surplus (deficit)***	**8,125**	**7,913**	**212**	**5,459**	**4,500**	**4,514**

Statement of Performance

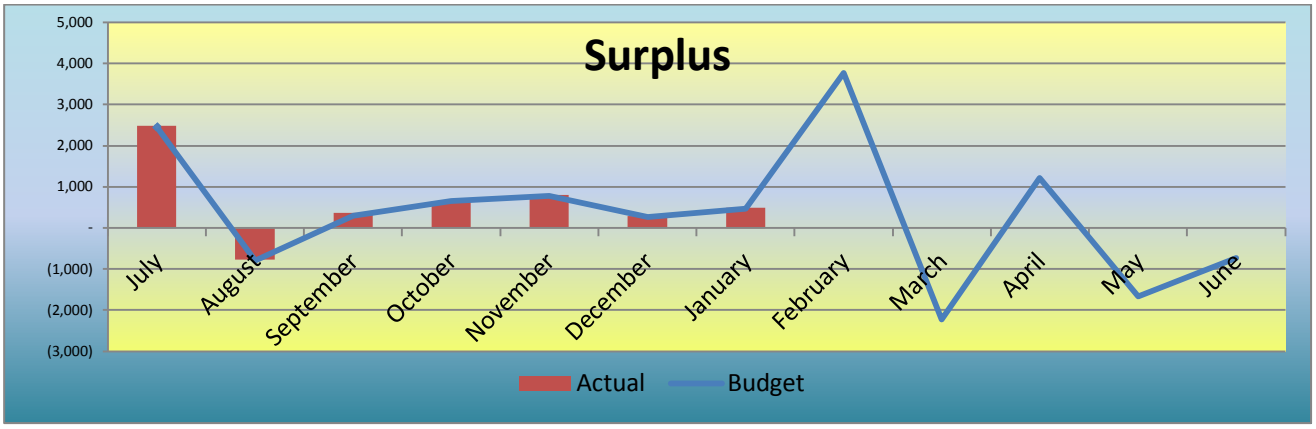
Month				Year to Date				Full Year	
Act	Bud	Var.	*$000*	Act	Bud	Var.	Last year	Bud	Forecast
			Revenue						
127,811	129,155	(1,344)	Crown	1,030,440	1,033,681	(3,241)	980,992	1,550,244	1,551,787
2,849	3,676	(827)	Other	24,925	29,879	(4,954)	29,879	44,659	37,768
130,660	**132,831**	**(2,171)**	**Total Revenue**	**1,055,365**	**1,063,560**	**(8,195)**	**1,010,871**	**1,594,903**	**1,589,555**
			Expenses						
46,547	46,289	(258)	Personnel	384,857	393,039	8,182	368,182	594,801	584,479
2,026	1,023	(1,003)	Outsourced Personnel	14,785	8,177	(6,608)	10,199	12,275	15,409
5,482	5,581	99	Outsourced Services	44,299	44,349	50	36,803	67,118	67,548
54,773	55,582	809	Funder Provider Payments	440,912	444,644	3,732	432,349	666,973	668,808
7,744	8,588	844	Clinical Sup.	70,147	69,272	(875)	72,227	104,953	107,146
5,880	6,361	481	Infrastructure	50,086	51,118	1,032	43,694	76,711	76,559
122,452	**123,424**	**972**	**Operating Exp**	**1,005,086**	**1,010,599**	**5,513**	**963,454**	**1,522,831**	**1,519,948**
8,208	**9,407**	**(1,199)**	**Operating surplus**	**50,279**	**52,961**	**(2,682)**	**47,417**	**72,072**	**69,607**
2,364	2,894	530	Depn.	22,196	23,152	956	21,705	34,728	34,304
515	1,225	710	Interest	7,860	9,800	1,940	8,302	14,700	12,640
1,512	1,512	-	Capital Chg.	12,098	12,096	(2)	11,951	18,144	18,149
3,817	**3,776**	**41**	**Net Surplus**	**8,125**	**7,913**	**212**	**5,459**	**4,500**	**4,514**

FINANCIAL POSITION AT JANUARY 2017

Statement of Performance by Operating Arm

Month Jan 2017			Net Result	YTD Jan 2017				Full year	
Act	$000	Var.	$000	Act	Bud	Var.	Last year	Bud	Forecast
3,542	3,557	(15)	*Hospital Provider*	25,396	25,575	(179)	22,766	41,140	45,189
(3,644)	(3,644)	-	*Integrated Care*	(25,400)	(25,453)	53	(17,564)	(43,592)	(43,519)
(1,453)	(1,477)	24	*Ko Awatea*	(9,993)	(10,227)	234	(8,463)	(17,453)	(17,218)
(1,555)	(1,564)	9	*Provider*	(9,997)	(10,105)	108	(3,261)	(19,905)	(15,548)
1,965	2,241	(276)	*Funder*	15,811	15,692	119	7,731	26,900	22,608
75	(207)	282	*Governance*	(1,506)	(1,450)	(56)	(530)	(2,495)	(2,546)
485	**470**	**15**	***Surplus (deficit)***	**4,308**	**4,137**	**171**	**3,940**	**4,500**	**4,514**

Forecast will be reviewed monthly till the end of the year.

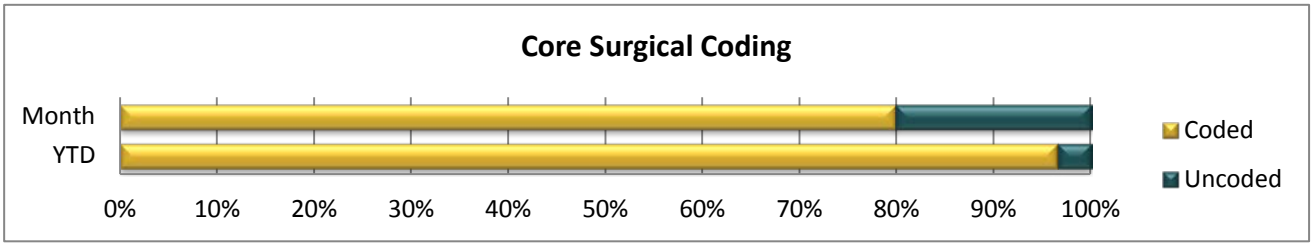


Volume Summary January 2017

Total WIES

Month					Year to date				
Act	Bud	Var.	%	Last. Yr.	Act	Bud	Var.	%	Last. Yr.
5,208	5,618	(410)	(7.3)%	5,343	40,683	41,030	(347)	(0.8)%	41,165
947	1,320	(373)	(28.3) %	1,055	10,215	10,726	(511)	(4.8)%	10,017
6,155	**6,938**	**(783)**	(11.3) %	**6,398**	**50,898**	**51,756**	**(858)**	(1.7)%	**51,182**

RMO Industrial action for the three days 17th to 20th January has significantly disrupted inpatient activity, particularly surgery. YTD WIES activity is now running below contract to January, reflecting the cumulative impact of industrial action. Acute surgical demand is continuing to place pressure on elective lists. Recovery plans are in place to deliver to performance balance of year. The costs of both strikes have been absorb to date.



Discharges

(note we don't budget for discharges)

Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
6,876	6,951	(75)	(1.1)%	*Acute*	51,069	51,572	(503)	(1.0)%
1,116	1,028	88	8.6%	*Elective*	9,698	9,458	240	2.54%
7,992	**7,979**	13	0.2%	***Total***	**60,767**	**61,030**	**(263)**	(0.4)%
0.77	**0.80**	0.03	4.0%	***Ratio WIES to discharges***	**0.84**	**0.85**	**0.01**	1.23%

Volumes Other

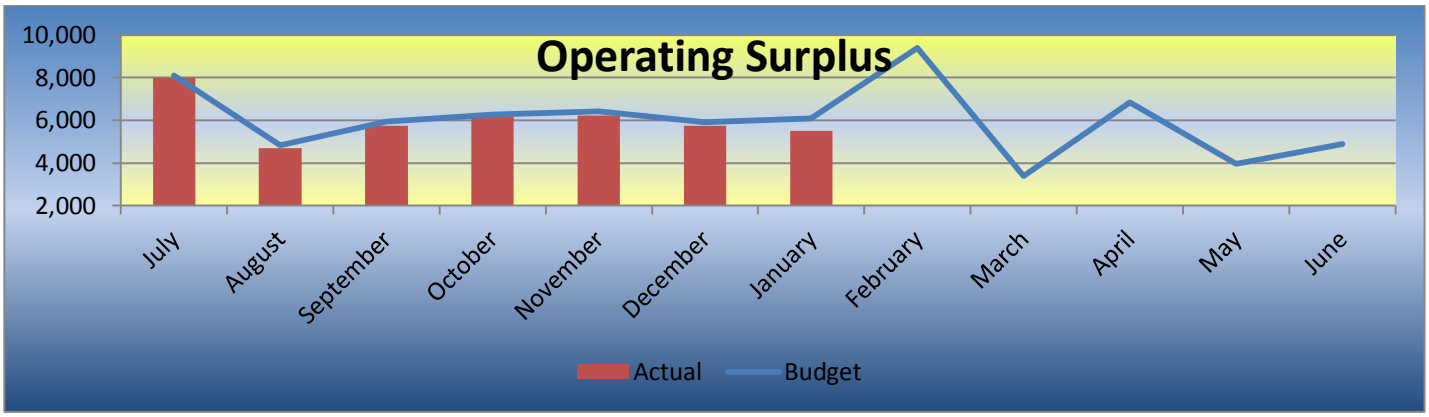
Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
641	619	22	3.55%	*Birth Numbers*	4,313	4,338	(25)	(0.6)%
9,081	9,323	(242)	(2.6)%	*ED Volumes*	66,744	67,533	(789)	(1.2)%
4,509	4,523	(14)	(0.3)%	*Renal Dialysis*	31,816	31,479	337	1.07%
41,423	49,316	(7,893)	(16.0)%	*Outpatient Summary*	387,381	391,954	(4,573)	(1.2)%
2.6	2.5	0.1	4.00%	*ALOS*	2.8	2.8	-	-

Emergency Department presentations YTD to January are below the same period last year, reflecting a mild winter and a lower than expected level of growth. A combination of lower temperatures over the summer period and integration work currently underway in the community has had a positive impact.

Statement of Performance

Month				Year to Date				Full Year	
Act	Bud	Var.	$000	Act	Bud	Var.	Last year	Bud	Forecast
			Revenue						
129,042	129,156	(114)	Crown	902,629	904,526	(1,897)	859,501	1,550,244	1,551,787
3,000	3,677	(677)	Other	22,012	26,203	(4,191)	26,203	44,659	37,768
132,042	**132,833**	**(791)**	**Total Revenue**	**924,641**	**930,729**	**(6,088)**	**885,704**	**1,594,903**	**1,589,555**
			Expenses						
49,133	49,837	704	Personnel	338,310	346,750	8,440	323,125	594,801	584,479
1,844	1,022	(822)	Outsourced Personnel	12,759	7,154	(5,605)	9,036	12,275	15,409
5,737	5,456	(281)	Outsourced Services	38,817	38,768	(49)	32,107	67,118	67,548
55,311	55,581	270	Funder Provider Payments	386,139	389,062	2,923	379,060	666,973	668,808
7,838	8,539	701	Clinical Sup.	62,403	60,684	(1,719)	63,715	104,953	107,146
6,659	6,297	(362)	Infrastructure	44,142	44,757	615	38,091	76,711	76,559
126,522	**126,732**	**210**	**Operating Exp**	**882,570**	**887,175**	**4,605**	**845,134**	**1,522,831**	**1,519,948**
5,520	**6,101**	**(581)**	**Operating surplus**	**42,071**	**43,554**	**(1,483)**	**40,570**	**72,072**	**69,607**
2,464	2,894	430	Depn.	19,832	20,258	426	18,943	34,728	34,304
1,059	1,225	166	Interest	7,345	8,575	1,230	7,345	14,700	12,640
1,512	1,512	-	Capital Chg.	10,586	10,584	(2)	10,342	18,144	18,149
485	**470**	**15**	**Net Surplus**	**4,308**	**4,137**	**171**	**3,940**	**4,500**	**4,514**

Better than 5%	Worse than 5%



Revenue

Month				YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
73,542	73,874	(332)	Provider	514,103	518,016	(3,913)	887,394
124,174	124,592	(418)	Funder	870,271	872,144	(1,873)	1,495,112
(66,898)	(66,770)	(128)	Elimination	(468,321)	(467,390)	(931)	(801,239)
1,224	1,137	87	Governance	8,588	7,959	629	13,636
132,042	**132,833**	**(791)**	**Total**	**924,641**	**930,729**	**(6,088)**	**1,594,903**

Provider:

Revenue is unfavourable to budget year to date. The delay of the opening of the new retail pharmacy has contributed $4.5m to this shortfall but has associated savings in staffing and drugs costs. The on-going success of the ACC arrears initiative is partly offset by lower non-resident billings, reduced Middlemore Foundation donation revenue and fewer Tahitian burns presentations.

Staff Costs (including Outsourced)

Month				YTD			Full Yr.
Act	Bud	Var.	$000	Act	Bud	Var.	Bud
50,261	49,889	(372)	Provider	344,923	347,114	2,191	595,434
716	970	254	Governance	6,146	6,790	644	11,642
50,977	**50,859**	**(118)**	**Total**	**351,069**	**353,904**	**2,835**	**607,076**
15,688	15,446	(242)	Medical	107,023	109,038	2,015	187,010
823	444	(379)	O/S Medical	5,173	3,108	(2,065)	5,330
16,511	15,890	(621)	Total Medical	112,196	112,146	(50)	192,340
19,100	18,560	(540)	Nursing	126,462	127,059	597	218,407
486	194	(292)	O/S Nursing	2,500	1,358	(1,142)	2,333
19,586	18,754	(832)	Total Nursing	128,962	128,417	(545)	220,740
6,373	7,082	709	Allied Health	46,109	49,496	3,387	84,620
25	11	(14)	O/S Allied Health	248	77	(171)	133
6,398	7,093	695	Total Allied Health	46,357	49,573	3,216	84,753
2,317	2,182	(135)	Support	15,716	15,295	(421)	26,267
39	1	(38)	O/S Support	193	7	(186)	12
2,356	2,183	(173)	Total Support	15,909	15,302	(607)	26,279
5,655	6,567	912	Management Administration	43,000	45,862	2,862	78,497
471	372	(99)	O/S Support	4,645	2,604	(2,041)	4,467
6,126	6,939	813	Total Man /Admin	47,645	48,466	821	82,964
49,133	49,837	704	Internal	338,310	346,750	8,440	594,801
1,844	1,022	(822)	O/S Support	12,759	7,154	(5,605)	12,275
50,977	**50,859**	**(118)**	**Total**	**351,069**	**353,904**	**2,835**	**607,076**

Provider:

- Net Medical staff costs are unfavourable YTD. Difficulty in attracting salaried psychiatrists to the DHB has led to an underspend in Mental Health staff costs, offset by outsourced medical costs for locum cover. SMO costs associated with the January RMO industrial action (net of RMO pay offset) have been fortuitously covered by existing medical vacancies, including SMO's in urology and ophthalmology. RMO industrial action has reached net costs of $2m.
- Net Nursing staff costs are unfavourable YTD, reflecting high bureau use to cover high acute demand across the services, particularly in the Neonate unit and Mental Health service. The impact of stat day credits and the bureau cover required for vacancies, leave and acute demand pressure have been part offset by existing vacancies.
- Net Allied Health staff costs are favourable YTD; driven by a shortage of anaesthetic technicians in the first half of the year, as well as existing vacancies partly offset by nursing FTE engagement for multidisciplinary positions. Benefits have been realised where Allied Health staff have taken extended leave over the holiday period.
- Net Support personnel costs are unfavourable YTD; an analysis of all current service provision is required

to identify possible opportunities to minimise future overspends predominantly within cleaning, orderly and security services. Work is underway with HR to implement a proactive performance management structure into Non Clinical Support involving performance management, management of sick leave, overtime and annual leave.

- Net Management and Admin staff favourable YTD; reflecting existing vacancies mainly in the Community teams and Ko Awatea. Existing vacancies across the services and high levels of annual leave taken over the holiday period have had a positive impact.

Outsourced Services

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
3,203	3,268	65	Corporate & Funder Services	22,484	22,882	398	39,225
2,534	2,188	(346)	Clinical Service	16,333	15,886	(447)	27,893
5,737	**5,456**	**(281)**	**Total**	**38,817**	**38,768**	**(49)**	**67,118**

Provider:

- Clinical outsourcing is driven mainly by the Surgical, Anaesthesia and Perioperative Division. RMO industrial action in October and January has had a negative impact on inpatient activity, necessitating the need to outsource to meet ESPI targets. Outsourced surgical volumes YTD are over budget by 33 patients; however the mix is weighted toward more complex and expensive Orthopaedic and General Surgical patients. This has been partially offset by a reduction Pacific Health contractual spending.

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

Month			*Major Categories*	YTD			Full Yr.
Act	**Bud**	**Var.**	***$000***	**Act**	**Bud**	**Var.**	**Bud**
			Personal Health				
21,328	21,186	(142)	IDF Personal Health	149,332	148,302	(1,030)	254,232
9,194	9,005	(189)	Pharmaceuticals	62,745	63,035	290	108,060
7,431	6,289	(1,142)*	Primary Practice Services – Capitated	49,086	44,023	(5,063)*	75,468
509	523	14	Child and Youth	3,783	3,661	(122)	6,276
484	463	(21)	Adolescent Dental Benefit	3,206	3,241	35	5,556
796	790	(6)	Chronic Disease Management and Education	4,741	5,530	789	9,480
483	480	(3)	Palliative Care	3,382	3,360	(22)	5,760
299	299	-	General Medical Subsidy	1,993	2,093	100	3,588
138	416	278	Other	5,411	2,901	(2,510)	4,993
40,662	**39,451**	**(1,211)**	**Total Personal Health**	**283,679**	**276,146**	**(7,533)**	**473,413**

* Budget is for CMDHB portion of After Hours service, only. DHB host arrangement did not cease on 30 June 2016 - Revenue from ADHB, WDHB and PHO's received to offset this cost. The Enrolment growth is higher than budgeted. Saving were budgeted in this account but are being achieved in other accounts (Mental Health, HOP)

Month			Major Categories	YTD			Full Yr.
Act	Bud	Var.	$000	Act	Bud	Var.	Bud
			Mental Health				
1,249	1,250	1	IDF Mental Health	8,739	8,750	11	15,000
884	890	6	Community Residential Beds & Services	5,986	6,230	244	10,680
715	753	38	Other Home Based Residential Support	4,939	5,271	332	9,036
337	327	(10)	Dual Diagnosis – Alcohol & Other Drugs	2,382	2,289	(93)	3,924
281	278	(3)	Crisis Respite	1,956	1,946	(10)	3,336
357	354	(3)	Child & Youth	2,290	2,478	188	4,248
178	178	-	Kaupapa Maori - Community	1,267	1,246	(21)	2,136
185	172	(13)	Community Services	1,297	1,204	(93)	2,064
460	2,008	1,548	Other	3,130	14,056	10,926	24,097
4,646	**6,210**	**1,564**	**Total Mental Health**	**31,986**	**43,470**	**11,484**	**74,521**

Mental Health NGO services spend is under budget as services are under review and up for retendering.

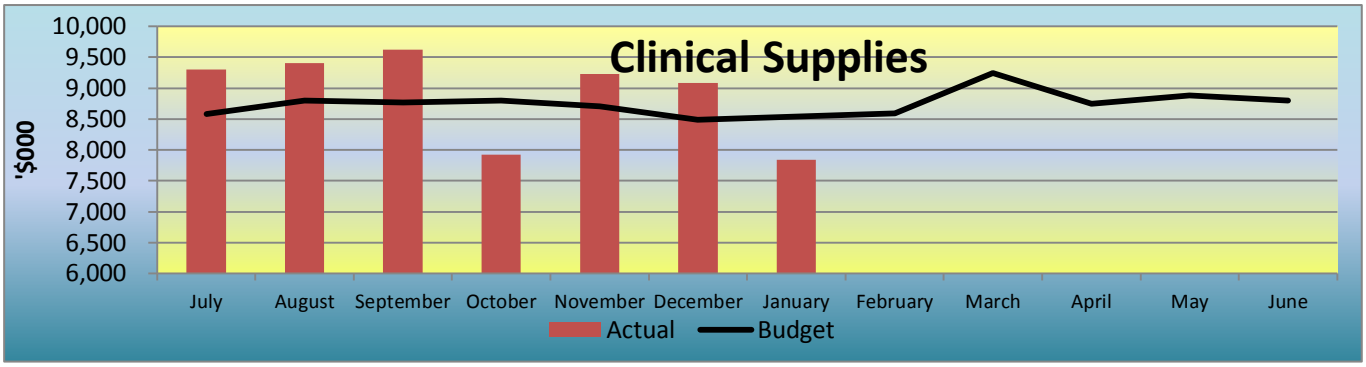
Month			Major Categories	YTD			Full Yr.
Act	Bud	Var.	$000	Act	Bud	Var.	Bud
			Disability Support Services				
4,568	4,406	(162)	Residential Care: Hospitals	31,953	30,842	(1,111)	52,869
1,932	1,964	32	Residential Care: Rest Homes	13,328	13,748	420	23,569
1,746	1,742	(4)	Home Support	12,217	12,194	(23)	20,904
1,436	1,615	179	Other	10,843	11,311	468	19,379
9,682	**9,727**	**45**	**Total Disability**	**68,341**	**68,095**	**(246)**	**116,721**
94	**103**	**9**	**Total Public Health**	**409**	**618**	**209**	**1,233**
227	**90**	**(137)**	**Total Maori Health**	**1,403**	**540**	**(863)**	**1,085**
56,449	**55,581**	**(868)**	**Funder**	**330,828**	**333,481**	**2,653**	**666,973**

Clinical Supplies

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
2,804	2,962	158	Treatment Disposables	22,190	21,194	(996)	36,585
600	822	222	Diagnostic Supplies & Other Clinical Supplies	5,890	5,808	(82)	9,952
1,194	1,237	43	Instruments & Equipment	9,035	8,800	(235)	15,202
270	315	45	Patient Appliances	2,061	2,222	161	3,855
1,351	1,502	151	Implants & Prostheses	10,123	10,646	523	18,641
1,333	1,353	20	Pharmaceuticals	10,666	9,576	(1,090)	16,532
286	348	62	Other Clinical Supplies	2,438	2,438	-	4,186
7,838	**8,539**	**701**		**62,403**	**60,684**	**(1,719)**	**104,953**

Provider:

- Clinical Supplies are unfavourable YTD. Driven by drug overspends in cancer drugs in Haematology, Renal (Rituximab) and Gastro (Infliximab - treatment of Crohns Disease).
  January month favourable variance of reflects a decreased workload due to high levels of annual leave over the holiday period and lower purchases as services consume the stock-pile of clinical supplies from December.

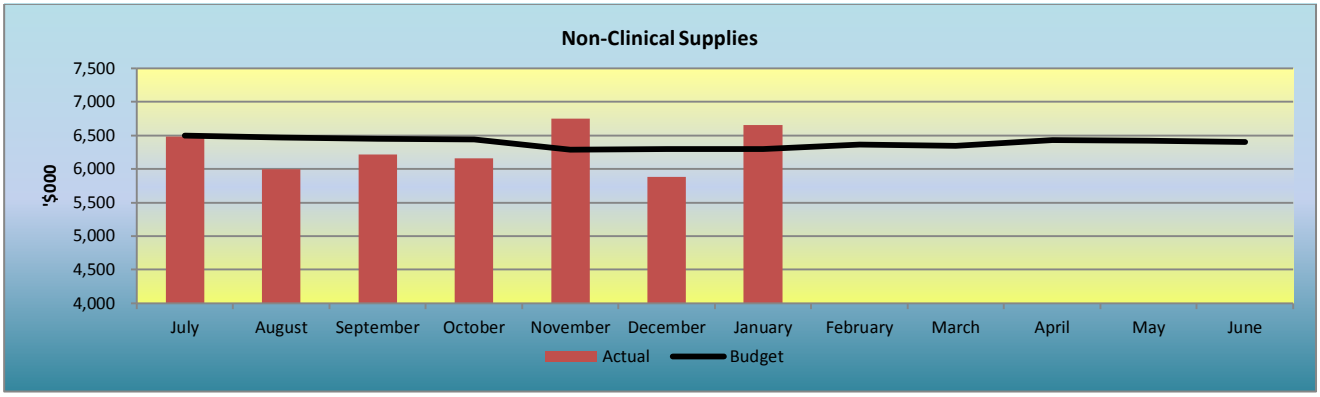


Non-Clinical / Infrastructure (excluding Interest and Capital Charge)

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
6,383	6,035	(348)	Provider	42,716	42,923	207	76,449
276	262	(14)	Governance	1,426	1,834	408	262
6,659	**6,297**	**(362)**	**Total**	**44,142**	**44,757**	**615**	**76,711**

Provider:

- Non-Clinical / Infrastructure are favourable YTD resulting from additional costs in the community that have predominantly been offset by favourable cost variances due to the delay in the opening of the retail pharmacy.


Non-Clinical Supplies
'$000
7,500
7,000
6,500
6,000
5,500
5,000
4,500
4,000
July
August
September
October
November
December
January
February
March
April
May
June
Actual
Budget

Interest and Capital Charge

Month				YTD			Full Yr.
Act	Bud	Var.	*$000*	Act	Bud	Var.	Bud
82	**167**	**(85)**	**Interest - Received**	1,256	**1,169**	**87**	**2,000**
1,059	1,225	166	Interest - Debt	7,345	8,575	1,230	14,700
977	**1,058**	**81**	**Net Interest**	**6,089**	**7,406**	**1,317**	**12,700**
1,512	1,512	-	Capital Charge	10,586	10,584	(2)	18,144

Ratios

Provider Arm (only)

Operating Costs to Revenue (%) last six months

	Jan 17	Dec 16	Nov 16	Oct 16	Sep 16	Aug 16	Jul 16
Medical	21.27	20.97	20.68	21.15	20.87	21.05	19.34
Nursing	25.95	24.77	23.95	24.88	23.76	24.95	23.74
Allied	8.65	8.76	8.98	8.63	9.05	9.95	8.60
Support	3.15	3.20	2.99	3.10	2.93	3.03	3.00
Management	6.82	7.46	7.46	7.43	7.27	7.67	6.81
Personnel	**65.84**	**65.17**	**64.06**	**65.18**	**63.88**	**66.65**	**61.49**
Outsourced Pers.	2.50	2.36	1.95	2.31	2.26	1.86	2.12
Total Personnel	**68.33**	**67.53**	**66.01**	**67.49**	**66.14**	**68.51**	**63.61**
Outsourced Clinical Services	7.60	7.19	7.0	7.6	7.7	7.3	7.1
Clinical Supplies	10.66	12.20	13.86	12.16	14.35	14.09	14.02
Infrastructure	8.68	8.04	14.85	14.60	14.14	13.86	14.62
Total Operating	**95.27**	**94.96**	**101.70**	**101.89**	**102.34**	**103.78**	**99.38**

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

	2017	2016	2015	2014	2013
Medical	20.76	21.2	20.9	20.7	21.2
Nursing	24.6	24.5	24.8	25.1	25.5
Allied Health	8.9	9.2	9.3	9.7	9.7
Support	3.1	3.1	3.0	2.9	2.7
Man/Admin	7.3	7.3	6.9	6.8	7.2
Personnel	**64.6**	**65.3**	**65.0**	**65.2**	**66.3**
Outsourced Personnel	2.2	2.0	2.0	1.8	1.8
Total Personnel	**66.8**	**67.3**	**67.0**	**67.0**	**68.1**
Outsourced	7.4	6.5	6.2	6.4	6.3
Clinical supplies	12.1	14.5	14.4	14.0	14.4
Infrastructure	8.3	13.1	13.2	13.0	12.4
Operating	**94.6**	**101.4**	**100.8**	**100.4**	**101.2**
Depn	3.9	3.6	3.6	3.8	3.1
Interest	1.4	1.5	1.5	1.1	1.5
Capital Charge	2.1	2.2	1.8	1.7	1.7
Total	**101.9**	**108.7**	**107.7**	**107.0**	**107.5**

Balance Sheet

			As at		
Actual	**Budget**	**Var**	**January 2017**	**1 July 2016**	**Movement**
	Current Assets	**Current Assets**	**Current Assets**	**Current Assets**	**Current Assets**
11	11	-	Petty Cash	11	-
48,344	36,345	11,999	Bank	31,767	16,577
881	906	(25)	Trust	899	(18)
4,628	292	4,336	Prepayments	292	4,336
43,395	49,343	(5,948)	Debtors	50,043	(6,648)
5,106	1,468	3,638	Inventory	1,468	3,638
-	-	-	Assets Held for Sale	-	-
102,365	**88,365**	**14,000**	**Total current Assets**	**84,480**	**17,885**
			Fixed Assets		
176,530	176,530	-	Land	176,530	-
604,726	627,450	(22,724)	Buildings, Plant & Equip	611,969	(7,243)
1,527	1,527	-	Investment Property	1,527	-
4,259	4,336	(77)	Information Technology	4,259	-
561	953	(392)	Information Software	561	-
4,416	4,570	(154)	Motor Vehicles	4,416	-
792,019	**815,366**	**(23,347)**	**Total Cost**	**799,262**	**(7,243)**
(164,312)	(164,784)	472	Accum. Depreciation	(144,526)	(19,786)
627,707	**650,582**	**(22,875)**	**Net Cost**	**654,736**	**(27,029)**
58,570	49,579	8,991	Work In-progress	39,110	19,460
686,277	**700,161**	**(13,884)**	**Total Fixed Assets**	**693,846**	**(7,569)**
38,084	40,623	(2,539)	**Investments in Assoc**	37,704	380
826,726	**829,149**	**(2,423)**	**Total Assets**	**816,030**	**10,696**
			Current Liabilities		
77,263	86,195	(8,932)	Creditors	85,859	(8,596)
8,510	-	8,510	Income in Advance	1,917	6,593
8,868	6,696	2,172	GST and PAYE	6,691	2,177
5,000	40,000	(35,000)	Loans	5,000	-
42,579	36,539	6,040	Payroll Accrual & Clearing	33,785	8,794
85,923	87,985	(2,062)	Employee Provisions	87,640	(1,717)
228,143	**257,415**	**(29,272)**	**Total Current Liabilities**	**220,892**	**7,251**
(125,778)	(169,050)	43,272	**Working Capital**	(136,412)	10,634
$598,583	**$571,734**	**$26,849**	**Net Funds Employed**	**$595,138**	**$3,445**

			Non-Current Liabilities		
287,500	257,500	30,000	Term Loans	287,500	-
20,333	22,789	(2,456)	Employee Provisions (non-current)	21,221	(888)
896	906	(10)	Trust and Special Funds	873	23
931	931	-	Insurance Liability - Non Current	931	-
309,660	**282,126**	**27,534**	**Total Non-Current Liabilities**	**310,525**	**(865)**
			Crown Equity		
123,659	123,659	-	Crown Equity	123,659	-
219,129	219,987	(858)	Revaluation Reserve	219,129	-
(53,865)	(54,038)	173	Retained Earnings	(58,175)	4,310
288,923	**289,608**	**(685)**	**Total Crown Equity**	**284,613**	**4,310**
$598,583	**$571,734**	**$26,849**	**Net Funds Employed**	**$595,138**	**$3,445**

Commentary:

Net borrowings: Are favourable to budget due to strong cash flows and timing of payments to healthAlliance for IT projects.

Loans: All Crown loans terminated on the 15th February and have reverted to Equity. The DHB's are working with MOH to minimise any impact this may have in the conversion from interest rates to a capital charge rate. This especial applies to future debt which would have been rolled over in the next few years at lower interest rates.

Prepayment: Advance payment to hA (February invoice paid in January) and Lease cost relating to the sale and lease back on equipment.

Debtors:

MOH Debtors $000	**Total**	**Current**	**30 day +**
Invoiced	8,371	3,624	4,747
Accrued	445		
Total	**8,816**		
Last month	**8,105**		

30 day + Disability Support contract has signed off by MOH (timing)
Accrued: Breast screening

Accounts payable: $1.0m higher than budget and $1.4m lower than June 2016 due to timing of payments.

Net Fixed Assets: Are $13.9m lower than budget (timing of capital spends and sale and lease back of assets). Counties have completed a sale and lease back arrangement with CML for $9.9m of asset which took effect from 31st January, the cash will be used to fund the new Ko Awatea II development.

Investments in Associates:
New Zealand Health Partners $ 5.8m

Note: we will need to continue to ensure that these investments have underlying value through the future success of NZHP.

healthAlliance $32.3m for ICT capital investment.

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

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			
			Cash was provided from:			
124,172	129,410	(5,238)	Crown Revenue	915,870	903,309	12,561
2,918	2,345	573	Other	20,756	17,973	2,783
82	167	(85)	Interest rec.	1,256	1,169	87
			Cash was applied to:			
(81,877)	(77,839)	(4,038)	Suppliers	(559,020)	(537,951)	(21,069)
(45,331)	(49,163)	3,832	Employees	(332,608)	(342,083)	9,475
(1,059)	(1,225)	166	Interest paid	(7,345)	(8,575)	1,230
0	-	-	Capital charge	(9,732)	(8,747)	(985)
(1,095)	**3,695**	**(4,790)**	**Net cash from Operations**	**29,177**	**25,095**	**4,082**
			Cash flows from investing activities			
			Cash was applied to:			
(2,307)	(3,233)	926	Fixed assets	(22,241)	(22,631)	390
9,978	-	9,978	Sale of Asset	9,978	-	9,978
-	(417)	417	Investments	(380)	(2,891)	2,511
-	1	(1)	Restricted & Trust Funds	43	5	38
7,671	**(3,649)**	**11,320**	**Net cash from Investing**	**(12,600)**	**(25,517)**	**12,917**
			Cash flows from financing activities			
			Cash was provided from:			
-	5,000	(5,000)	Debt	-	5,000	(5,000)
-	-	-	Other Non-Current Liability	-	-	-
-	5,000	(5,000)	**Net cash from Financing**	-	5,000	(5,000)
6,576	**5,046**	**1,530**	**Net increase / (decrease)**	**16,577**	**4,578**	**11,999**
41,779	31,310	10,469	Opening cash	**31,778**	31,778	0
48,355	**36,356**	**11,999**	**Closing cash**	**48,355**	**36,356**	**11,999**

Month			Summary	YTD		
Actual	**Budget**	**Variance**		**Actual**	**Budget**	**Variance**
41,779	31,310	10,469	**Opening cash**	31,778	31,778	0
(1,095)	3,695	(4,790)	Operating	29,177	25,095	4,082
7,671	(3,649)	11,320	Investing	(12,600)	(25,517)	12,917
-	5,000	(5,000)	Financing	-	5,000	(5,000)
48,355	**36,356**	**11,999**	**Closing cash**	**48,355**	**36,356**	**11,999**

Operating Cash:
Crown Revenue: Disability Support funding (timing).
Supplies: hA payment one month in advance will discontinue after February payment. Lease payment for assets sold under the sale and lease back arrangement. Inventory; build-up. Outsourced personnel required to cover vacancies. Creditor; lower than budget.

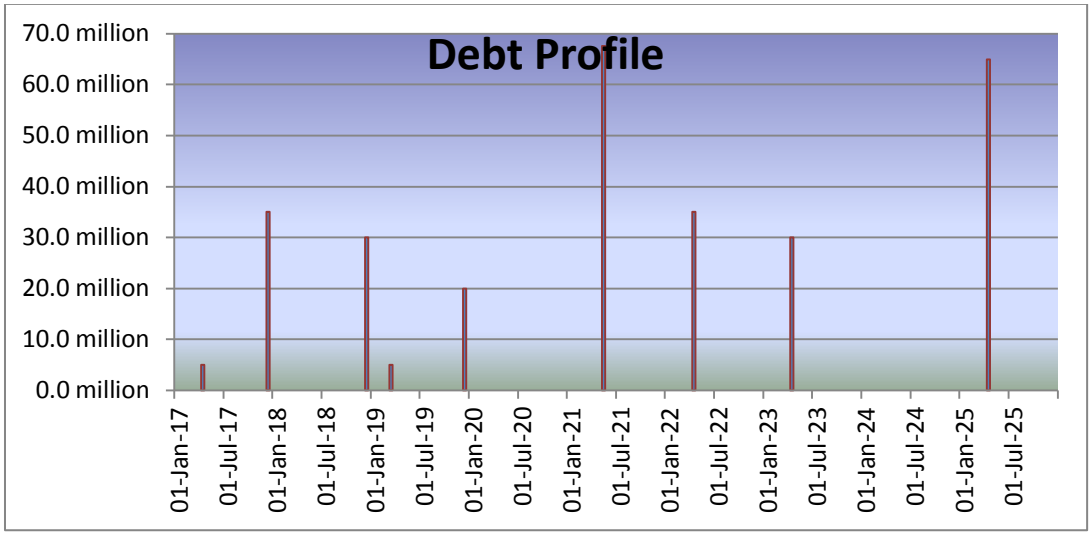
Investing Activities:
Sale and Lease back of equipment to MCL.

Treasury
All Crown loans terminated on the 15th February and have reverted to Equity. The DHB's are working with MOH to minimise any impact this may have in the conversion from interest rates to a capital charge rate. This especial applies to future debt which would have been rolled over in the next few years at lower interest rates.

Working capital facilities remain with Westpac via New Zealand Health Partnership 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
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
24.9	30-Jun-15	15-Apr-23	3.59%	Fixed, Semi-Annual
40.0	15-Apr-15	15-Apr-25	3.40%	Fixed, Semi-Annual
$292.5			**4.26%**	**Weighted Average**



FTE Reporting
Provider Arm: *(now reported in detail to the HAC committee).*

Personnel Costs per FTE

(Rolling average)

	Jan 2017	Dec 2016	Nov 2016	Oct 2016	Sep 2016	Aug 2016
Medical	190,912	189,871	190,227	189,174	188,072	186,423
Nursing	78,570	78,173	78,265	78,015	84,578	77,953
Allied Health	71,515	71,389	71,597	71,237	77,411	71,228
Management/Admin/Clerical	85,368	84,752	84,621	83,142	81,664	78,587
Support	53,486	53,450	53,594	53,223	57,253	52,757

Counties Manukau District Health Board
IS Operational Excellence – March 2017

Recommendation

It is recommended that the Board:

Receive the update on activities toward achieving IS Operational Excellence

Prepared and submitted by Leanne Elder, Deputy CIO on behalf of David Lenihan, Director Healthy Together 2020.

Executive Summary

The content of this report focusses on the Operational Excellence of the Regional Digital Programme in context for Counties Manukau Health. Progress is being made all areas and specific details are noted below.

Purpose

The purpose of this paper is to update the Board on the workstreams within the 'Achieving Operational Excellence' focus area for 2017. These activities ensure existing DHB technology assets and services meet business needs within the available budget. The focus area includes maturing asset management and security procedures, core system upgrades or replacements to address stability, performance or compliance issues and progress on key projects. This report is a highlight of progress, with management oversight at a detailed level provided by various leadership groups.

Background

Summary of Operational Excellence Work stream Activities

Operational Excellence	
Initiative	**Status Commentary**
Investor Confidence Rating (ICR)	A steering group has been set up to progress the organisational Asset Management improvement plan and the IS workstream is reporting steady progress to this committee.
Service Performance Management	Work continues improving Service Level Agreement (SLA) reporting. An SLA Review Framework has been drafted, and this framework has been sent to Regional CFOs and CIOs along with an example SLA for comment. No further updates have been received from hA and CMH to follow up The next phase of the programme will formally establish SLA and Customer agreements, but no dates have been communicated as yet from hA
Regional Cyber Security Programme	Health Alliance are working with PWC consulting services to finish the Regional Information Security Strategy & Plan, by the end of March 2017. In the meantime the security programme continues with the implementation of technical controls such as encryption, email security and network monitoring improvements. And a CM Health

Operational Excellence	
Initiative	**Status Commentary**
	education plan is being developed. Health Alliance is about to commence a follow up mobile device security review as a follow-up to an Audit completed in 2015.
Health Information Security Framework (HISF)	CM Health's work plan to support the adoption of the HISF framework is underway. This is being progressed by meeting with key contacts to ensure that the DHB meets the controls required to reduce the information security risk.
Risk management and assurance	healthAlliance continues to engage with the DHB's in the northern region to review the regional ICT Risk Register and the programme of work for 16/17. Auditing against the agreed programme continues as per schedule, with no significant issues identified.
Privacy	The Deputy CIO continues to work closely with the Risk and Privacy Officer to review and update privacy and security related policies. Demand for information and support in completing Privacy Impact Assessments continues to grow each month. And work continues on educating staff to produce high-quality documents for sign-off.
Stability and Performance	Health Alliance have established and resourced a stability programme to analyse and address core IT problem areas. An update from this programme has not been received following internal hA review and CMH to follow up
Upgrades and Fixes	The programme of work continues to optimise existing systems. Investments are prioritised by criticality to running the business and what we can afford. The upgrade budget for 17/18 is currently being finalised for prioritisation. As with past years the service demand will exceed budget availability.

Upgrades and Fixes Projects Supporting the Delivery of Operational Excellence.

A summary of the current status for each of the strategic operational excellence projects is as follows:

	Project	Purpose	Overall Status Last Period	Overall Status this Period
Care Connect	eReferrals inter & intra DHB and web referral*	Implement a safer, more efficient system for patient referrals within a DHB, and between DHBs, across the DHBs in the northern region.		
	eReferrals on line triage rollout*	Rollout of referral on line triaging to the few remaining services within CM Health that are yet to be provided this functionality. This allows referrals to be triaged anywhere and anytime.		
	Metro Auckland Clinical Pathways*	Development of decision support tools available at the point of care.		
National	National Maternity Clinical Information System (MCIS)	CM Health is an Early Adopter of the National Maternity Information System. The system was designed to allow the sharing of pregnancy events to be shared on a national basis.		
	National Patient Flow	Support CMH to achieve MoH compliance for the collection and reporting of National Patient Flow data.		
Upgrades	ie11 Internet Explorer upgrade*	Updating internet explorer a more secure and better-performing version.		
	Regional Radiology infrastructure upgrade*	Upgrade to Radiology software and hardware system to address operational performance issues.		
	Soprano Medical Documents (SMT)*	Upgrade to the eDischarges and Medicines reconciliation system.		
	Pager Replacement*	Replacement of pagers with modern equivalents with enhanced capabilities.		
	Wifi Rollout*	Strengthen existing wifi network and adding additional coverage areas.		
	Telecommunications Programme*	Replacement and enhancement of existing telephony systems for both clinical and non-clinical users.		
	Concerto*	Upgrade to the clinical information portal to introduce an up-to-date and stable version of Concerto.		
	iPM upgrade*	Upgrade of the patient administration system to introduce an up-to-date and stable version of iPM.		

* Regional Projects

Mitigating Actions for Projects with At Risk status

National Systems		
Project	**Cause**	**Mitigating Actions**
National Maternity Clinical Information System	Complexity of implementing a hybrid models (processes that will use MCIS and processes that will remain using the paper record) is complex to managed	Two activities are being progressed: • A team is being established to clarify the Counties Manukau way of using MCIS and put initiatives into place to support the consistent and on-going use of MCIS. • Test the hybrid processes in a simulated environment to see how paper can be introduced with as little duplication as possible and without introducing further risks. Further enhancements in Version 13 are scheduled for National release in mid-April and includes welcome features
Upgrades		
Project	**Cause**	**Mitigating Actions**
Pager Replacement	Schedule delayed due to technical resource availability and budget issues given that the small amount of seed funding initally allocated.	Design options continue to be progressed with good engagement from CM Health. Technical resource availability has been escalated within healthAlliance. A change request for additional funding has been approved by the Steering Committee and is now awaiting healthAlliance internal approval.
Telecommunications Programme	Schedule delay due to previous issues around scope and interdependencies across multiple telecommunications initiatives.	Approval received from February Steering Committee, IGG, and the healthAlliance Board to run joint planning and procurement for IaaS and TaaS services jointly, termed DataCentre as a Service (DCaaS). The programme will complete pre-procurement activities, before completing an RFP for services which is expected to end in June 2017. This will - determine

		preferred supplier or suppliers.
Concerto	Schedule at risk due to complexity of data migration and a large number of 'windowlets' undocumented that need analysis	Migration activities are being reviewed to understand the impact on the go-live date. Business Analysts are identifying the impact of the windowlet issue to understand the impact on the project timeline. All other activities continue in preparation for the go-live.
iPM	Schedule at risk due to technical resource availability for interface testing within hA	Additional resources would be helpful however due to the required knowledge of the environment; these are not able to be found. The team are working with hA to schedule current resources across projects as best they can.

Counties Manukau District Health Board
Socioeconomic factors and health status; implications for the population of CM Health

Recommendation

It is recommended that the Board:

Note the information provided regarding the impact of socioeconomic factors on health status and the implications for the population of CM Health and comparisons with the other Auckland Metro DHBs.

Prepared and submitted by Doone Winnard, Clinical Director Population Health on behalf of Margie Apa

Purpose and Summary

At the Board Induction day in January there were questions and discussion about the lower life expectancy and poorer health status of Counties Manukau populations compared with people living in the Waitemata DHB area. The response from CM Health staff was that this related at least in part to the different socioeconomic conditions in which communities in the two DHBs live. This paper provides more detail about that as context for future Board conversations and draws attention to recent commentary in the Lancet medical journal.

Background

Both socioeconomic circumstances and ethnicity 'matter for health' (MoH & University of Otago, 2006). In looking at health outcomes, ethnicity can be considered a marker of different experiences and exposures (MoH & University of Otago, 2006). In New Zealand, socioeconomic inequalities in health status as measured by mortality, hospitalisation and self-rated health have been highlighted, with concern, for two decades (National Health Committee, 1998).

Information about the socioeconomic circumstances in which people live for District Health Board purposes is drawn predominantly from Census data, both directly (e.g. the number of people living in households, income, education level) and indirectly through a derived measure called the New Zealand Deprivation Index (NZDep). NZDep2013 is a relative index of the socioeconomic deprivation of a small area (Meshblocks, 60-110 people), based on census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and internet at home for the people who live in the area.

Scores are grouped into deciles, with 1 representing the 10% of areas with the least deprived scores in NZ and 10 the 10% of areas with the most deprived scores; it is common to see data presented and cited with the deciles combined into quintiles with quintile 1 representing the 20% of areas with least deprived scores and quintile 5 the 20% of most socioeconomically deprived scores. It is important to remember that NZDep scores refer to areas, not individuals and are relative - 10% of areas will always be the most socioeconomically deprived, relative to other areas in New Zealand.

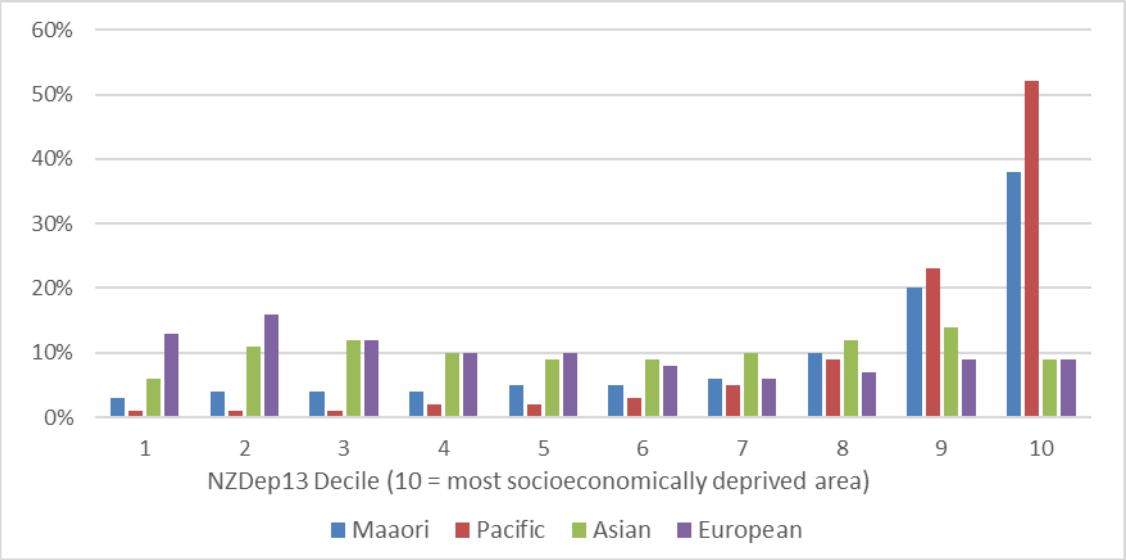
While they are closely related, there is understood to be a difference between poverty (associated with the availability of resources, related to patterns of ownership and distribution) and deprivation (associated with the conditions experienced) (Salmond et al, 2006). NZDep is a measure of deprivation. Pacific people have lower mortality rates than Maaori, both overall and for many specific causes, despite higher levels of deprivation. Potential reasons put forward for this include a 'healthy migrant' effect, an 'unhealthy' emigrant effect (where Pacific people nearing the end of their life may return to their home island (Tan and Blakely, 2012)), different levels of specific risk factors (e.g. smoking) and the Maaori experience of colonisation.

Socioeconomic position across the Auckland Metro DHBs

At the time of the 2013 Census, 36% of Counties Manuka residents were living in areas defined as the most socioeconomically deprived (Deciles 9 & 10, Quintile 5). All things 'being equal' this figure would be 20%. The percentage living in NZDep2013 Quintile 5 was much higher for Maaori (58%) and Pacific peoples (76%) than for European (17%), and Asian (22%) groups (total response ethnicity).

The pattern across NZDep2013 deciles varies between ethnicities, with the Maaori and Pacific population patterns being very skewed towards the deciles of higher socioeconomic deprivation, the European group relatively skewed towards lower socioeconomic deprivation (Figure 1). Asian groups have a 'bimodal pattern', with a relative peak in decile 3 and in decile 9 but at lower levels than for Maaori & Pacific peoples.

Figure 1 Pattern of distribution across NZDep2013 deciles by ethnic group



Source: University of Otago, Wellington (2014) NZDep2013 Area Concordance File; analysed by CM Health

The table and figure below summarise the socioeconomic picture, as indicated by the percentage of people living in Quintiie 5, by age and ethnicity for the population for the three metro Auckland DHBs. There are fairly stark differences across all population groups between Counteis Manukau Health and Waitemata DHB; for most groups the population of ADHB is intermediate between WDHB and CM Health. At a total population level, 8% of the WDHB were living in Quintile 5 at the time of the 2013 Census, compared with 36% for CM Health. The estimated population living in Deciles 9 & 10, the areas with the highest socioeconomic deprivation, in 2017 is approximately 196,500 people in Counties Manukau, about four times the number for Waitemata DHB (approximately 50,000) and twice the number for Auckland DHB (approximately 97,000).

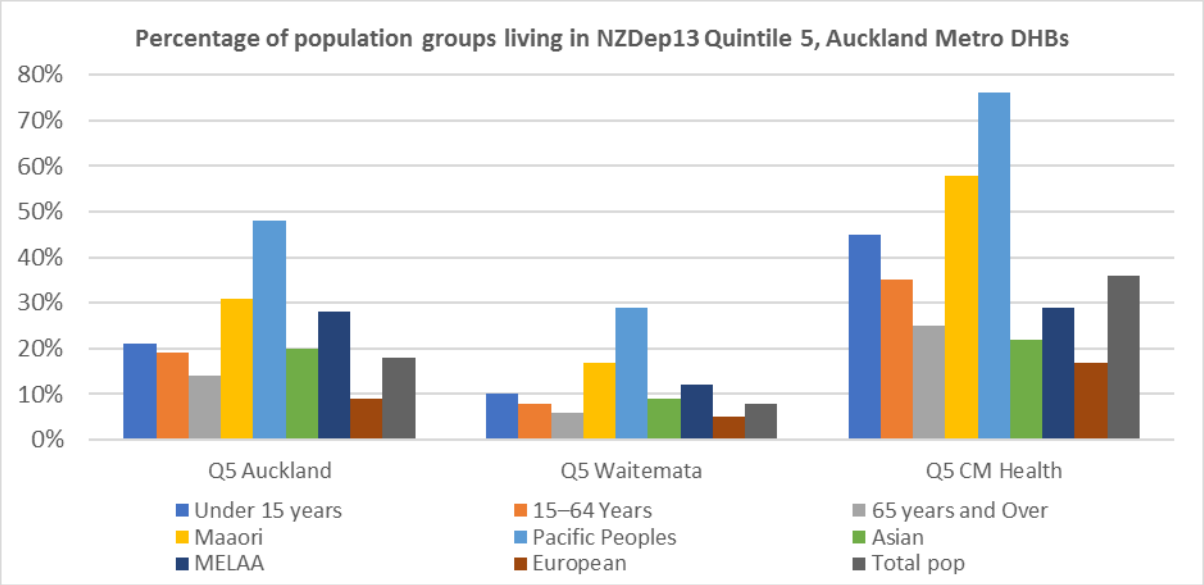
Table 1 Auckland metro region DHBs percentage of people living in NZDep2013 Quintile 5 by age and ethnicity, and indicative number in 2017 (rounding and total response ethnicity result in some mismatch between total population and column totals)

People living in Q5	**Q5 Auckland**		**Q5 Waitemata**		**Q5 CM Health**	
Population Group	Percentage	Indicative Number	Percentage	Indicative Number	Percentage	Indicative Number
Under 15 years	21%	17,700	10%	12,100	45%	55,000
15–64 Years	19%	70,800	8%	32,200	35%	125,000
65 years and Over	14%	7,900	6%	5,300	25%	15,600

Maaori	31%	12,900	17%	10,200	58%	50,500
Pacific Peoples	48%	26,300	29%	12,400	76%	86,900
Asian	20%	34,500	9%	11,500	22%	30,500
European	9%	(~23,000)	5%	(~15,700)	17%	(~28,600)
Total population	**18%**	**96,700**	**8%**	**49,800**	**36%**	**196,500**

(Total ethnicity responses for NZDep percentages mean the estimated number in ethnic groups other than Maaori will be slightly overestimated but give an indication of quantums for service planning).

Figure 2 Auckland metro region DHBs percentage of people living in NZDep2013 Quintile 5 (highest socioeconomic deprivation) by age and ethnicity



Source: University of Otago, Wellington (2014) NZDep2013 Area Concordance File; analysed by CM Health

Risk factors for illness and death, such as smoking, physical inactivity, obesity, diabetes are strongly patterned by socioeconomic position (e.g. A Portrait of Health – Key Results of the 2006/07 New Zealand Health Survey, Ministry of Health 2008; these results are consistent with international studies).

A recent Lancet paper detailed results of a multicohort study of 1·7 million adults followed up for mortality for an average of 13 years (Stringhini et al, 2017). Social rank based on occupation (professional, intermediate, and unskilled) was used to estimate the impact of socioeconomic position on mortality alongside more traditional 'risk factors' - current smoking, physical inactivity, high alcohol intake, obesity, diabetes, and hypertension. The fraction of deaths that could potentially be prevented if exposure of the population to the risk factor of interest was reduced to the minimum risk level was estimated for each risk factor, adjusting for other factors.

As described in commentary by NZ public health physician, Martin Tobias, 'on average low social rank accounted for 18·9% (men) and 15·3% (women) of all adult deaths in this study population' (Tobias, 2017). This fraction was third behand current tobacco smoking (29·0% for men and 21·0% for women) and physical inactivity (26·2% for men and 23·4% for women), ahead of other risk factors.

Implications

DHB efforts towards 'improvement, promotion and protection' of the health of the population we serve, as required of us by the NZ Public Health and Disability Act 2000 under which DHBs were established, need to take into account the social circumstances in which our populations live. These circumstances vary across the metro Auckland region.

All societies examined have social gradients in health, but the magnitude varies (Marmot, 2015). The WHO Commission on Social Determinants of Health, Closing the Gap in a Generation, 'linked health inequalities within and between countries to inequities in the distribution of power, money, and resources and to the inequities in conditions of daily life to which they give rise' (Marmot, 2015). ***Targeting health resources and interventions is best done using a mixture of place or locality based approaches, tailoring design to fit intervention-seeking preferences of population groups and subgroups, as well as individual approaches.*** Socioeconomic factors need to be influenced at a society level as well as at the whaanau/family level to impact health outcomes.

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Tan L, Blakely T (2012) Mortality by ethnic group to 2006: is extending census mortality linkage robust? New Zealand Medical Journal 125: 1357

Tobias M (2017) Social rank: a risk factor whose time has come? Lancet 2017, published online January 31, 2017 http://dx.doi.org/10.1016/S0140-6736(17)30191-5

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. Confidential Minutes of 15 February 2017/Actions	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
2. Review of 2017/18 Annual Plan, Statement of Intent & Maaori Health Plan	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)]	**Communication with the Sovereign** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S9(2)(j)]
3. Regional Oral Health Service	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
4. Principle Interventional Radiology Unit	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to

	good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
5. Scott Building Re-clad 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)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S9(2)(j)]
6. Integrated Infrastructure Investment Planning	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)]	**Communication with the Sovereign** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)]
7. Extension of Onelink Contract	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. Official Information Act – Charging Regime	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. 2017-18 Interim Budget Position	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)]	**Communication with the Sovereign** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)]
10. Northern Long Term Investment Plan	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)]	**Communication with the Sovereign** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)]
11. Healthy Together 2020 Technology	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)]
12. Risk Management Status 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)]	**Communication with the Sovereign** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of communications by or with the Sovereign or her representative. [Official Information Act 1982 S9(2)(f)]
13. Social Investment Board Progress Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]`