

# Counties Manukau District Health Board

## Board Meeting Agenda

Wednesday, 10 February 2016 at 1.30 – 4.30pm, Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

Time	Item
1.00 – 1.30pm	<b>Board Only Session</b>
	1. <b>Welcome</b>
1.30 – 1.35pm	2. <b>Governance</b> 2.1. Attendance & Apologies 2.2. Conflicts of Interest/Specific Interests 2.3. Confirmation of Public Minutes – 2 December 2015 2.4. Action Items Register
1.35 – 1.45pm 1.45 – 3.00pm	3. <b>Strategy</b> 3.1. Chair's Report (Verbal Update) 3.1.1. Cabinet Fees Framework Review (Information Only) 3.2. Chief Executive's Report (including Confidential Item on OIA – John Hanson) 3.2.1. Healthy Together 2020 Delivery (Appendix 1) (Margie Apa/Marianne Scott) 3.2.2. Social Investment Board Proposal (Appendix 2) (Margie Apa) – Confidential 3.2.3. Health & Safety Quarterly Report, History & Current Approach to Health & Safety at CMDHB & Presentation (Appendix 3) (Beth Bundy/Bev Stone/Meredith Connell)
3.00 – 3.05pm	4. <b>Information</b> 4.1. Healthy Food Policy (Information Only)
	5. <b>General Business</b>
3.05 – 3.10pm	6. <b>Resolution to Exclude the Public</b>
<b>Afternoon Tea Break</b>	
3.15 - 3.20pm 3.20 - 3.25pm 3.25 - 3.35pm 3.35 - 3.50pm 3.50 - 4.05pm 4.05 - 4.10pm 4.10 - 4.20pm	7. <b>Confidential</b> 7.1. Confirmation of Confidential Minutes – 2 December 2015 7.2. Action Items Register 7.3. Minister's Letter of Expectations (Lee Mathias) 7.4. Regional After Hours Services (Benedict Hefford/Louise McCarthy) 7.5. Project SWIFT Update (Sarah Thirlwall) 7.6. IS Projects Update (Leanne Elder) 7.7. Ko Awatea Service Expansion (Geraint Martin/Ron Pearson)

**Next Meeting: 23 March 2016**  
**Room 101, Ko Awatea, Middlemore Hospital, Otahuhu**

### Board Member Attendance Schedule 2016

Name	Jan	10 Feb	23 Mar	4 May	15 June	27 July	7 Sept	19 Oct	30 Nov
Lee Mathias (Chair)	<b>No Meeting</b>								
Wendy Lai (Deputy Chair)									
Arthur Anae									
Colleen Brown									
Sandra Alofivae									
Lyn Murphy									
David Collings									
Kathy Maxwell									
George Ngatai									
Dianne Glenn									
Reece Autagavaia									

\* Attended part meeting only

**BOARD MEMBERS’  
DISCLOSURE OF INTERESTS  
February 2016**

Member	Disclosure of Interest
Dr Lee Mathias, Chair	<ul style="list-style-type: none"> <li>• Chair Health Promotion Agency</li> <li>• Chairman, Unitec</li> <li>• Deputy Chair, Auckland District Health Board</li> <li>• Director, Health Innovation Hub</li> <li>• Director, healthAlliance NZ Ltd</li> <li>• Director, New Zealand Health Partners Ltd</li> <li>• External Advisor, National Health Committee</li> <li>• Director, Pictor Limited</li> <li>• Director, John Seabrook Holdings Limited</li> <li>• MD, Lee Mathias Limited</li> <li>• Trustee, Lee Mathias Family Trust</li> <li>• Trustee, Awamoana Family Trust</li> <li>• Trustee, Mathias Martin Family Trust</li> </ul>
Wendy Lai, Deputy Chair	<ul style="list-style-type: none"> <li>• Partner, Deloitte</li> <li>• Board Member Te Papa Tongarewa, the Museum of New Zealand</li> <li>• Chair, Ziera Shoes</li> <li>• Board Member, Avanti Finance</li> </ul>
Arthur Anae	<ul style="list-style-type: none"> <li>• Councillor, Auckland Council</li> <li>• Member The John Walker ‘Find Your Field of Dreams’</li> </ul>
Colleen Brown	<ul style="list-style-type: none"> <li>• Chair, Disability Connect (Auckland Metropolitan Area)</li> <li>• Member of Advisory Committee for Disability Programme Manukau Institute of Technology</li> <li>• Member NZ Down Syndrome Association</li> <li>• Husband, Determination Referee for Department of Building and Housing</li> <li>• Chair IIMuch Trust</li> <li>• Director, Charlie Starling Production Ltd</li> <li>• Member, Auckland Council Disability Advisory Panel</li> </ul>
Dr Lyn Murphy	<ul style="list-style-type: none"> <li>• Senior lecturer in management and leadership at Manukau Institute of Technology</li> </ul>

	<ul style="list-style-type: none"> <li>• Member, ACT NZ</li> <li>• Director, Bizness Synergy Training Ltd</li> <li>• Director, Synergex Holdings Ltd</li> <li>• Associate Editor NZ Journal of Applied Business Research</li> <li>• Member Franklin Local Board</li> </ul>
Sandra Alofivae	<ul style="list-style-type: none"> <li>• Member, Fonua Ola Board</li> <li>• Board Member, Pasifika Futures Ltd</li> <li>• Director, Housing New Zealand</li> <li>• Member, Ministerial Advisory Council for Pacific Island Affairs</li> </ul>
David Collings	<ul style="list-style-type: none"> <li>• Chair, Howick Local Board of Auckland Council</li> <li>• Member Auckland Council Southern Initiative</li> </ul>
Kathy Maxwell	<ul style="list-style-type: none"> <li>• Director, Kathy the Chemist Ltd</li> <li>• Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd)</li> <li>• Editorial Advisory Board, New Zealand Formulary</li> <li>• Member Pharmaceutical Society of NZ</li> <li>• Trustee, Maxwell Family Trust</li> <li>• Member Manukau Locality Leadership Group, CMDHB</li> <li>• Board Member, Pharmacy Guild of New Zealand</li> </ul>
Dianne Glenn	<ul style="list-style-type: none"> <li>• Member – NZ Institute of Directors</li> <li>• Member – District Licensing Committee of Auckland Council</li> <li>• Life Member – Business and Professional Women Franklin</li> <li>• Member – UN Women Aotearoa/NZ</li> <li>• Vice President – Friends of Auckland Botanic Gardens and Member of the Friends Trust</li> <li>• Life Member – Ambury Park Centre for Riding Therapy Inc.</li> <li>• Vice President, National Council of Women of New Zealand</li> <li>• Justice of the Peace</li> <li>• Member, Pacific Women’s Watch (NZ)</li> <li>• Member, Auckland Disabled Women’s Group</li> </ul>
George Ngatai	<ul style="list-style-type: none"> <li>• Chair Safer Aotearoa Family Violence Prevention Network</li> <li>• Director Transitioning Out Aotearoa</li> <li>• Director BDO Marketing</li> <li>• Board Member, Manurewa Marae</li> <li>• Conservation Volunteers New Zealand</li> <li>• Maori Gout Action Group</li> <li>• Nga Ngaru Rautahi o Aotearoa Board</li> </ul>

	<ul style="list-style-type: none"> <li>• Transitioning out Aotearoa provides services and back office support to Huakina Development Trust and also provide GP Services to their people</li> <li>• Chair, Restorative Practices NZ</li> </ul>
Reece Autagavaia	<ul style="list-style-type: none"> <li>• Member, Pacific Lawyers' Association</li> <li>• Member, Labour Party</li> <li>• Member, Auckland Council Pacific People's Advisory Panel</li> <li>• Member, Tangata o le Moana Steering Group</li> <li>• Employed by Tamaki Legal</li> <li>• Board Member, Governance Board, Fatugatiti Aoga Amata Preschool</li> <li>• Trustee, Epiphany Pacific Trust</li> </ul>

## BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

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

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

Wendy Lai	HBL Business Cases	Ms Lai declared a specific interest in regard to Deloitte's involvement with HBL on this work.	13 August 2014	That Ms Lai's specific interest be <u>noted</u> and that she may not participate in either the deliberations or determination of the Board in relation to this matter and is asked to leave the room.
Wendy Lai	Ko Awatea Panel Advisory Services	Ms Lai advised that Deloitte have been shortlisted to provide Panel Advisory Services to Ko Awatea. This work does not have any involvement with the APAC Business Case	5 November 2014	Noted. Ms Lai advised on the 3 December 2014 that Deloitte have now been selected to work with the Ko Awatea team to improve commercial awareness and increase income levels.
Lee Mathias	Otahuhu Boundary Change	The Chair noted her Specific Conflict of Interest, being Deputy Chair at ADHB.	25 March 2015	That Dr Mathias' specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.
Lee Mathias	Northern Region Electronic Health Record (NEHR) Project & Regional Information Strategy (RIS 10-20) Refresh	The Chair declared her specific interest as a Director of HealthAlliance.	25 March 2015	That Dr Mathias' specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.
Wendy Lai	FPSC	Ms Lai advised that Deloitte is involved with FPSC, but confirmed that she personally does not have any involvement.	6 May 2015	That Ms Lai's specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.
Wendy Lai	EPIC	Ms Lai noted that a Deloitte colleague worked with EPIC in the US. Mr Pearson and Mrs Zacest have met with him for his independent expertise on EPIC.	6 May 2015	That Ms Lai's specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.

Wendy Lai	Botany Land Discussions	Ms Lai advised that Deloitte has been appointed by the three parties involved in the Botany Land discussions (CMDHB, BUPA & East Health). She is not personally involved in this work.	17 June 2015	That Ms Lai's specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.
David Collings	Fencing of Swimming Pools Legislation	Mr Collings advised that he is the Chair of the Howick Local Advisory Board Swimming Pool Fencing Exemption Committee.	9 September	That Mr Collings' specific interest be <u>noted</u> and that the Board <u>agree</u> that he may remain in the room and participate in any deliberations, but be excluded from any voting.
Lyn Murphy	Fencing of Swimming Pools Legislation	Mrs Murphy advised that she is the Deputy Chair of the Swimming Pool Fencing Exemption Committee for Franklin Local Board.	9 September	That Mrs Murphy's specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.
Lyn Murphy	MIT Nursing Programme Report	Mrs Murphy is a Lecturer in the Faculty of Business & Information Technology at MIT.	9 September	That Mrs Murphy's specific interest be <u>noted</u> and that the Board <u>agree</u> that she may remain in the room and participate in any deliberations, but be excluded from any voting.

## Minutes of Counties Manukau District Health Board

Held on Wednesday, 2 December 2015 at 1.30 – 4.30pm Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

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Present: Dr Lee Mathias (Chair), Mrs Dianne Glenn, Apulu Reece Autagavaia, Dr Lyn Murphy, Mrs Sandra Alofivae, Mr George Ngatai, Mrs Kathy Maxwell, Mrs Colleen Brown, Ms Wendy Lai, Anae Arthur Anae

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

Apologies:

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### 1. Welcome

The Chair welcomed everyone to the meeting.

### 2. Governance

#### 2.1 Attendance & Apologies

Noted.

#### 2.2 Conflicts of Interest/Specific Interests

The Chair and Mr Ngatai advised updates to the Conflicts of Interest Register.

#### 2.3 Confirmation of Public Minutes – 21 October 2015

#### **Resolution**

That the public Minutes of the Board Meeting held on **Wednesday, 21 October 2015**, were taken as read and confirmed as a true and correct record.

**Moved:** George Ngatai      **Seconded:** Dianne Glenn      **Carried:** Unanimously

#### 2.4 Action Items Register

Noted.

### 3. Strategy

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

The Chair provided an update to the Board in the pre-Board meeting.

#### 3.2 Chief Executive's Report (Geraint Martin)

The report was taken as read.

Mr Martin advised that the financial position is very tight and being closely monitored. CMDHB are the only DHB to deliver a balanced position in both the Provider and Funder Arms, and he acknowledged the team for their excellent work.

MoH have indicated that there will be very significant revisions to PBF, with acceptance of CMDHB's significant population growth. This income has not been accounted for previously. Mr Martin acknowledged Dr Wing Cheuk Chen for his work on this.

The Chair advised that the Board would like to see a 'jigsaw' of the whole picture, incorporating; Strategy, Capital, Operation and Outcomes.

In addition, they would like to know that if there is a problem in one of these areas, what the implications will be.

Mr Martin confirmed that a complete picture will be coming to the February 2016 Board Meeting.

**Resolution**

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

**Moved:** Lee Mathias      **Seconded:** Dianne Glenn      **Carried:** Unanimously

**3.2.1 Quarter 1 Non Financial Performance Report 2015/16 (Dawn Kelly)**

The report was taken as read.

**Resolution**

That the Board **receive** the 2015/16 Summary Quarter 1 Report.

**Moved:** Wendy Lai      **Seconded:** Kathy Maxwell      **Carried:** Unanimously

**4. General Business**

**5. Resolution to Exclude the Public**

Individual reasons to exclude the public were noted.

**Resolution**

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6,7 and 9 of the NZ Public Health & Disability Act 2000, that the public now be excluded from the meeting as detailed in the above paper.

**Moved:** Lee Mathias      **Seconded:** Kathy Maxwell      **Carried:** Unanimously

The meeting was re-opened to the public.

The meeting closed at 4.50pm. The next meeting of the Board will be **Wednesday, 10 February 2016** at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board of **2 December 2015** are approved.

Signed as a true and correct record on **10 February 2016**.

Chair .....

Dr Lee Mathias (Chair)

**Counties Manukau District Health Board  
Action Items Register (Public)**

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
2 December	CE Report	<p>The Chair advised that the Board would like to see a 'jigsaw' of the whole picture, incorporating; Strategy, Capital, Operation and Outcomes.</p> <p>In addition, they would like to know that if there is a problem in one of these areas, what the implications will be.</p> <p>Mr Martin confirmed that a complete picture will be coming to the February 2016 Board Meeting.</p>	February	Geraint Martin	Included in February meeting papers.	✓



## Cabinet Fees Framework Review Information for Board Members

The Cabinet Fees Framework (CFF) provides consistency to the fees for members of around 550 government bodies with expenditure of over \$50M per annum in fees.

### Undertaking a review

The SSC is undertaking a three phase review to create a more fit for purpose CFF, guided by the following principles:

- a fair and consistent approach to fee setting
- expenditure of public funds within reasonable limits
- simplicity, accessibility and ease of use
- supporting the appointment of capable board members and a diversity of board members.

**Phase 1** will be limited to addressing the immediate issues with the CFF. It will result in a revised CFF presented to Cabinet for consideration in April 2016. The deliverables for Phase 1 include:

- reviewing the fee ranges
- incorporating standing exceptions into the CFF
- moving to payment of expenses on an actual and reasonable basis
- providing an interim solution for the fee ranges for boards of some larger Crown entities
- clarifying roles and authorities of SSC and monitoring departments
- amendments to remove ambiguities and inconsistencies.

**Phase 2** will scope an online tool to assist monitoring agencies to classify bodies and set fees, and establish a central database of bodies administered under the CFF. This would enable comprehensive and consistent information on bodies to be held centrally, improving the quality of reporting to ministers on fees paid under the Framework, and may also enable the reporting of progress to diversity.

**Phase 3** will scope the need and practicalities of replacing the current classification system with a new fee-setting methodology that better reflects the responsibilities of board members, reduces the need for exceptions, and provides for reassessment of the classification if board responsibilities change.

The business cases for Phases 2 and 3 will go to Cabinet in April 2016. Ministers will then decide whether to proceed with implementation of the online tool, database and new fees methodology during 2016 and 2017.

### Engagement

The SSC is committed to ensuring that the interests of monitoring agencies and boards are taken into account through the review.

A Reference Group of departmental representatives has been set up to provide advice and guidance to the Steering Group. Monitoring agencies will have the opportunity to provide feedback and input to the Phase 1 Review and contribute to the scoping of Phases 2 and 3. They will also keep the boards for which they are responsible informed on progress with the review.

If you would like further information about the CFF review please contact your monitoring agency. If necessary they will refer your enquiry to the SSC's Executive Management Services team who are responsible for the review.

# Counties Manukau District Health Board

## Chief Executive's Report

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### Recommendation

It is recommended that the Board:

**Receive** the Chief Executive's Report.

**Approve** the overview of our strategic intent for Health Together 2020, and the framework to deliver transformational change (Appendix 1).

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**Prepared and submitted by:** Geraint Martin, Chief Executive

### 1.0 Introduction

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

- **Strategic** – with a special focus on planning for 2015/16.
- **Operational** – including the reports from the Director of Strategic Development, Director of Corporate & Business Services and Director of Ko Awatea.
- **Compliance** – a report is included in the Confidential section of the meeting.

### 2.0 Strategic

2.1 At the end of last year, several key strategic milestones were reached. Most importantly, but not exclusively:

- Values Refresh
- Facilities Infrastructure
- SWIFT
- Community Health Services (CHSI)

In addition, we received:

- The external Treasury Gateway Review on SWIFT
- Our financial allocation for 2016-17
- A Cabinet commission to develop a proposal for the delivery of Better Public Services across the Social Sector (this will report in March 2016) to Minister Bennett.

2.2 Importantly the Gateway Review confirmed our initial view that:

- We were undertaking a necessary, comprehensive, ambitious, and to an extent, risky re-design of the health system.
- That we had developed a sophisticated suite of initiatives to deliver the change, which is adjudged to be high quality (as commented on by PWC).

As the Gateway Review concluded:

“The analysis is comprehensive and widely accepted. It has led the organisation to an informed position to plan for and execute a substantial business transformation geared to reduce hospital admissions and deliver more health care closer to home in less costly community and primary care settings”

However, the planning processes that have delivered an effective technical plan would not be fit for purpose to deliver whole sale change. Importantly, there was acknowledgement that through our investment in Ko Awatea the organization was skilled and “change ready”

The most important step, therefore, the need to reconfigure the broader transformation executive leadership, accountabilities, programme structure and address lack of clarity on funding. The recommendation is this needs to be addressed immediately. We need to reconfigure our strategy in order to successfully deploy and execute the change. In particular, that:

- We should create a ‘Transformation Team’ accountable directly to the CEO with the mandate to plan and execute the strategy with the organisation.
- That a focus should be on the integration together of the several strategies, not separately in silos.
- That the strong vertical silos of the organisation were effective for efficiency, but needed to be completed to an equally effective cross system approach.
- That there should be a reduction in the number of ‘strategic’ brands in the organisation and a concentrated focus on communication of the strategic picture as a whole, and how the component parts fits together.

Significantly, this external review reflects the internal views of the ELT. The end of 2015 saw our Strategic Refresh being completed, and we had already begun to consider what was needed to re-orientate the DHB to not just being:

- highly efficient and effective, but also;
- able to accelerate change – especially in integrating services and change programme.

Undoubtedly, such a large scale change can never be undertaken without risk, and it is recommended that the Delivery of the Healthy Together 2020 strategy be included within the Risk Management programme for Audit, Risk and Finance.

During December and January, I have conducted a review with ELT on how to take on board these recommendations. This was finalised at an ELT Workshop on the 28 January 2016.

Consequently, I include for the Board in my report:

- An overview of our strategic intent for Healthy Together 2020, which includes a framework to deliver transformational change (Appendix 1).

### 3.0 Operational

3.1 The DHB remains on course to deliver on its financial and service targets.

The usual monthly Financial Report is included later in my report, plus I have included an update on health targets below:

#### **Shorter stays in Emergency Departments**

We have continued to achieve the 'Shorter Stays in Emergency Departments' target. The performance for January 2016 was 96.5%.

#### **Improved access to Elective Surgery**

Performance against the elective surgery target has remained stable, with Surgical Services meeting this target in three of the previous four quarters. We have discovered that the MoH had queried domicile codes on some of our July discharges and as such they were not included in our numbers. We have not yet finalised how many discharges this affected, however, it may mean the 68 discharge shortfall for the 2015/16 first quarter may no longer exist and that we met the target.

A power outage at MSC on the 2 February meant that a number of outpatients and elective operating was cancelled. Despite this, diagnostic performance is now much more robust and timely and represents a significant improvement in patient care.

Surgery will continue to deliver on value and targets for year end. A recovery plan has been developed. The generator failure underlines the need for infrastructure at MSC, to be reviewed and invested in before further developments on the site.

#### **Faster Cancer Treatment**

We continue to make good progress towards meeting the Faster Cancer Treatment target with steady improvements reported every quarter. A detailed plan is being finalised for the period up to 1 April 2016, with key activity focussed on improving grading timeliness and data, finalising and implementing future-state pathways, and improving cross service/DHB transfers of care.

#### **Better help for Smokers to Quit**

Hospitalised patients continue to receive advice and support to quit smoking, with the target of 95% continually being met or exceeded. Note that the national target now includes the entire enrolled population of smokers, and as such, high compliance levels within the hospital are not immediately apparent in performance reported nationally by the Ministry of Health (the hospital target is now only reported in the Ministry's source data and individual target graphs)

#### **Diagnostics**

The Hospital Services Directorate teams are focused on achieving the required national diagnostic access targets (wait times for Radiology, Colonoscopy, and Cardiac services).

- MRI scanning: The indicator was met for the first time in December (87% vs. 80% within 42 days target), despite demand being above expected levels. This performance is expected to be sustained during 2016.

- CT scanning: Focus remains on the indicator and on improving the performance to 95%. In December, we fell short of the target, achieving 93% due to a significant increase in demand in the weeks leading up to the Christmas break. Forecasted volumes are expected to meet this target in January 2016.
- Colonoscopy: Colonoscopy targets for urgent and surveillance continue to be met month on month with routine targets forecasted to be met by mid-2016. Initiatives such as production planning modelling to reflect the impact of the expansion of medical and nursing workforce and theatre capacity will enable delivery.

## 4.0 Strategic Development

### Deep Dive – Grow Our Own Workforce and Tindall Foundation Contributions

Tindall Foundation has donated an estimated \$2.8million to Grow Our Own Workforce initiatives since 2010. That donation has funded the following programmes:

- Tertiary scholarships for up to 25 Maaori and Pacific Health Science students per annum
- Seed funding for the establishment of Health Science Academies in Tangarao College and James Cook High School and its evaluation
- Pu Ora Matatini scholarships for Maaori midwifery training that has culminated in 10 graduates; and
- Pilot funding awarded in 2015 to prototype a Maaori Virtual Health Science Academy hosted by Alfriston College, but aiming to foster a network of Maaori health science students across multiple Manurewa schools.

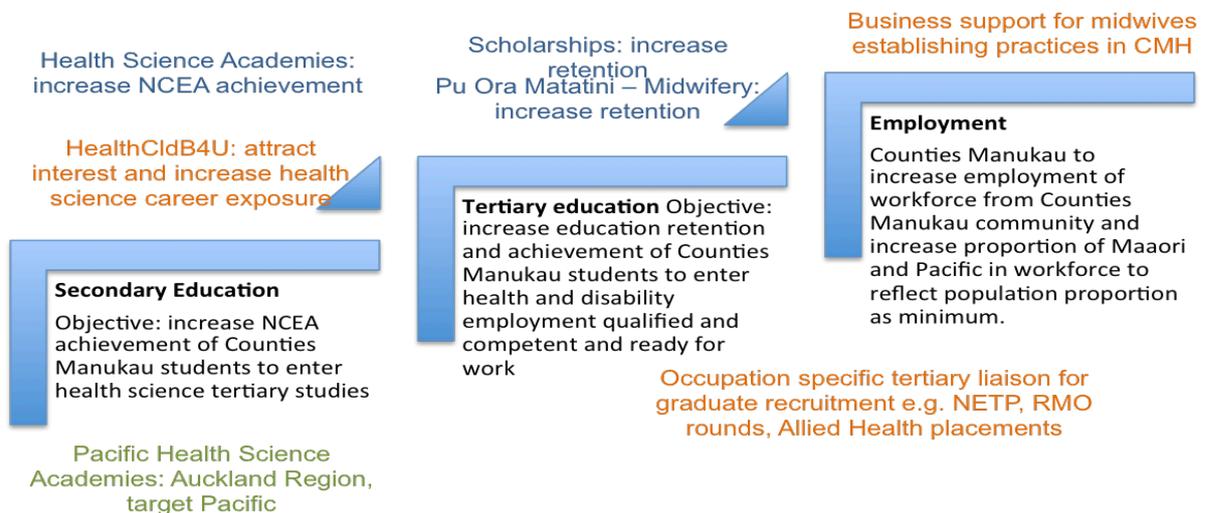
This Deep Dive alerts the Board that the activities currently funded by the Tindall Foundation are due to end in 2016 and alternative sources of scholarships to ensure sustainability of current students will need to be considered. By the end of 2016, the only initiative funded by Tindall will be the **Virtual Maaori Health Science Academy**. It would be timely for the Board to acknowledge the Tindall Foundation's contribution to CM Health workforce development towards the end of 2016.

Grow Our Own aims to contribute to a Maaori and Pacific workforce composition to be greater than or at a minimum equal the population covered within the District. Table 1 illustrates the current composition of population to workforce updated as at March 2015:

**Table 1 Current Composition of Maaori and Pacific Workforce vs current as at 2015**

	<b>Population Proportion %</b>	<b>Total Workforce % (headcount)</b>	<b>Clinical staff % (headcount)</b>
Maaori	16	6	5
Pacific	21	11	9
Asian	24	27	30
European and other ethnic groups	39	50	52
Didn't disclose ethnicity	n/a	6	5

**Tindall Foundation's contribution:** Tindall Foundation scholarship and Health Science Academies assists this goal by supporting entry into tertiary study to be eligible for a health professional career path. Figure 1 describes the range of activities that support the pipeline for Maaori and Pacific workforce and the blue text represents the initiatives funded by the Tindall Foundation.



Tindall Foundation Funded

Ministry of Health Funded

CMH Funded/Supported

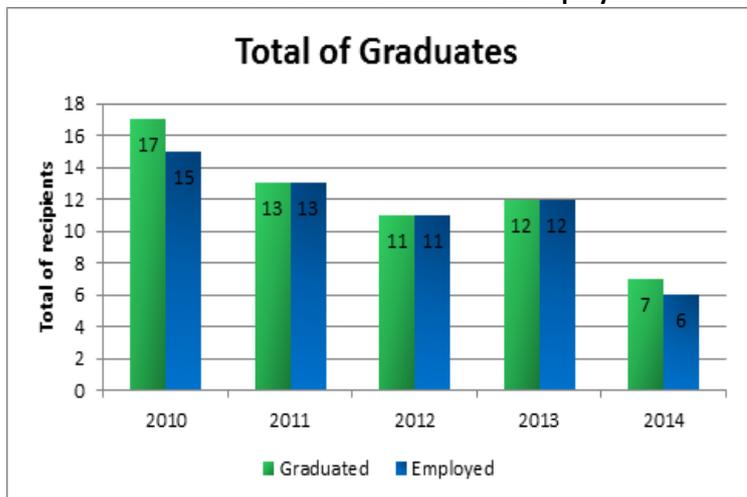
**Figure 1 Counties Manukau Workforce Pipeline and Initiatives**

**Health Science Academy** Tindall Foundation funded Health Science Academies have been operating in CM Health since 2011 in Tangaroa College and James Cook High School. The first cohort of graduands is due to complete their tertiary study in a 3 year degree as at end of 2016. The larger proportion of this cohort are nurses. The Ministry of Health funded 3 additional Health Science Academies across the region including Waitakere College, Onehunga High School and De La Salle. In the 2016 Calendar year, more than **279** Maaori and Pacific students will be enrolled in a Health Science Academy across the region.

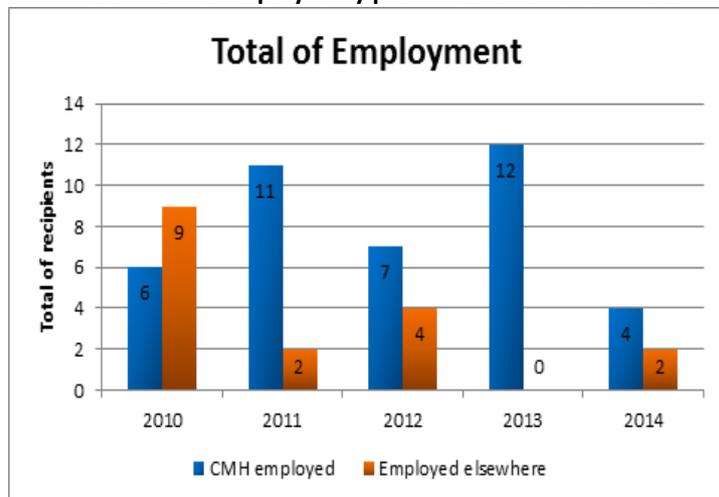
**Pu Ora Matatini** There are to date 9 Pu Ora Matatini funded Maaori midwives now employed out of the 15 Pu Ora Matatini scholarship awarded to date. Of the 15 scholarships - 9 have graduated and are now either self-employed or employed by the DHB as practicing midwives; 4 current students and 2 did not complete. There are an estimated 39 Maaori midwives now in training through AUT.

**Scholarships** By the end of 2016 when the Tindall Foundation scholarship funding ends, more than 100 students will have received financial support from scholarships. The following graphs confirm that Tindall funded scholars from 2011 were employed by CMH or another health organization.

**Table 2 Total Graduates and Employed**



**Table 3 Total employed by place - CMH or other health**



## Month Report on Business Plan

There are seven teams that provide 'corporate services' and two direct patient support services (Maaori and Pacific cultural support) in the Strategic Development Directorate. The highlights being:

Highlights
<p><b>Strategic Planning</b></p> <ul style="list-style-type: none"><li>• 14/15 Annual Report now published on the CM Health website.</li><li>• 15/16 annual plan review completed and improvements embedded into 16/17 planning cycle.</li><li>• 16/17 business planning guidance received from MoH, paper outlining process for 16/17 year submitted to ELT in December that reflected the strategy refresh and equity priorities.</li><li>• Integrated Investment Infrastructure strategic direction approved by Board to progress to more detailed planning. A cohesive strategy story and health equity measurement framework in progress. Asian health plan refresh in progress.</li></ul>
<p><b>Maaori Health Development</b></p> <ul style="list-style-type: none"><li>• Implementation of Manawhenua i Taamaki Makaurau Hauora Plan – currently awaiting approval from Manawhenua on the draft Letter of Agreement.</li><li>• ISA Agreement with NHC not to be renewed and notice was issued 20 November. CM Health is now meeting with providers to transition to take over contracts from 1 July 2016.</li><li>• Maaori workforce - cadetships and summer placement underway with internship planning for 2016. Health Science Academy discussions progressing with Alfriston College and Manurewa Marae.</li></ul>
<p><b>Pacific Health Development</b></p> <ul style="list-style-type: none"><li>• Lotu Moui Community draft plan in final stages for preparation for submission to ELT in February.</li><li>• Pacific workforce – regional mentoring and Health Science Academies tracking well with 279 students enrolled in MoH/CMH funded Academies across the region in 2015. This will grow with the establishment of a Virtual Maaori Health Science Academy.</li></ul>
<p><b>Communications Channels</b></p> <ul style="list-style-type: none"><li>• The business case to renew SouthNET intranet to ensure it is fit for purpose for the future is on track for first quarter of 2016.</li><li>• Key campaigns in progress:<ul style="list-style-type: none"><li>○ Winter 2016 has commenced</li><li>○ Wellness campaign and strategy for staff and community</li><li>○ refresh of Smokefree messages in local channels including ensuring public know CMH campuses are smokefree</li><li>○ Branding guidelines for the new values and strategy are in final form for completion end January</li><li>○ Hand hygiene campaign for staff</li><li>○ Patient Experience Week</li><li>○ Certification Audit</li></ul></li></ul>
<p><b>Population Health:</b></p> <ul style="list-style-type: none"><li>• Population analysis, descriptive epidemiology, literature and evidence review on priority service, population health and/or demographic need to inform annual and strategic planning:<ul style="list-style-type: none"><li>○ Information governance issues discussion paper developed for Social Investment Board working group; Paper on premature mortality in CM cohort identified as having insufficient housing finalised and submitted to NZMJ; TestSafe output comparison with MoH Virtual Diabetes Register.</li></ul></li><li>• Population health expertise across CM Health:<ul style="list-style-type: none"><li>○ NZMJ paper published on Mana Kidz programme, with subsequent media interviews on radio and television; Business case for new model for school-based health services in development; Contributions to Ko Awatea/CM Health research proposal for MoH RFP on self-sampling cervical screening for Maaori women; Alignment of annual planning with health equity strategic goal – presentation and discussion with ALT &amp; CHMIT, facilitation of workshops for child health and primary care Maaori Health and Annual Planning process, initial workshop on measurement framework for Healthy Together strategic goal.</li></ul></li></ul>

- Provide population health expert advice to national and regional planning and service reviews
  - CM Health submission on NZ Health Strategy; Feedback on StatsNZ Proposed Geographic Areas Standard for Census 2018, and on potential questions on housing quality for Census 2018; Participation in working group to revise national ethnicity data protocols (Wellington workshops); National leadership on DHB nutrition and beverage environments policies and implementation; Population health contribution to expert advisory group for Gout domain for Atlas of HC Variation, HQSC, and preparation of NZMJ editorial to coincide with release of Gout Atlas update end of January.

#### **Human Resources**

- People Strategy draft to be socialised with key stakeholders and will be presented to the Workforce and Education Committee in February prior to ELT and Board in March.
- Values based recruitment programme in final stages of development for launch in February. The Values Working Group is preparing a programme of activity for 2016 to embed, sustain and develop the culture of the organisation.
- Organisational competency framework will be presented to the Workforce and Education Steering Group in February.
- Application for data warehousing server requirement lodged with Capex Committee in January. Commitment from Waitemata & Canterbury DHBs to build and implement data warehouse together.

#### **Strategic PMO**

- Daptiv – a Project Coordinator has been recruited and commenced. The role involves the ongoing roll out and growth of Daptiv as well as a support role in selected projects. 225 initiatives registered with 59 users.
- CM Health project methodology – a regional project management forum was hosted by CM Health in November, focus was on workshopping approaches to addressing bottlenecks and managing service change. The 2015 Project Awards were held in December with a broad range of clinical and non-clinical, hospital and community service improvement activities nominated.

## **5.0 Financial settlement for 2016-17**

We have received and now reconciled the funding envelope advice in regard to 2016/17 funding and beyond.

Ron Pearson will give a high level overview of the funding package detail that was presented to Audit, Risk & Finance on 20 January, which has already been included on the Diligent Board paper website.

Overall, under the Population Based Funding Formula (PBFF), we have received \$41.9M against \$18.8M last year (which itself included a significant top up) reflecting a 220% dollar increase! We have received a 3.38% increase against the average for the sector of 2.90%. Despite us obviously wanting or needing more, this is a material correction to what we believe was well understated Population Base in the current year's funding. On top of this, we have the IDF adjustments reflecting increased inflows or outflows of tertiary services and pricing changes, which have unfortunately proved to be an approximately net negative \$3M movement giving us a net increase of \$39M.

I will be working with Ron and others over the near future as to how we allocate and prioritise this funding against both maintaining business as usual and the critical need for investment in our transformational change process/Healthy Together. This will require identification and locking in of significant continuing efficiency or cost savings to be able to achieve our overall clinical outcomes.

## 6.0 Finance

### FINANCIAL POSITION at December 2015

#### Summary: December Month

##### Month / Year to date

The half of the year closed with a small favourable variance of \$178k. The month continued the trend of a small but it is becoming increasingly harder to balance the month. The result for the month was a favourable variance of \$18k, with the actual result was actual \$(211)k v's budget \$(229)k. As noted in previous months the full years financial/ budgeted result includes the additional MOH advised revenue (\$2.7m) and this is accounted for in the final month of the financial year.

The Funder Arm was \$15k favourable to budget with a YTD favourable variance of \$531k.

Slow start to Mental Health spending benefits continuing in the month. This is now being offset by an expected increase in Residential Care expenditure to more 'normal' levels.

The Provider Arm consolidated, produced a result that was \$6k favourable to budget and a YTD favourable variance of \$311k. The Hospital side of the provider arm was favourable for the month by \$9k and has a YTD unfavourable variance of \$(213)k.

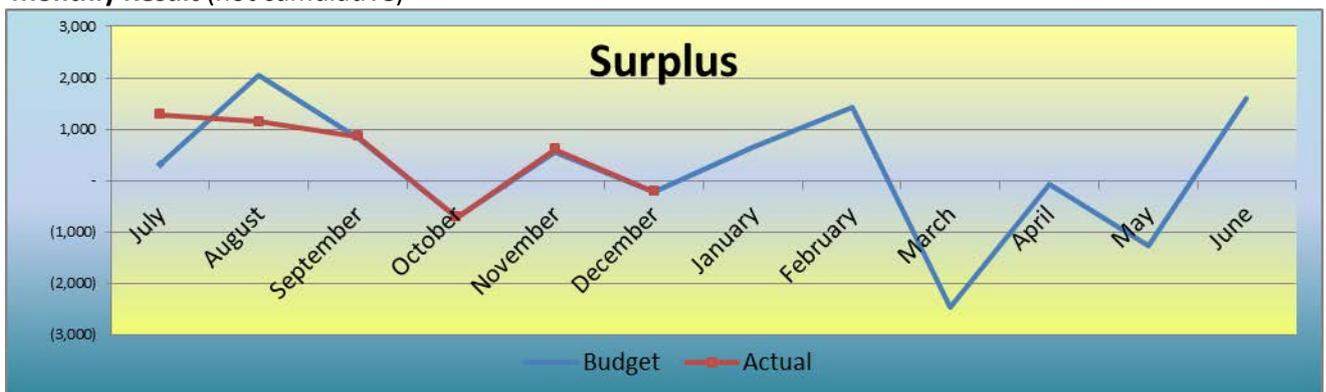
Governance was unfavourable for the month of \$(3)k and an YTD unfavourable variance of \$(684)k, the unfavourable variance.

We have re-affirmed to MOH (as at December 2015) that the forecast year end position remains as budgeted although there are clear and increasing signs of pressure within most DHB provider arms and we have/are taking further very active steps to manage this exposure to ensure budget achievement.

#### Statement of Performance by Operating Arm

Month December 2015			Net Result \$000	YTD December 2015				Full year	
Act	\$000	Var.		Act	Bud	Var.	Last year	Bud	Forecast
2,154	2,145	9	<i>Hospital Provider</i>	16,637	16,850	(213)	8,131	10,744	10,744
(2,104)	(2,095)	(9)	<i>Integrated Care</i>	(12,409)	(12,642)	233	(4,397)	(9,665)	(9,665)
(1,309)	(1,315)	6	<i>Ko Awatea</i>	(7,309)	(7,620)	311	(6,589)	(13,500)	(13,500)
<b>(1,259)</b>	<b>(1,265)</b>	<b>6</b>	<i>Provider</i>	<b>(3,081)</b>	<b>(3,412)</b>	<b>331</b>	<b>(2,855)</b>	<b>(12,421)</b>	<b>(12,421)</b>
1,031	1,016	15	<i>Funder</i>	6,624	6,093	531	4,979	14,893	15,593
17	20	(3)	<i>Governance</i>	(571)	113	(684)	(1,406)	230	(470)
<b>(211)</b>	<b>(229)</b>	<b>18</b>	<b>Surplus (deficit)</b>	<b>2,972</b>	<b>2,794</b>	<b>178</b>	<b>718</b>	<b>2,702</b>	<b>2,702</b>

#### Monthly Result (not cumulative)

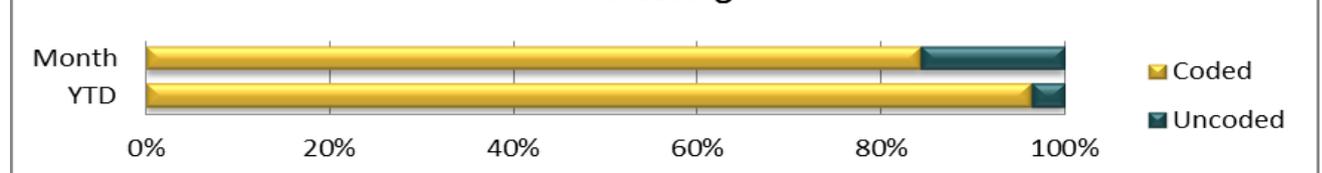


## Volume Summary December 2015

### Total WIES

Month						Year to date				
Act	Bud	Var.	%	Last. Yr.		Act	Bud	Var.	%	Last. Yr.
5,648	5,431	217	4.00%	5,603	<i>Acute</i>	35,773	34,712	1,061	3.06%	35,098
1,237	1,233	4	0.32%	1,500	<i>Elective</i>	8,767	9,013	(246)	(2.7)%	9,592
<b>6,885</b>	<b>6,664</b>	<b>221</b>	<b>3.32%</b>	<b>7,103</b>	<b>Total</b>	<b>44,540</b>	<b>43,725</b>	<b>815</b>	<b>1.86%</b>	<b>44,690</b>

### % Coding



Note: A change in MoH elective reporting, effective 1 July 2015 requires that Acute Arranged surgical activity be recognised as elective activity. These changes have not been carried out in the above table.

### Discharges

(note we don't budget for discharges)

Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
7,183	7,076	107	1.5%	<i>Acute</i>	44,696	43,864	832	1.90%
1,079	1,187	(108)	(9.1)%	<i>Elective</i>	7,550	8,327	(777)	(9.3)%
<b>8,262</b>	<b>8,263</b>	<b>(1)</b>	<b>(0.0)%</b>	<b>Total</b>	<b>52,246</b>	<b>52,191</b>	<b>55</b>	<b>0.11%</b>
<b>0.83</b>	<b>0.86</b>	<b>0.03</b>	<b>3.1%</b>	<b>Ratio WIES to discharges</b>	<b>0.85</b>	<b>0.84</b>	<b>(0.01)</b>	<b>(1.8)%</b>

### Volumes Other

(note we don't budget for discharges)

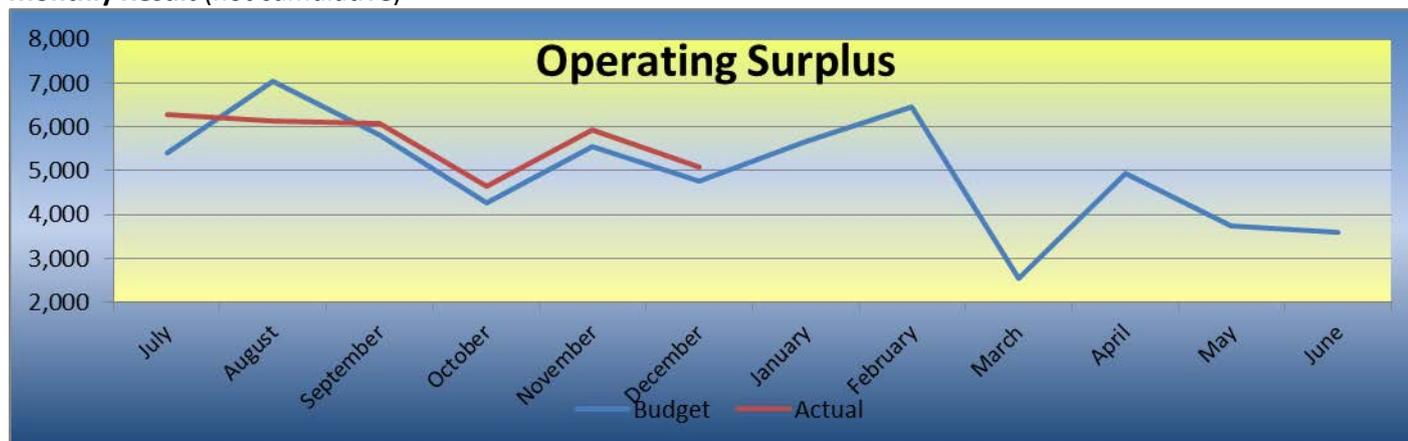
Month					Year to date			
Act	Last Yr.	Var.	%		Act	Last Yr.	Var.	%
590	640	(50)	(7.8)%	<i>Birth Numbers</i>	3,667	3,703	(36)	(1.0)%
9,350	9,149	201	2.20%	<i>ED Volumes</i>	58,065	55,645	2,420	4.35%
4,769	4,774	(5)	(0.1)%	<i>Renal Dialysis</i>	28,166	27,654	512	1.85%
49,318	51,905	(2,587)	(5.0)%	<i>Outpatient Summary</i>	330,721	338,503	(7,782)	(2.3)%
2.3	2.3	-	-	<i>ALOS</i>	2.3	2.3	-	-

**Statement of Performance**

Month			\$000	Year to Date				Full Year	
Act	Bud	Var.		Act	Bud	Var.	Last year	Bud	Forecast
123,898	123,154	744	<b>Revenue</b>	736,815	740,136	(3,321)	724,773	1,482,736	1,482,736
3,741	3,144	597	<i>Crown</i>	22,328	19,915	2,413	19,046	38,662	38,662
<b>127,639</b>	<b>126,298</b>	<b>1,341</b>	<b>Total Revenue</b>	<b>759,143</b>	<b>760,051</b>	<b>(908)</b>	<b>743,819</b>	<b>1,521,398</b>	<b>1,521,398</b>
47,842	47,411	(431)	<b>Expenses</b>	277,131	278,817	1,686	269,797	560,813	557,441
1,346	670	(676)	<i>Personnel</i>	8,816	3,979	(4,837)	7,060	7,981	17,655
4,165	4,605	440	<i>O/S Personnel</i>	26,723	27,454	731	25,278	55,132	53,670
54,561	55,053	492	<i>O/S services</i>	324,564	330,325	5,761	322,787	660,644	651,294
8,690	8,161	(529)	<i>Funder Provider payments</i>	54,925	53,051	(1,874)	53,357	106,408	110,156
5,956	5,492	(464)	<i>Clinical Sup.</i>	32,845	33,530	685	34,303	67,589	66,219
<b>122,560</b>	<b>121,392</b>	<b>(1,168)</b>	<b>Operating Exp</b>	<b>725,004</b>	<b>727,156</b>	<b>2,152</b>	<b>712,582</b>	<b>1,458,567</b>	<b>1,456,435</b>
5,079	4,906	173	<b>Surplus after operating Exp.</b>	34,139	32,895	1,244	31,237	62,831	64,963
2,622	2,731	109	<i>Depn.</i>	16,147	16,379	232	16,578	32,757	32,293
1,059	1,226	167	<i>Interest</i>	6,286	6,582	296	6,428	13,164	12,572
1,609	1,178	(431)	<i>Capital Chg.</i>	8,734	7,140	(1,594)	7,513	14,208	17,396
-	-	-	<i>Gain on Sale</i>	-	-	-	-	-	-
<b>(211)</b>	<b>(229)</b>	<b>18</b>	<b>Net Surplus</b>	<b>2,972</b>	<b>2,794</b>	<b>178</b>	<b>718</b>	<b>2,702</b>	<b>2,702</b>

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

**Monthly Result (not cumulative)**



Both the months and YTDs actual operating position result look satisfactory but are actually in a negative position given that there is additional revenue to cover the Capital Charge negative variance (month \$431k YTD \$1,594k) and Interest received (month \$165k YTD \$1,241k) thereby giving the true Operating position as negative variance for the month of \$(423)k and YTD of \$(1,591)k which is putting considerable pressure on the hospital arm in particular, offset fortuitously by lower depreciation. The capital charge variance relates primary to Revaluations.

## Revenue

Month			\$000	YTD			Full Yr.
Act	Bud	Var.		Act	Bud	Var.	Bud
70,997	69,125	1,872	Provider	421,606	417,006	4,600	832,606
119,009	119,106	(97)	Funder	710,761	714,636	(3,875)	1,431,972
(63,417)	(63,037)	(380)	Elimination	(379,573)	(378,218)	(1,355)	(756,435)
1,050	1,104	(54)	Governance	6,349	6,627	(278)	13,255
<b>127,639</b>	<b>126,298</b>	<b>1,341</b>	<b>Total</b>	<b>759,143</b>	<b>760,051</b>	<b>(908)</b>	<b>1,521,398</b>

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

- **Government Revenue:** MoH revenue compensation for capital cost increase (offset by capital cost); ACC arrears initiative.
  - **Patient/Consumer Sourced:** Non-resident additional billings (offset by bad debts); No Tahitian burns presentations in Dec.
  - **Other Income:** Interest received \$166k; Donation revenue shortfall \$(68)k reflects budget phasing variance due to timing of claims. A review of outstanding projects/claims is currently underway. Other \$(8)k.
  - **Funder Payments:** Internal transfers for contracts outside base funding. ie: 20k days and localities.
- Note that revenue includes additional unbudgeted project revenue (offset by cost) of \$154k, of which \$78k is new revenue to CMH

**Eliminations:** Internal transfers for contracts outside base funding.

## Staff Costs (including Outsourced)

Month			\$000	YTD			Full Yr.
Act	Bud	Var.		Act	Bud	Var.	Bud
48,375	47,317	(1,058)	Provider	281,115	278,212	(2,903)	559,626
813	764	(49)	Governance	4,832	4,584	(248)	9,168
<b>49,188</b>	<b>48,081</b>	<b>(1,107)</b>	<b>Total</b>	<b>285,947</b>	<b>282,796</b>	<b>(3,151)</b>	<b>568,794</b>

15,062	14,990	(72)	Medical	87,441	88,573	1,132	179,090
502	371	(131)	Outsourced	4,363	2,226	(2,137)	4,452
15,564	15,361	(203)	<b>Total</b>	91,804	90,799	(1,005)	183,542
17,847	17,483	(364)	Nursing	103,253	102,884	(369)	207,204
317	46	(271)	Outsourced	1,684	274	(1,410)	550
18,164	17,529	(635)	<b>Total</b>	104,937	103,158	(1,779)	207,754
6,696	7,020	324	Allied Health	39,299	40,854	1,555	81,684
77	31	(46)	Outsourced	184	189	5	380
6,773	7,051	278	<b>Total</b>	39,483	41,043	1,560	82,064
2,282	2,094	(188)	Support Personnel	12,990	12,144	(846)	24,086
40	27	(13)	Outsourced	232	162	(70)	324
2,322	2,121	(201)	<b>Total</b>	13,222	12,306	(916)	24,410
5,955	5,824	(131)	Management	34,148	34,362	214	68,749

			Admin				
410	195	(215)	Outsourced	2,353	1,128	(1,225)	2,275
6,365	6,019	(346)	<b>Total</b>	36,501	35,490	(1,011)	71,024
47,842	47,411	(431)	<b>Internal</b>	277,131	278,817	1,686	560,813
1,346	670	(676)	<b>Outsourced</b>	8,816	3,979	(4,837)	7,981
<b>49,188</b>	<b>48,081</b>	<b>(1,107)</b>	<b>Total</b>	<b>285,947</b>	<b>282,796</b>	<b>(3,151)</b>	<b>568,794</b>

**Internal:** Unfavourable for the month reflecting a provision for medical staff long service leave and higher clinical demand in cleaning and orderly services (discharge lounge, ICU, SAU). A high uptake of annual leave taken during December was largely offset by penal rates and overtime paid to cover shifts. A level of vacancies exist across the organisation in all personnel categories (mainly nursing) that are partially covered by bureau, overtime and casual staff.

Note that the Personnel cost variance above includes costs incurred in delivering additional unbudgeted Provider revenue of \$125k, 25FTE

**External:** Outsourcing to cover key vacancies.

### Outsourced Services

Month			\$000	YTD			Full Yr.
Act	Bud	Var.		Act	Bud	Var.	Bud
2,464	2,916	452	Corporate & Funder Services	15,981	17,499	1,518	28,296
1,701	1,689	(12)	Clinical Service	10,742	9,955	(787)	18,864
<b>4,165</b>	<b>4,605</b>	<b>440</b>	<b>Total</b>	<b>26,723</b>	<b>27,454</b>	<b>731</b>	<b>55,267</b>

**Provider** To meet MoH targets (e.g. gastro, renal, MRI); partly offset by personnel costs and savings in other expenses (hA).

Note that the Outsourced cost variance above includes costs incurred in delivering additional unbudgeted revenue.

### Independent Service Provider (Demand driven expenditure)

Month			Major Categories	\$000	YTD			Full Yr.
Act	Bud	Var.			Act	Bud	Var.	Bud
			<b>Personal Health</b>					
20,994	20,991	(3)	IDF Personal Health	124,224	125,946	1,722	251,892	
8,388	8,547	159	Pharmaceuticals	51,499	51,282	(217)	102,564	
7,951	7,100	(851)	Primary Practice Services – Capitated	44,253	42,600	(1,653)	85,200	
547	579	32	Child and Youth	2,816	3,474	658	6,948	
475	470	(5)	Adolescent Dental Benefit	2,811	2,820	9	5,640	
714	739	25	Chronic Disease Management and Education	4,404	4,434	30	8,868	
478	363	(115)	Palliative Care	2,878	2,178	(700)	4,356	
276	258	(18)	General Medical Subsidy	1,549	1,548	(1)	3,096	
458	1,128	670	Other	2,811	6,772	3,961	13,537	
<b>40,281</b>	<b>40,175</b>	<b>(106)</b>	<b>Total Personal Health</b>	<b>237,245</b>	<b>241,054</b>	<b>3,809</b>	<b>482,101</b>	

**Mental Health**

1,280	1,281	1	<i>IDF Mental Health</i>	7,685	7,686	1	15,372
813	777	(36)	<i>Community Residential Beds &amp; Services</i>	5,008	4,662	(346)	9,324
708	720	12	<i>Other Home Based Residential Support</i>	4,274	4,320	46	8,640
344	322	(22)	<i>Alcohol &amp; Other Drugs</i>	2,047	1,932	(115)	3,864
283	273	(10)	<i>Crisis Respite</i>	1,657	1,638	(19)	3,276
326	358	32	<i>Child &amp; Youth</i>	2,134	2,148	14	4,296
174	165	(9)	<i>Kaupapa Maori Community</i>	1,055	990	(65)	1,980
164	170	6	<i>Community Service</i>	980	1,020	40	2,040
621	1,437	816	<i>Other</i>	5,346	8,622	3,276	17,244
4,713	5,503	790	<b>Total Mental Health</b>	30,186	33,018	2,832	66,036

Overall a slow start to this year's ring fence additional funding thus the month and YTD underspend against budget.

			<b>Disability Support Services</b>				
4,401	4,130	(271)	<i>Residential Care: Hospitals</i>	26,204	24,783	(1,421)	49,567
1,755	1,809	54	<i>Residential Care: Rest Homes</i>	10,968	10,854	(114)	21,708
1,500	1,665	165	<i>Home Support</i>	9,659	9,990	331	19,980
1,736	1,573	(163)	<i>Other</i>	9,466	9,438	(28)	18,876
9,392	9,177	(215)	<b>Total Disability Support Services</b>	56,297	55,065	(1,232)	110,131

The month saw the underspend dry up and increased spending for new beds and new facilities. Pressure in the private hospital care.

137	159	22	<b>Total Public Health</b>	607	954	347	1,908
38	39	1	<b>Total Maori Health</b>	229	234	5	468
54,561	55,053	492	<b>Funder</b>	324,564	330,325	5,761	660,644

### Clinical Supplies

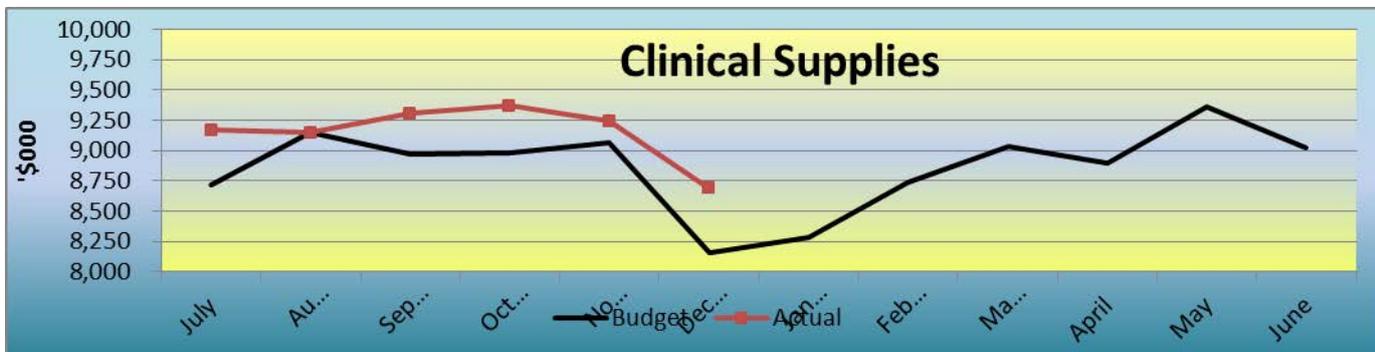
Month			\$000	YTD			Full Yr.
Act	Bud	Var.		Act	Bud	Var.	Bud
3,583	3,292	(291)	Treatment Disposables	22,088	21,299	(789)	42,825
791	685	(106)	Diagnostic Supplies & Other Clinical Supplies	5,080	4,191	(889)	8,403
1,187	1,060	(127)	Instruments & Equipment	7,142	6,917	(225)	13,910
268	269	1	Patient Appliances	1,867	1,799	(68)	3,629
1,155	1,191	36	Implants & Prostheses	8,505	8,461	(44)	17,156
1,422	1,343	(79)	Pharmaceuticals	8,334	8,434	100	16,588
284	321	37	Other Clinical Supplies	1,909	1,950	41	3,897
8,690	8,161	(529)	<b>Total</b>	54,925	53,051	(1,874)	106,408

### Provider

- Clinical Supplies:** unfavourable for the month.

*Clinical Support:* Blood products variance is driven by haematology, surgical, renal and burns patients, radiology stock up, savings not achieved, testing kit costs increases were driven by a 1% increase in volume and Xmas period stock up; other diagnostic cost increases in reagents, catheters and other diagnostic supplies; Drug overspend driven by demand across the organisation.

*Surgical.* Overspend driven by increased outputs compared with the December phasing and stocking of items due to the closure of suppliers for the Christmas and New Year holiday period.



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

Month			\$000	YTD			Full Yr.
Act	Bud	Var.		Act	Bud	Var.	Bud
5,808	5,228	(580)	Provider	31,144	31,942	798	62,749
148	264	116	Governance	1,701	1,588	(113)	265
5,956	5,492	(464)	<b>Total</b>	32,845	33,530	685	63,014

- Other expenses:** unfavourable for December explained by bad debts (offset by non-resident income); DHS unbudgeted initiatives: contribution to "Doctors as Leaders" programme and discharge lounge development.



### Interest and Capital Charge

Month			\$000	YTD			Full Yr.
Act	Bud	Var.		Act	Bud	Var.	Bud
<b>307</b>	<b>142</b>	<b>165</b>	<i>Interest - Received</i>	2,093	<b>852</b>	<b>1,241</b>	<b>1,699</b>
1,059	1,226	167	<i>Interest Paid - Debt</i>	6,286	6,582	296	14,712
<b>752</b>	<b>1,084</b>	<b>332</b>	<i>Net Interest Paid</i>	<b>4,193</b>	<b>5,730</b>	<b>1,537</b>	<b>13,013</b>
1,609	1,178	(431)	<i>Capital Charge</i>	8,734	7,140	(1,594)	14,136

- **Interest cost:** Interest received; **better** cash position.
- **Capital Charge:** unfavourable variance reflects the actual cost of capital charged by MoH (increase in the revaluation of land) against budget matched against additional revenue. Timing of top up payments expected but not confirmed until March.

### Ratios

#### Provider Arm (only)

Costs to Revenue (%) last six months

	Dec 15	Nov 15	Oct 15	Sep 15	Aug 15	July 15	Jun 15
<i>Medical</i>	21.18	20.58	21.13	20.38	19.93	21.01	24.02
<i>Nursing</i>	25.09	23.70	24.97	24.29	24.52	24.06	24.29
<i>Allied</i>	9.43	8.95	9.31	9.23	9.42	9.58	8.53
<i>Support</i>	3.21	2.96	3.12	3.05	3.04	3.09	2.92
<i>Management</i>	7.33	6.96	6.91	7.01	6.86	7.18	6.97
<b>Personnel</b>	<b>66.24</b>	<b>63.16</b>	<b>65.44</b>	<b>63.95</b>	<b>63.78</b>	<b>64.93</b>	<b>66.74</b>
<i>Outsourced Pers.</i>	1.90	2.24	1.93	2.52	2.22	1.71	2.61
<b>Total Personnel</b>	<b>68.14</b>	<b>65.39</b>	<b>67.37</b>	<b>66.47</b>	<b>66.00</b>	<b>66.64</b>	<b>69.35</b>
<i>Outsourced Clinical Services</i>	2.40	2.94	3.25	2.44	2.36	1.89	2.79
<i>Outsourced Corp (hA)</i>	3.37	3.97	3.82	3.35	4.01	3.87	3.90
<i>Clinical Supplies</i>	13.38	14.18	14.60	14.60	14.46	14.38	18.53
<i>Infrastructure</i>	14.49	14.04	13.22	13.43	12.93	12.99	6.12
<b>Total</b>	<b>101.77</b>	<b>100.52</b>	<b>102.26</b>	<b>100.29</b>	<b>99.75</b>	<b>99.77</b>	<b>100.68</b>

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

	<b>2016</b>	<b>2015</b>	<b>2014</b>	<b>2013</b>	<b>2012</b>
<i>Medical</i>	20.7	20.9	20.7	21.2	20.5
<i>Nursing</i>	24.4	24.8	25.1	25.5	24.7
<i>Allied Health</i>	9.3	9.3	9.7	9.7	9.5
<i>Support</i>	3.1	3.0	2.9	2.7	2.7
<i>Man/Admin</i>	7.0	6.9	6.8	7.2	7.8
<i>Personnel</i>	<b>64.6</b>	<b>65.0</b>	<b>65.2</b>	<b>66.3</b>	<b>65.2</b>
<i>Outsourced Personnel</i>	2.1	2.0	1.8	1.8	1.7
<b><i>Total Personnel</i></b>	<b>66.7</b>	<b>67.0</b>	<b>67.0</b>	<b>68.1</b>	<b>66.9</b>
<i>Outsourced Clinical Supplies</i>	2.5	2.5	2.7	2.9	2.8
<i>Outsourced Corporate</i>	3.7	3.7	3.7	3.4	3.3
<i>Clinical supplies</i>	14.3	14.4	14.0	14.4	14.7
<i>Infrastructure</i>	13.5	13.2	13.0	12.4	13.2
<b><i>Total</i></b>	<b>100.7</b>	<b>100.8</b>	<b>100.4</b>	<b>101.2</b>	<b>100.9</b>
<i>Depn</i>	3.8	3.6	3.8	3.1	2.8
<i>Interest</i>	1.5	1.5	1.1	1.5	1.3
<i>Capital Charge</i>	2.1	1.8	1.7	1.7	1.7

**Balance Sheet**

		Actual	Budget	Variance	Opening 1 <sup>st</sup> July 15	YTD Movement
<b>Current Assets</b>						
	Petty Cash	10	10	-	10	-
	Bank	177,436	28,841	148,595	55,246	122,190
	Trust	893	892	1	886	7
	Prepayments	968	752	216	945	23
	Debtors	40,834	50,074	(9,240)	45,074	(4,240)
	Inventory	2,127	1,320	807	1,320	807
	Assets Held for Sale	12,503	12,503	-	12,503	-
	<b>Total current Assets</b>	<b>234,771</b>	<b>94,392</b>	<b>140,379</b>	<b>115,984</b>	<b>118,787</b>
<b>Fixed Assets</b>						
	Land	144,683	144,683	-	144,683	-
	Buildings & Plant	654,107	652,846	1,261	625,018	29,089
	Investment Property	1,449	1,449	-	1,449	-
	Information Technology	5,406	5,392	14	5,332	74
	Information Software	5,215	5,314	(99)	5,008	207
	Motor Vehicles	4,291	4,417	(126)	4,291	-
	<b>Total Cost</b>	<b>815,151</b>	<b>814,101</b>	<b>1,050</b>	<b>785,781</b>	<b>29,370</b>
	Accum. Depreciation	(197,613)	(172,064)	(25,549)	(155,685)	(41,928)
	<b>Net Cost</b>	<b>617,538</b>	<b>642,037</b>	<b>(24,499)</b>	<b>630,096</b>	<b>(12,558)</b>
	Work In-progress	15,710	5,234	10,476	5,234	10,476
	<b>Total Fixed Assets</b>	<b>633,248</b>	<b>647,271</b>	<b>(14,023)</b>	<b>635,330</b>	<b>(2,082)</b>
	<b>Investments (hA IT / HBL)</b>	<b>31,998</b>	<b>35,090</b>	<b>(3,092)</b>	<b>29,390</b>	<b>2,608</b>
	<b>Total Assets</b>	<b>900,017</b>	<b>776,753</b>	<b>123,264</b>	<b>780,704</b>	<b>119,313</b>
<b>Current Liabilities</b>						
	Creditors	76,596	89,115	(12,519)	92,005	(15,409)
	Income in Advance	131,297	-	131,297	1,920	129,377
	GST and PAYE	23,117	15,442	7,675	12,929	10,188
	Loans (short term less than one year)	-	-	-	-	-
	Payroll Accrual & Clearing	28,778	32,393	(3,615)	36,861	(8,083)
	Employee Provisions	85,439	85,235	204	85,225	214
	<b>Total Current Liabilities</b>	<b>345,227</b>	<b>222,185</b>	<b>123,042</b>	<b>228,940</b>	<b>116,287</b>
	<b>Working Capital</b>	<b>(110,456)</b>	<b>(127,793)</b>	<b>17,337</b>	<b>(112,956)</b>	<b>2,500</b>
	<b>Net Funds Employed</b>	<b>\$554,790</b>	<b>\$554,568</b>	<b>\$222</b>	<b>\$551,764</b>	<b>\$3,026</b>
<b>Non-Current Liabilities</b>						
	Term Loans	292,500	292,500	-	292,500	-
	Employee Provisions (non-current)	20,183	20,283	(100)	20,283	(100)
	Trust and Special Funds	884	892	(8)	882	2
	Insurance Liability- Non Current	1,489	1,337	152	1,337	152
	<b>Total Non-Current Liabilities</b>	<b>315,056</b>	<b>315,012</b>	<b>44</b>	<b>315,002</b>	<b>54</b>
<b>Crown Equity</b>						
	Crown Equity	124,078	124,078	-	124,078	-
	Revaluation Reserve	173,729	173,729	-	173,729	-
	Retained Earnings	(58,073)	(58,251)	178	(61,045)	2,972
	<b>Total Crown Equity</b>	<b>239,734</b>	<b>239,556</b>	<b>178</b>	<b>236,762</b>	<b>2,972</b>
	<b>Net Funds Employed</b>	<b>\$554,790</b>	<b>\$554,568</b>	<b>\$222</b>	<b>\$551,764</b>	<b>\$3,026</b>

**Commentary:**

**Net borrowings:** Long and short term debt less bank balance better than budget by \$148.6m due to receiving January's MOH funding on the 31 December.

**Debtors:** \$9.3m lower than budget, \$4.2m lower than June 15, due to payments received mainly for Crown organisations (ACC and Pharmac).

<b>MOH Debtors \$000</b>	<b>Total</b>	<b>Current</b>	<b>30 day +</b>
Invoiced	7,148	3,570	3,578
Accrued	500		
<b>Total</b>	<b>7,648</b>		
<i>Last month</i>	<i>6,936</i>		

**Accounts payable:** \$12.5m lower than budget and \$15.4m lower than June 2015.

**Net Fixed Assets:** Are \$14.0m lower than budget (timing of capital spends).

**Investments in Associates:**

Health Benefits Ltd      \$ 5.8m for the FPSC project

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

healthAlliance      \$25.2m 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
<b>Cash flows from operating activities:</b>						
Crown Revenue	250,646	123,297	127,349	869,879	734,028	135,851
Other	3,434	2,859	575	20,235	18,251	1,984
Interest rec.	307	142	165	2,093	852	1,241
Expenses						
Suppliers	71,703	73,580	1,877	452,760	445,719	(7,041)
Employees	54,109	47,411	(6,698)	285,100	284,807	(293)
Interest paid	1,059	1,226	167	6,286	7,356	1,070
Capital charge	9,193	7,644	(1,549)	9,193	7,644	(1,549)
<b>Net cash from Operations</b>	<b>118,323</b>	<b>(3,563)</b>	<b>121,886</b>	<b>138,868</b>	<b>7,605</b>	<b>131,263</b>
Fixed Assets	(1,850)	(4,320)	2,470	(14,065)	(28,320)	14,255
Sale of Asset						
Investments (hA & HBL)	-	(948)	948	(2,608)	(5,691)	3,083
Restricted & Trust Funds	(1)	(1)	-	2	1	1
<b>Net cash from Investing</b>	<b>(1,851)</b>	<b>(5,269)</b>	<b>3,418</b>	<b>(16,671)</b>	<b>(34,010)</b>	<b>17,339</b>
Debt	-	-	-	-	-	-
Other non-current liability	-	-	-	-	-	-
<b>Net cash from Financing</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Net increase / (decrease)</b>	<b>116,472</b>	<b>(8,832)</b>	<b>125,304</b>	<b>122,197</b>	<b>(26,405)</b>	<b>148,602</b>
Opening cash	56,684	38,575	18,109	56,142	56,148	(6)
<b>Closing cash</b>	<b>173,156</b>	<b>29,743</b>	<b>143,413</b>	<b>178,339</b>	<b>29,743</b>	<b>148,596</b>

Summary	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
<b>Opening cash</b>	61,867	38,575	23,292	56,142	56,148	(6)
Operating	118,323	(3,563)	121,886	138,868	7,605	131,263
Investing	(1,851)	(5,269)	3,418	(16,671)	(34,010)	17,339
Financing	-	-	-	-	-	-
<b>Closing cash</b>	<b>178,339</b>	<b>29,743</b>	<b>148,596</b>	<b>178,339</b>	<b>29,743</b>	<b>148,596</b>

### Commentary:

Funding: All DHB's received funding for January 2016 (\$125m) on the last day of December. Therefore December saw two monthly funding deposits in the month.

Employees: December had five pay weeks in it, the budget is set on a 1/12 basis.

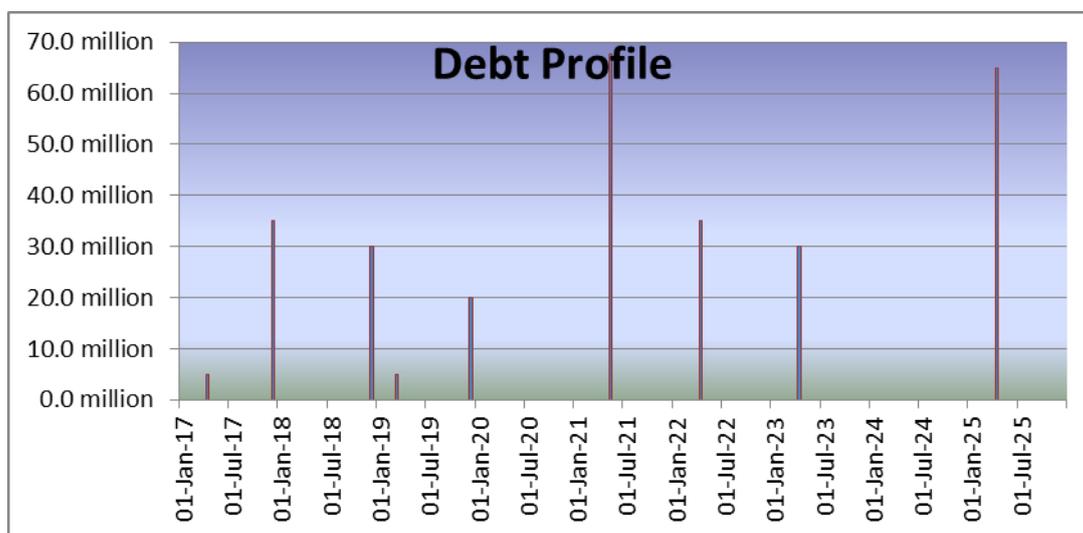
Capital Charge: Top up payments expected but timing not confirmed.

### Treasury

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

### Crown Debt

Drawn (\$ millions)	Date of Advance	Maturity	Interest rate	Rate
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
<b>\$292.5</b>			<b>4.26%</b>	<b>Weighted Average</b>



## FTE Reporting Provider Arm

FTE By Professional Group December 2015	Month				Year to Date		
	Actual	Budget	Variance	Comparative	Actual	Budget	Variance
	FTE	FTE	FTE	Variance to Prev Mnth	FTE	FTE	FTE
Medical Personnel	804	803	(1) U	↓	776	807	30 F
Nursing Personnel	2,626	2,583	(43) U	↑	2,623	2,601	(22) U
Allied Health Personnel	1,082	1,147	65 F	↑	1,093	1,136	43 F
Support Personnel	488	485	(3) U	↑	499	488	(11) U
Management/Administration Personnel	789	833	44 F	↑	800	834	34 F
<b>Total (before Outsourced Personnel)</b>	<b>5,788</b>	<b>5,850</b>	<b>62 F</b>	<b>↑</b>	<b>5,791</b>	<b>5,864</b>	<b>74 F</b>
Outsourced Medical	18	13	(5) U	↑	32	16	(15) U
Outsourced Nursing	28	4	(24) U	↑	30	5	(25) U
Outsourced Allied Health	6	2	(4) U	↓	3	3	0 F
Outsourced Support	8	5	(3) U	↓	8	6	(2) U
Outsourced Mangement/Admin	50	42	(9) U	↑	58	49	(9) U
<b>Total Outsourced Personnel</b>	<b>110</b>	<b>67</b>	<b>(43) U</b>	<b>↑</b>	<b>130</b>	<b>79</b>	<b>(51) U</b>
<b>Total Personnel</b>	<b>5,898</b>	<b>5,917</b>	<b>18 F</b>	<b>↑</b>	<b>5,921</b>	<b>5,944</b>	<b>23 F</b>

Total FTE (including outsourced) for December is 5,898FTE which is 18FTE favourable to budget.

Major variances as follows:

- Vacancies net of overtime, internal bureau, outsourced FTE and casual FTE are 54FTE
- Funded projects (not in budget) (22)FTE – localities and 20k days projects (ie: cancer care, breast feeding advocates, KF Gateway project etc).
- Net annual leave and other leave 100FTE – annual leave taken higher than budget.
- Unplanned and study leave (40)FTE requiring cover.
- Other (19)FTE – includes nursing orientation, ACC, stat days and budget phasing.

## Personnel Costs per FTE

(Rolling average)

	Dec 15	Nov 15	Oct 15	Sep 15	Aug 15	Jul 15
Medical	181,921	180,393	178,904	178,191	176,847	176,471
Nursing	78,273	78,249	78,118	78,312	78,274	78,135
Allied Health	70,950	70,907	70,888	71,025	71,066	70,963
Mgmt/Admin/Clerical	73,718	73,390	72,965	73,132	74,966	74,649
Support	51,742	51,618	51,413	51,599	51,442	51,368

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

Counties Manukau	Dec 15	Nov 15	Oct 15	Sept 15	Aug 15	Jul 15
Accrued FTE (as per MOH template)	847.0	870.5	849.1	874.1	888.0	856.7
Annual Leave loading	(77.0)	(77.0)	(76.2)	(76.9)	(76.9)	(76.5)
FTE's on holiday	85.5	62.0	73.2	44.9	43.8	69.3
Payroll FTE's	855.5	855.5	846.1	843.1	854.9	849.5
Contractors / Consultants (FTE equivalent)	10.0	10.0	10.0	10.0	10.0	10.0
Vacancy	2.0	2.0	11.3	14.4	2.6	8.0
Total	867.5	867.5	867.5	867.5	867.5	867.5
Number submitted Jan 09 for 31 Dec 08	867.5	867.5	867.5	867.5	867.5	867.5
Variance	-	-	-	-	-	-

## 7.0 Ko Awatea

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

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

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

Key themes of this transformation work currently include:

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

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

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

This month we would like to focus on the Enhanced Recovery After Surgery (ERAS) Implementation Programme.

### Background

From June 2012 until July 2013, New Zealand's Ministry of Health sought the expertise of Ko Awatea to lead a national collaborative in the management and implementation of an enhanced recovery after surgery (ERAS) programme, focusing on patients undergoing total joint replacements for hips and knees.

The adoption of the Ko Awatea led improvement principles for ERAS has proven to reduce variation in outcomes across patients, while also improving outcomes on a national basis. It delivers this by ensuring patients receive evidence based, protocol driven care in every instance of care. It has also proven to reduce length of hospital stay, waste in the form of cancelled operations and associated cost savings.

Counties Manukau Health, Ko Awatea and Surgical Services have continued to invest and develop significant expertise in the delivery and implementation of ERAS both at local and national levels. Colorectal surgery has long had an ERAS programme. Opportunities exist to extend this reach into acute and elective General Surgery and strengthen in Orthopaedics, to benchmark our data and move to advanced visualisation, analysis and dashboard tools.

### **The future**

The ERAS Society is a not for profit academic society, officially registered in Sweden in 2010, but with a history dating back to 2001. The ERAS Society works with partners to fulfil its mission of developing science and education but also to implement best practice in surgical care worldwide.

Encare was established in 2009 to implement ERAS protocols on a global basis by providing training to healthcare professionals on the ERAS protocols, and develop an interactive web-based information system for evidence based - best practice management (EBM). Encare has the rights to commercialise surgical protocols developed by the ERAS Society. The company has so far rolled out the audit system to more than 60 hospitals in Canada, France, Norway, Poland, Sweden, South Africa, Switzerland, United Kingdom and United States.

Counties Manukau Health, through Ko Awatea, have entered into a formal commercial partnership with worldwide leaders in ERAS, the ERAS Society and Encare, to achieve both clinical excellence in perioperative care for Counties Manukau Health and to maximise commercial opportunities to sell ERAS products in the Asia Pacific region.

The agreement provides CM Health and Ko Awatea with:

1. ERAS Centre of Excellence status (by April 2016), enabling Ko Awatea and CM Health to be recognised as an international best practice site.
2. Consultancy status, affording Ko Awatea the ability to act as an agent to coach, train and implement the ERAS programme into health systems within Asia/Pacific region. An intensive workshop is currently being planned to be presented at the APAC Forum 2016 in Sydney.
3. An Encare licence to become a national chapter, allowing Ko Awatea to convene and lead the first Chapter meeting, showcasing CM Health best practice and building national and international capability. It is hoped that this Chapter meeting will be held at APAC Forum 2016.
4. A heavily subsidised annual membership subscription to Encare.

This agreement allows Ko Awatea to scale and spread ERAS protocols across surgical services and improve clinical outcomes for patients in Counties Manukau Health and throughout the Asia Pacific region.

Robust data analysis allows international benchmarking and global learning from other perioperative sites within the Society.

Becoming an ERAS centre of excellence raises Counties Manukau Health and Ko Awatea's profile, affording the opportunity to develop a strong commercial model of ERAS products, grow a community of sites in the Asia Pacific region and scale and spread Ko Awatea's products, programmes and services in system innovation and improvement.

## 8.0 Health & Safety

Activities for the period ending 31 December 2015 continued to progress as outlined in the health and safety action plan and are up-to-date. The plan continues to focus on improvement activities outlined in the Health and Safety Management Framework. The emphasis is placed on moving the focus from a compliance to 'best practice' management approach with a shift to leadership engagement and business value add, which is the aim.

An 'Executive Health and Safety Audit' was introduced with David Collings, Board Member, undertaking the first audit cycle in the Scott Dialysis Unit and the Assessment Labour and Birthing Unit. These audits will be undertaken quarterly and supports the engagement of officers and senior managers' engagement as outlined by the new health and safety legislative requirements.

All critical issues identified during the 2014 Hazardous Substance Audit are on track to be resolved by January 2016. A Hazardous Substance Management Advisor will begin to work with the Facilities Service on February 2016. This marks a strategic shift in our approach to addressing the management of hazardous substances and is aligned with the new health and safety legislative requirements.

As requested by the Chair, a visit was undertaken to Unitec to gain understanding of their use of QR Codes. The health and safety team will continue to investigate this option with Building Capability as an e-learning module.

The organisational health and safety performance indicated a decrease in the number of injury claims from the last quarter from 79 to 58 for this quarter. The severity rate indicating injury severity also decreased which resulted in a reduction in lost time and claims costs. Musculoskeletal injuries was the primary cause of claims for this period.

Six injuries fulfilled the criteria defined in the health and safety legislation and required external notification to WorkSafe NZ. No further significant activity was required due to these notifications.

A Wellbeing Strategy is being scoped to align with the new occupational health requirements as defined by the health and safety legislation, but also to reflect the new organisational values and is being undertaken, in partnership with Human Resources.

The management of Occupational Health and Safety continues to be a progressive process which continues to mature as we aim to move from a compliance focus, to making a tangible difference.

The following papers (Appendix 3) will be presented at the Board Meeting:

- Health & Safety Quarterly Report
- Health & Safety History & Current Approach at CMDHB
- Presentation from Meredith Connell

# Healthy Together 2020 Delivery

*The big picture of what change will look like and how we will make it happen*



## **Contents**

<i>Introduction</i>	<i>03</i>
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# INTRODUCTION

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## 1. Strategy Context

Today, health care in Counties Manukau is at a critical crossroads. We are delivering more care and a broader range of healthcare services than ever before. Our population and their healthcare needs are growing faster than the rate of growth in funding and available resources to meet those needs.

Our challenge is to systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality. To meet those challenges, CM Health has made strategic decisions over the past 8 years that have charted our course for transformation and system integration as the way that we will best respond to those needs.

In July 2015, the Counties Manukau District Health Board signed off a new strategy for Counties Manukau Health (CM Health) “Healthy Together” that commits to the strategic goal:



# Healthy Together

*“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.”*

At the same time, CM Health also refreshed the organisation’s values that we aspire to live and breathe every day.



**Valuing everyone** – we make everyone feel welcome and valued

**Kind** - we care for other people’s wellbeing

**Together** – we include everyone as part of a team

**Excellent** - we are safe, professional and always improving

This document describes the delivery pathway for how we will build on the past 8 years of investment to accelerate transformation and achieve ‘Healthy Together’ by 2020. This document focuses on the enabling strategies that, when aligned, will accelerate transformation and integration.

**Our population in Counties Manukau is growing and changing, both youthful and ageing and with increasing ethnic diversity.** 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 and a high proportion of them living in poverty. Just over a third of our population live in areas of high socioeconomic deprivation; if the situation continues at current levels this could be as many as 202,150 people in Counties Manukau in 2020.

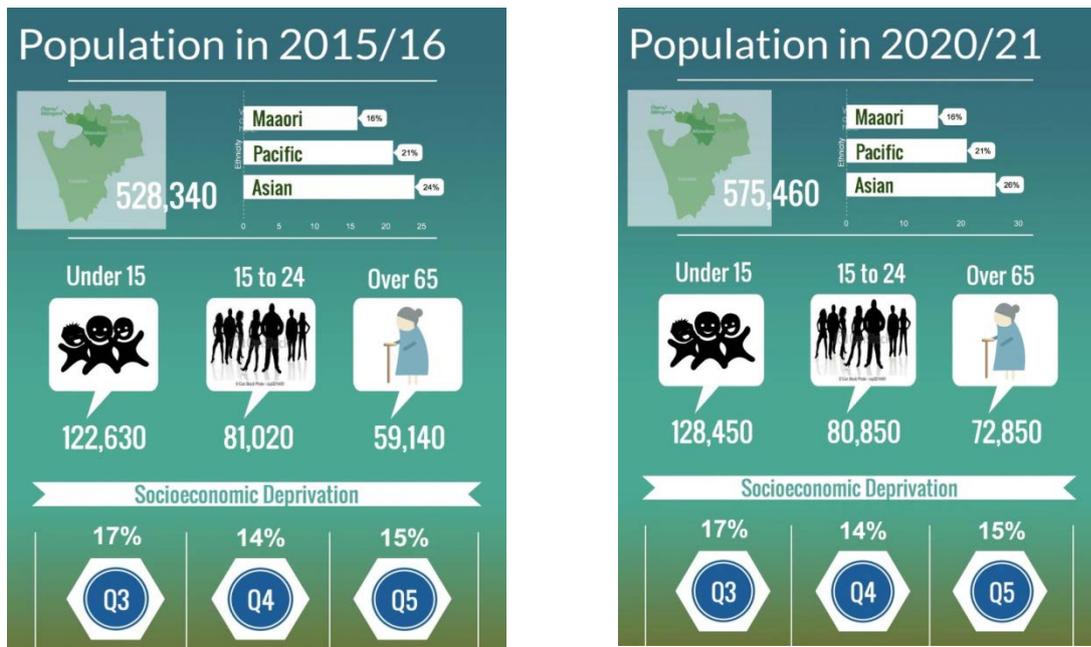


Figure 1: Population changes 2015/16 to 2020/21

## 2. Firm Foundations to go from the “Best in Australasia” to “Healthy Together”

Triple Aim has been at the heart of CM Health’s organisation strategic direction. CM Health’s Strategic Goal has been the ‘Best Healthcare System in Australasia by December 2015’ this has been independently evaluated by the University of Otago and will be reported to the Counties Manukau District Health Board in March 2016.

The Triple Aim Strategic Framework



Aims to achieve:

- Improved health and equity for all populations
- Improved quality, safety and experience of care
- Best value for public health system resources

The Triple Aim was translated into action in 2012 through 6 Executable Strategies together called Achieving a Balance which began the system transformation. By 2015 effective implementation of these strategies has laid a platform to launch the next steps of our transformation journey to accelerate system. We have much to be proud of.



Figure 2: These are the 6 executable strategies

1



**Better Health Outcomes for All**

CM Health has led the country in applying innovative approaches to health promotion.

2



**First, Do No Harm** has developed a range of safety programmes across the health system which for the first time has extended out from the hospital to aged residential care services.

Implementation and expansion of the Safety in Practice collaborative with 6 PHOs and 23 General practices with a focus on bundles of care for warfarin management, test results handling, medications reconciliation and opioids management.

Other highlights include standard clinical process for treatment of extremely ill patients with over 400 Central Line Associated Bacteraemia (CLAB) CLAB free days – in one area it is now over 1000 days. We continue with excellent care for people at risk of falls and many other initiatives.

3



**Patient and Whaanau Centred Care**

Increased patient engagement in health and treatment decisions including completion of more than 2000 advanced care conversations completed and more than 200 patients and whaanau being involved in various co-design initiatives including Experience Based Design.

4



**System Integration**

**Place:** Implemented four Locality Clinical Partnerships which bring together primary care and hospital clinicians with the community to re-design the way health is delivered locally within a global budget.

**People:** We have integrated the multiple programmes, funding pools and services for people with chronic illness and related reasons for being at risk of unplanned hospital admissions into

one new, comprehensive and pro-active approach through At Risk Individuals. Now over 17,000 patients with long term conditions are benefiting from this planned and proactive approach.

*Process:* Delivered many of our services differently with new models of care. This has included making the best use of technology such as virtual clinics, tele-medicine and tele-health.

5



***Ensuring Financial Sustainability***

Over \$400million of capital has been investment to modernise Middlemore Hospital over the last 5 years, whilst maintaining financial balance and delivering an annual surplus.

We are a **high performing health system** that has consistently met all National Health Targets for the previous 2 years, achieved national patient safety measures and achieved financial targets to break even or better.



6



***Enabling High Performing People through Ko Awatea, Centre for Health System Innovation and Improvement.***

Since opening in 2011, Ko Awatea has focused on cultivating and sustaining improvement across the system. We have become a skilled and change ready organisation which uses best practice methodology. As a result, we are already demonstrating in a number of areas that we can deliver significant system change successfully.

These achievements lay a critical foundation for the next steps in our journey. An evaluation conducted by University of Otago will be completed in early 2016. This evaluation will assess independently how we have performed against our goal as measured in System Level Measures.

**CM Health has laid a strong platform to launch the next phase of our journey to accelerate integration and achieve health equity for our community.**

# TRANSFORMATIONAL CHANGE MODEL

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### 3. Our Strategic Shape – Transformation in flight



Healthy Together builds on the Triple Aim framework and translates the three objectives to be better fit for purpose for an integrated healthcare system. Delivery of Healthy Together 2020 will rely on a health and social care system that is transformed from what we have today to what we anticipate our community will need in the future. Our transformational challenge is:

*“To systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality.”*

The following sections describe more specifically what implementation will look like from the perspective of the three strategic objectives – Healthy Services, Healthy People, Whaanau and Families and Healthy Communities –what we call **“Triple Aim 2.0.”**

### 4. How we will deliver Healthy Together 2020

*“If the transformation of health and social care that is necessary to make the system fit for the future is to be realised, then we will need to challenge our thinking and the assumptions that underpin existing models of care. We will need to look with fresh eyes at radically different approaches.” Kings Fund 2012*

The following section illustrates the implementation framework that aims to accelerate transformation and momentum for integration. Healthy Together 2020 will be delivered by aligning how we frame our current provision, leveraging different leadership and change approaches supported by **multiple enabling strategies aligned to strategy**. This will be led by the Director of Healthy Together 2020, reporting directly to the Chief Executive Officer.

The following section will describe how we will successfully deploy our change management capacity to deliver Healthy Together 2020.

## 5. Transformational change deployment

The ELT at its planning on January 28th has developed the following deployment model.

### Principles

The following principles were agreed as fundamental to a successful framework

- The Strategic Refresh, Gateway Review and the historical investment in change management made through Ko Awatea, presents a unique opportunity for Counties Manukau Health.
- That the Transformational goal had to be clearly articulated, relevant and understood.
- That a best practice, but practical model for change would be used. A centralised co-ordinated directorate was required for successful delivery.
- That the programme had to be properly resourced.
- That Healthy Together 2020 became the Strategic brand, replacing most of the logos and brands currently used and potentially causing confusion. This will also help to show how our various strategies need to be integrated, rather than work in isolation.
- That leadership, whether clinical or executive, was vital at all levels.
- That engagement of the organisation is critical.

### Deployment Model

The Deployment Model is focused on three areas:

1. Three major areas of change - Population Health, Primary & integrated Care and Secondary Care.
2. Identifying the Enabling Strategies to support change.
3. Establishing a Directorate of Healthy Together 2020 delivery who will be responsible for:
  - the establishment of a Health System Transformational Programme.
  - the integration of the main areas of change with the Enabling Strategies:
  - co-ordinating delivery of the programme;
  - the Directorate will be directly accessible to the CEO and will be overseen by a Project Board comprising senior ELT members and senior clinicians.

The following diagrams illustrate this:

<b>Area</b>	Population Health	Primary & Integrated Care	Secondary Care
<b>Organisational Content</b>	Multi-Sector	Localities, Community Hubs and Networks	Institution
<b>Key design challenge</b>	Collaborate, test and spread	Design, build, scale and embed	Efficiency, delivery, consistency and improvement

It is important to note that the leadership task in each area is different.

In Population Health, successful change is dependent not only building collaboration and behavioural change, but also on identifying successful interventions.

In Primary and Integrated Care, we need to continue to build the infrastructure and networks that will provide the platform for supporting people to remain well in the community and rely less on hospital care. The success in this area will need to include services previously seen as part of Secondary Care such as outpatients, renal dialysis, diabetes and Emergency Care. These services will need to be significantly redesigned to be fit for the future and are also the first affected by the impact of SWIFT Business Cases. It is proposed that a full complement of these services will be transferred to the management of the Director of Primary Care who will have the brief for Integrated Care in future.

In the case of Secondary Care, this should focus on these services that require institutional care only. The task of Secondary Care is to remain efficient and able to continue to improve – there is a large corpus of evidence as to how to do this and Ko Awatea has ensured we have a well skilled workforce in change management.

Importantly, there are two special risks we need to be mindful of and mitigate for:

- We cannot risk delivery and cost in the hospital area. This requires clear continued focus.
- The current hospital team do not have the ‘bandwidth’ to run and redesign services outside of inpatient hospital care, hence the need to recast Integrated Care.

Consequently each area will be led by a Senior Director – Margie Apa for Population Health, Benedict Hefford for Primary Care and Phillip Balmer for Hospital Care , all working with clinical partners.

#### Healthy Together 2020 Directorate and Enabling Strategies

The role of the Healthy Together Directorate will ensure the supporting strategies that CM Health has developed will be deployed successfully in each area to deliver change. In this case, the following diagram illustrates this:

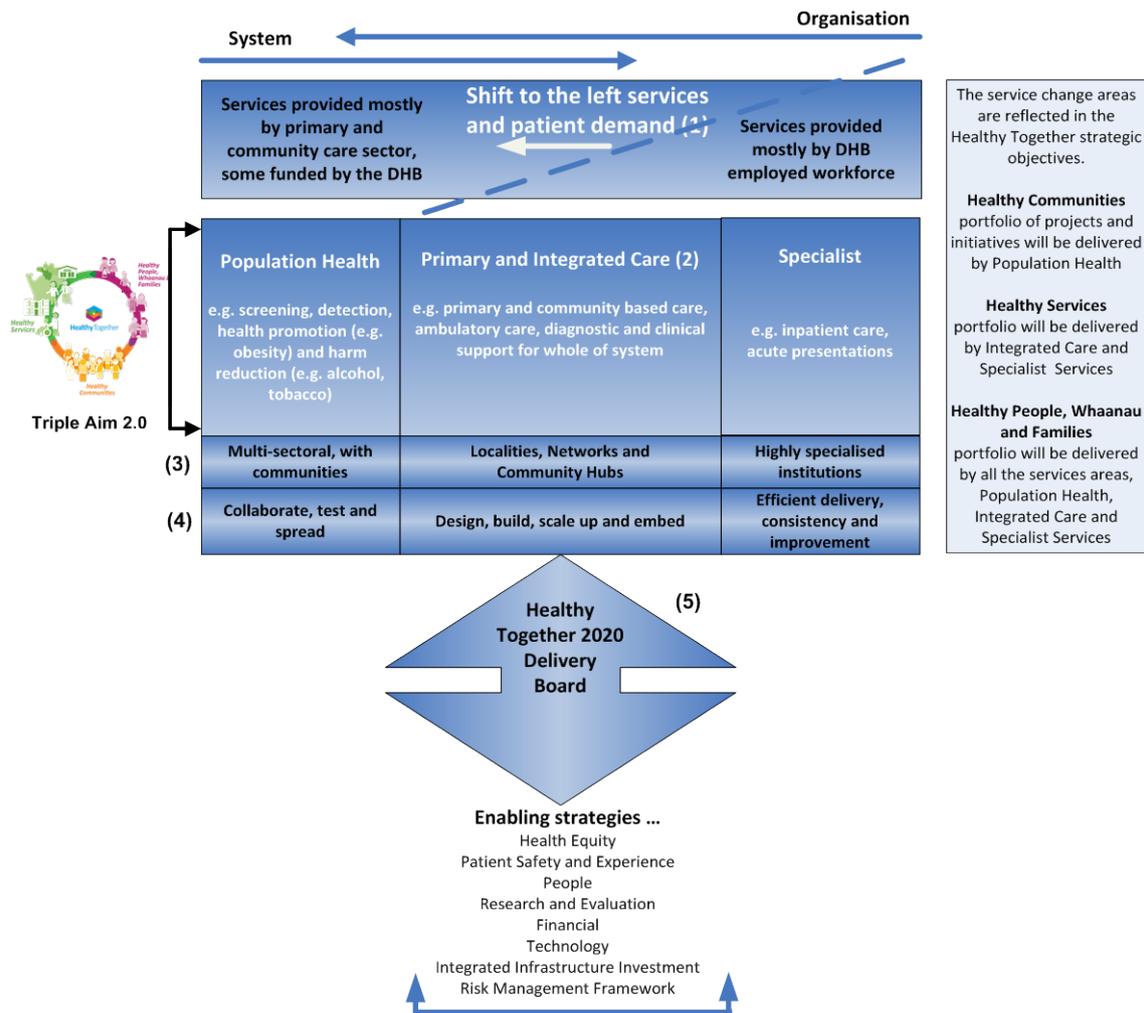


Figure 3: Transformational Change Framework for implementation

### 1. Shift to the left....

We must challenge conventional ways of thinking and hold multiple tensions in our frame:

- In some instances we need to leverage change across the healthcare system to impact the organisation (DHB employed and managed) e.g. funding integrated care in primary care settings; in others we will change things in the organisation to have a system wide impact (e.g. ARI)
- This means that the proportion of services managed by the DHB as employer and default provider will shift to a greater proportion being provided in and through primary and community based settings and providers.

**2. Expand our frame of 'integrated care' services...** to enable closer interaction with primary care teams, social care and importantly patients in community based care settings. This means a shift in the way we organise the management and clinical delivery of services to be 'primary care facing'. The conventional frames of 'provider arm', 'governance' and 'funder arm' categories of organising our costs are no longer relevant.

**3. The leadership task to activate networks and relationships** will vary depending on whom we are working with. This will range from building up centres of specialist expertise within institutions, to re-engineering the way clinical supports and ambulatory care work between both primary/community and

specialist services – tailored to the specific needs of each locality community; to cross-sector working with communities and social sector agencies.

**4. Using different change approaches..** we want to modernise the facilities that house centres of specialist expertise, we need to design and rebuild an integrated care space that works across primary/community and specialist, we need to scale up and embed proven initiatives within localities while we test and spread proven population health initiatives.

**5. Supported by streamlined decision making and aligned enabling strategies** - those strategies that align resources, focus effort and target actions at those priority areas that have a collective impact to accelerate transformation. Those 8 enabling strategies are described in the next section. Healthy Together 2020 delivery will be overseen by the new Healthy Together 2020 Directorate.

An important part of the process will be to identify key milestone deliverables in each of the years leading up to 2020. This will be linked to our System Level Measures and Equity Improvement Measures we will be able to monitor progress in detail. This will be reflected in reporting to the Board and in the Annual Plan.

The Healthy Together Directorate will be led by a Project Director, with detailed experience in delivering complex change. They will be supported by a Clinical Director who will also act as Chief Medical Information Officer (CMIO). These will be two new posts that are likely to be external appointments as we do not have the skills currently in the DHB. Additional to this team will be the Director Strategic ICT Transformation. This will form the initial core team with additional secondees to be added to the team in future to ensure a full complement.

In addition, the Project Board and Directorate will be supported by an Advisory Board of leaders in organisation change of recognised standing each skilled in change and an understanding of the New Zealand context. The three are:

- Paul Plsek – he is an internationally recognised consultant on improvement, innovation and large scale healthcare, he is a Ko Awatea Fellow having taught at Middlemore and APAC. He is the author of ‘The review of Virginia Mason’s Transformation Strategy in the USA’.
- Professional Helen Bevan, Director of NHS Institute and again a recognised expat with knowledge of the New Zealand context, and Ko Awatea Fellow.
- Joe McCollum, Director of Transformation for Spark New Zealand.

This expertise will be available mainly virtually, to minimise cost, but in person should that be justified. (Note – Paul Plsek and Helen Bevan are already New Zealand based as speakers for APAC 2016.)

There is always the opportunity to widen advice as required.

### Patient Care

The ELT has also agreed to establish a Patient Safety and Experience Project Board to take patient safety and care up to the next level. CM Health has a leading track record in patient safety, but we do not want to plateau or be complacent. We also have a growing need and ambition to improve the overall patient experience. The Project Board will be chaired by Gloria Johnson as CMO and have upon it clinical leaders from ELT and the health system and will be charged in developing this new approach. To support this, a new role Director of Patient Experience will be established, reporting to the Director of Nursing.

## Role of Ko Awatea

In this environment, Ko Awatea becomes ever more so the way we deliver change management, both in terms of capacity development and in choice of which change methodology should be used. A key relationship therefore will be between the Director of Healthy Together 2020 and Director of Ko Awatea. In many ways, the Director of Healthy Together 2020 will become a key customer of Ko Awatea, and Ko Awatea the 'app store' of change.

## Strength in Depth

To deliver such a wide and deep programme as we envisage, a key requirement for our People Strategy is to ensure at all levels that there is strength and depth, with the organisation being 'succession capable' when necessary. ELT agreed that Beth Bundy should lead this work-stream and that the role of Director of HR is now directly accountable to the CEO.

## **Risk Register**

It is proposed that the delivery at scale and pace of Healthy Together 2020 is placed on the Risk Register for detailed review by Audit, Risk & Finance. This is proposed not as a negative, but as a positive step toward ensuring success, and also recognises the uncertainty and risk of major change. In short to quote Machiavelli *"There is nothing more difficult to plan, nor more dangerous to manage than the creation of a new system"*.

## **Funding**

An initial budget of \$1.2million has been identified from the 2016/17 financial allocation to establish the Healthy Together 2020 Directorate. However this will be the only new funding required as existing funds and capacity will be redeployed into the Directorate.

## **Conclusion and Recommendation**

The purpose of this paper is to identify how we move to deliver the aspirational change set out in Healthy Together 2020. Critical to that successful delivery, is a positive response to our internal conclusions and external review of how we 'deploy' change management.

CM Health is a highly innovative and change capable organisation with a reputation for delivery. We have ensured this by being ready to change our approach when optimal to do so, not when we have to. We already have the capability to be a 'change ready organisation' because not only have we deliberately invested in our peoples' ability to do their job well, but also in knowing how to improve it. CM Health achieves what it does because of its commitment to the health and equity of Counties Manukau. In short, we have the passion to deliver. But we also have the cool headedness to change deliberately.

We are at a tipping point. The steps attained in this paper will ensure we 'tip' into controlled momentum for success rather than overload, and either of uncoordinated activity or unreformed patient demand. By ensuring we play to our strengths, with controlled operational delivery linked to a well coordinated change framework, supported and effectively performance managed, I believe strongly Healthy Together 2020 will be delivered.

## 6. Strategic objective deliverables



### Healthy Communities - Together we will help make healthy options easy options for everyone

To achieve Healthy Communities and playing our part to make healthy options easy options for everyone, will require successful implementation of our priority community initiatives with the following shifts and enablers.

Deliverables	Shift from	To	Key change roles
<b>Preventing ill health</b>	<ul style="list-style-type: none"> <li>▪ Fragmented health and social care services in communities</li> <li>▪ Hard to reach consumers being directed to hospital services</li> </ul>	<ul style="list-style-type: none"> <li>• Coordinated and connected local multi-disciplinary health and social services</li> <li>• Services targeted to people with the most complex needs and highest risks of poor outcomes</li> </ul>	<p>Director Healthy Together 2020 enabled by:</p> <p>Margie Apa as the lead for Population Health approaches (e.g. Smokefree 2020, reducing harm from alcohol) with;</p> <p>Benedict Hefford for community service integration and enabling investments (e.g. Community Hubs, Community Central etc)</p>
<b>Healthy neighbourhoods</b>	<ul style="list-style-type: none"> <li>▪ Consumers navigating siloed services themselves</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patients are able to navigate the system in a seamless way with minimal effort and providers are able to coordinate their contribution easily</li> <li>▪ Multi-disciplinary teams proactively engage, connect with and follow up people</li> </ul>	
<b>Help make healthy choices the easy choice</b>	<ul style="list-style-type: none"> <li>▪ Fragmented support for primary care teams for mental health, obesity</li> <li>▪ Community health promotion that misses the target populations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Communities see the health system as an active participant in improving community life</li> <li>▪ Better targeted advocacy and health promotion with education/information tailored for relevant segments of the community</li> </ul>	



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

<b>Deliverables</b>	<b>Shift from</b>	<b>To</b>	<b>Key change roles</b>
<b><i>Excellent, kind, high quality experience for everyone</i></b>	<ul style="list-style-type: none"> <li>Variability in how services are provided depending on who you see, where and when</li> <li>Difficulty in understanding information and what is being asked</li> </ul>	<ul style="list-style-type: none"> <li>Services are consistently provided to standards</li> <li>Language barriers are removed through tailored information or easy access to interpreters/language support</li> <li>Professionals go the extra mile for their patients</li> </ul>	<p>Director Healthy Together enabled by:</p> <p>Phillip Balmer as the lead for hospital service integration and enabling investments.</p>
<b><i>System wide information and communication technologies</i></b>	<ul style="list-style-type: none"> <li>Technology platforms are disconnected, not well structured or maintained</li> <li>Quality information is difficult to get and requires effort</li> <li>Difficult to tell how the system is performing</li> </ul>	<ul style="list-style-type: none"> <li>Electronic health records are shared across professionals</li> <li>Systems are connected, information is standardised and monitoring tells how the system is performing at any point in time</li> </ul>	
<b><i>Infrastructure investment that adds capacity</i></b>	<ul style="list-style-type: none"> <li>Infrastructure is not fit for purpose nor designed for how it is currently used</li> <li>The public finds hospital campuses difficult to get to, costly to get to and hard to navigate their way around</li> </ul>	<ul style="list-style-type: none"> <li>The capacity of services is increased to fit with changes in models of care</li> <li>Complementary services are located together at the same location</li> <li>Services are located together in multiple communities</li> </ul>	
<b><i>People and culture investment</i></b>	<ul style="list-style-type: none"> <li>Professional silos dominate how staff work</li> <li>The strategic direction of CM Health is not well understood</li> <li>Staff not able to contribute freely and feel valued</li> </ul>	<ul style="list-style-type: none"> <li>Improved patient experiences drive the organisation's culture</li> <li>Networks facilitate the sharing of ideas and lead to innovation</li> <li>Teams have a climate for innovation, agility and speed to lead change</li> </ul>	
<b><i>Healthcare Home</i></b>	<ul style="list-style-type: none"> <li>People have limited interaction with their usual healthcare providers</li> <li>Multiple providers are used</li> </ul>	<ul style="list-style-type: none"> <li>Care is planned with nominated providers who are able to share information and communicate easily</li> <li>Access to services is centralised so that appropriate access can be provided depending on the needs of the patient and not when the provider is available</li> </ul>	



## Healthy People, Whaanau & Families - Together we will involve people, whaanau and families as an active part of their health team.

To date, CM Health has implemented many programmes and projects that have achieved effective engagement from patients and their whaanau – more than 2000 people have engaged in advanced care conversations, more than 200 patients and staff have contributed to experience based design.

This will be enabled by a comprehensive shift of the system best described by Figure 4.

Supported by Community Hub based services in each locality integrated into hospital services, e.g. Diagnostics, Outpatients, Emergency Care, Procedures, Consultations Renal Dialysis

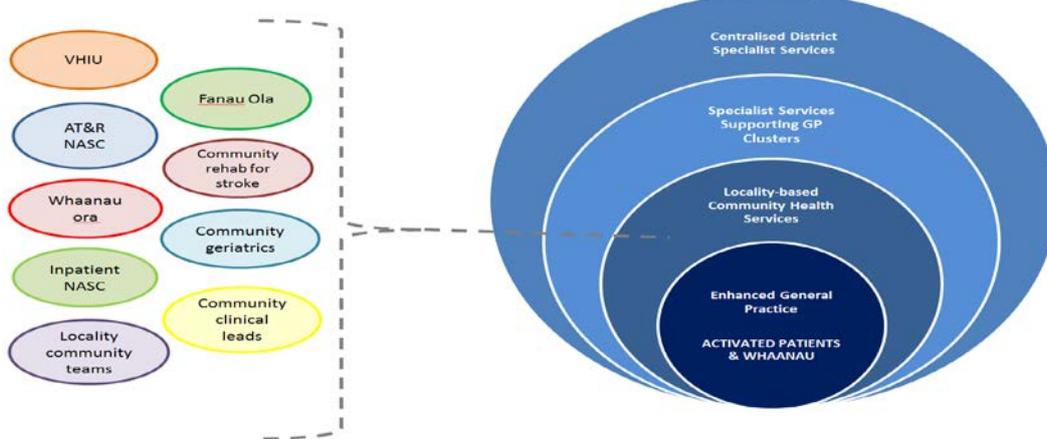


Figure 4: Community Networks and Integrated Care

Deliverables	Shift from	To	Key change roles
<b>Improved patient, whaanau and family experiences</b>	<ul style="list-style-type: none"> <li>People using health services when they are acutely unwell</li> <li>Providers only completing the expertise they have and not adequately addressing other presenting health and social issues</li> </ul>	<ul style="list-style-type: none"> <li>A person’s journey through the health system is proactive, planned, structured and all the players in it work locally, work collaboratively and are able to communicate with each other easily</li> <li>Individuals are partners in their own care so their role in the care plan is clear and they are provided the support and tools to carry it out</li> </ul>	Director Healthy Together 2020 enabled by: Benedict Hefford for community service integration; with Gloria Johnson leading the Patient Safety and Experience Clinical Board
<b>Advance on being a healthy literate system</b>	<ul style="list-style-type: none"> <li>People hear jargon, don’t understand it and don’t feel able to talk to professionals who look rushed and under pressure</li> <li>People don’t know what they don’t know nor do they know where to get information from</li> </ul>	<ul style="list-style-type: none"> <li>Information is tailored and relevant to people</li> <li>Professionals are able to tailor explanations using a range of tools</li> </ul>	
<b>Work better with whaanau and</b>	<ul style="list-style-type: none"> <li>People are unsure of where to go for help, when to go and lack</li> </ul>	<ul style="list-style-type: none"> <li>Services are accessed early through providers close to where people live or work</li> </ul>	

Deliverables	Shift from	To	Key change roles
<i>families</i>	confidence that the system will help them	<ul style="list-style-type: none"> <li>Services are consistently provided, reliable and located in places that are easy to get to</li> </ul>	
<i>People managing well at home</i>	<ul style="list-style-type: none"> <li>People receiving health care do not know how their health is tracking</li> <li>People need to go to centralised services for seemingly trivial or short appointments</li> </ul>	<ul style="list-style-type: none"> <li>People can access their personal information easily and are responsible for collating some of the content themselves</li> <li>People with long term conditions are able to self-manage and know when professional help is needed</li> <li>Services are provided in local settings, by phone or virtually</li> </ul>	

## What will this look like for people in 2020?

### For older people....

April is a 78 year old woman who lives in Waiuku with her two cats. April's husband passed away 5 years ago and her daughter lives in Hamilton. While she is not as active as she used to be, April likes to spend time in her garden and has a network of friends from the local bowling club where she still plays once a week. She has high blood pressure, which is controlled with medication, and a bit of arthritis, but otherwise sees herself as lucky to be in good health.

Figure 5 below summarises April's experience under current services structures and compares this to the different experience she will have under the new integrated Community Health Services approach.

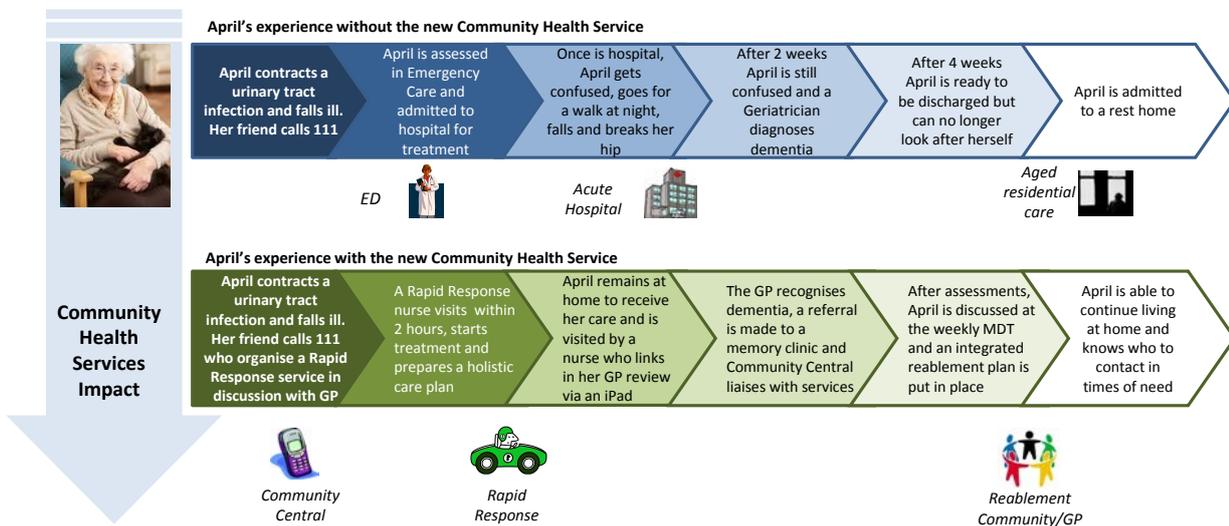


Figure 5: What care will look like for older people in 2020

### For adults with long term conditions....

Teuila is 46 years old, works as a part time cleaner and has been diagnosed with COPD. She has smoked since she was a teenager, has type II diabetes and is trying to achieve a healthy weight. She lives as part of the three generation family in Otara – Teuila and her husband sleep in the garage. Money is tight and Teuila only visits her General Practice when her COPD is severe enough to prevent her from working. Teuila has tried various smoking cessation treatments but has not managed to quit smoking.

Figure 6 below summarises the experience of Teuila under current services structures and compares this to the different experience she will have under the new integrated Community Health Services approach.

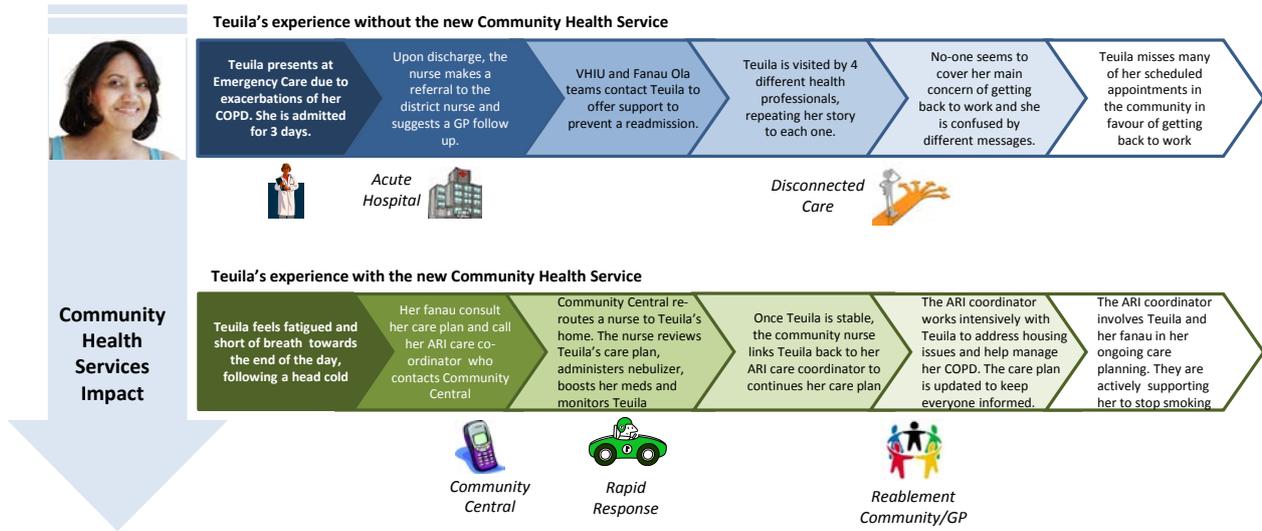


Figure 6: What care will look like for adults with long term conditions in 2020

# PRÉCIS OF ENABLING STRATEGIES

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## 7. Health Equity Strategy

### Twin track approach – tackle poor health and deliver results

#### What are we trying to achieve?

This enabling strategy will implement a health equity campaign that aims to “return 500,000 healthy life years to the people from Maaori, Pacific and high needs communities by 2020”. Led by Ko Awatea, this campaign will use ‘Break Through Series’ collaborative models to achieve improvement and support change; it will build a cross sector community of learners building on learnings from overseas (e.g. SCALE – Spreading Community Accelerators through Learning and Evaluation; Early Years Collaborative) and successful local programmes (e.g. Handle the Jandal, Manaaki Hauora, Early Learning Collaborative). We care about achieving health equity for our community. This will take a ‘twin-track’ approach – focusing services on delivering results and tackling the sharp differences in health that occur in Counties Manukau. While we acknowledge that the healthcare system is not the only determinant of health and wellbeing, ensuring a high performing system is accessible to all and contributes to healthy life years through the interventions that are provided within the scope of the public health system is our aspiration.

#### Improving Healthy Life years

***Our system is on a trajectory to improve healthy years in our current state.*** If current gains in life expectancy for the Counties Manukau population are maintained to 2020, it is estimated that our communities could gain 300,000 healthy years by 31 December 2020. How healthy life is defined is a value judgement and will differ between people. However, for the purposes of Healthy Together, the method used here is based on a review of life expectancy growth rate in CM Health over the past 10 years, review of the Global Burden of Disease (GBD) to estimate the proportion of Life Expectancy improvement that was healthy in New Zealand. There are many factors that impact these estimates. Adjustments must be made for many confounding factors.

	Single year life expectancy estimates	3 year rolling average life expectancy estimates
<b>Expected life expectancy improvement by 31 Dec 2020 (from 31 Dec 2013)</b>		
Female	0.7	1.1
Male	1.8	2.0
<b>Expected healthy life expectancy improvement by 31 Dec 2020 (from 31 Dec 2013)</b>		
Female	0.4	0.6
Male	1.2	1.3
<b>Estimated CM population in 2014</b>		
Female	265,510	265,510
Male	255,520	255,520
<b>Estimated gain of healthy life years by 2020 for CM population</b>		
Female	114,000	166,000
Male	295,000	330,000
<b>Total</b>	<b>410,000</b>	<b>497,000</b>

Table 1: Calculation of the healthy life years target by 31 Dec 2020

There are, however, stubborn and persistent gaps to tackle. It is well evidenced that the benefits from improving healthcare systems delivery do not fall evenly across population groups – there is a 9 year life expectancy gap between Maaori and non-Maaori, 6 years for Pacific. While Table 1 shows the potential for significant gains based on current delivery, Healthy Together 2020 represents a step change through integration. This enabling strategy aims to ensure that the benefit is also realised for those population groups who experience health disparities.

**Why does it matter to Healthy Together?**

**Healthy Communities** benefit from achieving equity when all communities are able to contribute meaningfully to their diverse communities (economically and socially) and create safe environments for children and young people to fulfil their potential.

**Healthy People, Whaanau and Families** benefit from achieving equity when all people are able to experience the same quality and safety of care consistently and systematically.

**Healthy Services** benefit from achieving equity when the causes of preventable presentations are reduced and resources are able to be targeted at those most in need.

**Action**

Implement a Health Equity Campaign that:

- Healthy communities: fosters a cross sector community of learners and investing in community building and learning systems
- Healthy People, Whaanau and Families: integration of healthcare for children and young people in schools; increased access to ARI and other long term conditions management programmes
- Healthy Services: build capability within the workforce to strengthen equity focus across healthcare services at all levels.
- Drive performance of national, regional and local indicators to achieve the same target performance for Maaori, Pacific and high needs communities (e.g. National Health Targets, IPIF, System Level Measures

**What will we see by 2020?**

500,000 healthy life years returned to people from Maaori, Pacific and high needs communities in Counties Manukau:

Primary Drivers	Measures (ethnic specific)	Interventions
Community driven insights Accelerate spread of proven methodologies	# collaborative teams, % of non-health sector groups in collaboratives, oral health, acute admissions and presentations	Build cross sector community of learners Collaborative networks Collective impact
Integration of care for children and young people		
Increased access to long term conditions management		
Reduce harm from tobacco, alcohol, obesity	Reduced number of smokers, increased smoking quit rates, increased enrolment in self-management programmes, alcohol related acute presentations	self-management programmes, targeted smoking cessation, clinical pathways and interventions targeting access and use for high need patients
Workforce capability to strengthen equity across system	# completion of equity assessments, # completion of equity masterclasses and training, reduced DNAs, # service redesign and collaboratives	Workforce learning and development programme, equity champions established, Equity assessment tools use, pathways implementation
Reduced clinical variation		

## By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Phases	Phase 1: Ideas harvest, formation of multi-sector collaboratives		Phase 2: Test the change package		Phase 3: Spread of change package		

## 8. Patient Safety and Experience Strategy

### What are we trying to achieve?

Patient experience is a good indicator of the quality of health services. A better experience, working in partnership with consumers and patient and whaanau centred care is linked to improved quality and safety outcomes. Ultimately our job as a healthcare system is to ensure that we treat each patient as if they were a member of our own whaanau and family. This means providing quality care, harmonising our skills, commitment, ambition and resources to ensure that “everyone is treated ‘in the right way, at the right time by the right person’ – every time.

We set the benchmark in 2015 with achievement against 17 system level measures to assure ourselves we were providing the best quality and safe care in Australasia for our population. They tell us we are among the best and we are leading in some indicators including hospital mortality rates. We have a strong track record of achievement in quality, safety and improving patient experiences – the 2nd DHB to achieve Health Excellence Bronze award, more than 2,000 patients electronically evaluate their care with 80% reporting it as excellent or very good. There are a many frameworks against which quality, safety and patient experience is measured and assessed:

- Nationally - National Health Targets, Integrated Performance and Incentive Framework (IPIF), Quality and Safety Markers (HQ&S), Serious and Sentinel reporting, certification and accreditation schemes
- Regionally – First, Do No Harm; Primary Care Safety in Practice,
- Organisationally and locally – Aiming for Zero Patient Harm, Patient Experience Survey and Week, Care Compass, Health Roundtable benchmarking, reducing clinical variation and handover. In the 14/15 Quality Accounts we reported for the first time against Locality specific highlights.

During 2015 the Consumer Council has become a well established forum for engaging consumer views in service co-design. This creates a platform for launching the next phase of work.

### Why does it matter to Healthy Together?

**Healthy Communities** benefit from a whole of system approach to quality, safety and improved patient experiences. By 2020, the investment in high quality and safe care in hospital settings will be complemented by accelerated progress of quality and safety initiatives in primary and community provided care.

**Healthy People, Whaanau and Families** benefits people, whaanau and their families who have certainty in what they can expect and experience consistent care. This will be enabled with a stronger Consumer Council that draws from consumer experiences across the whole healthcare system.

**Healthy Services** enabled through Ko Awatea, more than 600 staff to date have been through training and engagement in improvement activity. By 2020 this number will expand again with more of the front line

equipped with tools that make patient co-design and tools to improving patient experiences the new 'normal'.

Taking the quality and safety and improving patient experiences into primary and community settings will strengthen primary care teams as the healthcare home (Figure 7) represents a significant step change.



Figure 7: Patient Safety and Experiences enabling self-management and care closer to home

#### What will be different?

**Integrated Patient Safety, Quality and Experience:** In 2012, we actioned the 'Triple Aim' framework through 6 Executable Strategies. We actioned 'improved quality, safety and patient experience' through 2 separate executable strategies – First, Do No Harm and Patient and Whaanau Centred Care. In Healthy Together, we bring them together under one portfolio of work governed by an integrated Clinical Leadership Board. This is because the two are inextricably linked – safety and quality of care are at the core of improving patient's experiences of care.

**Whole of System Wide:** By 2020, patient safety, quality and patient experience will be a **system wide endeavour**. We have a strong platform from which to launch with the implementation of primary care based quality and safety initiatives and Localities beginning to implement local initiatives that are showing some impact on reducing acute presentations.

**Best Practice driven agenda within context of national and regional initiatives:** CM Health draws its direction from many national and regional performance frameworks. There have been many occasions, however, where meeting those national and regional benchmarks are not satisfactory and we know we can do better – in areas such as Falls, for example, we have set ourselves a higher benchmark for performance and a greater degree of rigor than nationally expected. By 2020, meeting national and regional safety and quality performance and setting our own performance expectations against other world class systems will be the new 'normal'.

#### Action

- By 30 June 2016, set up the Patient Safety and Experience project to consolidate Patient Safety, Quality and Patient Experience portfolio of initiatives
- Agree priority work programme of patient safety, quality and experience projects for implementation including benchmarks for performance in areas that are local priorities.

## What will we see by 2020?

Primary Drivers	Measures (ethnic specific)	Interventions
Improved Patient Safety and Quality of Care	System Level Measures, National Health Targets, Integrated Performance and Incentive Framework (IPIF), Quality and Safety Markers, Serious & Sentinel Events, Care Compass, Health Roundtable Benchmarks, Patient Safety in Practice etc.	Ko Awatea lead collaboratives Building improvement capacity and capability in front line Spread of proven improvement science methods
Improved Patient Experiences	Patient Experience Survey Measures, Patient and Whaanau Centred Care Consumer Council engagement	Spread of patient co-design and experience learning and development

## By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Tasks	Phase 1: Establish Improving the Patient Safety and Experience Project Board and priority work programme for 16/17 year.		Implement agreed priorities and regular measurement.		Implement agreed priorities and regular measurement.		

## 9. People Strategy

*“The systematic neglect of culture in health and healthcare systems is the single biggest barrier to the advancement of the highest standard of health worldwide”*

*Lancet 2014*

### What are we trying to achieve?

CM Health is one of the largest employers in the Counties Manukau District employing more than 7,000 people in more than 100 different roles at more than 20 sites across the District. A further estimated 5,000 more people are employed in the health and disability system outside DHB employment – many of which are funded by the DHB.

People are at the heart of healthcare services. The People Strategy aims to ensure “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”. A values led workforce is critical to effective engagement of people power in the District. Strategies are less likely to be effectively implemented if values that underpin organisation culture is neglected.

### CM Health Values...



## Will be reflected in People Strategy priorities...

Embedding **Values and Culture** in the way we do business

Growing **Capability** to transform the health system and respond better to changing health needs

Building our workforce **capacity** and diversity to do more in communities and deliver care closer to home

Providing effortless **systems and processes** that enable people to do their best



## Why does it matter to Healthy Together?

People power is critical to accelerating transformation and the integration of care in the District. Transformation and systems integration will be accelerated by a workforce that is able to:

- Bridge organisation and professional boundaries, facilitating networks and delivering seamless experience of care to patients providing the right intervention in the right setting closest to home
- Focus on inter-disciplinary, trans-disciplinary and cross-sectoral working to deliver higher value interventions in the community closer to patients' homes
- Develop community workforce capability where all patients have only one named care co-ordinator and the wider healthcare team work with that one point of co-ordination
- Everyone is skilled and equipped to work with the diversity of patients, families and their support networks that is in our community
- Specialist workforces across all professions are trained and supported to work across healthcare system and enable spread of technology platforms e.g. Telehealth
- Centralised district services offering highly specialised services are supported to maintain their expertise and technical speciality.

**Healthy Communities** benefit from a community based workforce that reduces the need and likelihood of going to hospital, enabling people to continue their lives in communities with minimal interruptions and disruptions to work, education and meaningful social engagement.

**Healthy People, Whaanau and Families** benefit from a highly trained and capable workforce and streamlined interactions with trusted health professionals who are able to assist co-ordination and navigation of complex healthcare experiences and engagement.

**Healthy Services** benefit from creating healthy productive workplaces where well trained professionals are supported and equipped with the tools to do their best.

## Action

- Completion of People Strategy & prioritised work programmes for 16/17 years and out
- Review capability building and assessment tools to inform Learning & Development priorities
- Complete upgrade of HRIMS systems and integration of HR systems to inform workforce analytics
- Enable implementation of CHSI and integrated care initiatives through workforce development

## What will we see by 2020?

Primary Drivers	Measures (ethnic specific)	Interventions
Embedded Values and Culture	Patients experience of staff and workforce, staff engagement and satisfaction with their work, workforce diversity reflects community	Diversity and Inclusion Strategy, values led talent sourcing and acquisition, retention and performance support
Growing Capability	# participating in needs assessments, # completing Ko Awatea Learning & Development programmes, # trained improvement and innovation, staff engagement and satisfaction with their work	Capability needs assessments, capability building in priority areas – leadership, patient and whaanau centred care, improvement/innovation and change
Building Workforce Capacity	# new roles created in integration workforce, increase supply of community based skills to manage complexity, reductions in acute presentations from community based workforce interventions	Ko Awatea Learning & Development offerings tailored to integration settings, values led talent sourcing and acquisition, new and more flexible models of employment
Effortless systems and processes	Increased leadership satisfaction with use of HR processes, reduced transaction costs of people related business systems,	Review of HRIMS systems, integration of HR systems, build data warehouse to drive analytics and early warnings of workforce risks

## By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Phases	Completion of People Strategy and its implementation plan. Review capability building and assessment tools.		Implementation of People Strategy Actions  Complete upgrade of HRIMS systems and integration of HR systems.		Implementation of People Strategy Actions.  Enable implementation of CHSI and integrated care initiatives through workforce development		

## 10. Research and Evaluation Strategy

### What are we trying to achieve?

Clinical research and evaluation must be at the heart of everything we do in healthcare. We need to be able to critically evaluate literature, design and implement clinical trials, evaluate our interventions, publish and disseminate the new knowledge we generate, and grow our own academies. CM Health agreed 'Te Kaupapa Rangahau Hauora o Counties Manukau District Health Board' a refreshed Health Research Strategy for CM Health in July 2015. This will be implemented as part of Healthy Together 2020 and build on existing experience while acknowledging the new challenges of modern health systems. There are many aspects of Healthy Together 2020 transformation that is unlikely to have precedence or experiences we can learn from due to the idiosyncrasies of the New Zealand healthcare system – hence the importance of research and evaluation to secure health system improvement. The vision for research and evaluation at CM Health is to *'achieve the highest level of health and wellbeing of the people of Counties Manukau by*

*undertaking relevant health research and translating the findings of research into the delivery of health services to our communities and beyond.”*

### Why does it matter to Healthy Together?

**Healthy Communities** Research and evaluation that involves the community is more likely to be responsive to the needs and produce research outcomes relevant to our local communities. The community benefits from the dissemination of findings and evidence that is directly relevant through service models that meet best practice and continuously improve.

**Healthy People, Whaanau and Families** benefit from building trust and confidence that health professional practice and service developments are being informed by the best available evidence and its adaptation in our local context.

**Healthy Services** benefit because staff are able to be part of building their own capability and capacity for research, they benefit from having access to evidence and literature that is contextualised for CM Health communities and are engaged in a research environment based within CM Health that can be sustained into the future.

### Action

- Build capability and capacity in research at CM Health
- Develop a Research Office that is fit for purpose, and provides one point of entry for CM Health researchers to access support, administration and advice
- Build Maaori and Pacific research capability and capacity
- Build a research environment that can be sustained into the future.

### What will we see by 2020?

Primary Drivers	Measures (ethnic specific)	Interventions
Research and evaluation relevant to CM Health community needs	Increased research output (e.g. publications), # number of Maaori and Pacific researchers, # research and evaluations conducted in CM Health, increased funding for research and evaluation, # of research relevant to CM Health communities	Establish centre for Research and Evaluation,  Establish investment fund for CM Health research and evaluation
Rapid dissemination of research and evaluation findings and its adaptation to service improvement	Reduced time to approve research applications, increased research output	
Sustained investment in research	Increased funding for research, number of new research applications, number of teaching sessions offered, post graduate research completed at CM Health	

### By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Phases	Establish Research and Evaluation Investment for 16/17 (subject to budget)		Implement CM Health Research and Evaluation Strategy		Implement CM Health Research and Evaluation Strategy		

## 11. Financial Strategy

### What are we trying to achieve?

A major cost structure change through reprioritisation and reallocation must occur to enable integration to progress and transformation to be realised. We continue to successfully roll out efficiency programmes each year that enable us to “live within our means” but don’t easily enable fundamental and transformational change in themselves. This was initiated in the 14/15 year with increased investment in primary care initiatives (ARI) to enable preventative care and early interventions that will be expected to be realised in benefits through reduced acute presentations. A step change is required in those shifts over the coming years if Healthy Together 2020 is to be realised.

It is likely that Government will continue to expect DHBs to live within their existing baselines with increasingly marginal adjustments for inflation and demographic related increases. It is also likely that PBFF related growth will continue to be constrained by policy levers that disadvantage CM Health. In addition, access to Crown capital for investment will continue to be constrained. The demand from a rapidly growing population that far outstrips growth in operational funding will mean that demand will continue to grow at fiscally unsustainable levels unless significant process change and related innovations are implemented.

The Healthy Together 2020 implementation framework assumes:

- Rebalancing cost structures within current Ministry of Health financial reporting will require some agile financial management so that we are able to match the accountability (e.g. shift from Provider Arm to Integrated Care) for those services throughout transformation
- Ensure that transformation is not slowed by business systems that don’t keep up with the change and, where our leadership can be applied advocate for more alternative models of reducing overhead costs to free up resources for the front line (e.g. national transaction processing).
- A much more flexible, higher quality and patient focused system. This is a challenge in the face of the traditional decade long timeframe for significant change in health. This will require either greater prioritisation, differential or ‘hump’ funding at a time of increasingly constrained funding

### Why does it matter to Healthy Together?

**Healthy Communities** benefit from public private partnerships that will enable investment in transformation for community provision where there is likely financial and service return to those communities. In some localities, integration may be led by businesses and/or community NGOs from those communities themselves.

**Healthy People, Whaanau and Families** benefit from reduced overheads (national and regional) that free up resources for front line delivery.

**Healthy Services** benefit from agile business systems that enable transformation and shifts in cost structures to different accountability arrangements, while still meet national Crown reporting requirements.

### Action

A financial management strategy that will enable transformation by shifting cost structures and business systems to match integration.

## What will we see by 2020?

Primary Drivers	Measures (ethnic specific)	Interventions
Integration means responsibilities for services and supports will shift across the organisation	Percentage of cost managed through Integrated Care, percentage of FTEs spread across 'Provider Arm' and 'Integrated Care', percentage of services managed by Localities and Community Service Hubs	Advocacy for further reductions in nationally managed overhead costs
Reduce overhead costs to free up for front line investment	Cost of transactions, cost of overhead as proportion of overall budget	

## By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Phases	Complete long term service plan and transformation work programme.		Develop matching financial strategy to enable transformation and integration at pace.		Implement financial strategy.		

## 12. Technology Strategy

### What are we trying to achieve?

During 2014/15, CM Health - through Project SWIFT (System Wide Integration for Transformation) – aims to increase 'whole of CM Health system' service capacity and clinical productivity, integration information, processes and workflow across the system spanning patient, community, hospital and intersectoral activities.

In 2015, the following investment decisions were made that will enable Healthy Together 2020 delivery including:

- A two-step investment programme to deliver and use high priority initiatives;
- Collaboration regionally to provide input and leadership to the Northern Electronic Health Record (NEHR) undertaking an implementation study.
- Progress the technology enablement of Primary and Community Connect to support Enhanced Primary Care; Community Health Services Integration (CHSI) and Patient and Whaanau engagement
- Progress the technology enablement of core Hospital systems to support diagnostic ordering, medication management, upgrades of key clinical systems and spread of point of care devices
- Strengthen relationships and support for healthAlliance to enable delivery of core regional components – data reservoir, Enterprise Service Bus and Mobility platform and managed services.

A Technology Strategy that builds on SWIFT work to focus on those priority technology enablers that will enable and accelerate transformation and integration will be refreshed during 2016.

## Why does it matter to Healthy Together?

**Healthy Communities** The establishment of Community Central as a hub for co-ordinating workflow and information sharing of primary and community based services will enable community based workforces to be mobile and more efficient – releasing time to care for patients and their families.

**Healthy People, Whaanau and Families** experience an improved service co-ordination because they will see health professionals and their carers able to access all their relevant information and providing more informed and comprehensive range of services closer to home. Services are better targeted because of more rapid analysis and assessments of patient experiences and customer analytics.

**Healthy Services** staff are enabled to be mobile, experience more efficient and productive workplaces due to greater automation of processes and reduced time in maintaining labour intensive processes releasing more time for clinical care.

### Action

- Technology Strategy that builds on SWIFT focusing on priority technology enablers that will accelerate integration and service transformation
- Completion of suite of business cases based on SWIFT project

### What will we see by 2020?

Primary Drivers	Measures (ethnic specific)	Interventions
Technology enabled mobile workforce delivering more care closer to home and in communities	# workforce working with mobile devices, reduced time waiting or in transport to/from base, %age of time in community and patient contact	Increased availability of technology enabled mobile devices, implementation of clinical system upgrades, establishment of Community Central linking to CHSIs
Automated clinical processes and systems	Reduced staff waiting times, increased patient contact time,	
Efficient targeting of resources at those groups/subgroups for whom more relevant	Reduced cost per patient contact time, increased access by hard to reach groups	

### By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Business Cases for Board approval	Technology Strategy developed building on SWIFT Business Cases  Primary and Community Technology Enablers: Enhanced Primary Care, Community Health Service Integration, Patient and Whaanau Engagement  Hospital Technology Enablers: Regional		Primary and Community Technology Enablers: cont'd  Hospital Technology Enablers: Clinical Documentation, Performance visibility, E-Referral/iPM interface, Clinical Pathway, Time & Attendance		Implementation of Business Cases as agreed.		

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
	Laboratory Orders, Regional Radiology Orders, National Medication Management, iPM Upgrade, CapPlan/Ansos One-Staff, Point of Care Devices, Concerto Portal Upgrade						

### 13. Integrated Infrastructure Strategy

#### What are we trying to achieve?

The last 15 years has seen CM Health focus its facilities investment on modernising Middlemore Hospital and developing our ambulatory services at Manukau and other satellite sites. We now have the modern hospital facilities that our community and workforce deserves that include the Edmund Hillary Block with additional wards; expanded acute, surgical and support services through the Harley Gray Building and a range of facilities upgraded across the district. In 2013, clinical leaders prioritised the major investments needed over the short to long term based on service need. These priorities are reflected in our recently completed Radiology Hub in Emergency Care, acute mental health inpatient unit under construction, fit out of Harley Gray level 1 for Laboratory Services, technology (ICT) strategy design and development and rehabilitation investments cases.

What we recognised in 2014/15, is that we needed to integrate our planning across all infrastructure developments with a district wide perspective to ensure we are investing wisely and aligned to our strategic priorities.

#### Why does it matter to Healthy Together?

**Healthy Communities** that benefit from integrating services closer to home requires facilities and infrastructure for services and teams to be integrated and located within communities. Communities benefit from seeing health and social care integration within their social and communal settings.

**Healthy People, Whaanau and Families** benefit from having more services located within communities through reduced hospital presentations and early intervention or proactive reablement on discharge from hospital.

**Healthy Services** Workforce teams based in Locality hubs more likely to work across silos if they are integrated at common sites, making opportunities for multi-disciplinary working easier and more convenient and closer to their clients and their whaanau.

#### Action

- Complete business cases for Board approval by Q3 16/17
- Build capacity for public private partnerships and exploration of commercial opportunities for community hub integration.

## What will we see by 2020?

Primary Drivers	Measures (ethnic specific)	Interventions
Integration of services in community settings need facilities and infrastructure that is fit for purpose to provide hub for services and teams	Number of community based sites (both public and privately owned). # of workforce located and/or working out of community based sites. % of workforce that is technology enabled and mobile in the community.	Business Cases for public and private investment in community hubs. Ongoing investment in hospital facilities to maintain modern infrastructure for specialist skills.

## By when? Timelines

Time	15/16 year		16/17 year				Outyears 17/18+
	Q3	Q4	Q1	Q2	Q3	Q4	
Board approval	Community Hub Business Cases for Mangere, Pukekohe (Stage 1)	Hospital Site Business Cases Specialised Rehabilitation, MRI (Middlemore Harley Gray), Dental Training/Oral Health	Community Hub Business Cases for Manukau, Papakura Birthing and Community Hub, Botany Community Hub	Hospital Site Business Cases for Manukau Radiology Hub, Manukau Shared Infrastructure, Middlemore Histology/CathLab/Renal Expansion	Hospital Site Business Cases for Middlemore and Manukau Parking	Community Hub Business Case for Pukekohe (Stage 2)	Further Community service developments as needed, e.g. Manukau Community Dialysis  Further Hospital developments across Manukau and Middlemore as needed, e.g. Radiology Main Department, Elective Theatre capacity

## 14. Risk Management Framework

### What are we trying to achieve?

Strategy and risk are two sides of the same coin – in exercising choices in our strategic direction we must manage the risks and/or consequences of those choices. Risk is an uncertain event or condition that, if it occurs, has a positive or negative effect on CM Health’s ability to achieve our objectives. This is to be distinguished from an ‘issue’ that is an event or a condition that has already happened and has impacted or is currently impacting on CM Health’s ability to meet those objectives – the risk has materialised.

There are always risks in change and transformation - shifting services from one delivery setting to another, or tasks moving from one professional to another even with the best planning. The purpose of a risk management strategy is to equip staff with the tools and methods to anticipate, identify and treat those risks as they arise.

### Why does it matter to Healthy Together?

Integrating risk into our decision making at all levels matters because we are aiming to transform our healthcare system in an environment within current funding and limited opportunities for ‘hump’ funding

of change and constrained access to Crown capital for investment. Shifting service models and how we provide care will create opportunities for improvement.

CM Health’s new Risk Management Framework will enable and support transformation to occur supported by a transparent framework to identify risks, clarify the organisation’s risk appetite and tolerance, make transparent decisions about treating or managing risks and actions are successfully followed up. The shift will be:

**Healthy Communities** benefit from an effective Risk Management Framework that will enable risks to service coverage are managed as services are integrated across Localities and in community settings

**Healthy People, Whaanau and Families** benefit from an effective Risk Management Framework that will consolidate clinical reporting of safety, quality and risks highlighted by patient experiences.

**Healthy Services** with effective risk management that will ensure that staff have transparency and clarity on processes for identifying risks, their treatment and management and ensuring appropriate escalation pathways are in place.

### By when? Timelines

Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Phases	Phase 1: Appoint Risk Manager and review Strategic Risks in context of transformation and new risk framework and reporting system.		Phase 2: Risk is everyone’s business - implement organisation wide training and capacity building on risk  Refresh risk reporting to support transformation programme.		Phase 3: Implement risk management framework.		

## 15. Hearts and Minds - Building a community of implementers

### What are we trying to achieve?

If we believe people are our most precious resource, then Healthy Together must be a strategy that people can ‘live in’, own and contribute to from whatever role, place or contribution in the healthcare system. A living strategy implementation is not going to be helped by top down instructions alone. Effective implementation will rely less on formal structures and more on networks across the healthcare system that connect people and colleagues. Healthy Together will come to life through building a community of ‘knowledge workers’ who are able to connect, share ideas and rapidly fire information to Healthy Together implementers at all levels of the system.

We will use our current and routine channels of communication (e.g. blogs, website). The challenge of current channels, however, is that they do not easily provide feedback or enable the creation of networks for implementers with common interests to connect. Digital tools are now available and can be tailored to be fit for purpose for CM Health. Creating a ‘digital’ community (register by email) of Healthy Together implementers across the whole system enabled by an App that will exist for 4 years to 2020 will enable:

- Forming of networks, rapid fire sharing of information, feedback loops on what people are observing, thinking, experiencing
- People can generate content themselves and post up for sharing, organise information in ways that are meaningful for them
- Assuming that many more health professionals will be carrying mobile devices in the future, workforce will be enabled to 'carry' Healthy Together with them
- Cut across hierarchies and organisation structures to connect with others with common interests (e.g. working on same or similar clinical processes).

### By when? Timelines

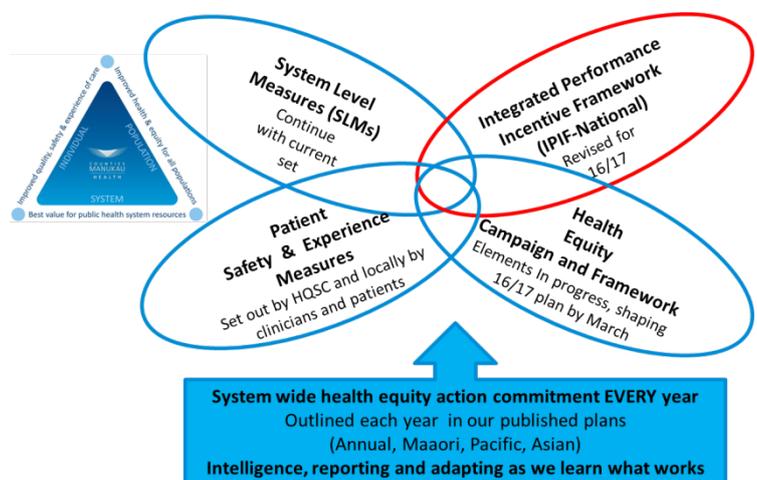
Time	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Phases	ROI for market testing and product development during 2016 with aim for stand up by mid year		Phase 2: Test the change package		Phase 3: Spread of change package		

## 16. How will we know we have achieved Healthy Together 2020?

The strategic goal for CM Health is to achieve equity in key health indicators for Maori, Pacific and other communities with health disparities by 2020. This is a complex ambition that requires capability and capacity building in multiple, complementary approaches. This recognises that the work that our people do every day across Counties Manukau contributes to achieving health equity; and this is enhanced through targeted actions (Health Equity Campaign, Annual, Maaori, Pacific and Asian Health Plans), with our progress and opportunities for improvement measured through our System Level Measures, Healthy Equity Goal Measurement Framework and national IPIF indicators.

The shifts we are looking for are to **drive targeted action and performance** in key measures for Maori and Pacific people and support our workforce with practical tools to make health equity happen at all levels of the system. The measurement frameworks will draw on all national and regional performance measures including but not limited to:

**Health Equity Campaign** with targeted collaborative effort aligned with our 3 strategic objectives to design and implement measurable areas for improvement and building workforces capability to strengthen the equity focus across all levels of the organisation.



**16 System Level Measures** look more broadly across the whole system using the triple aim as our framework. We will focus our analyses and intelligence on the measures that are not progressing as expected so that we can learn, adapt and improve as we go.

**IPIF** indicators have evolved nationally with an initial focus on primary care based improvement of their enrolled populations and reduce inequalities in health outcomes.

**Patient Safety and Experience measures** as set out by National Health and Quality Safety Commission and locally determined by our clinicians and patients.

## 17. Schedule of Key Milestones 2016 – 2018

Enabling Strategies	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
Health Equity Strategy	Phase 1: Ideas harvest, formation of multi-sector collaboratives		Phase 2: Test the change package		Phase 3: Spread of change package		
Patient Safety, Quality and Patient Experience Strategy	Establish Portfolio Clinical Governance Board and priority work programme for 16/17 year and outyears		Implement agreed priorities and regular measurement.		Implement agreed priorities and regular measurement		
People Strategy	Completion of People Strategy and its implementation plan. Review capability building and assessment tools to inform Learning & Development priorities		Implementation of People Strategy Actions: Complete upgrade of HRIMS systems and integration of HR systems to inform workforce analytics, Enable implementation of CHSI and integrated care initiatives through workforce development		Implementation of People Strategy Actions		
Research and Evaluation Strategy	Establish Research and Evaluation Investment for 16/17 (subject to budget processes).		Implement CM Health Research and Evaluation Strategy		Implement CM Health Research and Evaluation Strategy		
Financial Strategy	Complete long term service plan and transformation work programme.		Develop matching financial strategy to enable transformation and integration at pace.		Implement financial strategy		
Technology Strategy	Technology Strategy developed building on SWIFT Business Cases  Primary and Community Technology Enablers: Enhanced Primary Care, Community Health		Hospital Technology Enablers: Clinical Documentation, Performance visibility, E-Referral/iPM interface, Clinical Pathway, Time & Attendance		Implementation of Business Cases as agreed.		

Enabling Strategies	15/16 year		16/17 year				Outyears
	Q3	Q4	Q1	Q2	Q3	Q4	17/18
	Service Integration, Patient and Whaanau Engagement  Hospital Technology Enablers: Regional Laboratory Orders, Regional Radiology Orders, National Medication Management, iPM Upgrade, CapPlan/Ansos One-Staff, Point of Care Devices						
Integrated Infrastructure (Facilities)	Community Hub Business Cases for Mangere, Pukekohe  Hospital Site Business Cases Specialised Rehabilitation, MRI (Middlemore Harley Gray), Dental Training/Oral Health		Community Hub Business Cases for Manukau, Papakura Birthing and Community Hub, Botany Community Hub  Hospital Site Business Cases for Manukau Radiology Hub, Manukau Shared Infrastructure, Middlemore Histology/CathLab/Renal Expansion		Q3-4 16/17  Hospital Site Business Cases for Middlemore and Manukau Parking;  Community Hub Business Case for Pukekohe (Stage 2)  17/18+  Further Community service developments as needed, e.g. Manukau Community Dialysis  Further Hospital developments across Manukau and Middlemore as needed, e.g. Radiology Main Department, Elective Theatres		
Risk Management Strategy	Phase 1: Appoint Risk Manager and review Strategic Risks in context of transformation and new risk framework and reporting system.		Phase 2: Risk is everyone's business - implement organisation wide training and capacity building on risk  Refresh risk reporting to support transformation programme.		Phase 3: Implement risk management framework.		
Building Healthy Together Community of Implementers	ROI for market testing and product development during 2016 with aim for stand up by mid year		Phase 2: Test the change package		Phase 3: Spread of change package		

# DRIVER DIAGRAM

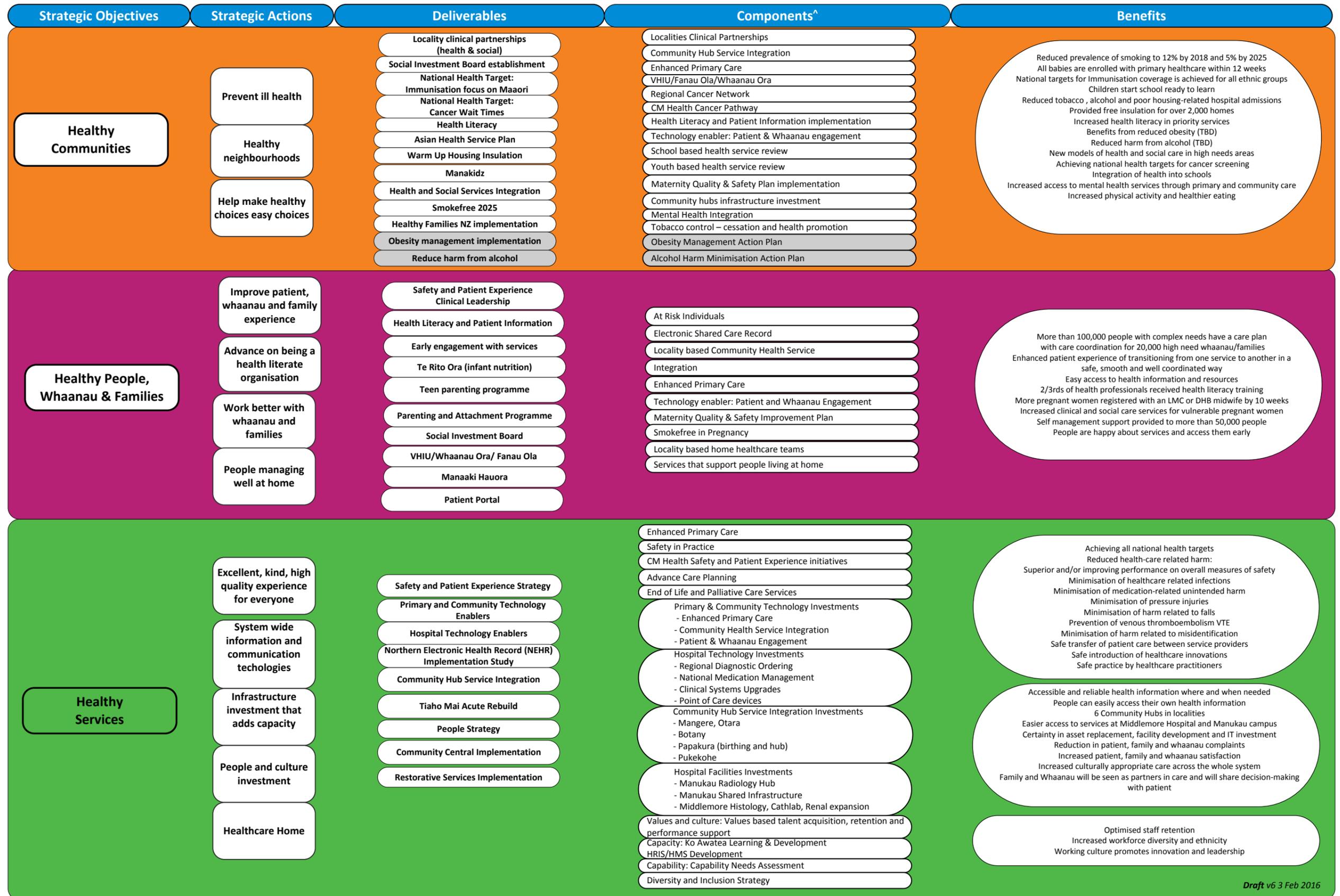
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# COUNTIES MANUKAU HEALTH – Healthy Together Strategy Driver Diagram

## We care about achieving health equity for our community

A driver diagram translates a high level improvement goal into a logical set of underpinning goals and projects. It captures an entire change programme in a single diagram and gives line of sight as to how every project lines up to deliver our strategic objectives. The diagram also provides a measurement framework for monitoring progress.

TBD = To be determined  
 ^ = greyed components are new initiatives



Draft v6 3 Feb 2016

## Counties Manukau District Health Board Occupational Health and Safety – Q2 Report

### Recommendation

It is recommended that the Board **receive** the Health and Safety quarterly report for the period ending 31 December 2015.

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

### Executive Summary

This paper reports on quarterly health and safety activity for the period ending 31 December 2015.

### Quarterly Report Highlights

#### Health and Safety Performance Overview

LAG INDICATORS		LEAD INDICATORS	
<b>Lost Time Injuries:</b>		<b>Audits:</b>	
Lost Time Injury Frequency Rate	9.73	Percentage Completed (Average)	86%
Lost Time Injury Severity Rate	679.12	Number of Hazards Identified	6
Lost Time Incidents	24	<b>Training:</b>	
Number of Injury Claims	58	Number of H&S Reps Trained	8
Cost of Injury Claims	\$45,930	Number of Managers Trained	0
<b>Incidents:</b>		Welcome Day Attendees	89
Total Number of Incidents	267	<b>Health Monitoring:</b>	
Number of Serious Harms	6	Pre-Employment Health Screening	381

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.

### Frequency and Severity Rate Definitions

The frequency rates indicate the number of lost time and / severity of those lost time injuries that occurred in an organisation per the number of hours worked by all employees. Frequency rates are generally calculated for 1,000,000 employee working hours (man-hours) in New Zealand e.g. the Lost Time Injury Frequency Rate (LTIFR) is calculated as:

$$\frac{\text{No. of Lost Time Injuries} \times 1000\ 000}{\text{Exposure Work Hours}}$$

The incident rate allows a comparison to be made about the safety in organizations having a different size or over different time frames.

Benchmarking targets cannot currently be defined or confirmed as more information is required to benchmark these figures. Consultation with industry health and safety leaders has confirmed that there is no external healthcare benchmarking data available for comparison.

## Quarterly Performance

### Serious Harm Notifications

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

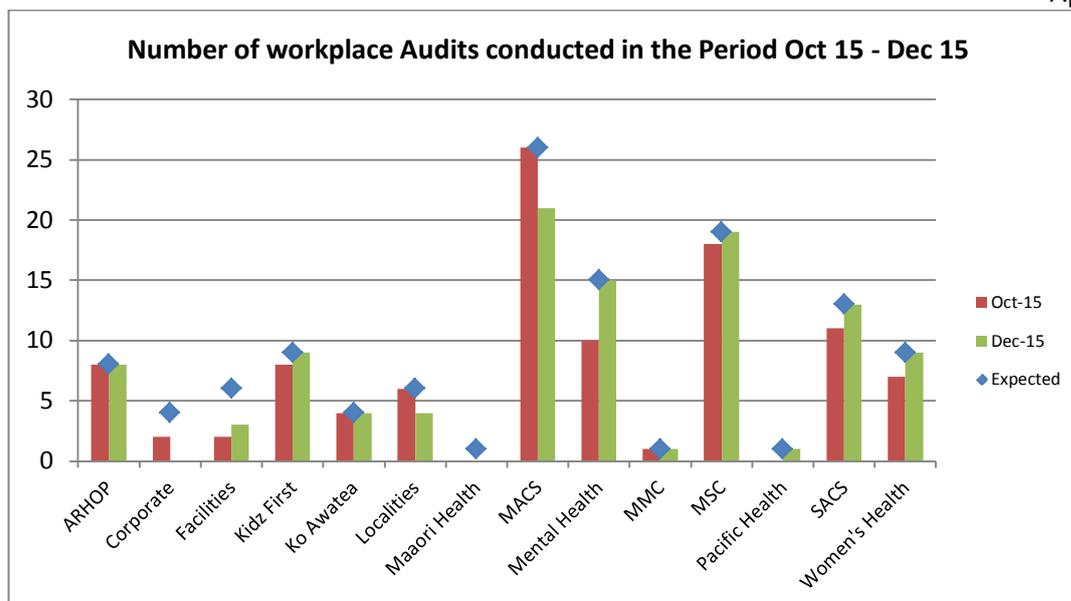
Division	Location	Injury	Details	Injured Person Classification	Hazard/Process involved	Date
Mental Health	Tiaho Mai	Fractured Rib	Fell during patient restraint	Employee	Restraint	20/10/2015
ARHOP	Auckland Spinal Rehab Unit	Severely Sprained Ankle	Unsupervised, visiting child jumped off deck	Visitor	Unsupervised visitors	22/10/ 2015
ARHOP	Ko Awatea	Fractured Wrist	Missed step and fell	Employee	Slip/Trip/Fall	23/11/ 2015
Mental Health	Ward 35 East	Fractured Thumb	Dementia patient grabbed thumb	Employee	Patient Handling	26/11/ 2015
Mental Health	Tiaho Mai (Huia Ward)	Fractured Nose	Assaulted by patient	Employee	Assault – Physical	29/11/ 2015
Kidz First	Community (service User Home)	Stress	Staff member subjected to alleged assault while home visiting (Investigation ongoing)	Employee	Home Visit (Lone Worker)	August 2015 (Reported on 16/12/2015)

- WorkSafe have requested a Duty Holder review on the incident relating to a fractured nose. This is a formal request from WorkSafe to the organisation to conduct a more extensive investigation than the standard.
- The incident of stress was reported to WorkSafe to ensure CM Health was compliant with the requirements; however details of the incident remain vague due to reluctance of staff member to provide additional details.
- CM Health has received formal response from WorkSafe indicating no further action or investigation is required for the remaining incidents.
- All incidents have been investigated to identify hazards and risks. Mitigation activities have been followed up.

### Audits (As per the 2015/2016 Health and Safety Action Plan)

#### Internal Audits

- The audit cycle is continuing on a bi-monthly schedule. During this reporting period, two cycles were completed in October and December 2015.
- The completion rates across CM Health for these audit cycles average 86%.
- The main reason for non-return appears to be the unavailability of Health & Safety Representatives. OHS is reviewing the escalation process for non-returns.
- The next internal Audits/Inspections will be undertaken in February 2016.



- The audits identified one new hazard, attributed to bubbling linoleum in theatres, which could result in musculoskeletal and/or slip/trip/fall injuries. This was considered a moderate risk and was escalated to Facilities for repair.
- The audits reported 246 *hazard events*\* across all three risk categories i.e. high/medium/low over the two audit cycles.
  - 242 of these have mitigation plans in place
  - 4 were escalated to the relevant Service Manager to manage as these required additional management support to implement the corrective action plans.
  - All of the hazard events related to building maintenance.

*\*Hazard events are not new hazards to the organisation but known hazards that were observed in the workplace at the time of the audit e.g. broken light switch cover – awaiting repair.*

#### Executive Audits

- OHS developed an audit tool to be used by CM Health Executive Leadership and Board Members.
- An audit was undertaken by David Collings, Board Member, of two randomly selected workplaces at CM Health.
- The audit reports are attached to this paper as Appendix A and B.
- These audits are planned for each quarter and will be reported accordingly.

#### External Audits

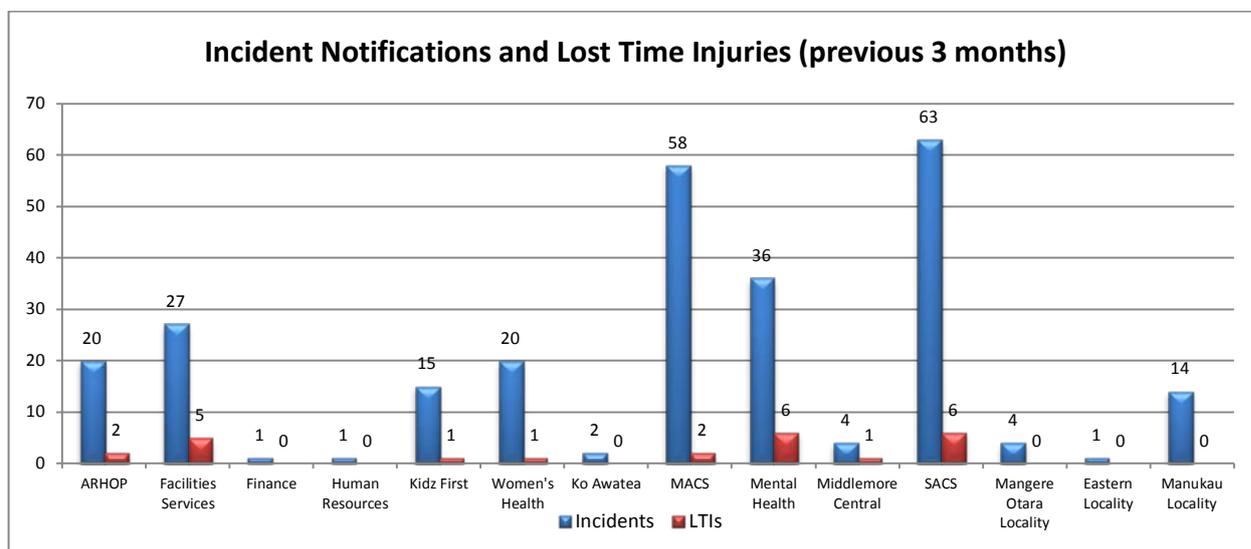
- No external Health and Safety audits were undertaken for this reporting period.

### **Injuries and Impact**

#### Incident Notifications

- The information presented is for the quarter October – December 2015.
- Slip/Trip/Fall and BBFE incidents have decreased across all Divisions. This could be attributed to the increase in awareness messages throughout the organisation.
- All incidents are initially reviewed by the H&S team and where necessary referred for operational intervention based on the severity of the incident, with OHS support as required.
- Assaults and Patient/Manual Handling were the main cause of incidents across MACS in this period, but overall notification shows a reduction in reporting from last quarter.

- Patient and Manual Handling and Slip/Trip/Fall incidents increased in SACS and notification of incidents have remained consistent to last quarter.
- Mental Health incident notifications continued to reflect a high number of Assaults with a slight increase in the number of Slip/Trip/Fall incidents recorded with incident notification remaining consistent.
- Incidents reported in Localities will in future be included in this report. For this reporting period, Papakura Home Healthcare indicated 14 incidents relating to workplace stress, primarily due to workload and staff numbers. This was managed with support from HR.



**Incident Notifications** - count of incidents with incident date occurring Oct – Dec 15.

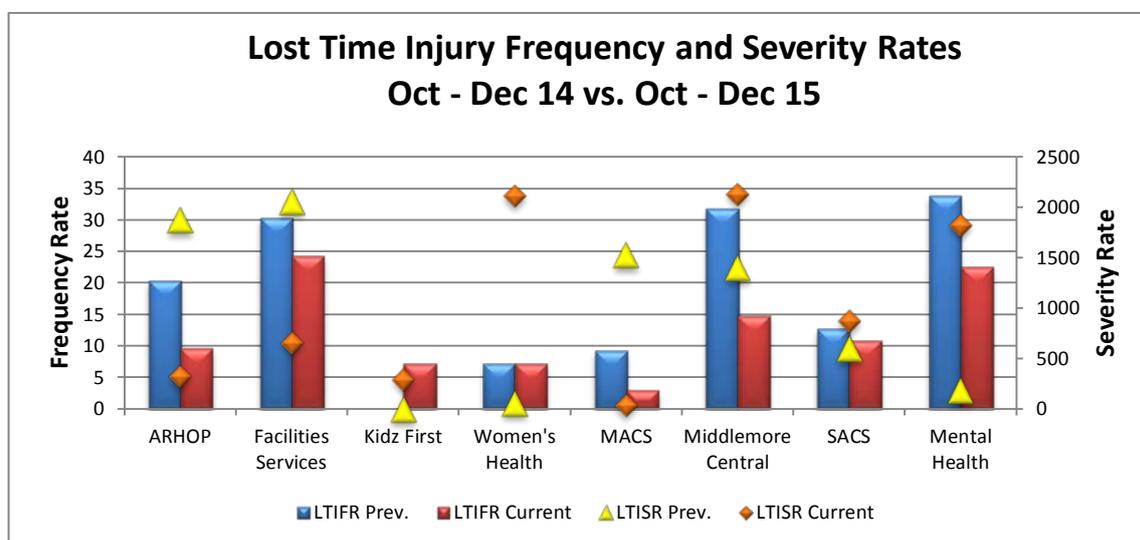
**Lost Time Injuries (LTI's)** - count of workplace injuries with injury date occurring Oct – Dec 15.

\* 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

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

LTIFR and LTISR for the quarter has decreased, indicating that the injuries sustained didn't required less time off from work.

	LTIFR	LTISR
<b>2015 Q4</b>	9.73	679.12
<b>2015 Q3</b>	13.22	953.83



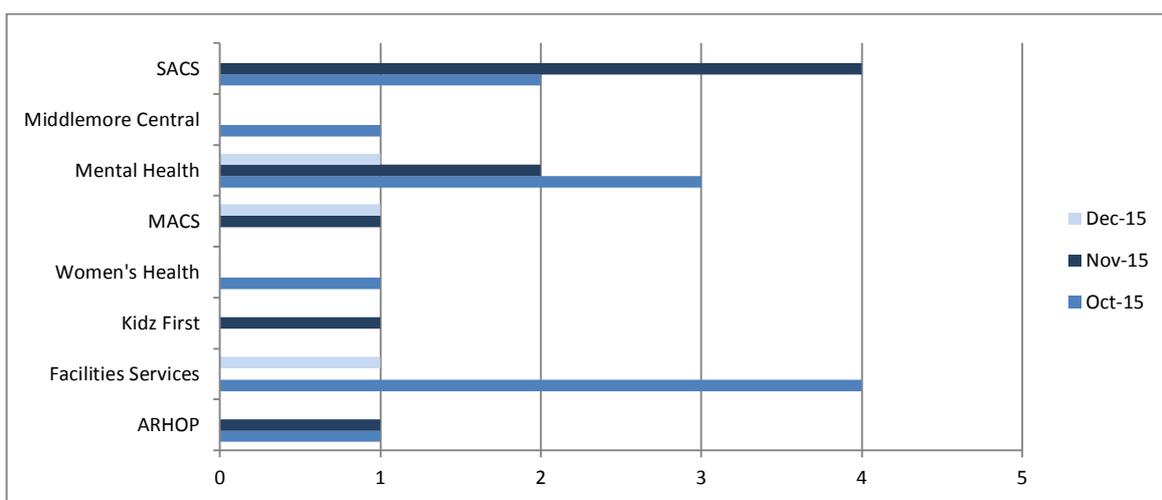
LTIFR (Lost Time Injury Frequency Rate) = (# of Lost Time Injuries / Hours Worked) x 1,000,000.

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

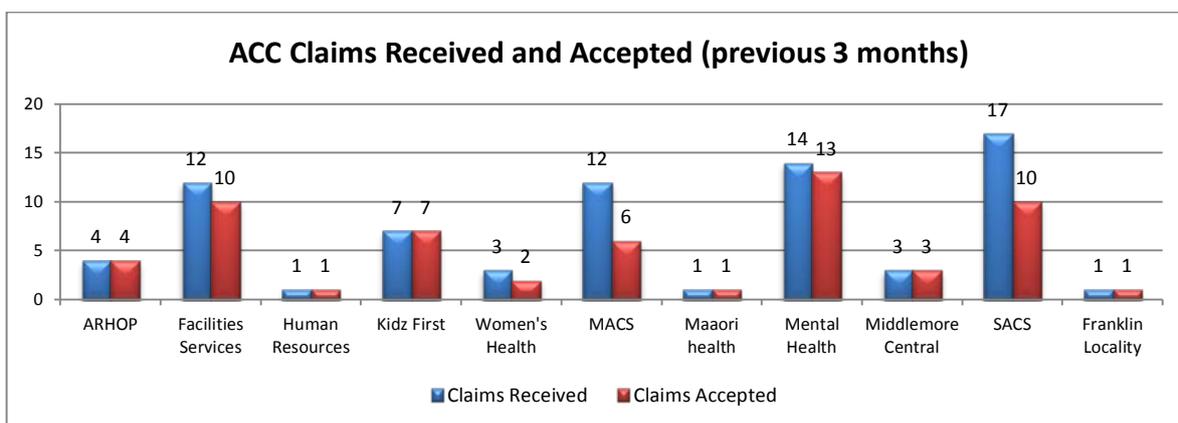
Explanation:

- Women’s Health: The high severity rate relates to an incident where a staff member fell, resulting in a contusion and neck sprain resulting in significant time off work.
- Middlemore Central: The high severity rate was due to a patient handling incident which resulted in time off work.
- Mental Health: Reports 6 assault and patient handling incidents with time off work, resulting in the increased severity and frequency rates.
- Facilities: The increased frequency rate was due to 4 patient and manual handling incidents.
- SACS: The increased severity rate is due to an injury where a staff member’s arm was caught in a lift, resulting in significant time off work.

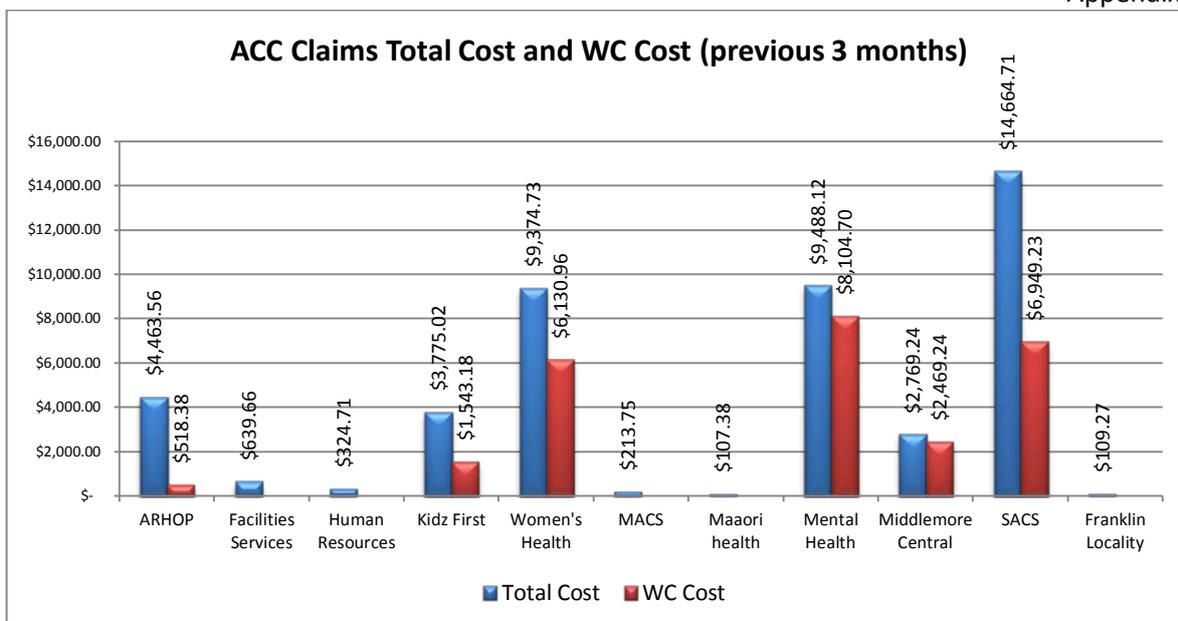
Number of Lost Time Injuries per Division



Injury Impact – Claims Overview



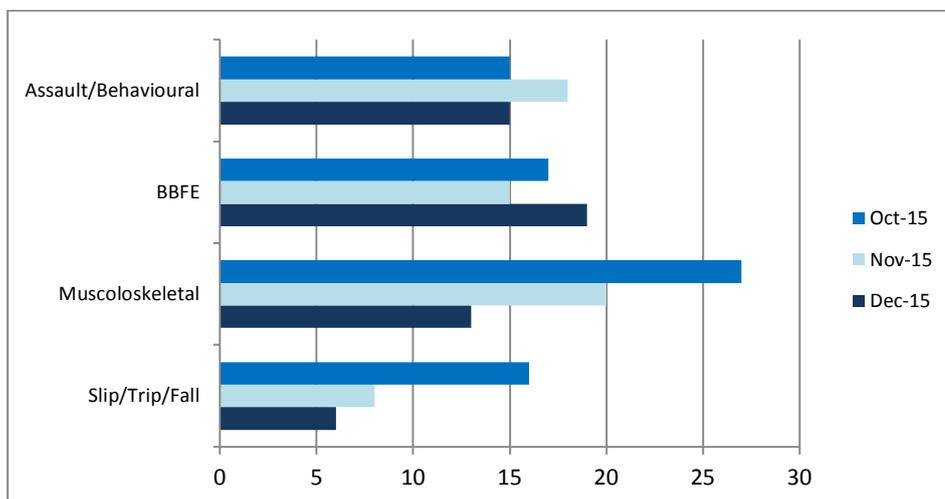
- A total of 82 ACC claims were received, with 24 being declined following investigation.
- Trends indicate effective management of claims lodged vs. claims accepted. Injuries resulting in ACC Claims are predominantly caused by musculoskeletal injuries.



\* This includes Medical and Social Compensation costs and Weekly Compensation cost estimates for days lost which are based on average salaries across divisions, as provided by Well NZ (Third Party Administrator).

- There has been a decrease in the number of lost time injuries however the number of days lost has increased due to a number of injuries requiring extended time away from work and intensive rehabilitation.
- The total claims cost for the period is \$45,930 and the Weekly Compensation Costs equates to \$25,715\*.
- This indicates a decrease in the costs compared to the previous quarter.

Injury Trends



- There was an overall decrease in the number of incidents reflected in the OHS critical risk profile from the previous reporting period.
- All incidents have been investigated.

## Health and Safety Management Framework Improvement

The Health and Safety Management Framework is underpinned by the Health and Safety Action Plan 2015.2016. The action plan was submitted to the Executive Leadership Team in July 2015 and is up to date. The Occupational Health and Safety team continues to progress work against this plan. The Health and Safety Action Plan 2015/2016 is attached in Appendix C.

The plan will continue to have an ongoing focus on the following priority areas:

### Hazard and Risk Management

- The Mental Health hazard/risk register pilot trial commenced has continued. This work is important to determine if the hazard/risk register is fit for purpose.
- The CM Health organisational hazard/risk register template was updated and the guideline was commenced and finalized. The guideline will be used as a training resource.
- A notification procedure to escalate significant hazards and risk to the Director of Hospital Services has been developed and utilized with a positive outcome.
- OHS input into the CM Health Enterprise Risk Management Framework was accepted. This will ensure the approach is aligned and consistently applied.
- The Moving and Handling project has continued with a focus on identifying appropriate resourcing avenues.
- A Wellbeing strategy is being scoped to align with the new occupational health requirements, the new organisational values and to identify what services are already in place.

### Incident Management and Injury Prevention

- The draft CM Health Incident Management Policy, including differentiation between workplace incidents and non-workplace incidents, is currently pending approval by the SSE committee.
- The OHS Workplace Management Incident Management procedure, as well the OHS Incident Investigation Guideline, was completed and will be published in Q3.

### Contractor Management

- As part of the Health and Safety plan, OHS began to develop an A3 problem solving process when the complexity of processes was identified within CM Health operations during the OHS review
- Our review has identified that the org had significant gaps in the management of contractors and H&S considerations in contracts and resulting in a potential compliance breach and a risk to the organisation.
- OHS initiated discussions with key stakeholders including healthAlliance to highlight current gaps and to determine what health and safety components current contract processes are in place and are required.
- This work commenced in December 2015, is ongoing and is in partnership with hA NZ and hA FPSC. CM health stakeholders include CM Health Chief Legal Advisor, GM Facilities and Executive Project Director.

Hazardous Substance Management

- All critical issues identified during the 2014 Hazardous Substance Audit have now been resolved.
- Facilities are managing the communication with WORKSAFE to advise that the work has been completed.
- The business proposal to transfer Andrew Nelson from OHSS into the Facilities service as the Hazardous Substance Management Advisor was accepted by Phillip Balmer, the Director of Hospital Services and Greg Simpson, GM Engineering and Property. The position has now been confirmed with the transition effective 1 February 2016.

Training

- During this quarter, training was provided to H&S representatives. All manager's training has been completed for the year.
- The training schedule for 2016 has been finalized and is due to commence in the next quarter.

<b>H&amp;S Representatives</b>	<b>Number</b>	
Total Number of H&S Representatives	221	
Total Number of Trained H&S Reps	160	
<b>H&amp;S Representative Training</b>	<b>Sessions</b>	<b>Attendees</b>
Representative Training (Update session)	2	8
Total Number of Reps Trained in this Quarter	8	
<b>H&amp;S Other Training</b>	<b>Sessions</b>	<b>Attendees</b>
Manager H&S Training	0	0
Nurse Orientation (Part of Onboarding)	6	24
Welcome Day (Contains H&S Component)	6	89

- 61 H&S Representatives are new and still to complete the Health and Safety Representative course in 2016.
- Review of the training is on hold until quarter 4, due to the Regulations supporting the new legislation being delayed until after the enactment of the Health and Safety at Work Act.
- A pilot orientation programme for experienced nurses has been extended and will continue in 2016.
- The training provided to managers has received constructive feedback. Training content will be reviewed further to reflect the impact of manager responsibilities under the new Act.

Employee (Worker) Participation

- The 2015 H&S Recognition Programme came to a close with an awards ceremony officiated by the Director of Hospital Services, Phillip Balmer, in the Ko Awatea Centre and an award presented by CEO, Geraint Martin, at Pukekohe Hospital.
- H&S Drop-In Forums commenced in October 2015 and are now scheduled to run monthly going forward. H&S team to provide satellite service at MSC fortnightly in place of drop in session, commencing December 2015.
- The JCC reporting tool has been developed, providing consistent reporting to the unions, in line with the new Worker Participation Guidelines.

Alignment of H&S IT Systems with CM Health Business improvement requirements

- Work has continued on the development of systems and processes to support the Health and Safety Framework and relevant communications.

**External, Legislative and Industry Updates**

- The Health and Safety Reform Bill which was passed by Parliament will come into effect on 4 April 2016. The new Act will be called the Health and Safety at Work Act.
  - A number of regulations will be developed dealing with matters such as:
    - Asbestos
    - Engagement, worker participation and representation (which WorkSafe advises will be available for public consultation)
    - General risk and workplace management
    - Major Hazard Facilities
- As requested by the Chair, a visit was undertaken to Unitec to gain understanding of their use of QR Codes. The program has been set up as part of the academic curriculum and allows trade students to scan a code which shows them visually how to operate hand tools safely. It is part of a Standard Operating Procedure process. The health and safety team will continue to investigate this option with Building Capability as an e-learning module.

**Next Steps**

The Board will continue to be updated quarterly on progress against the Health and Safety Action Plan 2015/2016.

**Appendix A – Executive Health and Safety Audit Report, October 2015 (Scott Dialysis Unit and ALBU)**

# ***Executive Health and Safety Audit***

***October 2015 – Scott Dialysis Unit***

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## *Guidelines for Executive Work Area Visits*

An important component of any due diligence safety programme is that officers, who regularly visit work areas, observe operations first hand and ask questions of Department / Service Managers, Team Leaders and Employees.

A checklist has been developed for use during work area visits and has been designed to achieve some consistency of content for Health and Safety standards and audit topics across Counties Manukau Health (CM Health).

The checklist forms part of the monitoring arrangements introduced as a result of a request from the CM Health Board and as part of the Health and Safety Management System.

It is designed to be used by members of the Board and Executive Leadership Team whilst onsite and should be completed with a manager who is based in the work area.

Findings from such a work place visit will be used to support the review and controls of the work area risks and hazards.

The Division / Service Manager remain responsible for ensuring that any agreed remedial action is completed.

Once the initial workplace audit has taken place, the findings should be discussed with the appropriate manager and any remedial actions agreed before being written into the document.

# ***Audit and Visit to Scott Dialysis Unit - 23/10/2015***

**Board Member:**

David Collings

**Accompanied by:**

Bev Stone, OHS Manager

Rob McAulay, H&S Advisor

Andrew Nelson, H&S Advisor

**Work Area Representative:**

Catherine Tracey, Service Manager

Wen Qian, Associate Charge Nurse Manager

**General Manager**

Brad Healey

## ***Executive Summary***

The visit to the Scott Dialysis Unit was a positive activity with full engagement and participation from the service manager and associate charge nurse manager.

The work area was welcoming, well organized, busy yet calm.

It was very full with patients receiving dialysis treatment and appeared to be at capacity for service delivery at the time.

It is well known that there is a current building project underway and as such, this audit did not focus on the restraints that have precipitated the need for redesign and possible reallocation of the unit. The staff appeared to be managing the stressors of these challenges with professionalism and dignity.

David Collings was able to engage with both above-mentioned staff members who made time available to him.

## ***Health and Safety Commitment***

- The associate charge nurse manager is motivated to keeping her staff safe with the support of the service manager
- Regular meetings and audits are undertaken
- Any current H&S issues are escalated, as required, to senior management
- A dedicated H&S notice board was visible and up-to-date

## ***H&S Engagement***

- Constructive involvement by the trained, area H&S Representative was visible
- There is a high level of awareness and risk management in the area due to the spatial restrictions and service delivery requirements.
- H&S information relating to staff injuries and risks, with feedback is provided to the staff working in the area at monthly meetings (and more regularly as needed)

## ***Risk Themes Identified***

- Time pressure at change over due to the cleaning requirements of the machines and the patients who have been waiting a while for their treatment (they are often impatient)
- Aggression and violence directed to staff by patients and family members

- Risk of infection of both staff and patients due to the lack of an effective isolation room. However, there have been no incidents to-date which bears testimony to the professional care of the staff in the unit
- Only one toilet facility for 20 beds (this is a focus in the building project)
- Higher risk of Blood, Body Fluid Exposure (BBFE) due to the type of care being provided but incidence is low
- Moving and handling issues related to obese patients and the beds which don't drop down low enough. These are new beds and are apparently not as 'good as the old ones'.

## *New / Ongoing Issues Raised*

- Awaiting a defibrillator which has apparently been held up by the procurement process being undertaken by health Alliance
- Facilities planning options still to be confirmed

## *Auditor Comment*

Specifically the auditor comments were:

"It has also become apparent and I raise it as a concern that a Health and Safety point of view does not appear to be included enough in the development of the design of facilities but rather that a H&S perspective is given after a building is completed.

This, I would presume puts undue pressure on H&S and may also be costing us more in the long run due to possibly having to retrofit a recent build.

Overall it is concerning that violence towards staff continues to be an issue along with lifting risks around handling of patients.

Also concerning is that the beds do not go low enough which exacerbates the problem above meaning patients require assistance even to get onto the beds in the first place.

Overall I felt the manager that I interviewed had a good grasp of general Health and Safety is being very proactive in this regard dealing with issues within the department while the area is under pressure.

In summary, he also added:

- "Unit is not fit for purpose due to chairs being changed to beds for treatment and care
- Come to a decision around Facilities – options for expansion
- Procurement issues end up putting pressure on staff and patient safety"

**Appendix B – Executive Health and Safety Audit Report, October 2015 (ALBU)**

# ***Executive Health and Safety Audit***

***October 2015 - ALBU***

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New Issues Raised.....	5
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# *Guidelines for Executive Work Area Visits*

An important component of any due diligence safety programme is that officers, who regularly visit work areas, observe operations first hand and ask questions of Department / Service Managers, Team Leaders and Employees.

A checklist has been developed for use during work area visits and has been designed to achieve some consistency of content for Health and Safety standards and audit topics across Counties Manukau Health (CM Health).

The checklist forms part of the monitoring arrangements introduced as a result of a request from the CM Health Board and as part of the Health and Safety Management System.

It is designed to be used by members of the Board and Executive Leadership Team whilst onsite and should be completed with a manager who is based in the work area.

Findings from such a work place visit will be used to support the review and controls of the work area risks and hazards.

The Division / Service Manager remain responsible for ensuring that any agreed remedial action is completed.

Once the initial workplace audit has taken place, the findings should be discussed with the appropriate manager and any remedial actions agreed before being written into the document.

# ***Audit and Visit to Assessment Labour Birthing***

***Unit - 23/10/2015***

**Board Member:**

David Collings

**Accompanied by:**

Bev Stone, OHS Manager

Rob McAulay, H&S Advisor

Andrew Nelson, H&S Advisor

**Work Area Representative:**

Gail McIver, Midwife Manager

**General Manager**

Nettie Knetsch

## ***Executive Summary***

The visit to ALBU was a positive activity with full engagement and participation from the area manager.

The work area was welcoming, well organized and calm even though it was a busy Friday morning that coincided with ward rounds by clinicians.

Due to the time pressure with another scheduled audit, David Collings was not able to engage with any staff working in the area and prioritized the time engaging with the area manager.

## ***Health and Safety Commitment***

- The area manager has a high level of Health and Safety understanding in keeping her staff safe
- Regular meetings and audits are undertaken
- Any current H&S issues are escalated to senior management

## ***H&S Engagement***

- Constructive Involvement by the trained, area H&S Representative was visible
- H&S Information relating to staff injuries and risks, with feedback is provided to the staff working in the area at monthly meetings (and more regularly as needed)

## ***Risk themes identified and raised***

- Aggression and violence directed to staff by patients and family members
- Staffing levels vs. increasing service demands and acuity of patients
- Moving and handling issues related to obese patients and the potential loss of the dedicated orderly service to move these patients safely

## ***New Issues Raised***

- New food trolleys are presenting an issue regarding the handling of flimsy food trays resulting in handling issues.
- Employee stress remains a concern
- MCIS – Education for staff remains a focus and priority

## ***Auditor Comment***

Specifically the auditor comments were:

As mentioned in this report, there is an issue with the new food trolleys and in particular the handling of flimsy food trays.

I found this very disappointing because when the new food contract was introduced we should not have expected any reductions in the level of service; both around the quality of food and the suitability of the equipment used in any new process.

I raise this of concern as it will be a matter that affects the whole hospital several times per day.

This needs to be addressed, and considered in the future for other contracts as this was an externally sourced contract and our own staff; from clinicians to health and safety were not able to be involved in the process of the selection of suitable fit for purpose services.

One area that I felt particular concern was around staff mental wellbeing when dealing with the loss a new born at birth. I was pleased to hear that staff do receive good support and counselling during this time.

Overall I felt the manager that I interviewed had a good grasp of Health and Safety in general, any issues that affected their particular area and demonstrated an attitude of being proactive in regard to this.”

In summary, he also added:

“From a board member’s perspective, I found it was very helpful and informative – and would have been of great value when looking at capital development around building, in particular, with this department (Corridors).”

## Appendix C: Health and Safety Action Plan 2015/2016

Health and Safety Action Plan 2015/2016						
H&S System	2015		2016			
	Q3	Q4	Q1	Q2	Q3	Q4
<b>Leadership and Practice</b>						
<b>Responsibility, Commitment &amp; Legal Obligations</b>	Develop annual (15/16) Health and Safety Plan in alignment with priority health and safety core objectives	Guideline development for health and safety leadership, planning and due diligence	Annual review of Health & Safety Policy (update and issue accordingly)  Assist in embedding of organisational H&S objectives	Develop annual (16/17) Health and Safety Plan in alignment with priority health and safety core objectives  Establish H&S leadership and performance measurement targets	Engage with stakeholders on inclusion of H&S in recruitment processes.	Bi-annual review & update of EPG
<b>H&amp;S Information, Document Management &amp; Communications</b>	Implementation of online Pre-employment Health Screening  Develop Health and Safety Recognition Programme collateral and communicate accordingly	Development of a Health and Safety Communications Strategy	Communicate legislative changes to organisation as appropriate  Review and update HSMS manual	Review and update OHS intranet pages	Prepare communications and information for bi-annual ACC Partnership Programme Audit 2016	Prepare and disseminate communications and information for National Safety Week
<b>Prevention as a Culture</b>						
<b>Hazard/Risk Management</b>	Progress formalised hazard risk assessment system: 2nd pilot trial of Hazard Risk Register tool/template	Amalgamate pilot feedback into the tool/template and develop Hazard Risk Register guidelines	Hazard Risk Register training	Support workplace area Hazard Risk Registers development (ongoing process)	Support workplace area Hazard Risk Registers development (ongoing process)  Review of organisational health and safety critical risk profile	Engage with HR regarding workplace Bullying & harassment  Investigate fatigue as an organisational risk
<b>Emergency Preparedness &amp; Response</b>	Consult stakeholders on comprehensive emergency drills	Check ER plans/schemes for currency Objective review dates	Engage with Emergency Response (ER) stakeholders to obtain ER information for incorporation into the HSMS manual	Incorporate ER detail into the HSMS manual	Pre-ACC Partnership Programme audit checks of organisational ER	Engage with organisational ER stakeholders for participation in the 2016 ACC Partnership Programme audit
<b>Contractor H&amp;S Management</b>	Investigate current state of health and safety as part of the contractor management process  Commence review of clinical access agreements for tertiary providers	Commence ACC-based self-assessment to identify gaps in the health and safety contractor management area  Finalise input of H&S as part of clinical access agreements for tertiary providers	Gather health and safety contractor management support documentation	Develop health and safety contractor management support documentation in consultation with stakeholders	Embed health and safety contractor management support documentation into consultation with stakeholders	

<b>Prevention as a Culture (Continued)</b>						
<b>Wellbeing and Medical Management</b>	Currently being scoped and developed		Initiate Flu Programme Plan	Flu Programme		
<b>Safe Design, Procurement &amp; Disposal of Assets</b>	Review health and safety as part of the procurement process	Investigate opportunity to embed health and safety into procurement processes and consult with stakeholders	Work with stakeholders to ensure health and safety is embedded into procurement processes			
<b>Hazardous Substances, Waste Management, Minimisation &amp; Sustainability</b>		Organisational HSNO certification due		Approved Handler certification due		Organisational HSNO certification due
<b>H&amp;S Training &amp; Competency</b>	Progression of organisational Manual Handling project  Investigate feasibility of a National DHB HS Symposium	Finalisation of eLearning general health and safety orientation course (implementation TBC in alignment with organisational requirements)  Manual Handling Project (ongoing)  Review health and safety training programme and update for 2017	Develop health and safety capability building (training) material  Review & update HS Rep training	Develop health and safety capability building (training) material (ongoing)  Facilitate health and safety capability building training  Identify preferred training provider network	Develop health and safety capability building (training) material (ongoing)  Facilitate health and safety capability building training	Investigate development of Job Task Cards in collaboration with Recruitment  Consult with the Building Capability team on Skills and training matrices
<b>Incident Management</b>	Health and safety system and structure development  Commence development of incident investigation guideline  Identify key CMH documents to embed health and safety data	Health and safety system and structure development (ongoing)  Development of incident investigation guideline  Embed health and safety data into identified key CMH documents	Health and safety system and structure development (ongoing)  Conduct half yearly incident data analysis	Health and safety system and structure development (ongoing)  Build capability in Incident Management	Investigate status of linkages between incident investigation findings and hazard & risk management  Conduct half yearly incident data analysis and update organisational risk register and generic hazard/risk register if required	Check that improvement opportunities are assimilated into the hazard & risk management system

<b>Worker Empowerment and Engagement</b>						
<b>Employee Consultation &amp; Involvement</b>	Develop Health and Safety Recognition Programme  Develop JCC reporting template	H&S Recognition Programme implementation  Investigate opportunity for regular Health and Safety "drop-in" forum	Health and safety committee tool and template development	Finalise Health and safety committee tool and template (subject to stakeholder involvement)  2016 H&S Recognition Programme commencement	H&S Recognition Programme  National Safety Week (TBC)	
<b>Audit and Performance Measurement</b>						
<b>Audit and Performance Measurement</b>	ACC 'Injury Management and Rehabilitation' partnership programme audit preparation	Undertake ACC 'H&S' self-assessment  ACC 'Injury Management and Rehabilitation' partnership programme 2015 audit is completed	Review assessment (audit) tools	Undertake audits as per the health and safety Audit Programme  Commence preparation for the full ACC Partnership Programme Audit 2016	Undertake audits as per the health and safety Audit Programme (ongoing)  Preparation for the full ACC Partnership Programme Audit 2016 (ongoing)	Undertake audits as per the health and safety Audit Programme (ongoing)  Completion of full ACC Partnership Programme Audit 2016

## Counties Manukau District Health Board

### The History and Current Approach to Occupational Health and Safety

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#### Recommendation

It is recommended that the Board:

**Receive** this information paper.

**Note** the background and changes that Occupational Health and Safety practice has undergone since its inception. The aim is to provide the background to the progress and the improvements which have led to current practice.

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

#### Executive Summary

Counties Manukau Health's shared vision is to work in partnership with its communities to improve the health status of all and to achieve health equity for our community. A safe environment for our people is a safe environment for our patients. The delivery of quality patient care is dependent on our employees. To ensure we can deliver the quality care we aspire to provide, we must become increasingly committed to protecting the health and safety of our people and the environments in which they operate. This is good business practice.

The management of Occupational Health and Safety has been a progressive process which continues to mature as we aim to move from a compliance focus, to making a tangible difference. The process is constantly evolving and growing as we aim to achieve a culture shift from operational application of Occupational Health and Safety practice and which looks beyond a return on investment to a return on value.

There is no escaping that Occupational Health and Safety is to some extent about technical systems, processes and audits. We are required by legislation to measure problems against the risk they pose, to put activities in place to ensure we have done 'something' and then aim to measure those interventions against a possible range of benchmarks. This drives a compliance focus which will only achieve a minimum standard in application and business integration but won't achieve the return on value, which is the optimum outcome.

However, Occupational Health and Safety is mostly about people, our people, and in particular human behavior. It's about our organisational values, strong leadership and risk management.

Good health and safety practice is about bringing new solutions to old problems, in a simple rather than complex manner with a skilled team who are both technical experts and business partners. It's about using strategy and tactics with a business added value that isn't a siloed after thought, but embedded into day-to-day operational activities as good business practice. *An astute understanding of the root of problem to be solved is critical in health and safety practice.*

Occupational Health and Safety must be viewed as a core business function that adds value with an understanding that it remains a progressive journey and not a destination.

## Counties Manukau Health's Approach to Occupational Health and Safety

### The past approach

The Occupational Health and Safety Service's vision is to empower and educate leaders to lead a safety culture step change in the organisation's Occupational Health and Safety performance, by building capability for effective and inspired leadership, influence and shared learning.

The progression has developed from compliance and a nurse led approach that was for the most, operational and transactional with limited leadership engagement, visibility and influence. The Occupational Health and Safety Service generally operated within a limited resource framework, with a team that was predominantly disconnected and siloed from the organisation. In addition, limited capability and capacity resulted in a reactive approach with an inability to deliver strategic interventions.

Historically, safety was seen as the responsibility of the Occupational Health and Safety Service that generally, had no governance or accountability to senior management. This meant that the identification of hazards, the development and implementation of controls, investigation and reporting was a technical requirement undertaken by the service, as part of their roles. Senior leadership had a lack of awareness and limited visible leadership into Occupational Health and Safety matters.

### The current approach

In recent years, the service has embarked on a progressive process of supporting senior leaders and managers to take ownership of health and safety. The goal was supported by engaging the 'right' stakeholders with the 'right' message, to advise with clarity, on the 'right' issue with an organisationally appropriate intervention. To be successful, stakeholders must be actively engaged and impact measured by:

- Focusing on delivering on our priorities
- Acting on lead indicators
- Working towards maintaining a compelling scoreboard – this results in active engagement, and engagement comes from knowing the scoreboard
- Creating shared accountability with regular meetings and shared learning opportunities

This has been underpinned by a 5 year plan that has a strategic focus with increased reporting to the Board, Executive Leadership Team and other appropriate leadership committees. The plan focusses on closing the gaps by using a robust improvement framework, supported by external Health and Safety consultants. This approach moves the focus from compliance to the implementation and delivery of an updated vision and plan that is comprehensive and aligned with the organisation's strategic goals and objectives by providing an advisory, proactive and empowering partnership approach with appropriate systems and processes.

The Occupational Health and Safety team have an increasing voice of influence. An upstream and downstream management approach to health and safety has been put in place to build organisational capability and awareness. To work towards our vision of reducing harm, we will focus on leading a 'safety culture step change' by implementing desired behaviours in the organisational management of health and safety.

The focus will be on four key areas:

- Leadership - develop and grow safety leadership by promoting a high standard of health and safety performance and the application and implementation of excellent health and safety practices within divisions, services and satellite areas
- Prevention as a culture by promoting values, attitudes, systems and procedures that prevent harm to our people at work

- Employee empowerment and engagement by using the individual and collective influence of division, service and satellite areas to contribute to changes in health and safety. This will be done through shared learning and development i.e. the provision of opportunities for division, service and satellite leaders to share skills, experience and resources to overcome common challenges.
- Health and Safety Performance Management by measuring our performance towards a step change with the maintenance of a compelling score board

To ensure the Occupational Health and Safety Service delivers the plan, the service has been realigned to work across the functional teams within the service with delegated accountabilities and visible, transparent work activities within agreed timeframes and priorities. A team of three Health and Safety Advisors are in place with strong leadership skills that can influence, engage and inspire our people. These advisors are currently working with our organisational managers to develop initiatives that reduce risk and improve the health and wellbeing of our people. The team has the ability to be flexible and adaptable to implement any industry and legislative changes quickly and are rapidly becoming trusted business partners.

### Next Steps

The aim is that Safety includes an equitable focus on Occupational Health and Wellbeing and is integrated as a vital part of the Counties Manukau Health vision and business delivery model as good business practice.

An opportunity exists to place equitable emphasis on employee safety. In addition, addressing occupational health issues has proven to vastly improve employees' wellbeing, which will ultimately deliver optimum patient safety and care to our communities.

The new legislation that will be enacted in April 2016 will drive a compliance focus. The Health and Safety Plan already outlines identified priorities to ensure the key changes are addressed i.e.

- Clarity around roles and responsibilities
- A risk management approach
- Worker Participation
- Occupational Health

Underpinning support structures and procedures will continue to be put in place. However, this will be a progressive 'journey' as organisational risks remain and require multiple stakeholder input. We will keep the Executive Leadership Team and Board updated about the critical Occupational Health and Safety risks that the Person Conducting a Business or Undertaking (PCBU) will be required to manage from a legislative perspective. This will be done by including members to undertake audits and with robust reporting pathways, which includes the quarterly Occupational Health and Safety updates to the Board, including the plan.

### Appendices

Please refer to attached appendices for explanation of the Health and Safety Management Framework:

**Appendix A:** Health and Safety Summary Update January 2016

**Appendix B:** Good Governance Practices Guideline for Managing Health and Safety Risks

**Appendix C:** CM Health - Health Safety Management System Framework

**Appendix D:** Strategic Plan to Implement the H&S Framework

**Appendix E:** Health & Safety Guideline to Due Diligence and Worker Participation

**Appendix F:** Presentation by Meredith Connell

# ***Preparation for the Health & Safety Law Reform.***

*Synopsis of Current State - January 2016*

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## Goals

- To strengthen appropriate leadership around health and safety culture in the organisation
- To lift the health and safety focus and performance by continually adapting the “Health & Safety Management Framework” to support the maintenance of legislative requirements
- Ownership of compliance will remain an organisational responsibility
- To improve our current organisational systems and structures
- To identify our risks and consistently maintain robust risk management processes

## Key Changes to H&S Law Reform

- Increased pillars of responsibilities on Boards and Senior Management
  - Policy and Planning
  - Delivery
  - Monitoring
  - Review
- Increased emphasis on residual risk management
- Worker participation and engagement
- Occupational Health management proportionate to the risk

## Current State Overview

- We are committed to excellence in Health and Safety in line with our business strategy
- The external environment around Health and Safety is changing
  - New legislation will be introduced in New Zealand in April
  - Health and Safety will become a corporate governance issue in NZ
- CM Health has systems and structures established
  - These systems and structures are applied in varying standards and forms
- There has not been a consistent approach to Health and Safety management within various services in the past – this is changing
- CM Health completed a self-assessment in 2013 in relation to health and safety capability and compliance
- Analysis of the feedback received has provided a broad view of CM Health performance and gaps
- Work on the Health and Safety Management Framework and improvements have progressed over the last 2 years

## What we have done

- External H&S Audit undertaken to review practice in CM Health with the aim of identifying gaps against the new legislation and a best practice framework used by health and safety consultants
- Health and Safety policy is in place
- The Health & Safety Management Framework was developed and endorsed by the Executive Leadership Team and an implementation plan is underway.
- 5 year H&S Plan has been developed and deployed
- A strategic plan to implement H&S Framework (aligned with the Institute of Director's Guidelines) has been developed
- Operational activities include identifying and maintaining compliance requirements and engaging managers to own health and safety within their work areas to develop a risk management approach
- H&S Guideline to Due Diligence and Worker Participation has been developed
- Alignment of H&S risk matrix and methodology to CM Health Risk Management Framework with Deloitte to align with legislative requirements for risk
- Hazardous Substance Audit undertaken and Advisor in place
- Executive and Board workplace inspections initiated
- Meredith Connell presentations to the ELT on the 26<sup>th</sup> January and the Board on the 10<sup>th</sup> February to build capability and learning
- A designated health and safety board member is in place
- Reporting:
  - I. CEO H&S Report to the Board
  - II. Quarterly H&S Report to the Board
  - III. Additional reporting into Audit, Risk and Finance (copy of the Board Report)
  - IV. Monthly H&S Report to the Executive Leadership Team
- HR / H&S Management meetings with the CEO 6 weekly

## Key CM Health issues to consider

- Budget considerations related to new legislative training recommendations
- Worker participation – operational time resourcing
- Serious harm notification to WorkSafe including patient harm incidents
- No robust manual handling program to address primary injury causation
- H&S Injury profile remains unchanged
  - Manual Handling and musculo-skeletal injuries
  - Blood, body fluid exposure
  - Slips, trips and falls
  - Assaults due to aggression and violence
  - Ageing work force
- Fatigue
- Legislative 'rumblings' on bullying and stress in the workplace
- CM Health Change processes occur without risk assessments

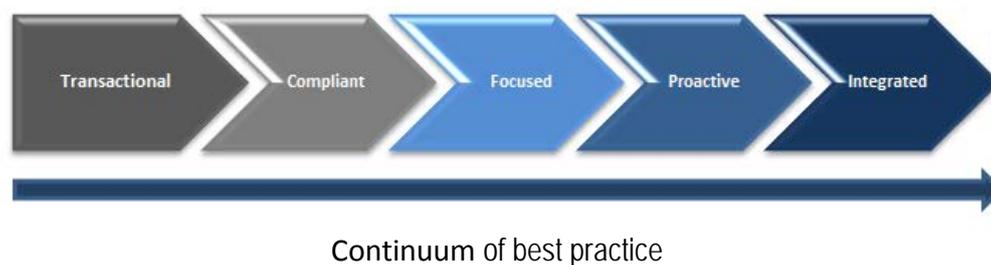
## Improvement Opportunities and Next Steps

- Regional Internal Audit – Workforce Health and Safety Governance Review scheduled for March 2016
- Changes in the legislation provides the opportunity for the development of a consistent organisational approach
- Membership application for CM Health CEO to the Business Leaders Health and Safety Forum
- Role of CM Health leaders and managers to be embedded in operational activity by increasing reporting into organisational reporting structures, participation in workplace inspections and risk management activities
- Proposal to be drafted for consideration by the appropriate members of the Executive Leadership Team re capping of costs, due to harm, to be allocated to services within the health and safety budget with the aim that services will proactively manage their risks and reduce costs
- (Opportunity for health and safety to be recognised as a business-as-usual activity with alignment to value add activities and strategies)
- Continue the Health and Safety Management Framework implementation
- To ensure we meet and exceed current and new legislative requirements, we will undertake a repeat Health and Safety capability and governance audit in 2016/2017

*Current Health and Safety Legislation hype is creating panic focused on fines, jail time and other 'legalistic stuff'.*

*Remember, we don't get excited about compliance ... we get excited about opportunities and improvement!*

## Safety Governance Pathway



CM Health has progressed from Transactional and Compliant and is currently transitioning from Compliant to Focused

# Occupational Health and Safety Strategic Plan in diagrammatic format

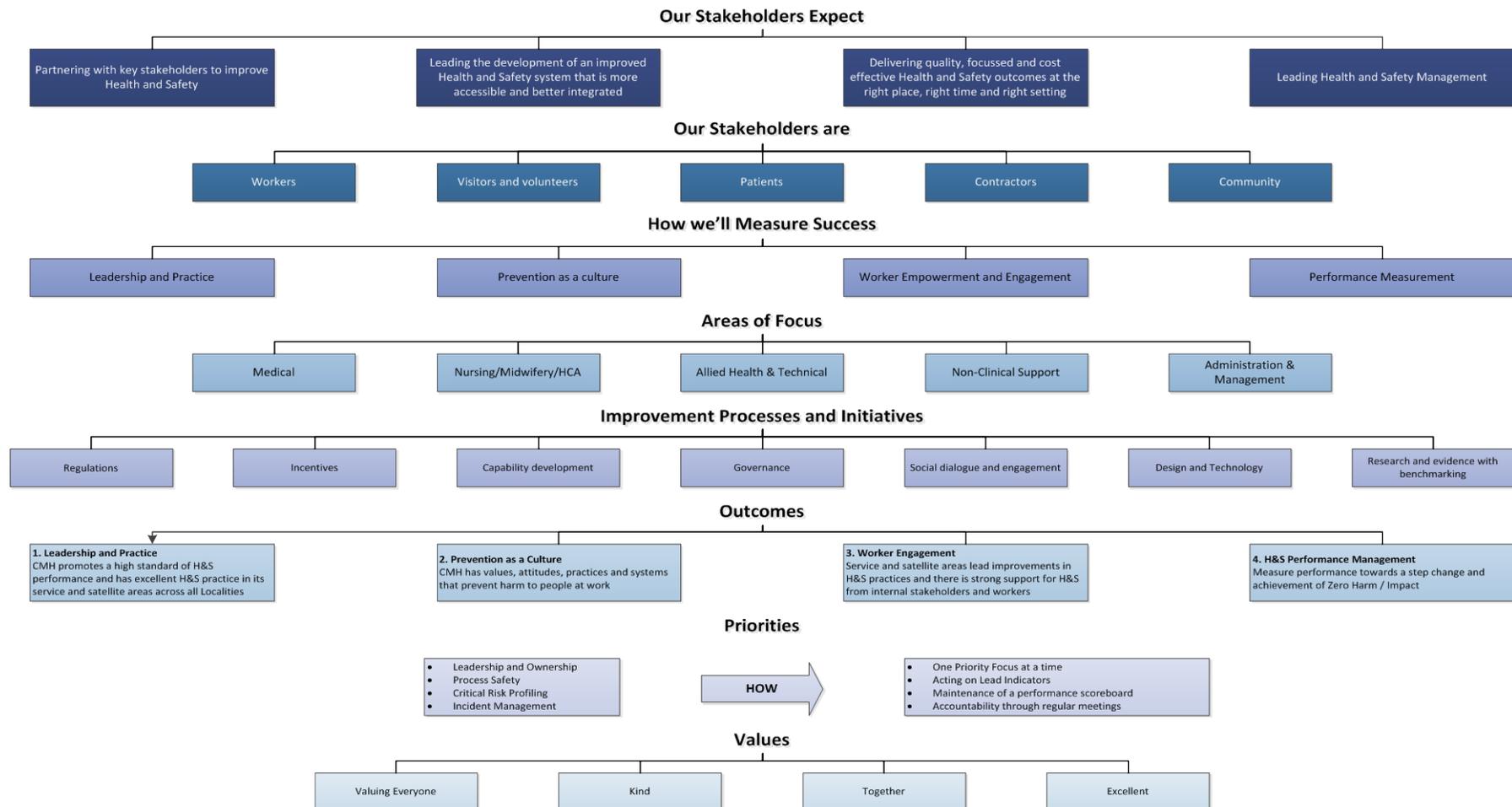
## Occupational Health & Safety Strategic Plan 2015 - 2020

**Purpose**  
If Health and Safety is demonstrated by leadership as a priority, overall Health and Safety performance will improve

**Vision:**  
For CM Health to have a clearly defined best practice Health and Safety management framework comprising of business excellence and user friendly systems and structures that allow risk to be understood, identified and controlled. It is consistently applied across the organisations, resulting in minimisation of business impact and harm has been prevented to our people

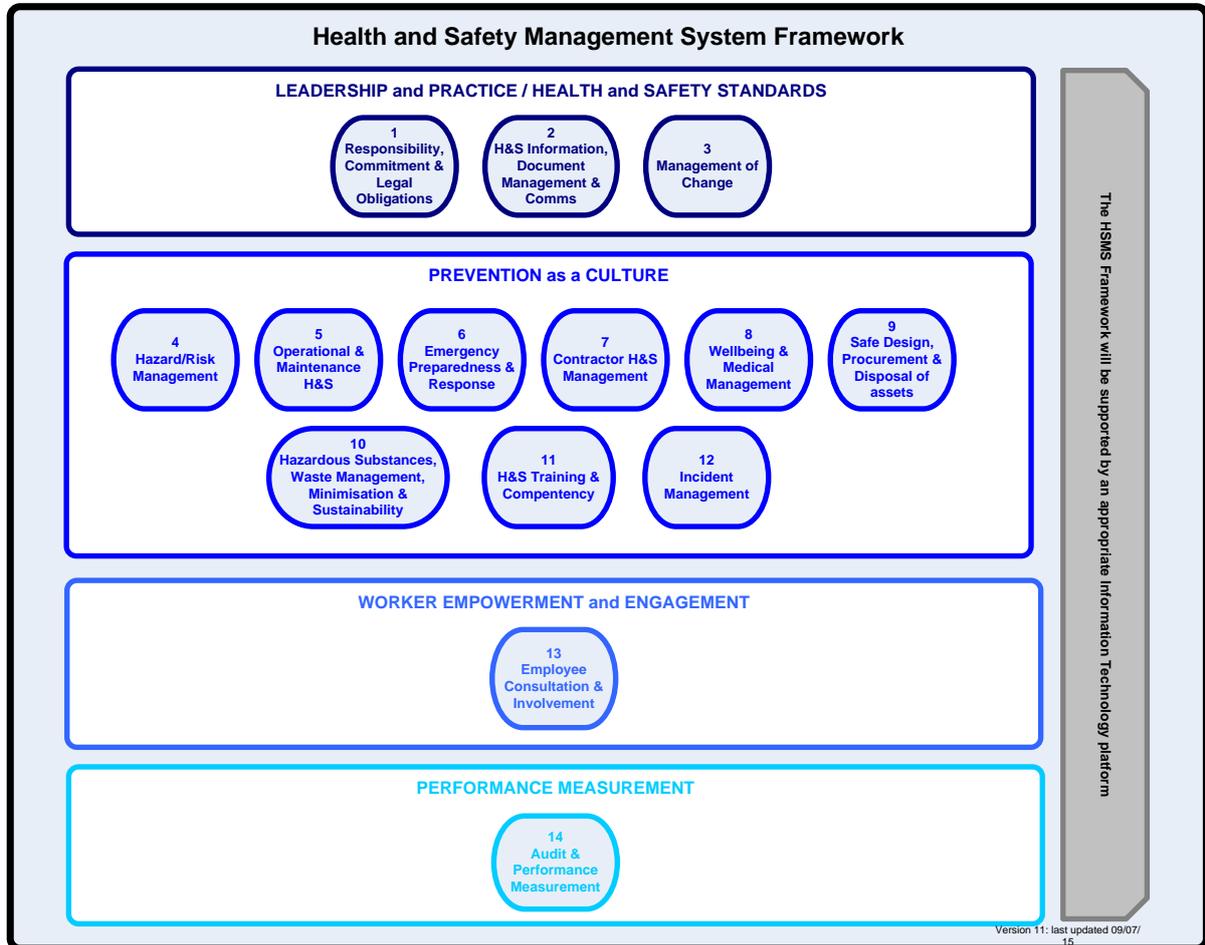
**Mission**  
To lead a step change in Health and Safety performance by:

- Advancing a common vision for Zero Harm / Impact across all levels of the business
- Modelling and growing inspirational, highly visible safety leadership
- Creating a compelling case for change and a strong workplace safety culture
- Sharing skills, experiences, and resources to overcome common challenges



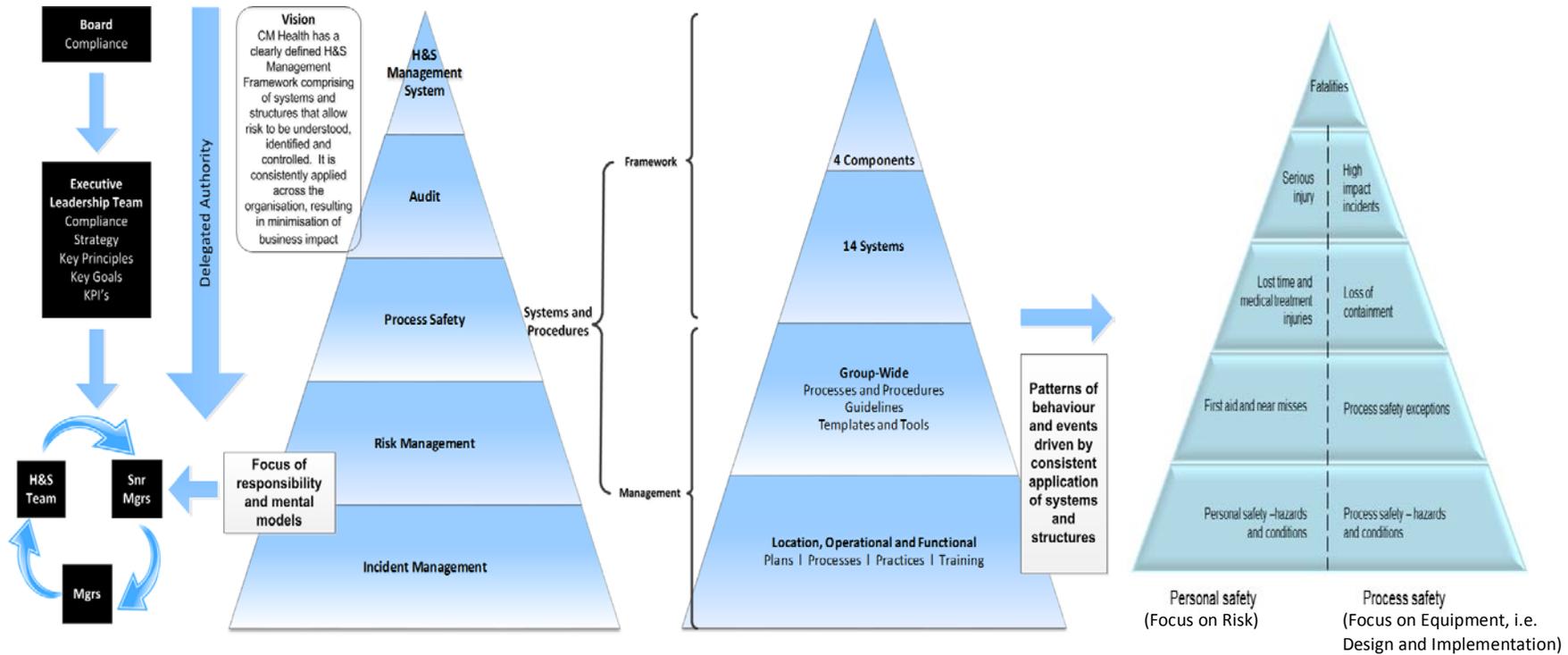


# CM Health's Health and Safety Management Framework

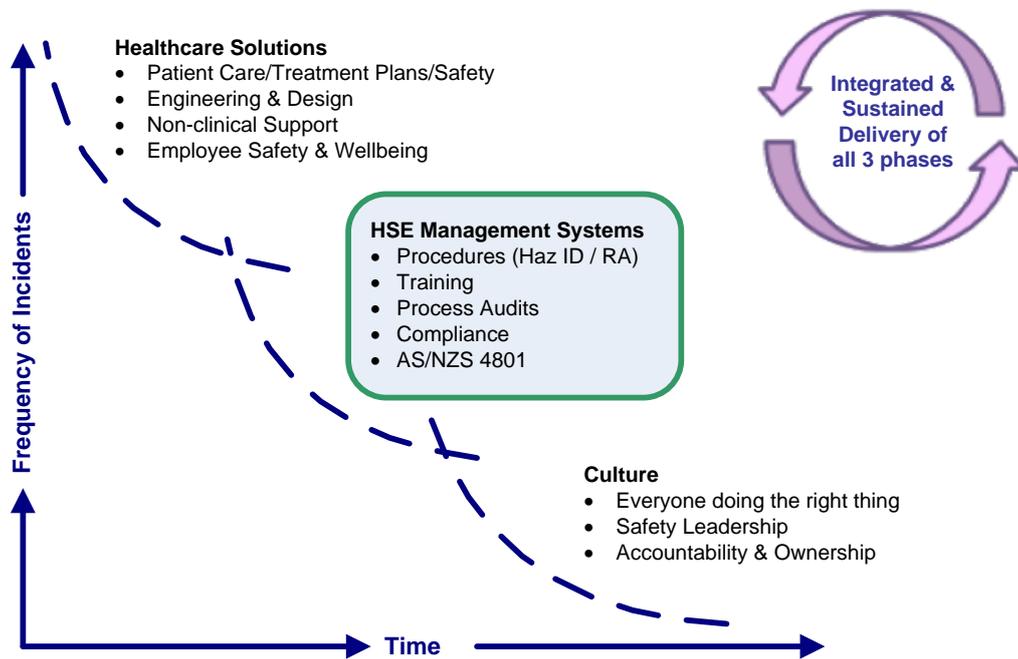


A comprehensive framework based on 4 Components and 14 Systems that drives the Health and Safety 5 year plan

# An Integrated Health and Safety Management Framework Approach



# Three Phase Approach



Integration of Health and Safety in a health care environment



Ministry of Business,  
Innovation & Employment



# Good Governance Practices Guideline for Managing Health and Safety Risks

“The board and directors are best placed to ensure that the company effectively manages health and safety. They should provide the necessary leadership and are responsible for the major decisions that must influence health and safety: the strategic direction, securing and allocating resources and ensuring the company has appropriate people, systems and equipment.”

Royal Commission on the Pike River Coal Mine Tragedy

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978-0-478-41345-8 (online)

May, 2013

This guideline was developed by the Institute of Directors in New Zealand (IoD) and the Ministry of Business, Innovation and Employment (MBIE) as a result of the key findings and recommendations laid out in the final report of the Royal Commission on the Pike River Coal Mine Tragedy. The development of the guideline was assisted by the New Zealand Council of Trade Unions (NZCTU), Business Leaders' Health and Safety Forum, Employers and Manufacturers Association (EMA), New Zealand Institute of Management (NZIM) and Business New Zealand.

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# Introduction

The governance of an organisation is a framework of interlocking values, principles and practices. Through this framework boards of directors exercise governing authority and make decisions in order to achieve the organisation's purpose and goals. They also ensure that the organisation operates with high standards of ethical behaviour, abiding by all laws and regulations.

It is important to distinguish between the governance and management of an organisation. The focus of directors should be on determining the organisation's purpose, developing an effective governance culture, holding management to account and ensuring effective compliance<sup>1</sup>. Directors work with management to develop the organisation's strategy and business plans which are then implemented by management.

Health and safety governance is as important as any other aspect of governance. It is a fundamental part of an organisation's overall risk management function which is a key responsibility of directors. Failure to manage health and safety risk effectively has both human and business costs. The price of failure can be the damaged lives of workers, their families and friends as well as direct financial costs, damaged reputations and the risk of legal prosecution.

It is important to remember that an organisation's duty to provide a safe and healthy work environment extends further than its employees. Legislation in New Zealand extends that duty to all those who could be affected by the activities of the organisation such as contractors, visitors and customers.

Organisations that learn to manage health and safety well, learn that the capability that drives success in this area is the same capability that drives success in other areas of the business. Organisations with a good health and safety culture and reputation are valued by workers, investors and stakeholders.

Because of their position in the organisation directors have a unique opportunity and an obligation to make a difference by providing leadership in this critical area of governance. It is also important to ensure that when an organisation achieves success that it is celebrated.

**"Leadership is about what I say,  
what I do, and what I measure"**

Business Leaders' Health and Safety Forum

<sup>1</sup> The Four Pillars of Governance Best Practice; Institute of Directors in New Zealand (inc.), Wellington, 2012.

Health and safety should be part of everyday business, it makes good business sense.

## PURPOSE AND SCOPE OF THIS GUIDELINE

The purpose of this guideline is to provide advice on health and safety governance and to:

1. Demonstrate how directors can influence health and safety performance
2. Provide a framework for how directors can lead, plan, review and improve health and safety
3. Assist directors to identify whether their health and safety management systems are of a standard and quality that is effective in minimising risk
4. Encourage directors to create strong, objective lines of reporting and communication to and from the board.

The principles discussed in this guideline apply to all members of governing bodies including directors, trustees and councillors of organisations of all types and sizes (including voluntary organisations). It is however, intended to have particular application to directors of medium to large sized organisations (20 or more employees). A separate guideline for directors of smaller organisations is being developed and will be available soon.<sup>23</sup>

This guidance is neither a policy statement nor a statutory document. While a court may take the document into account, there is no compulsion for it to do so. The document does however refer at times to relevant New Zealand legislation and to specific provisions within legislation. Where the word 'must' is used in the document to specify a requirement, this is intended to convey a legal requirement. Where the document intends a good practice imperative, rather than a legal one, the word 'should' is used.

This guideline was developed by the Institute of Directors in New Zealand (IoD) and the Ministry of Business, Innovation and Employment (MBIE) as a result of the key findings and recommendations laid out in the final report of the Royal Commission on the Pike River Coal Mine Tragedy. The development of the guideline was assisted by the New Zealand Council of Trade Unions (NZCTU), Business Leaders' Health and Safety Forum, Employers and Manufacturers Association (EMA), New Zealand Institute

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2 This document does not provide industry-specific advice. It is recommended that you seek such advice as a regular part of best practice. Ideally, you will have somebody with industry knowledge on your board who can provide this advice.

3 This document can be used by any organisation regardless of the number of workers. However, SMEs and NGOs often have different needs which may not be specifically addressed in this document.

# Why Effective Governance is Important

of Management (NZIM) and Business New Zealand.

## THE NEED TO IMPROVE

We know that many New Zealand organisations can and should improve their health and safety record. Each week one to two New Zealanders are killed while at work. In addition, there are an estimated 600 to 900 deaths each year from occupational diseases such as asbestosis. The financial cost is estimated to be \$3.5 billion or more each year. When looking at our performance in comparison to other developed countries we have much room for improvement.

The statistics do not begin to describe the impact on those who have been harmed, their families, friends and colleagues. The need to address this human cost is in itself sufficient reason to improve our record of harm prevention.

## THE BENEFITS OF GOOD HEALTH AND SAFETY

A positive and robust health and safety culture that begins at the board table and spreads throughout the organisation adds significant value, including:

- enhanced standing among potential workers, customers, suppliers, partners and investors as a result of a good reputation for a commitment to health and safety
- workers participating positively in other aspects of the organisation. A good organisational culture spreads wider than health and safety
- decreased worker absence and turnover. Engaged workers are more productive workers
- reduced business costs, for example a reduction in ACC levies as a result of improved health and safety performance and outcomes
- potentially increased economic returns. A report from the International Social Security Association found a return on prevention ratio of 2.2.<sup>4</sup>

The Pike River mine case provides a sobering example

of how ineffective governance can contribute to catastrophic results.

### CASE STUDY – PIKE RIVER COAL MINE TRAGEDY

An explosion at the Pike River mine on 19 November 2010 caused the deaths of 29 men.

In its final report into the tragedy the Royal Commission reached the following conclusions about corporate governance at the mine:

- **the board's focus on meeting production targets set the tone** for executive managers and their subordinates
- **the board needed to satisfy itself that executive managers were ensuring workers were being protected.** The board needed to have a company-wide risk framework and to keep its eye firmly on health and safety risks. It should have ensured that good risk assessment processes were operating throughout the company
- **an alert board would have ensured that these things had been done and done properly.** It would have familiarised itself with good health and safety management systems. It would have regularly commissioned independent audits and advice. **It would have held management strictly and continuously to account**
- **the Chairman's general attitude was that things were under control unless told otherwise.** This was not in accordance with good governance responsibilities. Coupled with the approach taken by executive managers this attitude exposed the workers to health and safety risks.

<sup>4</sup> The Return on Prevention: Calculating the costs and benefits of investments in occupational safety and health in companies; International Social Security Association (ISSA), Geneva, 2011.

# Essential Principles of Health and Safety Governance

## LEADERSHIP

It is the role of directors to provide leadership and policy that sets the direction for health and safety management. Directors create and demand expectations and exercise due diligence in holding management strictly and continuously to account for meeting them. Directors should:

- ensure there is an active commitment and consistent behaviour from the board that is aligned with the organisation's values, goals and beliefs. This will encourage a positive workplace culture
- ensure leadership is 'informed leadership'. Directors need to be aware of the organisation's hazards and risks. They should have an understanding of hazard control methods and systems so that they can identify whether their organisation's systems are of the required standard. They should understand how to 'measure' health and safety performance so they can understand whether systems are being implemented effectively. Directors should be prepared to seek advice from industry and health and safety experts as required
- set an example and engage with managers and workers, this could include visiting work sites. This provides leadership and improves their knowledge of health and safety matters.

## WORKER PARTICIPATION

Worker participation is an important part of health and safety risk management not only because it is a legal requirement but because it has proven to be highly effective. Research has shown that worker participation (and trade union participation) leads to better health and safety outcomes<sup>5</sup>. At the most fundamental level workers should be encouraged to contribute to continuous improvement by raising issues, generating ideas, and participating in system development, implementation, monitoring and review either directly or through their representatives.

Directors should set the overall tone for participation by holding management to account to ensure workers are involved. Questions as simple as "what are our workers saying about this issue?" or "how do our workers feel about it?" can bring a new dimension to the discussion.

**"The main conclusion that emerges from our findings overall is that worker representation and consultation in the UK have a significant role to play in improving health and safety at work. They have the potential to raise health and safety awareness amongst both workers and managers, effect improvement in arrangements for managing health and safety, improve the practical implementation of these arrangements, and contribute to improved health and safety performance. Most importantly they represent means by which workers' voices can be heard and acted upon to the benefit of those that experience the risks of the production process."**

David Walters et al (2005)

<sup>5</sup> The role and effectiveness of safety representatives in influencing workplace health and safety, Walters, D.R. Theo Nichols, Judith Connor, Ali C. Tasiran and Surhan Cam, (2005), HSE Research Report 363, Sudbury, HSE Books.

## LEGISLATIVE COMPLIANCE

An organisation's officers and directors must always comply with relevant laws and regulations and they must ensure their organisation's compliance. This requires that directors keep informed and up-to-date with legislative changes.

The overarching legislation that governs health and safety practice in New Zealand is the [Health and Safety in Employment Act 1992 \(HSE Act\)](#). This is supported by other key legislation such as the [Accident Compensation Act 2001](#) and the [Hazardous Substances and New Organisms Act 1996 \(HSNO\)](#). The HSE Act also has a number of regulations and approved codes of practice. A summary of the HSE Act titled [A Guide to the Health and Safety in Employment Act 1992](#) is available from MBIE.

Under the HSE Act the primary responsibility is placed on the employer who has a general duty to provide a safe and healthy work environment. The duty extends to all persons who may be affected by the activities of the organisation including, employees, contractors, public, visitors and customers and to the organisation's activities as a supplier to other organisations.

Directors can be held personally liable for an organisation's failure to comply with the HSE Act if they are held to have "...directed, authorised, assented to, acquiesced in, or participated in..."<sup>6</sup> a failure to comply.

A case study on Icepak Coolstores is included in this section and provides an example of a situation where a director was prosecuted.

### CASE STUDY – Icepak Coolstores

A director of Icepak Coolstores Ltd was convicted and fined \$30,000 after pleading guilty to a charge of breaching health and safety regulations. The specific charge was that **he acquiesced in the failure of the company to take all practicable steps** to ensure the safety of its employees while at work. This followed the coolstore explosion and fire at Tamahere near Hamilton in April 2008. The explosion killed a firefighter and left seven other firefighters with serious injuries.

Icepak Coolstores had installed a propane-based refrigeration system which they were aware was unique as an industrial operation of this kind and had never been adapted to use a highly flammable, explosive substance. The Fire Service had not been made aware of the presence of the explosive material nor were there any warning signs indicating its presence. The Crown claimed that directors had ignored a number of 'red flags' which should have alerted them to the risk such as propane gas regularly leaking, site gas detectors that needed replacing and several sources of ignition such as forklifts and switchboards.

The term 'acquiescence' is not defined in the Act and there was no discussion during the case regarding the meaning as the director had entered a guilty plea. The Department of Labour's position was that acquiescence meant the director was aware of the circumstances of the offending (not necessarily aware that there was an offence committed, just aware of the circumstances), was in a position to do something about it (the fact they were working directors of the business assisted with this) and didn't do anything about it.

<sup>6</sup> Health and Safety in Employment Act 1992, Section 56 (1).

The requirements for directors may be expressed as exercising 'due diligence'. While this concept is not currently used in legislation in New Zealand it is now defined in Australian legislation in the [Model Work Health and Safety Act \(WHS Act\)](#). Section 27 of the WHS Act requires officers to take reasonable steps to:

- a) acquire and update their knowledge of health and safety matters
- b) understand the operations being carried out by the person conducting the business or undertaking in which they are employed, and the hazards and risks associated with the operations
- c) ensure that the person conducting the business or undertaking has, and uses, appropriate resources and processes to eliminate or minimise health and safety risks arising from work being done
- d) ensure that the person conducting the business or undertaking has appropriate processes in place to receive and respond promptly to information regarding incidents, hazards and risks
- e) ensure that the person conducting the business or undertaking has, and uses, processes for complying with duties or obligations under the WHS Act.<sup>7</sup>

Boards and directors should aspire to move beyond compliance to 'best practice' – an approach that has shown results superior to those achieved by other means and that is used as a benchmark.

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<sup>7</sup> Guidance for officers in exercising due diligence; Comcare (Australian Government).

# The Role of Directors in the Governance of Health and Safety

The role of directors is outlined in the following pages in terms of four key elements:

- 1 Policy and Planning
- 2 Deliver
- 3 Monitor
- 4 Review

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The discussion of each element begins with a table that outlines director and management responsibilities. At the end of each section you will find a series of diagnostic questions and director actions. The diagnostic questions are designed to be used by directors as a tool to determine whether the organisation's practices are consistent with the board's beliefs, values, goals and approved systems. They can also be used as a basis for identifying areas that could be improved. The actions for directors are divided into two categories – baseline actions and recommended practice. Baseline actions are a suggested minimum requirement while recommended practice reflects taking the next step towards best practice.

Directors should never turn a blind eye to health and safety information. If they become aware everything is not as it should be they need to take decisive action.

# 1 Policy and Planning

## DIRECTOR RESPONSIBILITIES

- To determine the board's charter and structure for leading health and safety.
- To determine high level health and safety strategy and policy, including providing a statement of vision, beliefs and policy.
- To hold management to account for implementing strategy.
- To specify targets that will enable them to track the organisation's performance in implementing board strategy and policy.
- To manage the health and safety performance of the CEO, including specifying expectations and providing feedback.

## MANAGER RESPONSIBILITIES

- To determine and implement business and action plans to give effect to board strategy.
- To determine targets that will enable them to track their own performance.
- To implement performance management processes for workers that specify health and safety expectations, and provide feedback on performance.

## BOARD CHARTER AND STRUCTURE

The board should have its own charter setting out its role in leading health and safety in the organisation as well as the role of individual directors. The board may consider delegating a lead role in health and safety to an individual (if you have someone on the board with the necessary expertise) or a committee. Where specialist expertise is required consideration should be given to the engagement of an expert advisor. However, it must always be remembered that while tasks can be delegated, overall responsibility cannot be.

## HEALTH AND SAFETY POLICY (VISIONS AND BELIEFS)

A health and safety policy (also known as a vision and beliefs statement) will be the formal mode of communication that demonstrates the board's commitment to, and beliefs about the management of health and safety. An example from the Todd Corporation is included in this section. As a positive statement about values, beliefs and commitments it represents a long-term view that will set the tone for how they, and others in the organisation, will behave. These policies will be most robust where management and workers are involved in the preparation and 'reality testing'. However, they should ultimately be approved and 'owned' by the board. These policies should reflect the organisation's responsibility to provide a safe and healthy work environment not just for its workers but for contractors, visitors, customers and anyone who may be affected by the organisation's activities.

## SETTING TARGETS

Directors should set targets for the organisation that will provide direction, focus and clarity of expectation.

They should:

- be measurable
- be challenging but realistic
- contain a mix of lead and lag indicators, ensuring a greater weighting on lead indicators which focus on prevention.

A good discussion of the use of indicators is included in the publication [How Health and Safety Makes Good Business Sense – A Summary of Research Findings](#) which is available on the MBIE website.

## RELATIONSHIP WITH FINANCIAL TARGETS

It is important that directors send a clear message to management and the wider organisation that health and safety and financial targets are complementary. It is important that directors ensure their organisation does not have a culture where financial targets are prioritised at the expense of health and safety.

## ZERO HARM

'Zero harm' is often used as an aspirational target. Before applying this target, consider the strength of your organisation's risk and reporting culture. If it is a weak one, there may be a risk of cover-ups and non-reporting. Always remember, the key is to know what is happening in your organisation so that the board can make the right decisions.

## MANAGEMENT STRUCTURE AND PERFORMANCE

The board should ensure that there is an effective linkage between their health and safety goals and the actions and priorities of senior management. The board achieves this linkage through the CEO. Managers allocate health and safety responsibilities and accountabilities throughout the organisation, with details included in role descriptions and performance management processes. It is also good practice for knowledge and commitment to health and safety to be assessed during the recruitment of senior managers.

Lead indicators measure activities designed to prevent harm and manage and reduce risk, whereas lag indicators measure performance results. Care should be taken with the use of lag indicators because of their potential to encourage perverse outcomes such as the non-reporting of incidents, 'near misses' and injuries.

## DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to determine whether they are effectively meeting their responsibilities and accountabilities. They can also be useful in determining whether the organisation's practices are consistent with the board's strategies, beliefs, values, goals and approved systems.

1. How do you ensure that the targets you establish for your organisation are aligned with your health and safety strategies and goals in both the long and short-term, are challenging but realistic, and have no unintended perverse consequences?
2. How is your board structured to deliver its commitment to health and safety and where and how is this structure described?
3. What are the key health and safety responsibilities and accountabilities of operating managers and how are these different from support staff?
4. How do you ensure that the CEO understands and meets the board's expectations with regard to health and safety management?
5. What process do you use to assess the CEO's health and safety performance? How does this process recognise good and bad performance?
6. What processes are in place for ensuring that managers clearly understand their health and safety responsibilities and are held accountable for carrying them out?
7. How are the organisation's workers involved in the establishment of your organisation's vision, beliefs and policy?

### CASE STUDY – PROGRESSIVE ENTERPRISES

With 18,500 workers across almost 200 locations and 135 million people visiting their stores each year, Progressive Enterprises has a diverse and significant risk profile. While they believed they were putting safety first it was not being reflected in their performance with an LTIFR of over 20. In 2009 they started thinking more deeply about what safety actually meant and started to really engage workers.

In a drive to build credibility and engage workers the Countdown to Zero programme was launched. As part of the programme additional equipment was purchased to reduce specific risks such as injuries from deli slicers. The investment was not small with that upgrade alone costing over \$4000 per machine.

Recognising they weren't preparing workers appropriately to deliver the desired safety performance, a significant amount was invested in training. This was very well received by workers. A recent course saw every single band saw operator come along on their day off, not because they had to but because they wanted to.

Changing the culture was fundamental to the process. Implementing measures of performance that meant something to workers and ensuring that all incidents were reported was vital. The organisation now has a culture where the first thought is not blame but how to support the affected person followed by what can we learn and how do we share that.

The investment Progressive has made in health and safety has delivered results – the LTIFR is now under 5 and the financial cost of injuries at work has halved since 2009. It has also had a real impact on staff attitudes and beliefs with over 95% of staff strongly agreeing that safety is important to the organisation.<sup>8</sup>

8 Our countdown to zero injuries; Dave Chambers - Managing Director Progressive Enterprises: [www.zeroharm.org](http://www.zeroharm.org)

## ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
<b>Organisational Beliefs, Vision, Policy</b>	
Develop, approve and publish a safety vision and beliefs statement that will express the organisation's commitment to health and safety.	Consider involving workers and their representatives in the development of a vision and beliefs statement. This will help to ensure that it is 'owned' by the whole organisation.
<b>Targets</b>	
Establish targets for tracking the organisation's effectiveness in implementing the board's health and safety strategy and goals.	Include both lead and lag indicators in targets and ensure they do not create perverse incentives.
<b>Board Policy, Structure, Process</b>	
Decide how to structure the board so that health and safety has appropriate focus and expertise.	Consider nominating a non-executive director as a health and safety 'champion', or a committee that can focus on this key area.
Determine a board charter that will describe the board's own role and that of individual directors in leading health and safety in the organisation.	Ensure the board charter describes detailed structures and processes to be used to plan, deliver, monitor and review leadership of health and safety.
<b>Management Structure and Performance</b>	
Provide the CEO with a role description that includes health and safety responsibilities and accountabilities.	
Ensure that management operates with a structure that appropriately recognises the respective health and safety responsibilities and accountabilities of operating and support staff.	
Apply a performance review process to the CEO role and ensure that a similar process applies to other management.	Ensure that performance review and reward systems do not encourage cover-ups and other unwanted behaviours that are inconsistent with the board's beliefs and values.

## EXAMPLE OF POLICY STATEMENT

# Health and Safety Policy



### **Our Health & Safety Vision:**

***“We will all have a safe workplace”***

We believe that:

- No business objective will take priority over health and safety
- All incidents are preventable
- Whilst management have ultimate accountability, we all have responsibility for health and safety
- All personnel have the responsibility to stop any job they believe is unsafe or cannot be continued in a safe manner

To achieve this we will:

- Maintain and continually improve our Health, Safety and Environmental Management System
- Proactively identify hazards and unsafe behaviours and take all steps to manage these to as low as reasonably practicable
- Set targets for improvement and measure, appraise and report on our performance
- Assess and recognise the health and safety performance of employees and contractors
- Consult and actively promote participation with employees and contractors to ensure they have the training, skills, knowledge and resources to maintain a healthy and safe workplace
- Accurately report and learn from our incidents
- Support the safe and early return to work of injured employees
- Design, construct, operate and maintain our assets so that they safeguard people and property
- Require our contractors to demonstrate the same commitment to achieving excellence in health and safety performance
- Comply with relevant legislation, regulations, codes of practice and industry standards

Jon Young

A handwritten signature in black ink that reads 'Jon Young'.

Group Chief Executive Officer  
Todd Corporation Limited

## 2 Deliver

### DIRECTOR RESPONSIBILITIES

- To lay down a clear expectation for the organisation to have a fit-for-purpose health and safety management system.
- To exercise due diligence to ensure that the system is fit for purpose, being effectively implemented, regularly reviewed and continuously improved.
- To be sufficiently informed about the generic requirements for a modern, 'best practice' health and safety management system and about their organisation and its hazards to know whether its system is fit-for-purpose, and being effectively implemented.
- To ensure sufficient resources are available for the development, implementation and maintenance of the system.

### MANAGER RESPONSIBILITIES

- To lead the implementation of health and safety management systems and programmes.
- To identify resource requirements for the development, implementation and maintenance of the health and safety system, obtain approval for their provision, and secure and allocate resources accordingly.
- To allocate responsibilities and accountabilities to managers and workers for implementation of the system and its components.
- To monitor the effectiveness of the system and implement continuous improvements.

### HEALTH AND SAFETY MANAGEMENT SYSTEM

Organisations should have a fit-for-purpose health and safety management system that is integrated with other management systems. The size, sophistication and detail of the system will reflect the organisation's risk profile, with high hazard organisations requiring more substantial systems.

Merely having a good system will not achieve good health and safety. Systems need to be implemented with rigor and consistency. Directors should hold management to account for effective implementation.

The main aim of a health and safety management system is effective hazard and risk management. This is the process by which hazards that have the potential to cause harm are identified and controls to eliminate, isolate or minimise the risk of harm are implemented. Harm refers to illness, injury or both. It also includes physical or mental harm caused by work-related stress.

Risk assessment requires a judgement about the probability of an incident happening and the potential seriousness if it does happen. Attention needs to be paid to the full spectrum including those incidents that are more likely to occur but with less serious consequences, and those incidents that are less likely to occur, but with catastrophic consequences when they do.

Guidelines on the requirements for an effective health and safety management system are described in [Standards AS/NZS 4801:2001](#) and [AS/NZS 4804:2001](#). Further guidance to safety management practices and injury management can also be obtained from ACC ([www.acc.co.nz](http://www.acc.co.nz)):

- ACC442 ACC Workplace Safety Management Practices Audit Standards (aligned with the Australia/ New Zealand Standards for Occupational Health and Safety Management Systems (AS:NZS 4801:2001)
- ACC2465 ACC Partnership Programme Injury Management Practices Audit Standards

## KEY ASPECTS OF A HEALTH AND SAFETY MANAGEMENT SYSTEM

### Hazard and risk management

Organisations must identify all actual and potential hazards and implement controls for those assessed as significant. During organisational change, risk assessments should be undertaken so that the full health and safety impact of the changes can be understood and managed.

### Incident management

Organisations should have well-defined processes for reporting and investigating incidents to identify root causes. The aim of incident management is to identify and implement remedial actions to prevent the incident happening again.

### Emergency management

Organisations should develop plans for managing potential emergencies that may arise in the workplace. These plans should be communicated to all persons working on site. Plans should be regularly tested by simulation.

### Injury management

Organisations should have processes for ensuring that injured persons are properly cared for. In the case of serious injuries and fatalities this care should extend also to families and work mates.

### Participation

Under the Act organisations with more than 30 employees, or when requested by an employee or a union, must develop and agree a participation agreement.

### Continuous improvement

The need to continuously improve the health and safety management system is a fundamental requirement. Directors should hold management to account for doing this. Guidance on continuous improvement can be found in AS/NZS 4801 and 4804. Continuous improvement also includes the audit and review process.

Two areas that overlay the system are resources and leadership. The organisation must be provided with the resources required for it to operate safely. This includes people, plant and equipment, systems and budget. Leadership should be shown at all levels throughout the organisation. Management must define its commitment to health and safety, establish objectives, targets and plans for giving effect to this commitment, and lead the organisation in their achievement.

## DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to determine whether they are effectively meeting their responsibilities and accountabilities.

1. How do you know that the organisation's health and safety management system is fit for purpose and represents best practice?
2. What systems are in place to ensure that hazards and risks are identified, assessed and effectively managed?
3. Have you thought about potential incidents that are less likely to occur, but with catastrophic consequences if they do?
4. Where there is significant organisational change that has implications for health and safety how do you ensure that this is reported to the board?
5. How good is the organisation's emergency management plan and state of readiness that will ensure an effective response to any potential emergency? When was it last tested?
6. How does the organisation ensure that it has the right people with the right skills and motivation managing health and safety?
7. How does the organisation ensure that all plant and equipment used on site meets an acceptable standard?
8. How does the organisation ensure that contractors have satisfactory health and safety standards?
9. How does the organisation ensure that the goods and services it supplies to other organisations meet satisfactory health and safety standards?
10. Does the organisation have an adequate budget for its health and safety programme?

*"We insist that safety is our number one priority. Above all else, we value human life and expect that our port colleagues will go home to loved ones at the end of their shift in the same condition they entered the port gate."*

Mark Cairns, Port of Tauranga

## ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
<b>Health and Safety Management Systems</b>	
Ensure that management develops, implements, audits and regularly reviews and updates an effective health and safety management system consistent with accepted standards.	Undertake training to ensure a good understanding of the requirements of the health and safety management system and particularly of hazard and risk management practices.
Review management reports on reviews and audits of systems and control plans.	Commission periodic external audits and reviews of the system.  Ensure that workers and representatives participate in audits and system reviews.
Become personally aware of your organisation's hazards and control systems. Review risk registers.	Ensure you have a detailed knowledge of your organisation's hazards and control systems. This should be refreshed regularly including through engagement with managers and workers which may include site visits.
Ensure that hazards are identified by management and that control plans are in place for their effective management.	Periodically (at least every two years) obtain/review independent advice on the adequacy of hazard control plans and the effectiveness of their implementation.
Ensure that management implements procedures for the selection of contractors and monitoring their activities so that you are assured of their health and safety.	Ensure that management insists on contractors having health and safety standards that match your organisations.
<b>Resources – People</b>	
Ensure that management have staffed the organisation with sufficient personnel with the right skill mix, supported by specialists as required to operate the business safely.	Ensure that the organisation has effective processes in place for recruitment, training and direction of managers so that they are skilled and motivated to reinforce a positive health and safety culture and ensure the health and safety of their people and teams.

Ensure management implements a system of worker participation that enables workers and their representatives to participate in decision-making, implementation and monitoring of their workplace health and safety management systems.	Ensure that the organisation implements a 'just culture' whereby there is an atmosphere of trust in which people are encouraged to provide safety-related information, without fear of retribution or blame for honest mistakes but are still held accountable for wilful violations and gross negligence.
Encourage a culture where reporting of events is expected and followed up.	Monitor the overall workplace health and safety culture using survey techniques.
<b>Resources – Plant and Equipment</b>	
Ensure that plant and equipment is provided by management that is fit for purpose, well maintained and supported by training and safe operating procedures.	Ensure well established and documented standards for plant and equipment that are used at procurement and during on-going operation and maintenance. Plant and equipment are not allowed on site if it does not meet this standard. This also applies to equipment used by contractors.
<b>Resources – Systems</b>	
Ensure that management provides systems that will support the effective management of health and safety.	Ensure management provides computer based systems for capturing data on health and safety incidents, analysis and reporting. Good systems will also assist with the tracking of action plans following incidents and audits etc and will assist to ensure their timely completion. The health and safety management system will be documented and available for all to read. Information from it will be regularly communicated to workers.
<b>Resources – Budget</b>	
Provide sufficient funds for the effective implementation and maintenance of the health and safety management system and for improvement programmes.	Ensure there is a policy of dealing with health and safety on the basis of need rather than budget limits.

### 3 Monitor

#### DIRECTOR RESPONSIBILITIES

- To monitor the health and safety performance of the organisation.
- To outline clear expectations on what should be reported to the board and in what timeframes.
- To review reports to determine whether intervention is required to achieve, or support organisational improvements.
- To make themselves familiar with processes such as audit, risk assessment, incident investigation, sufficient to enable them to properly evaluate the information before them.
- To seek independent expert advice when required to gain the required degree of assurance.

#### MANAGER RESPONSIBILITIES

- To give effect to board direction by implementing a health and safety management system using the 'plan, do, check, act' cycle.
- To provide the board with reports on health and safety management system implementation, and performance as required.
- To implement further actions following board review of reports.
- To ensure root cause investigations are carried out using independent investigators in the case of serious incidents.

The implementation of long-term goals and strategy through business planning is the responsibility of management. However, the board needs to ensure, through appropriate monitoring, that these strategies are being effectively implemented.

Directors must never turn a blind eye to undesirable information. They should, instead, always seek out complete and accurate information that will enable them to know whether the organisation is meeting all of its health and safety obligations and goals. Directors must always act decisively whenever that information suggests that it is not.

## ROUTINE REPORTS TO BOARD

The following information should be on the board's agenda and reviewed on a regular basis:

- data on all incidents, including near misses and occupational illness. Effective monitoring of these statistics can alert the board to underlying problems before any serious incidents occur
- data on absence rates due to sickness that can be indicators of issues such as stress and fatigue
- data on trends including routine exposure to risks that are potentially harmful to health such as high noise levels, toxic chemicals and bullying
- progress with the implementation of formal improvement plans
- actions in place aimed at preventing harm, such as training, and maintenance programmes
- the health and safety performance and actions of contractors
- reports on internal and external audits, and system reviews.

Directors should be alert to the possibility that there is reluctance to report such information and should satisfy themselves that any such obstacles have been eliminated.

## INCIDENTS

Incident investigations should identify root causes and put in place measures to prevent the incident happening again. Investigations should not be about apportioning blame. When looking for root causes there should be consideration of human factors that can contribute to incidents and the possibility of systemic failure such as culture, workload or lack of training.

Directors should review serious incident reports and be satisfied with the integrity of the process, and that the incident investigation has correctly identified root causes, and that an effective action plan has been put in place to address the issues identified. Directors should require further reports covering the completion of actions so that they can be satisfied that the implementation of actions arising from incidents is both effective and timely.

## DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to verify that the information they receive is appropriate, accurate and comprehensive.

1. Are you asking the right questions? Do you determine what information you receive or does management?
2. How do you know that the information you are receiving is supported by a strong and honest reporting culture?
3. How does your organisation's performance compare with other comparable organisations and how do you know?
4. Does the organisation have the capability to carry out 'root cause' investigations, or know where to get it?
5. How do you know that actions identified in incident investigations are effectively implemented?
6. How much of the information that you receive is also shared with workers?
7. Are you receiving sufficient information about health as well as safety?

### CASE STUDY – COCA-COLA AMATIL NZ

Following a worsening trend in workplace accidents in 2010, it implemented a five-step reform of health and safety measures. The five steps were clear and uncomplicated:

1. Set measurable goals relating to what they wished to achieve with its health and safety reform
2. Use robust and fit-for-purpose health and safety (including hazard) management systems and ensure they are fully integrated into the company
3. Change the culture (including improvement of the reporting culture)
4. Introduce practical programmes (such as stretching before manual labour)
5. Visible leadership – one of the key actions undertaken by the managing director responsible for health and safety was to join the health and safety leadership forum. Another more simple action was to sit in on health and safety committee meetings.

In the year following implementation of the health and safety measures there was a marked increase in reported injuries, but the severity of the injuries had declined. There were 155 near hits reported in November 2011. This indicated a substantial uptake of values by workers at the company and a change in attitudes toward health and safety along with the overall reporting culture. It also indicated that the systems put in place were working. In 2011, the company saw a 90% decrease in ACC costs and in the first quarter of 2012, had zero lost time injuries.

## ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
<p>Specify clear requirements regarding reporting and timeframes for significant events in the board’s charter.</p>	
<p>Ensure that in the case of serious incidents management have sought external input or review to provide independence and avoid potential vested interests.</p>	
<p>Review serious incidents, including serious non-compliance and near misses and be personally satisfied with the adequacy of management actions in response.</p>	<p>Directors should receive basic training in incident investigation methodology sufficient to ensure that they are able to distinguish between adequate and inadequate investigations.</p> <p>In the case of serious health and safety incidents, obtain independent advice on the adequacy of the investigation and remedial actions.</p>
<p>Ensure that improvement goals are developed annually by management and that regular progress reports are received by the board.</p>	<p>Separate organisations and work sites will have their own business goals. Visible tracking of goals by directors will demonstrate commitment and leadership and encourage commitment from line management to take these goals seriously.</p> <p>For example a site manager may be invited to a board meeting to report on progress with an annual improvement plan or this may be the subject of discussion during a site visit.</p>
<p>Specify clear requirements for the regular reporting of health and safety performance results, and review these reports at meetings for indications of trends, system breakdowns and improvement needs.</p>	<p>Ensure you have a sound understanding of, and focus on, hazards that would have a significant impact on the business.</p> <p>Ensure reports allow tracking of both lag and lead indicators.</p> <p>Directors should satisfy themselves that there are no obstacles to free and frank reporting.</p> <p>Boards should develop their own reports on health and safety performance for shareholders and other stakeholders. Health and safety performance should be included in external reports.</p>

## 4 Review

### DIRECTOR RESPONSIBILITIES

- To ensure the board conducts a periodic (eg annual) formal review of health and safety to determine the effectiveness of the system and whether any changes are required.
- To ensure the board considers whether an external review is required for an independent opinion.

### MANAGER RESPONSIBILITIES

- To organise regular audits and reviews of the health and safety management system (internal and external) and its implementation.
- To take remedial actions as required arising from any audit or review.
- To report to the board on the outcomes of audits and reviews.
- To assist the board with the formal health and safety review by providing information and other input as required.

The board should conduct a formal review of health and safety performance on a periodic basis. This enables the board to establish whether their health and safety principles have been embedded in the organisation's culture. Similarly the review will consider whether the policy and system are being effectively implemented and whether they are still fit for purpose.

### AUDITS AND SYSTEM REVIEWS

Audits and system reviews arranged by management will inform the board's formal review. Directors should ensure that reviews are undertaken on a regular basis. The objective of an audit is to assess the quality of system implementation and the objective of a system review is to assess whether the system is fit-for-purpose and representative of best practice.

It is normal for audits and system reviews to recommend actions for improvement. Directors should ensure that these recommendations are properly considered by management and where agreed, implemented.

It is desirable that an internal audit or review team comprises a cross section of managers and worker representatives so that a range of perspectives, knowledge and skill is brought to the table. This approach also supports the message that health and safety is everybody's responsibility. Directors should consider if the appropriate people were involved in the review or audit.

It is good practice for the organisation to periodically seek independent and objective assurance from an external audit and/or system review. An external opinion can bring a fresh pair of eyes and new ways of thinking. Involving worker representatives in the selection of external auditors and reviewers is good practice that will help ensure the required objectivity.

### FORMAL REVIEW OUTCOMES

The formal review will identify strengths and weaknesses in the system and its implementation.

It is just as important that good performance is recognised and celebrated as it is that opportunities for improvement are identified.

Improvement action plans arising from the formal review should be tracked by directors at regular board meetings.

## DIAGNOSTIC QUESTIONS

The following diagnostic questions are examples that can be used by directors and boards as prompts to verify that they are conducting adequate formal reviews of health and safety.

1. What do you do to ensure an appropriate and thorough board level review of health and safety?
2. What information do you use for the review and who do you involve?
3. How do you ensure that your review uses best practice as a benchmark?
4. How do you ensure that workers contribute to this review?
5. How do you ensure maximum independence and objectivity of reviews and audits?
6. How do you recognise and celebrate success?
7. How do you ensure that actions identified in the review are communicated and effectively implemented?

### CASE STUDY – HOLCIM NEW ZEALAND

In the mid-90s Holcim New Zealand's safety record was poor. With a LTIFR of 43.8 there was significant room for improvement. While a series of short-term measures saw improvements it wasn't until 2003 when the organisation sought outside help that things really started to change. External audits highlighted there was much more to do than expected and it was clear a change would require a lot of energy and drive. Holcim committed to putting in that effort and put in place the following measures:

- management and the board committed to demonstrating visible safety leadership
  - safety is a key agenda item at board meetings
  - a safety council was created which meets each month to set policy and direction and review progress
  - all of the management team are actively involved in health and safety – they each must spend two half days a year working on-site
  - all managers must attend a four-day safety leadership programme

- adopted a philosophy of 'zero harm, safety first'
- each division has health and safety staff
- the safety manager reports direct to the CEO
- focus on the development of useful lead indicators
- significant effort on developing a safety culture among staff; staff engagement surveys now reflect the effort put into safety
- development of a contractor management programme including a pre-selection process, inductions and specific Holcim site training.

These measures have had a significant impact on Holcim's health and safety performance, the organisation now has an LTIFR of below 3. The focus has shifted significantly with 500 employees completing nearly 6600 safety tours (audits) in 2011. Health and safety is now owned by all Holcim employees in their drive for 'zero harm, safety first'.<sup>9</sup>

<sup>9</sup> Safety – one of the toughest leadership challenges; Jeremy Smith - Managing Director Holcim New Zealand: [www.zeroharm.org](http://www.zeroharm.org)

## ACTIONS FOR DIRECTORS

BASELINE ACTIONS	RECOMMENDED PRACTICE
Specify arrangements for the formal review of health and safety in the board's charter including frequency, who is involved and how, what input is required etc.	Provide opportunities for worker representatives and workers with relevant skills and knowledge to participate in internal audits and reviews and in the selection of external auditors and reviewers.
Ensure that input to the formal review includes audits (internal and external), system reviews, performance results, significant incidents, organisational changes and benchmark data.	Periodically commission a culture survey to assist the review.
As an outcome from the review determine an action plan and track progress.	

# Conclusion

As a director, managing your organisation's health and safety risk is just as important as managing financial and reputational risk and it should receive the same focus.

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Boards are responsible for determining high level health and safety strategy and policy which managers are required to implement. This strategy and policy must take into consideration all those affected by the organisation's activities, not just workers. Board responsibility however, does not stop with the issuing of strategy and policy as they should also ensure that it is implemented effectively. They do this by holding management to account through processes of policy and planning, delivery, monitoring and review. This includes recognising when the organisation is doing well and celebrating success. Through these processes the board should ensure that they have created an environment in which a commitment to health and safety is part of everyday business. Having a positive health and safety culture and an integrated, embedded and effective health and safety management system in which managers and workers take individual ownership will have significant benefits for the organisation.

Unless the board is aware of a serious issue, they cannot address it. Information is key. Ensure your management team is telling you all you need to know and don't leave anything to chance. Remember – if it seems too good to be true, it probably is.

# Director Health and Safety Checklist

-  How do the board and all directors demonstrate their commitment to health and safety?
-  How do you involve the organisation's workers in health and safety? Do they feel able to express any concerns?
-  How do you ensure that your organisation's health and safety targets are challenging, realistic and aren't creating unintended consequences?
-  What data is the board receiving on health and safety? Is this sufficient?
-  How do you ensure all staff are competent and adequately trained in their health and safety responsibilities and accountabilities?
-  Does the organisation have sufficient resources (people, equipment, systems and budget) for its health and safety programme?
-  Does the organisation have a schedule of audits and reviews to ensure the health and safety management system is fit for purpose?
-  How do you ensure that actions identified in incident reports, audits and reviews are communicated and effectively implemented?
-  How do you ensure that the organisation's risks are assessed and appropriate mitigation measures put in place?
-  How connected are you to what happens at the organisation's work sites? What measures are in place to inform you?
-  Does the organisation have policies and processes in place to ensure contractors used by the organisation have satisfactory health and safety standards?
-  How does your organisation's performance compare with other comparable organisations and how do you know?
-  How do you recognise and celebrate success?

# Resources

## KEY LEGISLATION

All available online at [www.legislation.govt.nz](http://www.legislation.govt.nz)

- Health and Safety in Employment Act 1992
- Accident Compensation Act 2001
- Hazardous Substances and New Organisms Act 1996

A wide range of regulations and codes of practice can be found on the MBIE website [www.mbie.govt.nz](http://www.mbie.govt.nz).

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## STANDARDS

All available from Standards New Zealand online at [www.standards.co.nz](http://www.standards.co.nz)

- AS/NZS 4801:2001 – Occupational Health and Safety Management Systems - Specification with guidance for use
  - AS/NZS 4804:2001 – Occupational health and safety management system - General guidelines on principles, systems and supporting techniques
  - AS/NZS ISO 31000:2009 – Risk management - Principles and guidelines
- 

## PUBLICATIONS AND WEBSITES

- Ministry of Business, Innovation and Employment – [www.mbie.govt.nz](http://www.mbie.govt.nz)
  - A Guide to the Health and Safety in Employment Act 1992
  - Taking All Practicable Steps
  - How Health and Safety Makes Good Business Sense
  - A range of health and safety factsheets on topics such as serious harm, taking all practicable steps and employee participation systems are available online at [www.osh.govt.nz/order/catalogue/factsheets.shtml#hse](http://www.osh.govt.nz/order/catalogue/factsheets.shtml#hse)
  - A series of health and safety publications can be found at [www.osh.govt.nz/order/catalogue/hse-publications.shtml](http://www.osh.govt.nz/order/catalogue/hse-publications.shtml)
- ACC – [www.acc.govt.nz/publications](http://www.acc.govt.nz/publications)
  - Measuring your capabilities in Workplace Safety Management - ACC Workplace Safety Management Practices Audit Standards (ACC442)

- Guidance for Officers in Exercising Due Diligence – [www.comcare.gov.au/\\_\\_data/assets/pdf\\_file/0020/102566/Guidance\\_for\\_officers\\_in\\_exercising\\_due\\_diligence.pdf](http://www.comcare.gov.au/__data/assets/pdf_file/0020/102566/Guidance_for_officers_in_exercising_due_diligence.pdf))
- Institute of Directors in New Zealand [www.iod.org.nz](http://www.iod.org.nz)
- The Four Pillars of Governance Best Practice (Available from the Institute of Directors in New Zealand)
- Leading Health and Safety at Work, Leadership actions for directors and board members [www.hse.gov.uk/pubns/indg417.pdf](http://www.hse.gov.uk/pubns/indg417.pdf)
- World Class CEO Safety Leadership Assessment (Business Leaders' Health and Safety Forum) [www.zeroharm.org.nz/leadership/leadership-assessment/](http://www.zeroharm.org.nz/leadership/leadership-assessment/)
- The return on prevention: Calculating the costs and benefits of investments in occupational safety and health in companies, International Social Security Association Research Report – [www.issa.int/content/download/152234/3046913/file/2-Return-on-prevention.pdf](http://www.issa.int/content/download/152234/3046913/file/2-Return-on-prevention.pdf)

# Glossary

<b>All practicable steps</b>	A key concept in the HSE Act that relates to a requirement to take all steps that a reasonable, prudent person would take in the same situation. For a full definition or explanation of “all practicable steps”, refer to the HSE Act and/or the Department of Labour fact sheet, both of which are referenced in the following resource list.
<b>Best practice</b>	A method or technique that in like circumstances has consistently shown superior results in comparison to results achieved using other means – used as a benchmark.
<b>Harm</b>	Illness, injury or both. This includes physical or mental harm caused by work-related stress.
<b>Hazard</b>	Is defined in the HSE Act as an activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation, or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm; and includes: <ul style="list-style-type: none"> <li>• a situation where a person’s behaviour may be an actual or potential cause or source of harm to the person or another person; and</li> <li>• without limitation, a situation described above resulting from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person’s behaviour.</li> </ul>
<b>Lost time injury frequency rate (LTIFR)</b>	Number of reported injuries that resulted in at least one day being lost from work after the day of the injury or illness per million hours worked.
<b>Near miss</b>	A situation or incident where harm might have occurred.
<b>Organisational culture</b>	Collective set of values and beliefs held and exercised within an organisation or workplace.

<b>Serious harm</b>	<p>Is defined in the HSE Act as:</p> <ul style="list-style-type: none"> <li>• any of the following conditions that amount to or result in: permanent loss of bodily function, or temporary severe loss of bodily function: respiratory disease, noise-induced hearing loss, neurological disease, cancer, dermatological disease, communicable disease, musculoskeletal disease, illness caused by exposure to infected material, decompression sickness, poisoning, vision impairment, chemical or hot-metal burn of eye, penetrating wound of eye, bone fracture, laceration, crushing</li> <li>• amputation of body part</li> <li>• burns requiring referral to a specialist registered medical practitioner or specialist outpatient clinic</li> <li>• loss of consciousness from lack of oxygen</li> <li>• loss of consciousness, or acute illness requiring treatment by a registered medical practitioner, from absorption, inhalation or ingestion of any substance</li> <li>• any harm that causes the person harmed to be hospitalised for a period of 48 hours or more commencing within seven days of the harm's occurrence.</li> </ul>
<b>Significant hazard</b>	<p>Is defined in the HSE Act as a hazard that is an actual or potential cause or source of:</p> <ol style="list-style-type: none"> <li>a) serious harm; or</li> <li>b) harm (being harm that is more than trivial) the severity of whose effects on any person depend (entirely or among other things) on the extent or frequency of the person's exposure to the hazard; or</li> <li>c) harm that does not usually occur, or usually is not easily detectable, until a significant time after exposure to the hazard.</li> </ol>
<b>Workers</b>	Employees of the organisation, its contractors and its subcontractors.
<b>Zero harm</b>	An expression used by many organisations to describe an aspirational target of no harm of any sort to workers.

All definitions that relate to legislation are correct as at 30 April 2013.







# ***Counties Manukau Health – Health and Safety Management Framework***

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***Version 8***

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## Introduction

The Health and Safety Management System (HSMS) provides Counties Manukau Health (CMH) with a means of delivering consistent and effective H&S practices across all of its business activities and operations. Application of the HSMS assists CMH to deliver against its business objectives detailed in its H&S policies.

## Scope

Where practicable, generic HSMS documentation will be developed and applied across all CMH business operations. This approach will have a number of benefits:

- Simplification of business systems
- Increased business clarity
- Reduced business risk
- Reduced training requirements
- Reduced document maintenance
- Enhancing a single corporate culture
- Increased business efficiency and lower long term costs
- Improved corporate profile in the public domain

## Normative References

The HSMS takes a structured approach for managing business activities using an integrated methodology built upon a platform of recognised national and international Standards, namely:

ISO 9001	Quality Management System (QMS)
AS/NZS 4801	Occupational Health and Safety Management System (OSH MS)
NZS 7901	Safety Management System for Public Safety (SMS PS)

CM Health Corporate Compliance Requirements <i>(to be defined)</i>	ACC Workplace Safety Management Programme	AS/NZS 4801 OHS Management	ISO 9001 Quality Management	NZS 7901 Safety Management System for Public Safety	Regional DHB Strategic Plan	Other <i>(to be clarified)</i>
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Each of the 14 system standards will contain a minimum of five (5) sections (in the finalised documents).

<b>Section 1: Aim</b>	A one or two-paragraph statement stating the aims or plan of action covered by the System document.
<b>Section 2: Interfaces / Details of:</b>	<ul style="list-style-type: none"> <li>• Other Systems</li> <li>• Documents</li> <li>• Divisions</li> <li>• Contractors</li> <li>• External Parties impacted by the System document</li> </ul>
<b>Section 3: Procedure</b>	How the System expectations will be achieved. (This must be written in a simple and easily interpreted style)
<b>Section 4: Roles and Responsibilities</b>	Who and what actions will be undertaken to achieve the System expectations.
<b>Section 5: Assessment and Feedback</b>	The measures (Key performance indicators – lag & lead) and reporting & / or communication requirements to verify the expectations of the System are being met.

The intent of this structured systems approach to formal document architecture is to:

- Drive conformity throughout the business
- Remove bureaucracy
- Provide clarity
- Provide a sustainable framework for achieving the organisation’s Safety & Health goals

## ***Counties Manukau Health H&S management system overview (context to the organisation)***

An effective HSMS is built upon a series of interlinking systems, which supports an organizational culture that can deliver:

- Zero injuries
- Zero non-compliance issues
- Continual H&S improvement

The HSMS sets out the expectations by which this can be achieved, focusing on high frequency / low consequence events (typically related to personal safety) and low frequency / high consequence events (typically related to process safety).



The HSMS follows and incorporates the shared CMH organisational values.

CMH Shared Values	
<b>Valuing Everyone</b>	Make everyone feel welcome and valued
<b>Kind</b>	Care for other people’s wellbeing
<b>Together</b>	Include everyone as part of the team
<b>Excellent</b>	Safe, professional, always improving

## ***HSMS due diligence and leadership***

Health and Safety governance is the relationship between board members and senior executives in the health and safety leadership of an organisation. It provides:

- The structure through which the vision and commitment to safety is set;
- Agreement on how safety objectives are to be attained;
- A framework for how monitoring performance is to be established; and
- Processes in which to comply with relevant legislation.

## Safety Governance Pathway

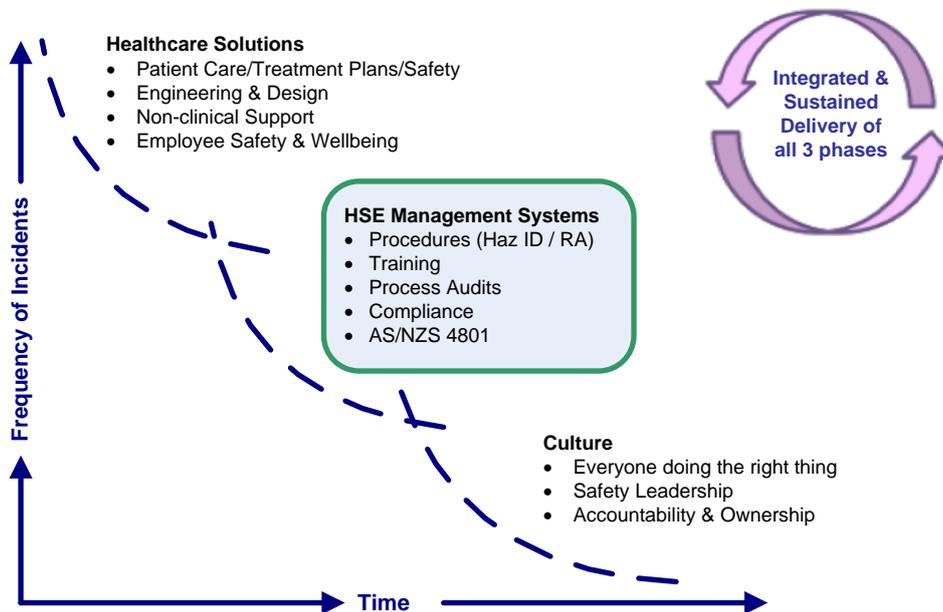


The HSMS requires full commitment and support of the Executive Leadership Team who appoint management representatives for the HSMS. The management representatives are responsible for the establishment, implementation and maintenance of the system for their services and divisions and for reporting to senior management on the status and effectiveness of the HSMS.

Stewardship of the HSMS and related H&S programmes and activities will be undertaken by the H&S Committee/Form once established. Once established, the Committee will convene on a quarterly basis as a minimum. Additional members may be seconded onto the Committee on an 'as needed' basis.

HSMS ownership ultimately lies with line management and it is their responsibility to ensure the expectations of the HSMS are achieved via a three phase approach.

## Three Phase Approach



# Planning and Application of THE H&S management System standards

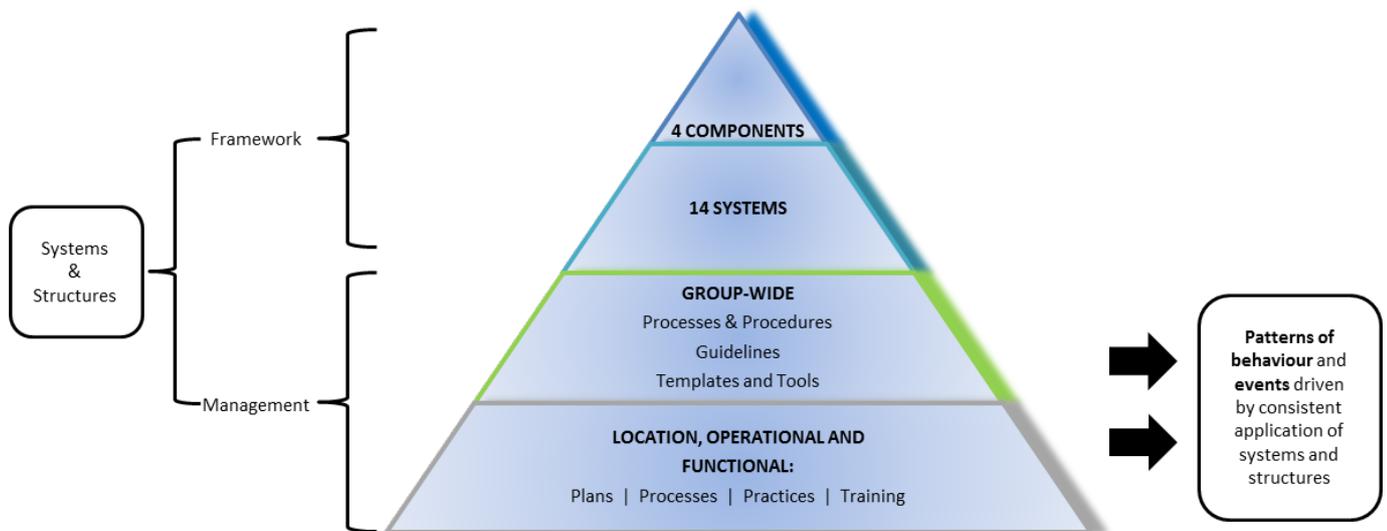
It is accepted that not all policies, processes, procedures or guidelines apply equally to every site, service, or division. The HSMS has been designed to provide sufficient structure for organisational standardisation, yet allow sufficient flexibility for operational and functional area application or for any location specific variation.

By taking a risk based approach, each division can assess the applicability of each of the system requirements in the HSMS.

In some cases the system documentation will apply to CMH, while others will be work area specific. Service line management will be responsible for establishing:

- Applicability of the system requirement
- Agreement of the pace of system deployment
- Priority of system deployment

## Schematic of HSMS document hierarchy

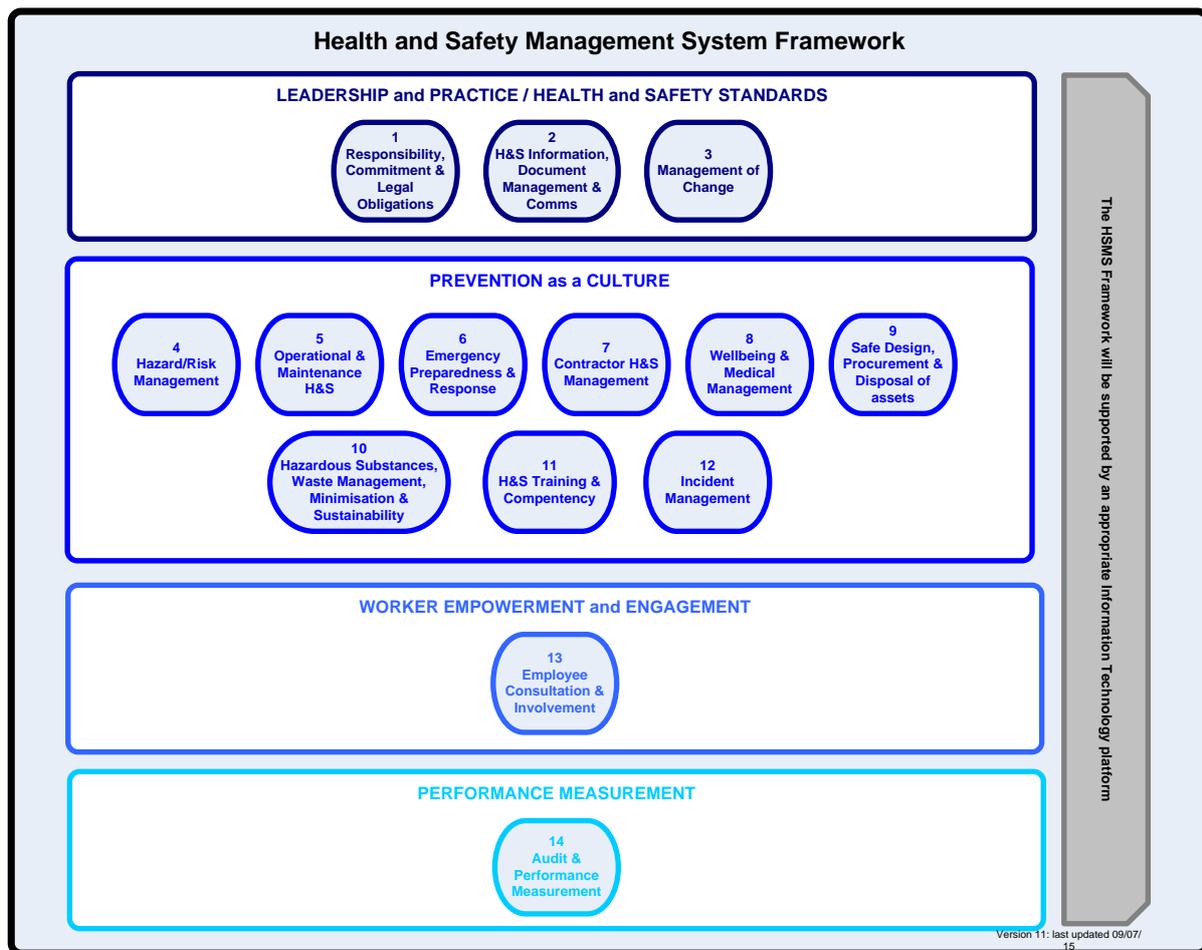


The selection, pace and priority of system implementation will be commensurate upon the risk-benefit for the business.

# Outline of the H&S Management System Expectations (Support and Operation)

The HSMS consists of 4 Components in alignment with the Regional Strategic Plan with 14 Systems (figure 1), each of which incorporates the underlying principles and expectations to be met in the design, construction, maintenance and operation of our facilities and assets.

## Health and Safety Management System Framework



Where possible, generic policies, processes procedures and guidelines will be developed for deployment across all division's and operational and functional Divisions/Services.

Where existing H&S documentation is in place, it must be reviewed and where necessary modified in order to meet the expectations of the HSMS. Alternatively, operational and functional areas have the option to either:

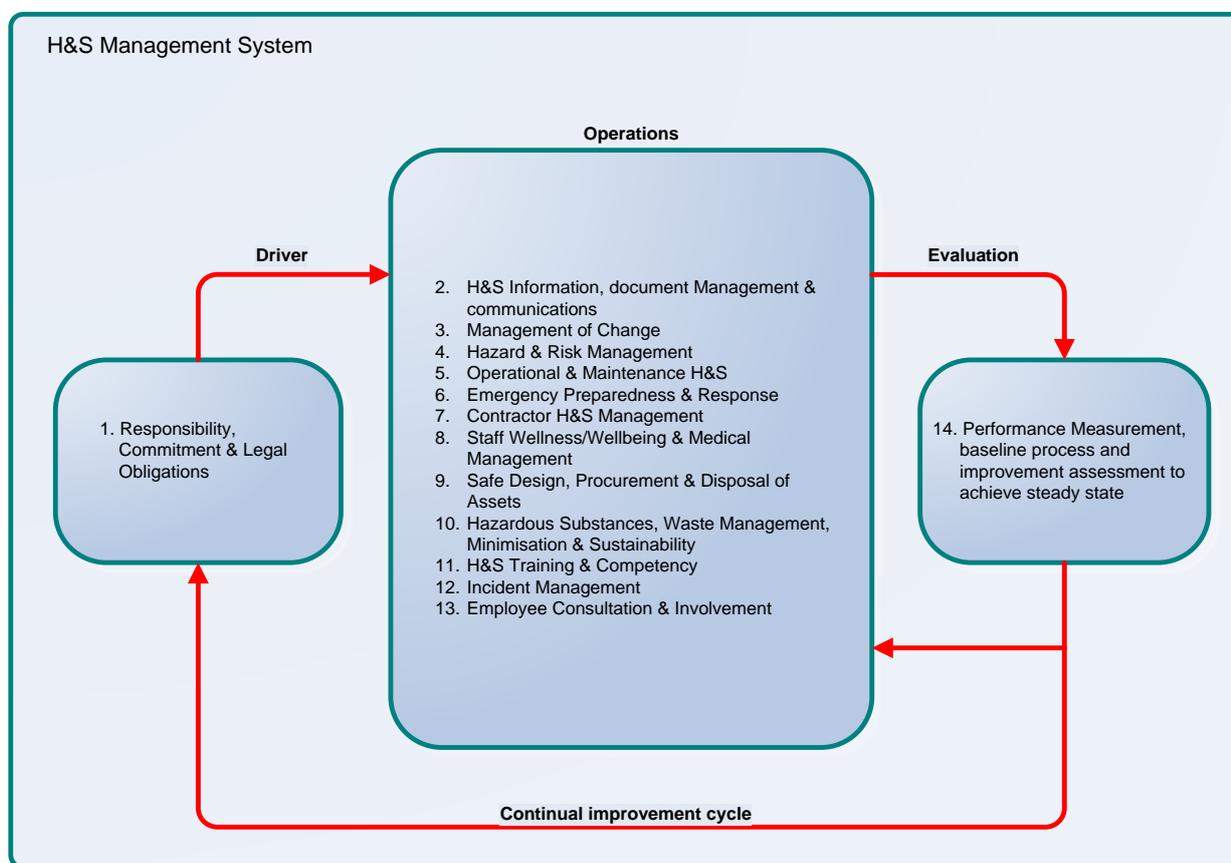
- Develop and include their own appendices to generic business documents, or
- Develop their own processes, procedure and/or guidelines, providing the intent and expectations of the HSMS are satisfied or exceeded.

# Performance Evaluation and Improvement

To evaluate the effectiveness of the HSMS and to drive continual improvement in H&S performance, the system requirements for 'Responsibility, Commitment & Legal Obligations' and 'Performance Management' must be fully embedded into normal business operations. The inter-relationship between the 'Responsibility, Commitment & Legal Obligations' and 'Performance Management' System requirements and the wider HSMS is represented in the 'Driver – Evaluation cycle' (figure 2).

Monitoring, measurement and analysis of data, internal/external audits and management review as part of standard CMH business operations will capture non-conformance and drive the corrective action and improvement process.

## Driver - Evaluation Cycle



# H&S Management System Standards (Expectations)

## System 1: Responsibility, Commitment & Legal Obligations

- 1.1 H&S Policies shall incorporate management commitment to comply with relevant legislation, codes of practice and industry standards.
- 1.2 Contractors will demonstrate the same level of commitment in achieving H&S performance excellence.
- 1.3 H&S Policy shall be communicated to all employees and contractors.
- 1.4 H&S Policy shall be reviewed on at a yearly basis.
- 1.5 H&S management is established, communicated and supported at all levels of the organisation.
- 1.6 Senior management displays visible and active commitment to the HSMS process.
- 1.7 Management establishes and documents the scope, priority and pace for the implementation of the HSMS consistent with the complexity and risks involved in their operations.
- 1.8 Roles, responsibilities, authorities and accountabilities within the HSMS are clearly detailed in staff position descriptions.
- 1.9 H&S and process safety results shall be incorporated as a component of staff performance reviews.
- 1.10 Specific, measurable, achievable, relevant and time bound objectives and targets are established for the HSMS, the performance of which is regularly monitored.
- 1.11 Annual targets are set for H&S (including measures relating to public safety and public asset damage) and process safety, that are both proactive (lead) and reactive (lag).
- 1.12 CMH and Divisional objectives and targets are established to measure performance and drive continual improvement in line with CMH H&S objectives and targets.
- 1.13 H&S objectives and targets are consistent with identified business risks.
- 1.14 Objectives and targets are regularly reviewed and progress updated with consolidated reports being reviewed by the Executive Leadership Team and the Board.
- 1.15 The HSMS is reviewed and endorsed by the Executive Leadership Team at planned intervals.
- 1.16 The HSMS expectations are translated into procedures and practices.
- 1.17 Active employee involvement and participation in the HSMS process is clearly demonstrated.
- 1.18 Management has a process for ensuring adequate and competent resources are available for undertaking H&S and process safety activities and for maintaining/implementing the HSMS.
- 1.19 H&S and process safety outcomes are clearly articulated as being line management responsibility.

- 1.20 H&S Committees are established for each Operational and Functional Division, with trained H&S Representatives. Consultation on H&S issues, reviews of H&S policies, objectives and targets are undertaken by these H&S committees.
- 1.21 Excellence in H&S performance by staff and contractors is formally recognised.
- 1.22 A process is in place to ensure Divisions and functional areas are aware of emerging H&S legal requirements.
- 1.23 CMH participates in influencing the development of new or existing H&S legal requirements.
- 1.24 Management are advised and apprised of emerging and changing H&S legislation.
- 1.25 Regulations, Standards and Codes of Practice to which CMH must comply are identified and the relevant documentation made readily available to appropriate employees.
- 1.26 All facilities identify the H&S licences, permits and other obligations applicable for their operations and verify that all conditions stipulated are being satisfied.
- 1.27 The Executive Leadership Team is notified of any significant changes to licensing conditions, permits or of any H&S non-compliances.
- 1.28 A Legal Register that summarises the legislation relevant to CMH is developed and periodically reviewed.

## **System 2: H&S Information, Document Management and Communications**

- 2.1 HSMS documents have nominated owners who are responsible for the management of the document.
- 2.2 Technical reviewers are assigned to verifying the technical content of HSMS documentation.
- 2.3 A process is in place for the approval issue, review, update and re-approval of H&S documents.
- 2.4 Document changes and review statuses are readily identifiable and users can confirm they have a complete version of the document.
- 2.5 Relevant revisions of documents/records are written in a manner that is easily understood by the end user, available at the point of use; remain legible, identifiable and traceable.
- 2.6 H&S documents sourced from external parties are identified and their distribution and version update managed.
- 2.7 A list of critical and/or sensitive H&S documentation shall be developed with the retention period and management requirements of such information defined.
- 2.8 A process is in place to manage the easy retrieval, retention, protection, identification, storage, removal of obsolete and destruction of records and critical and/or sensitive documentation.
- 2.9 Drawings, Critical Operating Procedures and H&S documentation necessary for sound operation and maintenance of facilities are identified, accessible, and current.
- 2.10 Information on the potential hazards of materials involved in operations are kept current, readily accessible and communicated to appropriate parties.

- 2.11 Information on applicable laws and regulations, licenses, permits, codes, work place standards and practices is documented and kept current and available to appropriate parties.
- 2.12 Relevant records covering operations, maintenance, inspections, and facility changes are maintained.
- 2.13 A process is in place to protect the privacy of confidential information while ensuring staff members have access to their own medical and industrial hygiene monitoring results.
- 2.14 Communication and consultation with relevant associations, community businesses and government agencies is maintained so CMH can contribute to the development of industry codes of practice, public policy, relevant legislation and educational programmes.
- 2.15 A process is in place to receive, document and respond to relevant communications/complaints from external parties in regards to the company's safety risks, H&S performance and/or the HSMS.
- 2.16 Relevant H&S information is readily accessible to the community.
- 2.17 Parties who should formally receive H&S information have been identified.
- 2.18 A process exists to inform external parties about the safety and operation of assets and the hazards associated with them. This shall include information to enable those parties to report faults, defects, failures and emergencies.

### **System 3: Management of Change**

- 3.1 A process is in place for the management of both temporary and permanent changes to processes, equipment, materials, key employees, operating environment, ownership or legislation.
- 3.2 The Management of Change process shall incorporate:
  - Authorisation requirements to approve changes
  - Input and endorsement by competent employees where the change is of a technical nature
  - Risk assessments to establish H&S implications and required controls
  - Verification of compliance with regulations and approved standards
  - Identification of permit and/or resource consent requirements
  - Changes to documentation, drawings and diagrams
  - Involvement of employees who may be impacted by the changes
  - A strategy for the communication of changes to relevant parties
  - Where changes are of a temporary nature, time limitations are specified
  - Training requirements
- 3.3 Temporary changes shall not exceed initial authorisation for scope or time without review and approval.
- 3.4 For temporary or permanent changes of employees in H&S critical positions, the incumbent shall ensure their replacement is fully informed of the H&S requirements and assessed as being understood.
- 3.5 Potential impacts to public safety and damage to public property are considered during the management of change process.

## System 4: H&S hazard identification, risk assessment and management

- 4.1 Hazards and environmental aspects shall be identified, assessed for significance and controls and mitigation measures implemented for the on-going management of risk.
- 4.2 All workplace hazards shall be managed so that the residual risks are as low as reasonably practicable (ALARP).
- 4.3 In cases where ALARP is not achieved, a formal process is in place to notify management and seek approval for the activity to continue while plans for improved risk control are being implemented. All decisions relating to risk management are clearly documented.
- 4.4 Each workplace shall record a summary of its hazards and their significance, risk assessments (inherent and controlled), summary of risk treatments and whether the residual risk is ALARP in a Hazard and Risk Register (HRR).
- 4.5 Risk assessments shall be conducted for on-going operations, projects, acquisitions, change and on products/materials in order to identify and address potential hazards to employees, facilities, the public and environment.
- 4.6 Risk controls shall be periodically reviewed to verify their effectiveness, with selected operating facilities being subject to Process Hazard Analysis reviews. The frequency of these reviews will be commensurate with the inherent risk of the hazard(s) and the facilities performance history.
- 4.7 Results from risk assessments shall be documented and retained so that they are readily retrievable.
- 4.8 Employees will receive training in hazard recognition and risk assessment methodology. The level of training must be commensurate with the risk inherent within the Operational or Functional Division.
- 4.9 Operational risk assessments shall include representation from employees that are potentially exposed to the hazard.
- 4.10 Hazard Standards shall be developed for the management of specific risks posed by hazardous operations, materials or activities.
- 4.11 Facilities that run multiple shift operations shall develop a Fatigue Risk Management System.
- 4.12 Risk assessments shall be reviewed and updated at specified intervals or whenever new hazards are introduced, changes occur or following an incident.
- 4.13 Management addresses assessed risks and appropriate action is taken commensurate to the nature and magnitude of the risk.
- 4.14 The risk assessment/risk management system includes a follow-up process to ensure that decisions have been implemented.
- 4.15 A procedure is in place to identify the environmental aspects and impacts of activities, products and services.
- 4.16 Adequate controls, signage and protective equipment are available to manage and/or alert visitors and members of the public of hazards in the workplace.
- 4.17 Risk management programmes are in place for employees involved with hazardous products or hazardous activities e.g. Job Safety Analysis, Step Back 5 x 5 programme etc.

- 4.18 Security and safety assessments will be undertaken to identify appropriate controls for staff working:
- Normal and extended hours
  - In remote locations, and
  - In lone worker situations
- 4.19 Security systems and controls are in place to prevent harm to members of the public and their assets resulting from CMH operations.
- 4.20 Security control measures are commensurate with the risks presented by the location, operation or the information stored therein.

## **System 5: Operational and Maintenance H&S**

- 5.1 Critical and Standard operating procedures are developed and implemented for processes with higher H&S risks.
- 5.2 Critical and Standard operating procedures, maintenance and inspection procedures are developed, reviewed and updated at specified intervals (or when changes are made) by technically competent employees.
- 5.3 An assessment shall be made as to whether an operational or maintenance procedure is Critical or Standard based on the potential risk should the procedure not be followed and the complexity of the task.
- 5.4 A work management system is in place that incorporates checks and authorisations that are consistent with physical and operational risks.
- 5.5 Where Critical and Standard operating procedures are in place, competent employees shall perform the work in accordance with procedures.
- 5.6 Operating procedures shall be developed, implemented and maintained to address start-up, normal operations, routine shutdown, and emergency shutdown.
- 5.7 Critical alarm, control, and shutdown equipment is identified, tested and undergoes preventive maintenance.
- 5.8 A process is in place, which controls the temporary disarming, or deactivation of critical alarm, control and shutdown equipment.
- 5.9 Facilities that operate multiple shifts shall have processes to enable the effective and safe handover of control and work activities between crews.
- 5.10 Interfaces between operations are assessed and procedures are in place to manage identified risks.
- 5.11 A process is in place for the planning, scheduling and management of maintenance work.
- 5.12 Appropriate and effective statistical techniques are utilised for scheduling preventative maintenance requirements and for assessing the effectiveness of changes and/or modifications.
- 5.13 Risks associated with scheduled and unscheduled maintenance are considered and managed to ensure hazards are managed to acceptable levels.
- 5.14 H&S guidelines and safety rules shall be supplied to all staff, contractors and visitors to CMH facilities.
- 5.15 Publications are developed outlining general H&S practices and/or standards required at CMH facilities.

- 5.16 Publications are developed outlining general H&S practices and/or standards to ensure the health and safety of staff working offsite is managed with equal care and attention to those working at CMH facilities.
- 5.17 A set of uniform safe work practices are defined and implemented to safeguard employees and plant and to ensure compliance with all relevant legislation and standards.
- 5.18 Worksites are inspected, hazards identified and all necessary precautions and special conditions implemented before the Work Permit is authorised and issued for work to commence.
- 5.19 Work is planned and performed on the correct equipment, which has been isolated, properly prepared and made available as scheduled.
- 5.20 Employees responsible for operations and safety in the work area are informed of the work to be undertaken.
- 5.21 All employees involved in the work have been properly instructed in safe work procedures, including the appropriate personal protection equipment and emergency response equipment to be used during the work.
- 5.22 Suitable personal protective equipment, firefighting equipment and emergency response and rescue equipment is available for use on-site.
- 5.23 The number of work permits issued and types of jobs are known in any one area so that adequate spacing for a safe work environment is maintained.
- 5.24 The worksite is inspected during the course of the work to ensure that safe conditions and work practices are maintained, and at the completion of the work, that it has been left in a safe condition and that operations can safely recommence.
- 5.25 A process is in place to ensure that the safety equipment used in conjunction with the work permit system such as gas testers, breathing apparatus and rescue equipment, is correctly calibrated and maintained at all times.
- 5.26 The employees responsible for issuing work permits and confined space entry permits are trained and hold current certificates of competency.

## **System 6: Emergency Preparedness and Response**

- 6.1 A risk based approach is applied to identify potential emergency situations that could impact on the business and effective emergency response plans developed.
- 6.2 Emergency response plans are readily available that address situations involving staff, contractors, visitors, members of the public and public assets.
- 6.3 Emergency response plans shall be documented, accessible and clearly communicated. The plans will include:
  - Organisational structure, responsibilities and authorities.
  - Internal/external communications procedures.
  - Procedures for accessing employees and equipment resources.
  - Procedures for assessing essential safety, health, and environmental information.
  - Procedures for interfacing with external emergency response agencies.
- 6.4 Equipment, resources and trained employees required for emergency response are defined and readily available.

- 6.5 Training simulations and exercises are regularly undertaken to test the effectiveness of emergency response plans, equipment, resources employees' competency and interfaces. These simulations/exercises should consider involvement of external emergency response agencies and contractors.
- 6.6 Emergency response plans are formally reviewed after emergency simulation/exercises, post-emergency, incidents requiring deployment of emergency equipment or on at least an annual basis.
- 6.7 Emergency key contact lists are available and regularly maintained.
- 6.8 Emergency response equipment and resources are included on a maintenance schedule where their availability and functionality is assessed.
- 6.9 First aid facilities, trained first aiders and civil defence resources are readily available which as a minimum meet relevant regulatory guidelines.
- 6.10 Contractors required to manage emergency situations on behalf of CMH, are required to develop their own emergency response plans that interface with CMH's emergency response plans. The contractor's plans must be formally assessed and approved by a CMH representative (who technically competent in emergency response planning).

## **System 7: Contractor H&S Management**

- 7.1 A process is in place for the evaluation and selection of contractors. This will include a formal risk assessment of the work/services/products being supplied and an appraisal of their capabilities to fulfil the contract in a safe and environmentally sound manner.
- 7.2 Contractor performance requirements are defined and communicated. They include:
  - Responsibility for providing employees appropriately screened, trained, qualified, and able to perform specified duties
  - A process for self-monitoring and stewardship, and
  - Where applicable, provisions are in place to confirm certificates, and licenses are current.
- 7.3 Where required, contractors will develop, implement and maintain H&S Management Plans that have been reviewed and endorsed by technically competent CMH representatives for the work being undertaken.
- 7.4 Interfaces between organisations providing and receiving services (i.e. principal, contractors and sub-contractors) are effectively managed.
- 7.5 A monitoring system is in place to assess contractor performance, provide feedback, and ensure deficiencies are corrected.
- 7.6 Activities conducted by contractors and sub-contractors on CMH's behalf are undertaken in accordance with policies and practices that are equivalent in intent to CMH's H&S policies and HSMS.
- 7.7 Site specific hazards and incident reporting requirements are communicated to the contractor and hazards the contractor may bring onsite are communicated to appropriate CMH employees.
- 7.8 At the conclusion of a contract or on an annual basis, the H&S performance of the contractor is formally assessed. The size and complexity of the assessment should be commensurate with either the size or complexity of the contract or the risks associated with the work being undertaken.

- 7.9 Clinical access and service agreements in place to include health and safety clause.

## System 8: Wellbeing and Medical Management

- 8.1 Industrial hygiene hazards and **environmental** monitoring requirements are identified, quantified and reduced to acceptable levels.
- 8.2 Staff exposed to industrial hygiene or biological hazards will be included in personal health surveillance programmes.
- 8.3 **H&S monitoring** equipment shall be calibrated and maintained according to manufacturer's instructions.
- 8.4 **H&S monitoring** and the analysis of results is undertaken by technically competent employees.
- 8.5 Hazards that could result in staff wellness issues are identified, documented and risk assessed, with controls introduced to manage these to as low as reasonably practicable.
- 8.6 Tasks are identified that require a person's fitness to work is assessed prior to starting a new or changed job.
- 8.7 Early intervention strategies are in place, including managing the recovery of staff following injury, and intervention as soon as a potential injury is identified.
- 8.8 A programme is in place to support the safe and early return to work of injured staff.
- 8.9 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.
- 8.10 Baseline and on-going medical assessments are conducted on staff working in the vicinity of products and/or environments that could be harmful to health.
- 8.11 A programme is in place to monitor the effect of exposure to chemical or physical agents at work (either following a critical event or from continued exposure) to enable the early detection of health effects and to take timely action to avoid deterioration or further deterioration of health.
- 8.12 A process is in place for monitoring sub-optimal results and the information is fed back into the hazard/risk assessment process and the controls reassessed.
- 8.13 A process is in place to meet regulatory requirements relating to medical issues and reporting in the workplace.
- 8.14 Technically competent providers of medical, rehabilitation and ergonomic services are identified to provide advice on workplace injuries; practices and return to work programmes.

## System 9: Safe Design, Procurement and Disposal of Assets

- 9.1 H&S aspects and liabilities of proposed purchases or disposals are fully considered within the decision making process.
- 9.2 Appropriate environmental assessments are conducted prior to the acquisition, lease or disposal of assets.
- 9.3 Hazards are eliminated, isolated or minimised during the design phase of a project.

- 9.4 A formal project management program is used for new and modified facilities, during their design, approval, procurement, construction, commissioning and handover phases.
- 9.5 Appropriate hazard studies are undertaken at defined stages during a project in order to identify and evaluate personal and process safety risks.
- 9.6 During the design phase of a project, assessment of potential harm to staff, contractors, members of public or their property and the environment are assessed for start-up, normal operations, routine shutdown, maintenance, emergency operation and emergency shutdown.
- 9.7 Hazards present in decommissioned equipment or facilities are identified and managed to acceptable risk levels.
- 9.8 The long-term shutdown or abandonment of facilities are planned and managed.
- 19.9 Practices are in place to limit access of staff and/or members of the public to decommissioned equipment or facilities.
- 9.10 Control systems are in place to ensure the correct materials, products or services are being purchased that meet the correct performance specifications.
- 9.11 A process is in place that ensures the correct product and quantity are receipted and that they are appropriately stored and maintained until required.
- 9.12 Incoming materials are receipted, inspected and tested (as appropriate to their criticality) prior to their release for use.
- 9.13 A process is in place for the management of non-conforming materials.
- 9.14 A process is in place to ensure operations and assets do not present a significant risk of serious harm to members of the public or significant damage to property owned by a person.

## **System 10: Hazardous Substances and Waste Management, Minimisation and Sustainability**

- 10.1 Up to date safety information detailing the correct handling, storage, use and disposal of hazardous products is readily available for all product streams, process chemicals and hazardous substances used and/or stored on site.
- 10.2 The risks posed by hazardous substances used at CMH facilities are assessed by technically competent employees in relation to their impacts to staff, public and the environment.
- 10.3 Facilities with hazardous substances will develop a Hazardous Substances Register that summarises as a minimum, the trade and technical name of the product; the volume of substance being stored; its location on site; the hazard(s) the substance presents and the controls that are in place.
- 10.4 Facilities with hazardous substances will have the required signage to meet regulatory requirements.
- 10.5 Opportunities for minimising waste generation are identified and assessed and when economically viable, opportunities are pursued consistent with business priorities and community expectations.
- 10.6 All waste generated as a result of operations are:  
Effectively managed.  
Disposed of in a cost effective manner that is compliant with statutory requirements.

- 10.7 Long-term environmental impacts of waste disposal and potential long-term issues are identified and communicated.
- 10.8 Emissions and wastes are tracked and evaluated to identify pollution prevention and emission control strategies.
- 10.9 The principles of sustainability are integrated into business activities.

## **System 11: H&S Training and Competency**

- 11.1 A process is in place for screening, selection, placement, and on-going assessment of the qualifications and abilities of staff and contractors to meet specified job requirements.
- 11.2 Criteria are in place to ensure the necessary levels of individual and collective experience and knowledge are maintained and are carefully considered when employees' changes are made.
- 11.3 An assessment is conducted to identify H&S critical positions and a training matrix developed identifying the competencies and skills required for those positions.
- 11.4 A process is established for the delivery of H&S awareness training that highlights significant risks and environmental aspects, H&S policies, the HSMS, Critical Operating Procedures and Hazard Standards.
- 11.5 A process is in place to provide initial, on-going, and periodic refresher training to meet job and legal requirements and to ensure understanding of the proper protective measures to mitigate potential H&S hazards. H&S training must:
  - Assess staff knowledge and skills relative to requirements
  - Consider the literacy, language and readability of training materials
  - Take account of vision and hearing impairments
  - Evaluate the effectiveness of the training
- 11.6 All employees working at or visiting a CMH facility must receive a H&S induction that details(as a minimum),
  - the workplace hazards,
  - the requirement for hazard/incident reporting, and
  - emergency response procedures
- 11.7 Position Descriptions will detail the H&S competencies for a given role and whether it is an H&S critical position.
- 11.8 A process is in place to assess, document, and provide feedback on employee H&S performance.
- 11.9 Staff will have the required H&S competency for a position or adequate controls/restrictions/supervision will be implemented where full job competency has not yet been attained.
- 11.10 Annual H&S training/refresher programmes are developed for staff with designated H&S responsibilities.
- 11.11 A process is in place to identify recurring and/or recertification training requirements for staff.
- 11.12 H&S training is delivered by technically competent employees.

## System 12: Incident reporting, Investigation and Management

- 12.1 H&S incidents and near misses (including those involving members of the public or public assets) are accurately reported, collated in a central database, investigated, analysed, and documented.
- 12.2 The methodology utilised for an incident investigation is appropriate with the severity and complexity of the incident being reviewed.
- 12.3 A process is in place for the reporting of serious harm incidents involving staff or members of public or incidents that result in significant property damage to the appropriate statutory authorities.
- 12.4 Following an incident or near miss, a review of the organisational generic Hazard and Risk Register (HRR) is undertaken to identify potential failures in controls and introduce improvements.
- 12.5 Processes exist to enable incidents and near misses to be investigated in a timely manner by technically competent staff so that root causes and contributing factors are identified and corrective actions identified to prevent recurrence of related incidents.
- 12.6 Responsibilities for corrective actions are assigned, time bound and tracked through to closure.
- 12.7 Assessments are undertaken to establish the effectiveness of corrective actions.
- 12.8 Procedures are in place for the inclusion of General Counsel, Human Resources and Corporate Affairs to provide input into incident responses and management.
- 12.9 Findings from investigations are retained, periodically analysed to determine where improvements to practices, standards, procedures or the HSMS are warranted and used as a basis for improvement.
- 12.10 Lessons learned from incidents / near misses are shared amongst CMH and other relevant organisations and associations.
- 12.11 Summary data on process safety incidents, personal injury, public safety and H&S non-compliances shall be regularly reported to the Board, Senior Leadership Team, H&S Safety Committees and relevant management, staff and contractors.
- 12.12 A process is in place that analyses historical incident trends and that the information is used to identify improvement opportunities within the HSMS.
- 12.13 A process exists for capturing and recording customer concerns (internal and external), and that these results are reviewed and analysed on a regular basis to identify trends, and process improvement opportunities.
- 12.14 Following an incident or near miss in a work area, a review of the work area Hazard and Risk Register (HRR) is undertaken to identify potential failures in controls and introduce improvements (aim is for ALL work areas to have this review in place).

## **System 13: Employee Consultation and Involvement**

- 13.1 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.
- 13.2 H&S Committees are established to meet the requirements of the organisation (to be defined following organisational review) with trained H&S Representatives.
- 13.3 A mechanism is established outside of the “line” reporting chain for escalating health and safety concerns.
- 13.4 Appropriate rehabilitation assistance is provided in the workplace to assist people following an injury.

## **System 14: Audit and Performance Measurement**

- 14.1 Formal H&S assessments are undertaken for all operations (including those undertaken by contractors). These shall be assessed at pre-determined frequencies to establish the degree to which HSMS expectations are being met.
- 14.2 A process is in place to assess the effectiveness of the HSMS as it relates to public assets and public safety.
- 14.3 The frequency and scope of assessments shall reflect the complexity of the operation, level of risk, and performance history.
- 14.4 Facilities with Critical Operating Procedures shall assess the compliance and effectiveness of those procedures on at least an annual basis.
- 14.5 Multi-disciplinary teams including expertise outside the immediate Operating Division are used to conduct assessments.
- 14.6 A process is in place to manage non-conformities and for taking corrective and preventative action.
- 14.7 The effectiveness of the assessment process shall be periodically reviewed and findings used to make improvements.
- 14.8 Information from H&S assessments is communicated to the Board, Senior Leadership Team and relevant management.

## Terms and Definitions

Adverse Event	Is an incident that has resulted in unanticipated death or loss of function not related to the natural course of a patient's <u>illness or condition</u> .
ALARP	As Low as Reasonably Practicable. Applied to the reduction of risk by taking measures to reduce risk until the cost of further measures is grossly disproportionate to the benefits they would deliver.
Competent Person	A person having the current knowledge, skills, and experience required to perform the activity in a safe manner.
Contractor	A person, company or other legal entity engaged by CMH to do any work for gain or reward.
Contributing factor	A circumstance, action or influence which has contributed to an incident or near miss.
Harm	Is illness and/or injury, physical and/or mental harm.
Hazard	Anything with the potential to cause harm or loss to person, property or environment.
Hazard	Any source of potential damage, harm or adverse health effects on something or someone under certain conditions at work.
Hazard Standards	Standards that define the requirements for managing specific risks posed by a hazard, such as: <ul style="list-style-type: none"> <li>• Asbestos and synthetic mineral fibres</li> <li>• Electrical safety</li> <li>• Excavations</li> <li>• Hazardous products (e.g. benzene, hydrogen sulphide, mercury, vanadium)</li> <li>• Legionella</li> <li>• Lifting equipment (including cranes, gantries, forklifts, and material handlers)</li> <li>• Lone worker situations</li> <li>• Manual handling and ergonomics</li> <li>• Occupational noise</li> <li>• Radiation</li> <li>• Working at heights (including elevated work platforms and scaffolding)</li> <li>• Working in confined spaces</li> </ul>
Hazard Risk Register (HRR)	
Health and Safety Management System (HSMS)	
Incident	Any event that could have (near miss) or has resulted in harm, damage or loss, to any person, property or place (including environment).

Incident	An unplanned event resulting in or having a potential for injury, ill-health, environmental damage or other form of loss.
Incident Management	A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and acting to prevent recurrence.
Line Management	Management with direct responsibility and accountability for all aspects of activities, operations, products and services, including environment, health and safety.
Near miss / close call	An event that could have resulted in harm or loss but did not.
Near Miss	An unplanned event that did not result in injury, harm, damage or environmental impact but had the potential to have done so in slightly different circumstances.
Practicable	That which is reasonably capable of being done.
Public Property	Property owned by another person other than Counties Manukau Health.
Risk	The possibility (likelihood) of suffering harm or loss from a hazard.
Risk	The likelihood that a hazard will actually cause its adverse effects, together with a measure of the consequence.
Risk Assessment	The assessment of the consequence of each hazard and the likelihood of it occurring in order to determine the effort required to make the task or asset as safe as reasonably practicable.
Serious & Sentinel Event	A Serious or Sentinel Event (SSE) has, or has the potential to result in, serious lasting disability or death, not related to the natural course of the patient's illness or underlying condition.
Serious Harm	Significant injury as described in Schedule 1 of the Health and Safety in Employment Act 1992.
Serious Incident Review Panel (SIRP)	Is a process followed by Mental Health to review serious incidents involving patients under the Mental Health Act.
Severity Assessment Code (SAC)	Is a numerical risk score from the National Incident Management System.
Significant Hazard	A hazard that is an actual or potential source of serious harm or harm that does not usually occur or is not easily detectable. (At CM Health all hazards risk assessed as Moderate or High are considered as significant).
Significant hazard	A hazard that is an actual or potential cause or source of: (a) Serious harm; or (b) Harm, more than trivial, the severity of whose effects depend on the extent or frequency of exposure to the hazard; or (c) Harm that usually is not easily detectable, until a significant time after exposure to the hazard.
Sustainability	Meeting the needs of today, without adversely impacting on the needs of tomorrow.
System Failure	A fault, breakdown or dysfunction within process(es) or infrastructure.

Worker	Any person who carries out work in any capacity for CM Health (full-time, part-time, casual and temporary), including associated personnel (contractors, students, visiting health professional, etc.) working in, or contracted to provide a service on any CM Health site.
Workplace	Is any place where work is carried out for or on behalf of CM Health whilst person is deemed at work.

The 10 clauses of the High Level Structure as set out in ISO Quality Management system Standard 9001:2015 has been applied to CMH Health and Safety Management System.

<b>Clause 1: Scope</b>	Explanation of where the referred CMH HSMS requirements apply.
<b>Clause 2: Normative References</b>	Reference to that fact that terms and definitions exist in other CMH HSMS standards and relevant, current legislation and/or industry standards, codes of practice and guidance documents.
<b>Clause 3: Terms and Definitions</b>	Applicable health and safety and CMH HSMS terms and definitions.
<b>Clause 4: Context to the Organisation</b>	Examination of CMH and its organisational context (including the needs and expectations of interested parties). Consideration of the external and internal issues (positive and negative) that are relevant to the strategic direction of CMH and how these issues could both impact the health and safety system AND how the health and safety system can support CMH's organisational strategy.
<b>Clause 5: Leadership</b>	Charges senior management with accountability in the section for organisational roles, responsibilities, authorities, policy (as applicable) and participation, consultation and representation. There is responsibility for leading, not just managing, demonstrating commitment to customer satisfaction, and establishing and communicating the HSMS system standard, responsibilities and authorities.
<b>Clause 6: Planning</b>	Organisations are required to take a risk based approach to the development, implementation and improvement of their health and safety system standards.
<b>Clause 7: Support</b>	Infrastructure, process environment, monitoring and measuring devices, and knowledge needs must be determined, provided and maintained to support the HSMS standard.
<b>Clause 8: Operation</b>	Processes must be controlled and monitored, customer requirements determined and reviewed, goods and services monitored, suppliers (external providers) and their products and services assessed, includes design and production of goods and services, post-delivery activities, non-conforming goods and services.

<b>Clause 9: Performance Evaluation</b>	Monitoring, measurement and analysis of goods and services, processes, the health and safety system standard, and customer satisfaction. Analysis and evaluation of data, internal audits and management review.
<b>Clause 10: Improvement</b>	Non-conformances, corrective actions and improvements.

# ***Strategic Plan to Implement the H&S Framework***

***Counties Manukau OHS will lead a Safety Culture step change in CMH H&S performance, through effective and inspired leadership, influence and shared learning.***

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## Vision

Counties Manukau Health (CMH) has a clearly defined best practice global H&S management framework comprising of business excellence and user friendly systems and structures that allow risk to be understood, identified and controlled. It is consistently applied across the organisation, resulting in minimisation of business impact and harm has been prevented to our people.

## Mission

To lead a step change in H&S performance by:

- Advancing a common vision for Zero Harm / Impact across all levels of the business
- Modelling and growing inspirational, highly visible safety leadership
- Creating a compelling case for change and a strong workplace safety culture
- Sharing skills, experiences, and resources to overcome common challenges

## Who are the Stakeholders?

The governance of Health and Safety at CMH will be stewarded by the CEO and the Executive Team.

An H&S Governance Group will be established that include internal subject matter experts and regional managers, who will commit to making H&S a critical aspect of their business units.

Managers will be expected to acknowledge that they are in a unique position to improve H&S in their division, service and satellite areas and across the wider organisation. The division, service and satellite area H&S Committees will be expected to have robust and productive demonstration of safety leadership, the promotion of a culture of harm prevention, show evidence of employee empowerment and the measurement of the site / regional specific H&S performance.

The H&S Governance Group will be in a position to increase the tempo of priority activities and to lead the step change i.e. implementing desired mental models and behaviour patterns in H&S.

## Why are we doing this?

The costs to the organisation are undefined but any costs due to H&S impacts are unacceptable and unsustainable in the long term.

Organisational leaders can change this and drive the safety culture of division, service and satellite areas with decisions and resources that promote responsibility for ensuring the H&S of our people.

If H&S is demonstrated by leadership as a priority, overall H&S performance will improve.

CMH does have systems and structures within the division, service and satellite areas. However, within our continually changing organisation, an improvement opportunity exists to strategically focus on the following:

- Audit to set a baseline of consistent data
- Change Process Safety (Including hand over and communications from internal ‘experts’)
- Critical Risk Management and Assessment as it relates to:
  - High Frequency / Low Consequence Events i.e. Personal Safety and
  - Low Frequency / High Consequence Events i.e. Plant and Process Safety
- Incident Management

## What will we do?

Effective leaders can improve H&S by:

- setting and maintaining the CMH H&S vision and building a culture where people want to be safe
- making H&S a priority and ensuring it is a core part of the division, service or satellite area
- ensuring the right risks and hazards are managed, the right performance and results are monitored and the right improvements and investments are made.

To grow safety leadership, the H&S Governance Group will provide opportunities for other stakeholders in our organisation to learn, share and contribute towards making our workplace safer.

By joining with other managers, safety performance in all division, service and satellite areas will be raised, while shaping and influencing an environment that promotes a safe workplace. CMH must strive towards a common vision and mental model that Zero Harm / Impact can be achieved and that “an acceptable injury rate” does not exist.

## How will we do it?

To work toward our vision of reducing harm, the next two years will be focussed on leading a “Safety Culture Step Change” by implementing desired mental models and behaviour patterns in H&S. The focus will be on 4 key areas:

- Leadership - develop and grow safety leadership by promoting a high standard of H&S performance and the application and implementation of excellent H&S practices within division, service and satellite areas
- Prevention as a culture by promoting values, attitudes, practices and systems that prevent harm to our people at work
- Employee empowerment and engagement by using the individual and collective influence of division, service and satellite areas to contribute to changes in H&S. This will be done with shared learning and development i.e. the provision of opportunities for division, service and satellite leaders to share skills, experience and resources to overcome common challenges.
- H&S Performance Management by measuring our performance towards a step change and achievement of zero harm with the maintenance of a compelling score board

# How do we execute the strategy?

To be successful stakeholders must be actively engaged and impact will be measured by:

- Focussing on one priority at a time i.e. the important work
- Acting on the Lead indicators
- Maintaining a compelling scoreboard. This results in active engagement and engagement comes from knowing the scoreboard
- Creating a platform of accountability through regular meetings and shared learning opportunities

FRAMEWORK FOR ACTION	
Vision	Counties Manukau Health (CMH) has a clearly defined best practice global H&S management framework comprising of business excellence and user friendly systems and structures that allow risk to be understood, identified and controlled. It is consistently applied across the organisation, resulting in minimisation of business impact and harm has been prevented to our people.
Outcomes	<div style="display: flex; justify-content: space-between;"> <div style="width: 24%;"> <p><b>1. Leadership and Practice</b></p> <p>CMH promotes a high standard of H&amp;S performance and has excellent H&amp;S practice in its service and satellite areas across all Localities</p> </div> <div style="width: 24%;"> <p><b>2. Prevention as a Culture</b></p> <p>CMH has values, attitudes, practices and systems that prevent harm to people at work</p> </div> <div style="width: 24%;"> <p><b>3. Employee Engagement</b></p> <p>Service and satellite areas lead improvements in H&amp;S practices and there is strong support for H&amp;S from internal stakeholders and employees</p> </div> <div style="width: 24%;"> <p><b>4. H&amp;S Performance Management</b></p> <p>Measure performance towards a step change and achievement of Zero Harm / Impact</p> </div> </div>
Objectives	<div style="display: flex; justify-content: space-between;"> <div style="width: 24%;"> <p>1a. Set high CMH expectations for H&amp;S and ensure that regulatory standards are achieved</p> <p>1b. Provide leadership in H&amp;S through manager's roles and engagement</p> <p>1c. Improve co-ordination and alignment of service and satellite area activities</p> </div> <div style="width: 24%;"> <p>2a. Increase the recognition among service and satellite area managers that H&amp;S benefits and adds value to their service and satellite areas</p> <p>2b. Increase the commitment and capability of managers to systematically and effectively manage H&amp;S</p> <p>2c. Ensure that employees participate effectively in processes for improving H&amp;S</p> </div> <div style="width: 24%;"> <p>3a. Develop and implement service and satellite area led initiatives to improve H&amp;S</p> <p>3b. Encourage and enable service and satellite area leaders and stakeholders to promote H&amp;S to their teams and peers</p> <p>3c. Raise awareness and understanding of H&amp;S in the wider business</p> </div> <div style="width: 24%;"> <p>4a. Focus on one priority at a time i.e. the important work</p> <p>4b. Act on the Lead indicators</p> <p>4c. Maintain a compelling scoreboard. This results in active engagement and engagement comes from knowing the scoreboard</p> <p>4d. Create a platform of accountability through regular meetings and get together</p> </div> </div>
Actions	<p>The Strategy identifies broad actions within each objective. The action plans list specific deliverables to be implemented and are based on:</p> <div style="display: flex; justify-content: space-around;"> <span>Regulations Social dialogue and engagement</span> <span>Incentives Design and Technology</span> <span>Capability development Research and evidence with benchmarking</span> <span>Governance</span> </div>
Priorities	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="width: 45%;"> <p>Leadership and Ownership Process Safety Critical Risk Profiling Incident Management</p> </div> <div style="width: 10%; text-align: center;"> <p>HOW</p> </div> <div style="width: 45%;"> <p>One Priority Focus at a time Acting on Lead Indicators Maintenance of a performance scoreboard Accountability through regular meetings</p> </div> </div>

## How do we lead a step change?

<p><b>H&amp;S Governance Group members will play a critical role in creating this change as individuals, as leaders of their division, service or satellite area and as part of a wider collective group.</b></p>	<p><b>Where are we now?</b></p>	<p><b>How?</b></p>
<p><b>Managers</b> What can individual managers do to lead a step change?</p>	<ul style="list-style-type: none"> <li>• H&amp;S leadership, knowledge and practice are variable among our senior managers and there are limited opportunities for development.</li> <li>• Many managers want to improve H&amp;S but they don't know how to influence outcomes and build a safety culture. They struggle to find the time for personal development and only a few see Zero Harm/Impact as an achievable target.</li> <li>• Safety leadership is generally not seen as a desirable competency.</li> <li>• Safety is generally led by middle management.</li> </ul>	<p>Organisational leaders:</p> <ul style="list-style-type: none"> <li>• acknowledge their responsibilities in leading safety in their division, service and satellite areas</li> <li>• ensure H&amp;S is an integral part of their business practices</li> <li>• ensure the right risks are managed</li> <li>• hold themselves and others accountable for their performance</li> <li>• commit to safety leadership practices, including ongoing development</li> <li>• promote safety leadership as a core competency, especially in high risk industries.</li> </ul>
<p><b>Division, Service and Satellite areas</b> What can division, service and satellite areas do to lead a step change?</p>	<ul style="list-style-type: none"> <li>• Most division, service and satellite areas see H&amp;S as a compliance issue that brings additional costs but is of limited value.</li> <li>• Their improvement efforts are driven by financial incentives or concerns about breaching the law.</li> <li>• Risk management is inconsistent, measures are narrow and generally backward looking, and systems are immature.</li> <li>• Some division, service and satellite areas are performing well. These divisions, service and satellite areas generally have effective safety leadership.</li> </ul>	<p>Division, service and satellite areas consistently ensure:</p> <ul style="list-style-type: none"> <li>• they take an organisational stance to create a positive safety culture</li> <li>• treat H&amp;S as a value added business process and a condition of employment</li> <li>• make H&amp;S a core part of their business, just like finance or marketing</li> <li>• monitor relevant results and recognise good performance</li> <li>• manage their risks, including the provision of equipment, training and other resources</li> <li>• managers and individuals are accountable for their actions or inaction.</li> </ul>
<p><b>H&amp;S Governance Group</b> What can the Group do to lead a safety culture step change?</p>	<ul style="list-style-type: none"> <li>• There is limited information sharing or pooling of resources between organisations, especially in areas of safety leadership.</li> <li>• Organisational leaders are rarely involved in coordinated</li> </ul>	<p>Leaders and division, service and satellite areas work together to:</p> <ul style="list-style-type: none"> <li>• share experiences, pool resources, develop initiatives and create discussions that help prevent workplace injuries and ill health</li> <li>• influence and encourage positive changes to policy, regulation and legislation.</li> </ul>

<b>How change is created</b>	<b>where we want to be in 5 years</b>
<p>Organisational leaders lead a step change by:</p> <ul style="list-style-type: none"> <li>• making a commitment to improve visible safety leadership, knowledge and practices</li> <li>• accessing expert advice and learning from examples</li> <li>• challenging peers and be accountable for improving H&amp;S by focussing on lead indicators</li> <li>• learning from colleagues who have similar challenges</li> <li>• promoting safety leadership as a core and sought after capability.</li> <li>• (Review, Facilitate, Question, Leverage)</li> </ul>	<p>Organisational leaders will be:</p> <ul style="list-style-type: none"> <li>• ensuring safety performance is a critical requirement for their division, service and satellite areas and supply chains</li> <li>• demonstrating mature attitudes towards safety leadership</li> <li>• have improved understanding of their roles as safety leaders in building a positive safety culture</li> <li>• taking an ethical stance towards H&amp;S</li> <li>• committed to participating in their own development, including sharing ideas and experiences with peers</li> <li>• engaging with the Executive Team on H&amp;S</li> <li>• viewing safety leadership as a core capability.</li> </ul>
<p>Division, service and satellite areas lead a step change by:</p> <ul style="list-style-type: none"> <li>• shared learning from each other sharing stories of success and failure</li> <li>• building strength in areas of common interest and risk</li> <li>• promoting successful practices supporting industry bodies and associations</li> <li>• building strong safety leadership programmes</li> <li>• promoting a platform to create positive change.</li> </ul>	<p>More division, service and satellite areas units will be:</p> <ul style="list-style-type: none"> <li>• sharing H&amp;S learning and embedding H&amp;S as a core value</li> <li>• focussing on risk management, especially critical risk</li> <li>• sharing information and performance results</li> <li>• committed to continuous improvement</li> <li>• monitoring a range of relevant leading and lagging H&amp;S outcomes.</li> </ul>
<p>The H&amp;S Governance Group can lead a step change by:</p> <ul style="list-style-type: none"> <li>• pooling resources and skills</li> <li>• sharing information and performance results</li> <li>• influencing other division, service and satellite areas via communication of change and process safety practices</li> <li>• creating the right safety culture by influencing policies, processes and practices, and working with other key stakeholders</li> <li>• participate in the development of systems and structures</li> </ul>	<p>The H&amp;S Governance Group:</p> <ul style="list-style-type: none"> <li>• has actively engaged members, created value and is sustainable</li> <li>• actively promotes and shares business excellence practices within and outside the Governance Group</li> <li>• creates a pathway for safety leadership development</li> <li>• creates opportunities for organisational leaders to influence the direction and shape of H&amp;S</li> <li>• links to, and complements, other industry associations</li> <li>• makes progress towards Zero Harm / Impact.</li> </ul>

# *Our strategy to lead a safety culture step change*

**To achieve improved H&S performance a 'step change' in our safety culture and behaviour is required. This means new mental models are required in approaching H&S in CMH.**

Rob Jager  
Chair, Shell Companies in New Zealand  
Chair, Business Leaders' H&S Forum

Many factors contribute to poor organisational H&S performance, including attitudes towards safety, other organisational priorities, a relatively immature regulatory environment, and a lack of adequate resourcing and investment. None of these contributing factors are simple to remedy. But despite the challenges, other organisations have dramatically reduced injuries in their workplaces, in some cases almost to zero.

These organisations have shed light on what is achievable and what is required for a step change to occur. A common feature of these organisations is effective safety leadership and a jointly held belief that H&S is an integral part of their organisation. They will not compromise safety over day to day operational pressures and constantly seek to improve their safety performance.

The CMH H&S Governance Group must aspire to achieve similar performance. This presents a real opportunity to lead a step change in H&S by growing world-class safety leadership in more of our organisational leaders.

The H&S Governance Group is based on the understanding that organisational leaders have a large and direct influence on H&S performance, and that by working together, sharing ideas and using their influence, H&S performance is improved.

CMH organisational leaders have the opportunity to set the conditions and influence the culture in the division, service and satellite areas and have significant leverage within our critical risks and process safety initiatives. The H&S Governance Group will be a strong collective voice and a force for change.

Zero Harm / Impact cannot be reached by in silo. All CMH employees must be engaged and empowered in recognition that everyone has a responsibility in achieving this goal.

The H&S Governance Group has the ability to work with and influence our wider stakeholder groups, and will not replicate work already undertaken. The strategy to lead a step change focuses on where, organisational leaders, can make the biggest contribution through leadership, shared learning and influencing others.

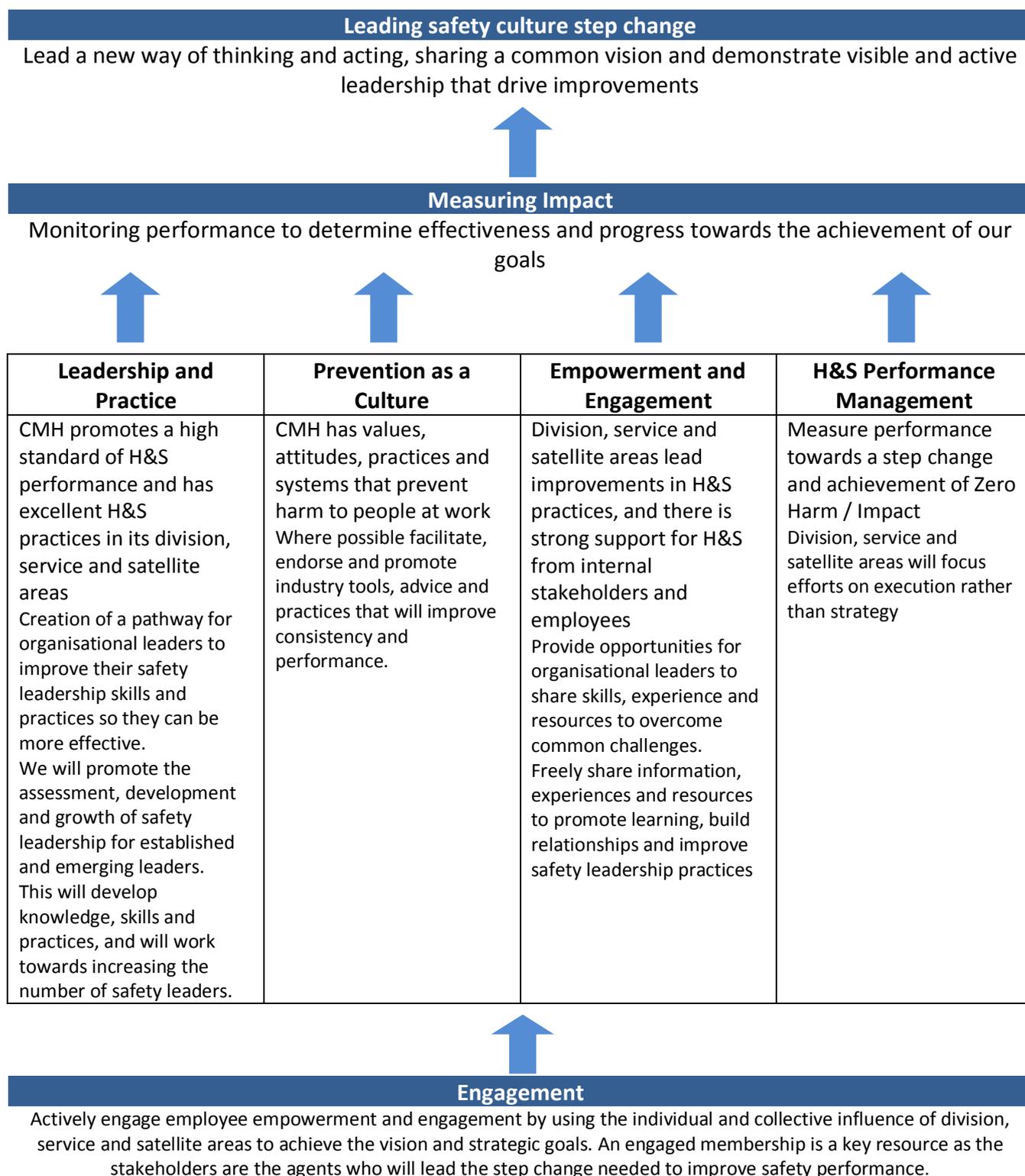
To deliver this strategy our internal stakeholders must be actively engaged. This will increase operational capacity, will promote learning opportunities, and build long-term financial stability. It will also ensure individuals and division, service and satellite areas take the steps required to improve performance.

Ultimately, the H&S Governance Group is about delivering results. Measures will be developed to monitor performance towards Zero Harm / Impact, as well as measuring levels of engagement and the steps we take to achieve our goals.

# Our strategy beginning 2016

Leading a safety culture step change in workplace H&S performance, through effective and inspired senior leadership, influence and shared learning

The strategies, and the goals and activities that support them, are ambitious and focused on results. Together they can bring about a step change - a new way of thinking and acting - where organisational leaders drive improved H&S performance.



# Our Goals and activities

## Goal 1: Leadership and Practice

CMH promotes a high standard of H&S performance and has excellent H&S practices in its division, service and satellite areas

H&S leadership involves promoting a high level of performance within the division, service and satellite areas. The H&S Governance Group is able to set expectations, provide information and support and ensure regional regulatory requirements are achieved. This can be achieved by shared learning, practices and policies.

An important aspect of this goal is that division, service and satellite areas will collaborate with one another and co-ordinate their intervention activities.

Objectives	Activities
1a. Set high CMH expectations for H&S and ensure that regulatory standards are achieved	<ul style="list-style-type: none"> <li>• Create an <b>effective governance / committee structure</b>, to lead and oversee the implementation</li> <li>• Social construction to occur for key stakeholders to build it into their <b>strategic and business planning processes</b></li> <li>• Develop <b>performance indicators and targets</b> for H&amp;S performance across all levels, and track progress against these using improved measurement systems</li> <li>• Develop, review, align and evaluate <b>systems, structures and guidelines</b> to H&amp;S MS with consideration of regional legislative frameworks so they are <b>clear, relevant, and effective</b></li> <li>• Identify specific division, service and satellite areas support requirements to ensure they achieve and surpass H&amp;S MS <b>requirements</b></li> <li>• <b>Improvement activities</b> (such as audits, inspections, investigations and prosecutions) are undertaken</li> <li>• Review the effectiveness and efficiency of <b>corrective activities</b> and ensure that their focus aligns with the H&amp;S Management System</li> </ul>
1b. Provide leadership in H&S through the manager's roles and ownership	<ul style="list-style-type: none"> <li>• Confirm <b>performance expectations</b> in relation to H&amp;S practices</li> <li>• Evidence of Managers <b>active participation</b> in H&amp;S</li> <li>• Provide practical support to improve division, service and satellite areas <b>reporting</b> in relation to H&amp;S</li> <li>• <b>Review</b> H&amp;S practices to embed best practice and monitor progress and improvement opportunities</li> <li>• Review division, service and satellite areas critical risk identification and process <b>guidelines and practices</b>, to include H&amp;S</li> </ul>
1c. Improve co-ordination and alignment of division, service and satellite areas activities	<ul style="list-style-type: none"> <li>• Clarify and, where appropriate, <b>realign the roles and responsibilities</b> of managers with the aim of strengthening shared learning opportunities</li> <li>• Increase <b>joint planning</b> to ensure better co-ordination and alignment of H&amp;S activities</li> <li>• Improve <b>collaboration</b> between division, service and satellite areas to achieve <b>alignment</b> for initiatives and within the H&amp;S framework</li> <li>• Improve division, service and satellite areas <b>co-ordination</b> for the management of critical risks and process safety in business units</li> <li>• Set <b>priorities</b> based on international best practice and research <b>aligned</b> with the overall CMH strategy and HSMS</li> <li>• Develop more effective <b>processes for sharing</b> data and information between division, service and satellite areas</li> </ul>

## Goal 2: Prevention as a culture

### CMH has values, attitudes, practices and systems that prevent harm to people at work

A preventive workplace culture is a shared set of values, beliefs, attitudes, and patterns of behaviour that supports the prevention of harm to people at work. It emphasises the proactive management of hazards to eliminate them wherever practicable – and, if this is not possible, it then focuses on isolating and minimising the hazards.

Workplaces with preventive cultures have a strong management commitment to H&S, effective H&S management systems, involvement of workers and their unions, communications based on good faith, and a willingness to learn from past mistakes. Preventive cultures are ones where H&S is integrated into everyday business practice. It is not an optional ‘add on’.

Objectives	Activities
2a. Increase the recognition among division, service and satellite areas managers that H&S benefits and adds value to their division, service and satellite areas	<ul style="list-style-type: none"> <li>• Understanding of the <b>benefits of a preventive approach</b> to H&amp;S is clear</li> <li>• <b>Practical tools</b> to support division, service and satellite areas identify and quantify business benefits are communicated</li> <li>• <b>Communicate the benefits</b> of H&amp;S to directors and senior managers in each service</li> <li>• <b>Increased reporting</b> of H&amp;S performance in business reports (such as annual reports), to enable benchmarking and encourage best practice</li> </ul>
2b. Increase the commitment and capability of managers to systematically and effectively manage H&S	<ul style="list-style-type: none"> <li>• Provide <b>practical guidance and tools</b> to support the systematic and effective management of H&amp;S</li> <li>• <b>Build the capability</b> of managers to effectively manage H&amp;S systems, with a focus on high-risk activities</li> <li>• <b>Raise managers’ awareness</b> about the benefits of H&amp;S and employers’ legal obligations</li> <li>• Promote the systematic and effective management of H&amp;S through industry accreditation programmes and industry <b>training programmes</b></li> <li>• Acknowledge excellence in H&amp;S management through <b>recognition schemes and awards</b></li> </ul>
2c. Ensure that employees participate effectively in processes for improving H&S	<ul style="list-style-type: none"> <li>• Raise awareness about the benefits of <b>employee participation</b>, and also about employers’ legal obligations to involve workers in H&amp;S</li> <li>• Provide practical guidance for division, service and satellite areas on employee participation systems and practices to support <b>effective employee involvement</b> in H&amp;S matters</li> <li>• Recognise the role that <b>H&amp;S representatives</b> play in the workplace, and provide them with support, resources, and practical tools</li> <li>• Build the <b>capability of H&amp;S representatives</b> through training</li> <li>• Promote and embed <b>legal requirements</b> relating to employee - participation systems</li> </ul>

## Goal 3: Employee Empowerment and Engagement

**Division, service and satellite areas lead improvements in H&S practices, and there is strong support for H&S from internal stakeholders and employees**

Other workplaces, trade unions, employer organisations, industry and training associations are the linchpins for providing learning opportunities to improve organisational H&S. Information gleaned can be the provision of advice, information, industry standards, training programmes, influential role models and best practice examples.

Effective empowerment requires a paradigm shift to incorporate engagement. Employees are to be included and part of developing goals and objectives that align with the business strategy with shared responsibilities. This will remove divisiveness and an authoritarian approach. Involvement leads to participation and ultimately results in empowerment. Leadership will develop as a result.

Empowerment is making the decision yourself and requires ownership. Engagement is discretionary. Empowerment removes the focus from a compliance driven H&S system.

Objectives	Activities
3a Develop and implement division, service and satellite areas led initiatives to improve H&S	<ul style="list-style-type: none"> <li>• Create and strengthen division, service and satellite areas <b>H&amp;S committees to direct and co-ordinate</b> specific service initiatives</li> <li>• A system to effectively <b>support employee-led initiatives is in place</b></li> <li>• Develop and implement division, service and satellite areas <b>strategies and plans aligned to the H&amp;S MS</b></li> <li>• Localised division, service and satellite areas <b>specific standards</b> and guidance material are developed for significant H&amp;S issues and critical risks</li> <li>• H&amp;S Governance Group shares <b>best-practice information</b>, learning and examples</li> <li>• Develop and modify division, service and satellite areas programmes for <b>training and accreditation</b>, to achieve an increased focus on H&amp;S</li> <li>• Build the <b>evidence base for division, service and satellite areas led initiatives</b> through investment in research and development</li> <li>• Strengthen the competency of occupational safety and health professionals and practitioners through <b>specialised education and training, and certification and professional development programmes</b></li> </ul>
3b Encourage and enable division, service and satellite areas leaders and stakeholders to promote H&S to their teams and peers	<ul style="list-style-type: none"> <li>• Identify <b>division, service and satellite areas stakeholders to act as champions</b> or spokespersons for improved H&amp;S</li> <li>• <b>Support those leaders</b> by providing them with information and communication resources that will be relevant to their sites and functions</li> <li>• <b>Establish H&amp;S committees</b></li> <li>• <b>Evaluate the effectiveness</b> of the activities carried out by division, service and satellite areas leaders and committees</li> </ul>
3c Raise awareness and understanding of H&S in the wider organisation	<ul style="list-style-type: none"> <li>• Raise the profile of H&amp;S as an issue of <b>personal responsibility</b>, by drawing attention to the impact of well-being and work-related disease / injury on individuals, families and businesses</li> <li>• Increase awareness and understanding of specific H&amp;S issues through <b>awareness and education programmes</b></li> <li>• Promote the opportunity for <b>development of personal skills in H&amp;S</b> within the division, service and satellite areas in H&amp;S</li> <li>• <b>Make links</b> between H&amp;S and community-based injury prevention and safety initiatives</li> </ul>

## Goal 4: Performance Measurement

### Measure performance towards a step change and achievement of Zero Harm / Impact

CMH is a changing organisation. In achieving Health and Safety excellence, new ways to achieve strategic organisational change must be identified and by focusing efforts on execution rather than strategy, results can be achieved.

Simple and cost effective application of international best practices and standards will be considered to enable appropriate benchmarking to be identified.

Objectives	Activities
4a. Develop a series of measures that track the H&S Governance Group's progress towards Zero Harm / Impact	Include measures of: <ul style="list-style-type: none"> <li>• activities the H&amp;S Governance Group is undertaking to lead a step change</li> <li>• membership engagement</li> <li>• the incidence and severity of workplace injuries</li> </ul>
4b. Act on lead indicators	Develop a suite of <b>key lead indicators</b>
4c. Maintain a compelling scoreboard.	Awareness of the scoreboard results in active engagement. <ul style="list-style-type: none"> <li>• Communication</li> <li>• Consultation</li> <li>• Distribution and awareness messages</li> </ul>
4d. Create a platform of accountability	<ul style="list-style-type: none"> <li>• Regular meetings</li> <li>• Shared learning opportunities</li> </ul>

## Priorities

The priorities outlined will help to focus the implementation objectives more sharply and target resources more effectively.

These priorities account for the potential impact i.e. injuries and harm CMH has due to unidentified risk. They also reflect a need to focus on any emerging issues, and to assist division, service and satellite areas and groups of workers who have particular needs or who are at more risk.

The key tasks are the 4 Components, which include 21 elements of the CMH H&S Management System i.e.:

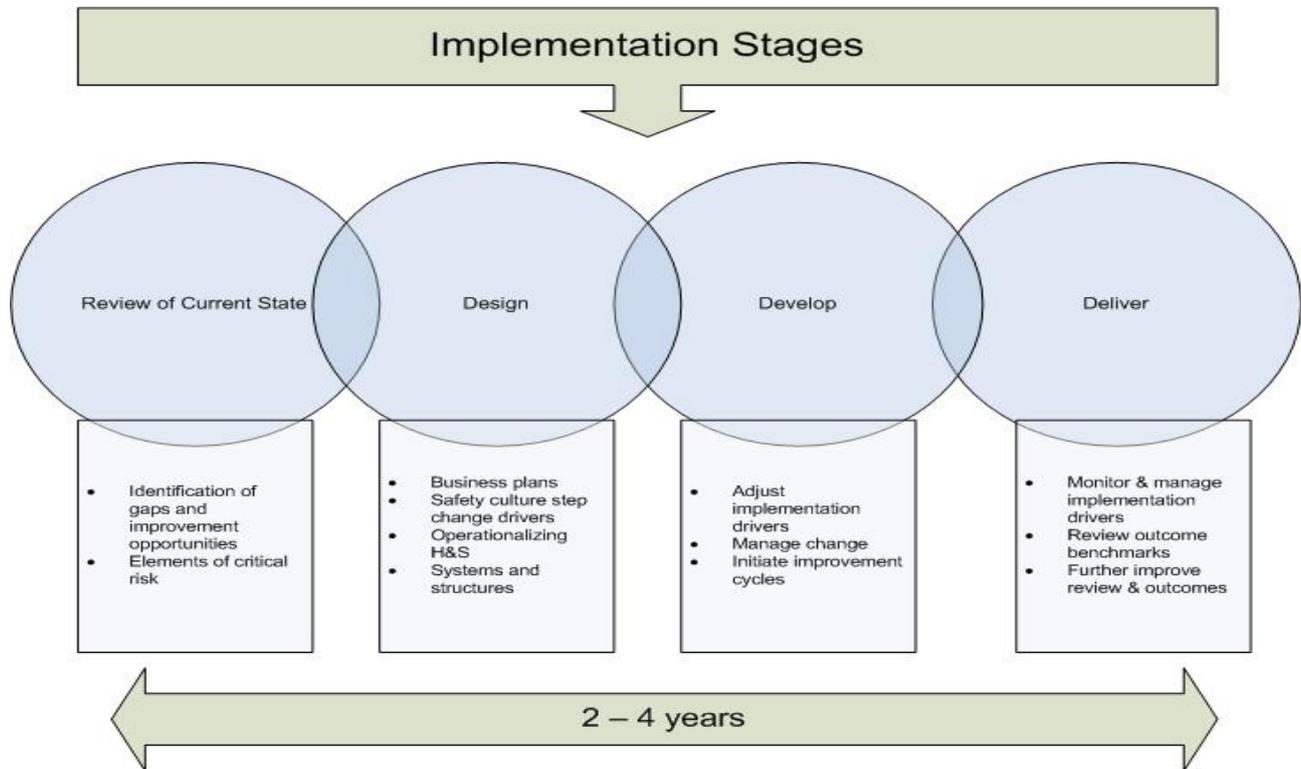
- Safety Culture
- Process Safety
- Risk Management
- Incident Management

The focus is:

- Undertaking an audit to set a baseline of consistent data
- Change Process Safety (Including hand over and communications from internal 'experts')
- Critical Risk Management and Assessment as it relates to:
  - High Frequency / Low Consequence Events i.e. Personal Safety and
  - Low Frequency / High Consequence Events i.e. Plant and Process Safety
- Incident Management

# Implementation stages

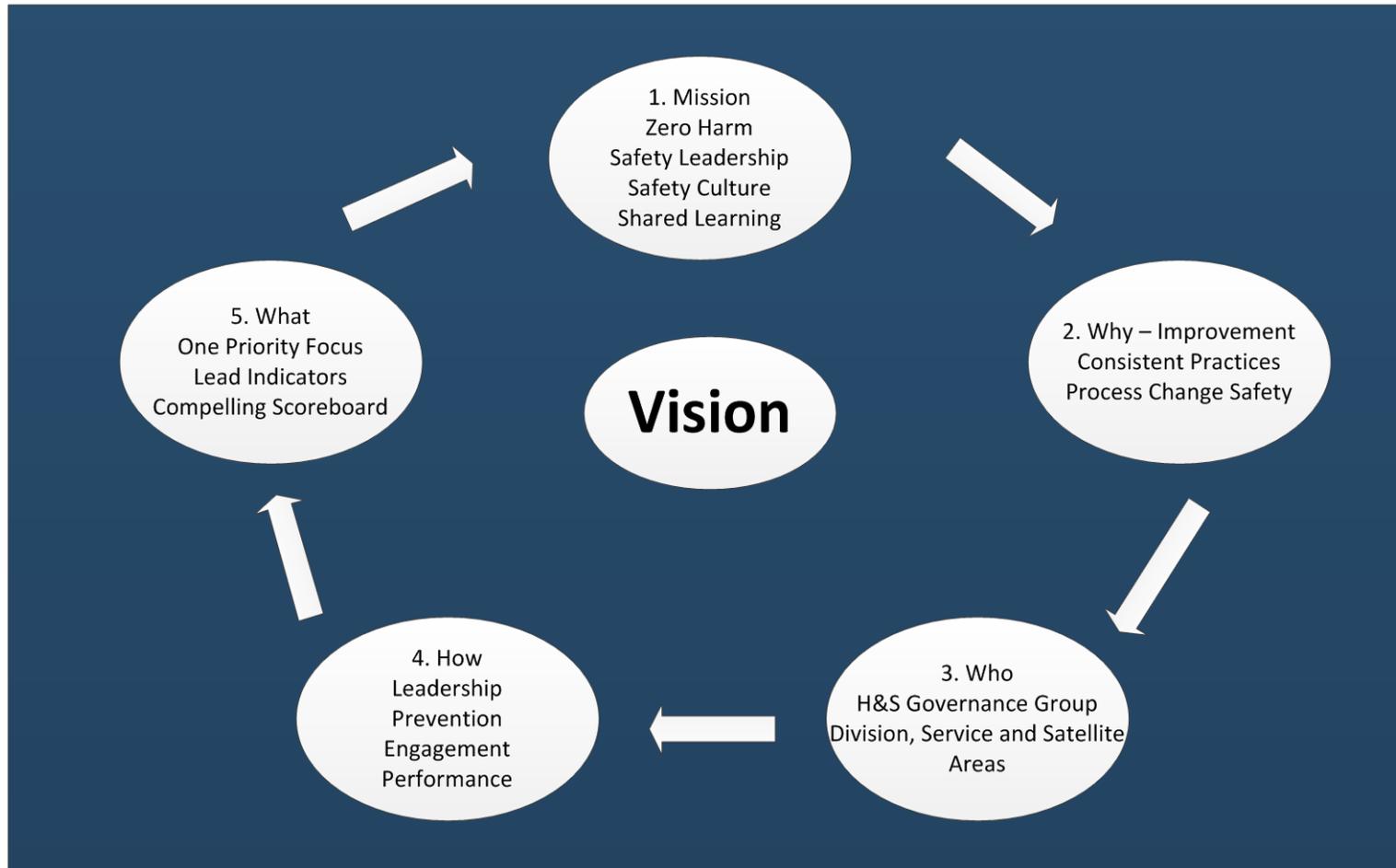
- Review of current state
- Design of systems and structures
- Develop systems and structures
- Deliver systems and structures



# Appendix 1 – Implementation Strategy Diagram

## Vision

CMH has a clearly defined best practice H&S management framework comprising of business excellence and user friendly systems and structures that allow risk to be understood, identified and controlled. It is consistently applied across the division, service and satellite areas, resulting in minimisation of business impact and harm has been prevented to our people.



## ***Appendix 2 – Stakeholders***

## ***Appendix 3 – Operationalising Health and Safety***

# ***Health & Safety Guideline to Due Diligence and Worker Participation***

***November 2014***

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<b>Counties Manukau District Health Board</b>			

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# Counties Manukau Health – Health and Safety Guideline to Due Diligence and Worker Participation

## Contents

The Counties Manukau Health - Health and Safety Guideline to Due Diligence and Worker Participation provides an organisational structure for ensuring a high standard of Health and Safety, this includes some general information regarding Health and Safety operations at Counties Manukau Health and, in particular:

1. Counties Manukau Health Guideline for Worker Participation in Health and Safety; and
2. Counties Manukau Health Guideline for Due Diligence in Health and Safety.

## Employer Commitment

Counties Manukau Health is committed to demonstrating best practice regarding workplace Health and Safety where possible. In doing so, it will take all reasonably practicable steps to continuously improve Health and Safety in the workplace.

Health and Safety is everyone's personal responsibility and Counties Manukau Health has developed systems and procedures to provide a structure by which Health and Safety can be managed based on the requirements of the Health and Safety in Employment Act 1992, AS/NZS 4801:2001 (which is used as the benchmark to assess Occupational Health and Safety Management systems for organisations) and the proposed Health and Safety Reform Bill.

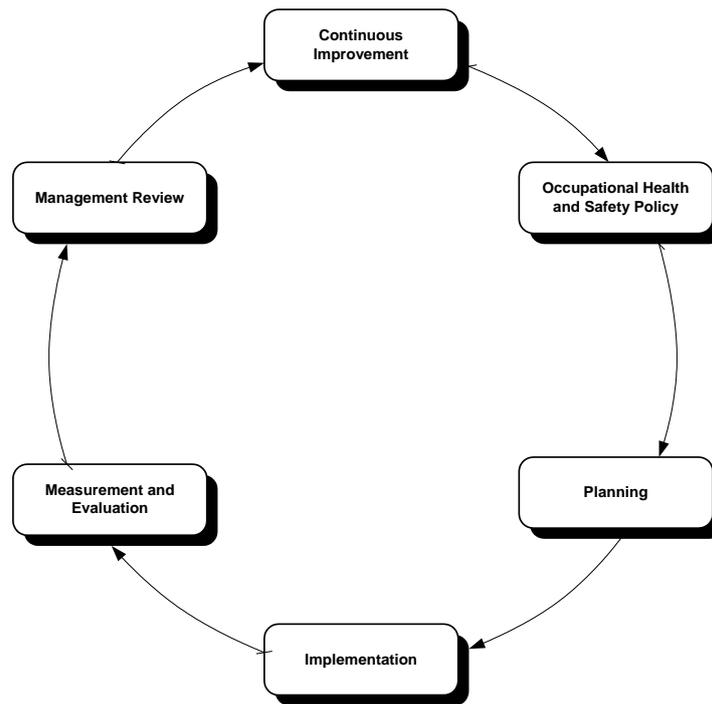
Counties Manukau Health acknowledges its duty to engage its workers in practices that provide reasonable opportunities for workers to participate effectively in improving work Health and Safety in Counties Manukau Health on an ongoing basis. It is necessary that clear systems and processes be developed to guide how that engagement and collaboration should occur.

These systems can include, but are not limited to, the selection, election and appointment of Health and Safety Representatives, the establishment of Health and Safety Committees and the development of other forums to facilitate the involvement of Counties Manukau Health workers in the management of Health and Safety.

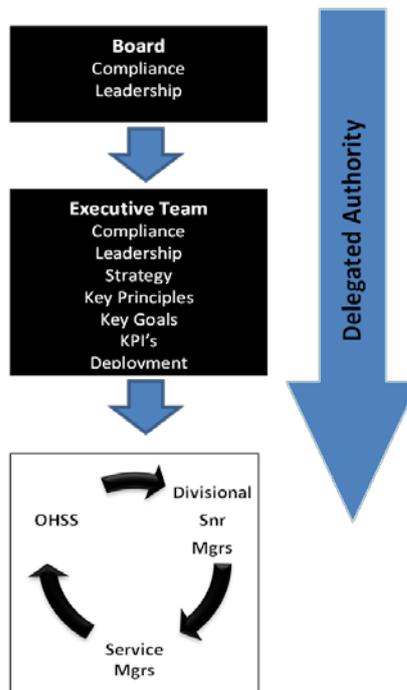
Health and Safety will improve with cooperation between Counties Manukau Health and workers, and where appropriate with input from Unions representing workers.

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## Continuous Improvement



## Delegation of Authority



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## Interpretation and Consultation of Guidelines

This guideline shall be interpreted:

- consistently with any regulator issued guidelines (as applicable);
- consistently with any Health and Safety legislation and/or regulation; and
- in conjunction with any other Health and Safety provisions contained in individual and collective employment agreements.

This guideline has been produced as part of Counties Manukau Health's commitment to best practice and drive to become "reform ready" prior to the Health and Safety at Work Bill coming into force. To that end it has been drafted, so far as possible, to incorporate both regimes. For the avoidance of doubt:

- All persons subject to this guideline understand and acknowledge that all relevant rights and obligations contained in the Health and Safety in Employment Act 1992 apply to them.
- Any reference to terminology that is only relevant to the Health and Safety Reform Bill shall be interpreted as forming part of Counties Manukau Health's drive towards best practice and proactive reform readiness.
- Definitions of some specific terms used in this guideline are shown in **APPENDIX 3: DEFINITIONS**.

### Consultation

This guideline has been prepared:

- with advice and/or documentation from independent health and safety professionals, including health and safety lawyers.
- in accordance with the Government issued guideline materials that were available at October 2014.

Moving forward, Counties Manukau Health will consult and cooperate with all relevant organisations with regard to the following Health and Safety matters:

- Hazard identification and risk assessment for work carried out for Counties Manukau Health;
- Making decisions about ways to control hazards, to eliminate or minimise those risks;
- Making decisions about the adequacy of facilities for the welfare of workers;
- Proposing changes that may affect the health or safety of workers;
- Making decisions about the procedures for:
  - Consultation with workers; or
  - Resolving work health or safety issues at any Counties Manukau Health workplace; or
  - Monitoring the health of workers; or
  - Monitoring the conditions at any Counties Manukau Health workplace; or
  - Providing information and training for workers at any Counties Manukau Health workplace.

This guideline is intended to supplement the regional guideline which has been prepared in consultation with relevant Unions, worker groups and other applicable parties.

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## Objectives

The objectives of the Counties Manukau Health - Health and Safety Guideline to Due Diligence and Worker Participation are to:

1. Assist Counties Manukau Health to achieve excellence in workplace Health and Safety by drawing on the combined skills, knowledge and experience of all workers;
2. Enable Counties Manukau Health workers to participate in the development of systems, processes and procedures for controlling workplace hazards;
3. Provide a mechanism, outside of the “line” reporting chain, for escalating Health and Safety concerns;
4. Raise awareness, participation and commitment of all staff to Health and Safety at work, through peer support and coaching; and
5. Assist in ensuring appropriate rehabilitation aids are provided in the workplace to assist people following an injury.

## Targets

The targets of the Counties Manukau Health - Health and Safety Guideline to Due Diligence and Worker Participation are:

1. Daily, weekly, monthly or six monthly safety audits (as deemed appropriate) completed for all areas and as defined by the Divisional Hazard Management Plan;
2. All Health and Safety issues raised by workers are resolved in an appropriate timeframe as determined by the risk matrix, but in any event within a month of the issue being raised.
3. All Health and Safety Representatives are actively involved in meetings and development of Health and Safety management systems;
4. All Health and Safety Representatives have received the designated training; and
5. Strategies are identified and implemented to proactively reduce incidents, and increase worker awareness of Health and Safety.

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# Health and Safety Policy



## Health and Safety Policy

Counties Manukau Health's commitment to and policy on health and safety at work applies across our entire business.

### Our Commitment

Counties Manukau Health (CMH) is committed to achieving excellence in health and safety management and also to working together to prevent harm as a result of any work activities. CMH is committed to upholding the following:

- Promoting a culture where our staff and the people with whom we work share this commitment
- Actively train our managers and employees to understand their responsibilities to develop appropriate policies and procedures that allow us to work safely and in a manner which protects themselves, their colleagues and any other person from harm
- Ensuring our managers and employees are able to meet the required health and safety competencies, responsibilities and accountabilities that demonstrates a high level of commitment to health and safety
- Incorporating and promoting a healthy and safe culture in the development of standard work practices and organisational processes
- Encouraging employees to participate in the review and improvement of the safety management system by involving and discussing with them in ways which reduce workplace hazards and improve control systems
- Setting objectives and targets which enable a continual reduction in harm, and regularly review performance as part of a continuous improvement action plan
- Use effective risk management methodology to manage workplace hazards successfully
- Maintaining effective hazard, incident and non-conformance reporting and analysis
- Offer appropriate rehabilitation to any employee who has suffered a work-related injury or illness
- Comply with, or exceed the spirit and intent of relevant legislation and statutory requirements, Codes of Practice, guidelines and industry standards and allow adequate provision of resources to meet these requirements

CMH value our staff and the people with whom we work, celebrating health and safety initiatives and innovation. The CMH safety management system aims to be adaptable, functional and aligned with our visions and values. It provides the cornerstone for creating a safe and healthy workplace environment and relationships.

The core system is integrated into the strategic objectives across all divisions within Counties Manukau Health and operates at a local and site level.

In this way, we strive to achieve a health and safety performance we can be proud of, that earns the confidence of our clients, stakeholders and community, and positively contributes to the sustainable development of our people and organisation.

Chief Executive Officer  
Counties Manukau Health

Dated 11.03.14

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## Duties of Counties Manukau Health

Counties Manukau Health will be a "Person Conducting a Business or Undertaking" (PCBU) under the Health and Safety Reform Bill which is anticipated to come into force by 1 April 2015. Employees of Counties Manukau Health will not be considered PCBUs under this regime.

Counties Manukau Health must ensure, so far as is reasonably practicable, that the Health and Safety of workers and other persons within Counties Manukau Health are not put at risk from work carried out as part of the operation of any business referred to as part of Counties Manukau Health.

To ensure that Counties Manukau Health can fulfil its duties with regard to the legislation, the following must be undertaken by the organisation:

- Counties Manukau Health must ensure that the work environment of all Counties Manukau Health workplaces, under their direct control, is maintained so that all employees, visitors and other persons **are without risks** to Health and Safety so far as is reasonably practicable;
- Counties Manukau Health must maintain plant and structures that are under the direct control of any Counties Manukau Health workplace, to ensure that all plant and structures remain safe for use;
- Counties Manukau Health must engage workers so far as reasonably practicable and in accordance with these guidelines;
- Counties Manukau Health must provide and maintain safe systems of work for all Counties Manukau Health workplaces;
- Counties Manukau Health must ensure that handling, storage and transport of plant, structures and chemicals is undertaken, so that persons are without risks to Health and Safety at any Counties Manukau Health workplace;
- Counties Manukau Health must provide adequate facilities for the welfare of employees, at any Counties Manukau Health workplace, including ensuring access to those facilities;
- Counties Manukau Health must provide for information, training, instruction and supervision that is necessary to protect all persons from risks to their Health and Safety arising from work carried out as part of any operations under the direct control of any Counties Manukau Health workplace;
- Counties Manukau Health must ensure that the health of employees and the conditions at any workplace under the direct control of Counties Manukau Health are monitored for the purpose of preventing illness and/or injury of employees arising from any operations undertaken by a Counties Manukau Health workplace;
- Counties Manukau Health must, so far as is reasonably practicable, maintain all Counties Manukau Health premises that an employee of Counties Manukau Health may occupy, to ensure they are not exposed to potential harm while in the premises. This includes accommodation that is owned by, or under the management or control of Counties Manukau Health and the occupancy is necessary for the purposes of the employee's engagement, because other accommodation is not reasonably available; and
- Counties Manukau Health will undertake work in accordance with the due diligence guidelines.

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## Duties of Counties Manukau Health Workers

Effective implementation of a Health and Safety system requires the active involvement of all workers. They have an obligation to comply with statutory and organisational requirements, procedures and rules that are introduced to protect the Health and Safety of workers at the workplace, including the general public and the surrounding environment.

Notwithstanding, industry and collective agreements and the obligations imposed by them, all workers must:

- Perform work safely in accordance with the training they have received and report substandard work conditions or practices;
- Follow lawful written and verbal Health and Safety instructions issued by management or any other person who has legislative authority;
- Report all personal injuries immediately to management regarding any medical treatment for incident reporting and recording;
- Cooperate with and participate in all initiatives to make the work environment safe and healthy;
- Take reasonable care of their own and others safety at the workplace;
- Maintain good housekeeping standards at all times;
- Observe all warning signs and notices;
- Seek specific instruction regarding the hazards associated with performing tasks, which they may not be completely familiar with;
- Wear clothing and footwear appropriate to their job and use all personal protective devices specified and/or routinely expected for that job; and
- Operate specified plant and equipment, ONLY if properly trained and authorised to do so.

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# Counties Manukau Health Guideline for Worker Participation in Health and Safety

## Health and Safety Representatives' Role and Functions

### The Powers and Functions of a Health and Safety Representative for a work group/area are:

- To represent the workers in the work group/area in matters relating to Health and Safety;
- To monitor the measures taken by Counties Manukau Health, to ensure Health and Safety within their work group/areas;
- To investigate complaints from members of the work group/area relating to Health and Safety;
- To inquire into anything that appears to be a risk to the health or safety of workers in the work group/area, arising from the conduct of any Counties Manukau Health operations;
- To inspect a workplace or any part of a workplace at which workers in the work group/area work:
  - At any time after giving reasonable notice to Counties Manukau Health;
  - At any time, without notice, in the event of an incident, or any situation involving a serious risk to the health or safety of a person emanating from an immediate or imminent exposure to a hazard; and
  - Accompany an Inspector during an inspection of the workplace or part of the workplace at which a workers works.
- Health and Safety Representatives may consult the regulator or an Inspector about any Health and Safety issue;
- Health and Safety Representatives may also be present at designated meetings between worker/s and management at the discretion of the worker/s involved;
- Health and Safety Representatives may request that a Health and Safety Committee be formed;
- Health and Safety Representatives may request information from Counties Manukau Health to enable the Health and Safety Representative to perform his or her functions. Personal information concerning a worker must not be given to the Health and Safety Representative without that worker's consent, unless the information is in a form that does not and could not reasonably be expected to identify the worker. Health and Safety Representatives may disclose personal information only with that person's consent and only to the extent necessary for the performance of the Health and Safety Representative's functions or powers;
- Health and Safety Representatives may assign a deputy and/or be accompanied or assisted by another person and will be provided with the resources, facilities and assistance as reasonably necessary to perform his or her functions and powers;
- Health and Safety Representatives, acting in good faith, do not have a duty to act and are not liable for any act done or omitted in the performance of his or her functions or powers;
- Health and Safety Representatives may be removed by the regulator; and
- Health and Safety Representatives are allowed as much time as is reasonably necessary to perform his or her functions, at the same pay that he or she would otherwise be entitled to receive for performing his or her normal duties.

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A Health and Safety Representative does not require training to act as a Health and Safety Representative. If a Health and Safety Representative requests to be formally trained in the qualification under the relevant Health and Safety regulations, Counties Manukau Health will allocate paid time to undertake the course and pay the Health and Safety Representative's course fees for the person. In addition, the Health and Safety Representative may, on approval from the Executive Management, undertake tasks as specified above.

## Health and Safety Committees

The Chief Executive Officer has overall responsibility for Health and Safety at Counties Manukau Health.

### Health and Safety Committee Overview

The Health and Safety Representatives and Health and Safety Committees are mechanisms for providing information and input into decision-making processes.

A multi-tiered Health and Safety Committee structure is envisaged and the number of layers may vary depending on the size and physical location of the areas covered and the practicality of a multi-tiered structure.

Delegated Health and Safety Committee chairpersons and Health and Safety Representatives will be represented at an executive Health and Safety Committee, or similar fora.

### Health and Safety Committee Responsibilities and Membership

The Health and Safety Committee is responsible for ensuring that all areas comply with relevant legislation, regulations, codes of practice and that Health and Safety policy is reviewed.

The membership is made up of Executive Leadership Team members, Senior Managers and members of the HR team, including the OHS Manager and Health and Safety Representatives. Members are selected for their ability and expertise to contribute to Health and Safety.

Other people may be invited to the meeting if their expertise is required.

The Health and Safety Committee will:

- Monitor Health and Safety issues;
- Ensure compliance with all legal requirements;
- Review and develop Health and Safety policy;
- Review and monitor progress on the Health and Safety Business Plan;
- Review outstanding issues from site Health and Safety meetings;
- Ensure continuance of ACC WSMP Programme; and
- Participate in a consultative approach to Health and Safety.

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## Health and safety Committee Focus

The focus of the Divisional Health and Safety Committee will include, but not be limited to:

- The overview of Health and Safety, including the evaluation of reports of injuries, near misses, illnesses and the status of corrective actions taken;
- Ensuring compliance with Counties Manukau Health, Health and Safety policies and procedures and the requirements of current Health and Safety related legislation;
- Coordinating the consultation process with the workers and the Health and Safety Representatives, including Council Health and Safety related policies; and
- Enhance, promote and communicate Health and Safety.

## Functions of Health and Safety Committees

The functions of the Health and Safety Committee are to:

- Resolve issues escalated by workers;
- Ensure safety audits are undertaken;
- Ensure adequate worker participation in Health and Safety across the organisation;
- Ensure Health and Safety procedures are current and appropriate;
- Recommend when to engage specialists; and
- Implement Counties Manukau Health's Health and Safety Policy.

## Health and Safety Committee Structure

### Divisional Level

At a Divisional level selected Service Managers and Delegated Health and Safety Representatives from the services within the division will be represented on the Health and Safety Committee.

- The Health and Safety Committee will be chaired by the Divisional GM or delegated Service Manager;
- The Health and Safety Committee will be formed by the Health and Safety Representatives from the work groups within the division, together with delegated service managers; and
- Minutes will be kept at each Health and Safety Committee meeting.

### Service Level

At the Service Level, Department Managers and department work group/area Health and Safety Representatives will form the Health and Safety Committee.

- The Health and Safety Committee will be chaired by the Service Manager or delegated department Manager;
- The Health and Safety Committee will be formed by nominated Health and Safety Representatives from Departments or work group/areas within the Service together with Union representatives;
- In addition, Health and Safety Representatives may be asked to sit on the Divisional Health and Safety Committee; and
- Minutes will be kept at each Health and Safety Committee meeting.

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## Departmental Level

At the Departmental (or work group/ area) level a specific Health and Safety Committee is not required. However in the absence of a Health and Safety Committee a similar meeting (for example quality or service improvement) is to specifically include Health and Safety on the agenda.

- The meeting will be chaired by the Department Manager or other delegated staff member;
- Health and Safety is to be a specific agenda item;
- Departmental Health and Safety Representatives are expected to participate in the Health and Safety component of the meeting as a minimum; and
- Minutes will be kept at each meeting.

## Operationalising Health and Safety

Refer: Appendix 4: Health and Safety participation structure.

## Health and Safety Committee Terms of Reference

Health and Safety Committees are required to work within the general intent of Counties Manukau Health's Health and Safety policy and procedures.

The scope of each Health and Safety Committee extends only to the area and/or group that they represent. Any matters that affect other groups or committees should be referred to the relevant group manager or committee for action. Matters of a genuine corporate nature should be referred to the Occupational Health and Safety Manager.

The role of a Health and Safety Committee is to include, but not be limited to, the following:

- Provide a forum where management and worker representatives can discuss and respond to matters relating to Health and Safety;
- Consult with the Occupational Health and Safety Service on any proposed changes to Health and Safety practices, procedures or policies; and
- Review accidents and incidents in the group or area of responsibility, and make recommendations to management for how future incidents can be prevented.

The Health and Safety Committee will:

- Meet periodically, suitable to the size and nature of its coverage area;
- Monitor the Health and Safety performance of its coverage area. This will include hazard management, risk assessments, technical audits, six monthly audits and accidents/incidents investigations;
- Approve local Health and Safety procedures;
- Make recommendations on Health and Safety policy, systems, procedures and rules to the Counties Manukau Health, Health and Safety Committee;
- Resolve Health and Safety issues that have not been resolved after following the normal process;
- Identify, review and disseminate Health and Safety information for workers in their work group/area; and
- Coordinate required of groups by Counties Manukau Health's Health and Safety management processes.

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These general Health and Safety activities include:

- Review of hazard registers and workplace audits to ensure that any new findings, risks and controls are included in the register and communicated;
- Review of accident and incident investigation findings;
- Review and monitor group Health and Safety objectives and plans;
- Reviewing group accident and incident statistics, identify trends and recommend actions;
- Monitor planned Health and Safety training for the group or area, such as first aid training, fire warden training, and worker Health and Safety Representative training; and
- Support with the rehabilitation and return to work of injured workers.

## Quorum

A quorum of the Health and Safety Committee shall consist of at least four permanent members with at least one management and one worker representative present.

## Chairperson and Secretary

The chairperson and/or the secretary may be elected on a rotating basis at the current meeting for the next meeting. These persons may be a worker, Health and Safety Representative, or a management representative.

## Membership

Management representatives may not exceed the number of worker representatives on the Health and Safety Committees. All Health and Safety Representatives have automatic membership to the relevant Health and Safety Committee in their allocated work group/area.

## Frequency of Health and Safety Committee Meetings

The Health and Safety Committee(s) shall meet monthly, or at more regular intervals or quarterly by agreement.

## Meetings

Generally, items for the agenda should be submitted to the Secretary 10 days prior to normal meetings to allow for the preparation of the agenda or for the obtaining of any reports or information by management or workers.

Minutes shall be taken by the secretary and distributed to all managers in the work group/area, all Health and Safety Committee members and the OHS Manager.

The Health and Safety Committee members shall ensure that workers they represent have access to the minutes.

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## Order of business

The order of business shall be set down in an agenda and should include:

- Apologies;
- Minutes of previous meeting;
- Matters arising from the minutes;
- Health and Safety Plan;
- Incident Management;
- Hazard Management;
- Training;
- Emergency Management;
- Contractor Management;
- New or changes to business; and
- Date, time and place of next meeting.

## Minutes

Minutes should be placed on the Health and Safety section of the staff notice boards. Minutes shall reflect action points and responsibilities with appropriate timeframes. A copy of the minutes will be held by the Health and Safety Consultant for a minimum of five years.

## Resignations

Should a representative wish to resign from the Health and Safety Committee, notice in writing of their intention is to be sent to the secretary as well as the relevant manager.

## Documentation

Coordinate Health and Safety Representative reports and maintain the work group/area Health and Safety minutes.

## Additional Information

### Right to Refuse Dangerous Work

Workers have a right, and an obligation, to refuse work that they believe is likely to cause serious harm. However, a worker may not refuse to do work that, because of its nature, inherently or usually carries an understood risk of serious harm, unless the risk has materially increased beyond the understood tolerable risk, for which they have been trained and equipped.

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## Escalation and Problem-Solving Process

In the event that a worker refuses to perform work on the grounds in paragraph 1.30, the following steps must be taken:

- The worker must advise both their manager and their Health and Safety Representative immediately;
- If the manager is not available, the worker must notify their manager's authorised deputy.
- If their Health and Safety Representative is not available, the worker must advise the relevant Health and Safety Consultant;
- The worker, Health and Safety Representative and manager must attempt to resolve the matter as soon as practicable;
- The worker must continue to refuse to perform the work until they are satisfied it is no longer likely to cause serious harm and/or they have the necessary training, equipment and supervision;
- If the matter cannot be resolved, a WorkSafe New Zealand Inspector can be contacted; and
- Counties Manukau Health may direct the worker to carry out safe alternative work within the scope of his or her employment agreement until the worker can resume normal duties.

Without limiting the above, reasonable grounds exist to refuse to do work if a trained Health and Safety Representative has advised the worker that the work is reasonably likely to cause them serious harm.

## Hazard Notices

A trained Health and Safety Representative may issue a Hazard Notice in the following circumstances:

- When there are reasonable grounds to believe a hazard exists; and
- The hazard has been brought to the attention of the employer; and
- An attempt has been made to discuss the hazard with the employer; and
- The employer refuses to discuss or take steps to deal with the hazard; or
- Agreement cannot be reached on how to deal with the hazard; or
- The Health and Safety Representative believes on reasonable grounds that the employer is in breach of its obligation to ensure the Health and Safety of its workers, or other persons, in relation to the hazard.

When a trained Health and Safety Representative issues a hazard notice, an Inspector may be notified.

The employer and the Health and Safety Representative must work together in good faith to resolve the issue.

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## Approval

Immediately the terms of reference for Health and Safety Representatives are ratified when they are formalised into Counties Manukau Health's Health and Safety and HR documentation processes.

It should be noted that this document is not static and may change as the business finds necessary to ensure best practice.

Any changes will be made in consultation with the Executive Leadership Team, the National Health and Safety Committee, Health and Safety Representatives and the Union. In some cases, other staff may also need to be consulted.

## General Agreement in Relation to Worker Participation

Notwithstanding the terms of this guideline all workers must be provided with a reasonable opportunity to participate effectively in ongoing processes for improvement of Health and Safety for Counties Manukau Health.

## Adverse, Coercive and Misleading Conduct

### Adverse Conduct

Workers (including prospective workers), Health and Safety Representatives and Health and Safety Committee members are protected from conduct such as:

- Dismissal; or
- Termination of contract for services; or
- Refusal or omission to offer terms of employment or engagement, conditions of work, fringe benefits, opportunities for training, promotion and transfer as are made available to other workers in similar circumstances; or
- Subjection to any detriment, in circumstances where other workers would not be subject; or
- Retiring of, or causing the worker to retire or terminate a contract.

Where that conduct is engaged in because the worker, prospective worker, Health and Safety Representative or Health and Safety Committee member:

- Is engaged in, or has Health and Safety functions; or
- Has assisted a Health and Safety Representative, Health and Safety Committee member, regulator or Inspector; or
- Raises, has raised, or proposes to raise an issue or concern about Health and Safety to the employer, regulator, Health and Safety Representative, or any other person with any Health and Safety duty or obligation; or
- Has ceased or refused to perform dangerous work, as defined above.

### Coercive conduct

Workers (including prospective workers), Health and Safety Representatives and Health and Safety Committee members are protected from actions taken against them with intent to coerce or induce that worker, Health and Safety Representative or Health and Safety Committee member from performance of, or refraining from performance of, their functions, duties or powers.

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### Misrepresentation

False or misleading misrepresentations must not knowingly, or recklessly, be made to another person about that other person's:

- Health and Safety rights or obligations;
- Ability to initiate or participate in processes or proceedings; or
- Their ability to make a Health and Safety complaint or an inquiry to a person or body that is empowered to provide a solution to that complaint or an inquiry.

### **Review of System**

This guideline, and the system it describes, will be reviewed six months from the date the guideline is signed off, in accordance with this guideline.

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# Counties Manukau Health Guideline for Due Diligence in Health and Safety

## Health and Safety Due Diligence – System Objectives and Targets

### Objectives

The objectives of the Counties Manukau Health and Safety Due Diligence Guideline are to:

- Assist Counties Manukau Health to achieve excellence in workplace Health and Safety by drawing on the combined skills, knowledge and experience of its executive;
- Enable Counties Manukau Health Executive to guide the development of systems, processes and procedures for controlling workplace hazards;
- Provide a mechanism for members of Counties Manukau Health Executive to exercise due diligence to ensure that Counties Manukau Health complies with its duties and obligations;
- Enable members of Counties Manukau Health Executive to acquire, and keep up-to-date, knowledge of work Health and Safety matters;
- Enable members of Counties Manukau Health Executive to gain an understanding of the nature of the operations of the business or undertaking of and generally of the hazards and risks associated with those operations;
- Enable members of Counties Manukau Health Executive to ensure that Counties Manukau Health has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to Health and Safety from work carried out as part of the conduct of the business or undertaking;
- Enable members of Counties Manukau Health Executive to ensure that Counties Manukau Health has appropriate processes for receiving and considering information regarding incidents, hazards and risks and for responding in a timely way to that information; and
- Enable members of Counties Manukau Health Executive to ensure that Counties Manukau Health has, and implements, processes for complying with any duty or obligation of Counties Manukau Health under relevant legislation.

### Targets

The Targets of the Health and Safety Due Diligence Guideline are:

- Ensuring the requirements of the Health and Safety programme are established, implemented and continuously improved;
- Relevant members of the Counties Manukau Health Executive are actively involved in meetings and development of Health and Safety management systems; and
- Strategies are identified and implemented to proactively reduce incidents and increase worker awareness of Health and Safety.

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# Due Diligence Overview

## Specific Responsibilities

Accountability, for ensuring that the Health and Safety Policy is implemented, lies with the Executive Leadership Team.

The Executive Leadership Team has the authority and responsibility for ensuring the requirements of the Health and Safety programme is established, implemented and continuously improved.

## Senior Management

The Senior Management of Counties Manukau Health accepts that the safety and wellbeing of all staff, contractors, visitors and patients is an integral and vital part of the successful performance of Counties Manukau Health operations. Counties Manukau Health Management is committed to continually improving the organisation's safety record.

## Performance Review

Health and Safety objectives and responsibilities are included in individual job descriptions.

Managers may, in future, be reviewed against the delivery of their designated Health and Safety responsibilities as defined by the proposed Health and Safety legislation.

## Continuous Improvement

Senior management will, in consultation with appointed Health and Safety Representatives and Unions, annually review the organisation's Health and Safety systems to ensure their ongoing effectiveness and continuous improvement. Evidence of a review would be in the form of a tabled presentation and discussion with one or more members of the Executive Leadership Team at a meeting with the aim of updating them on any changes made with logic.

A review should be carried out at least every 2 years on any Health and Safety related policies.

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## Board of Directors

As Officers of Counties Manukau Health, each Board Member of the Board of Directors has a duty to ensure they have sufficient knowledge of Counties Manukau Health's Health and Safety.

All Officers of Counties Manukau Health have specific duties relating to Health and Safety.

As Counties Manukau Health's appointed administrative control panel, the Board of Directors is accountable for Counties Manukau Health's Work Health and Safety performance. To ensure that these Officers may fulfil their duties, the Board is to:

- Determine the Board of Directors' charter/structure for leading Health and Safety;
- Set and review quantifiable Health and Safety targets;
- Monitor compliance with the outcomes achieved under the Health and Safety policies and programmes;
- Review executive summary incident investigation reports of incidents, work related illnesses, diseases and environmental harm that require notification to the Health and Safety Regulatory Authority and ensure that action has been taken to prevent recurrence;
- Ensure that the Executive Leadership Management, Senior Management, HR Management and Occupational Health and Safety Manager are adequately trained to plan, organise and control Health and Safety activities that fulfil Counties Manukau Health's policy and procedures and legislative guidelines;
- Ensure that management, at all levels, has sufficient knowledge and training to fulfil their Health and Safety responsibilities;
- Ensure that all relevant employees have sufficient knowledge and training to ensure compliance with relevant policies, procedures and instructions pertaining to safety in the workplace at all Counties Manukau Health workplaces;
- Review training summaries and ensure that all Counties Manukau Health employees are suitably trained in Health and Safety and the tasks they are required to undertake;
- Review and authorise expenditure on Health and Safety equipment and other items needed, to achieve any implemented safety controls, repairs and safety programme goals;
- Develop quantifiable Health and Safety targets in conjunction with all managers at all levels and formalise the targets in the annual strategic planning process;
- Review the Health and Safety targets every three months;
- Ensure that independent legal advice is sought when necessary, in order to gain assurance as to Health and Safety compliance;
- Ensure that Management at all levels, consult with employees regarding any changes to Health and Safety policy and/or procedures that may directly impact their Health and Safety at all Counties Manukau Health workplace;
- Ensure that a system is in place to allow relevant employees to consult with management regarding any significant incident, including environmental harm;
- Monitor the progress of Health and Safety investigations and those reported on Counties Manukau Health's Incident Report System, to ensure that suitable action has been taken to prevent incident recurrence; and
- Regularly review all aspects of Health and Safety at all scheduled meetings.

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## Executive Leadership Team

As part of Counties Manukau Health’s administrative control panel, the Executive Leadership Team is responsible for ensuring that Counties Manukau Health’s Health and Safety protocols are executed and all reporting procedures are documented and forwarded to the Board of Directors for review. To help facilitate these duties, the Executive Leadership Team in consultation with the HR Management is to undertake the following:

- Develop reports for achieved Health and Safety targets;
- Report on compliance levels achieved under the Health and Safety policies and programmes;
- Ensure compliance with relevant workplace policies, procedures and instructions;
- Ensure that consultation with management at all levels is undertaken regarding any significant incident including environmental harm; and
- Ensure attendance at designated training sessions, to ensure suitable knowledge is attained with regard to Health and Safety protocols at any Counties Manukau Health workplace.

The Executive Leadership Team will also be responsible for the following:

- Implement and review the Health and Safety targets set by the Board of Directors;
- Ensure that unsafe conditions requiring CAPEX allocation that could affect employees and others at any Counties Manukau Health workplace are reported to the Board of Directors for review and budgetary allocation;
- Demonstrate, by example, good Health and Safety responsible practices;
- Ensure in consultation with the HR Management, that incident investigation reports of incidents, work related illnesses, diseases and environmental harm, that require notification to the Health and Safety Regulatory Authority, are reviewed and suitable action has been taken to prevent recurrence;
- Communicate clearly to all employees their Health and Safety responsibilities and the consequences of non-compliance;
- Ensure all work or activities are based on a risk management approach where hazards and potential environmental harm are identified, assessed and controlled where applicable, prior to the commencement of work, in consultation with the relevant personnel for the area;
- Ensure that management at all levels consult with employees regarding any changes to Health and Safety policy and/or procedures that may directly impact their Health and Safety at any Counties Manukau Health workplace;
- Ensure development of training sessions to ensure suitable knowledge is attained by employees at all levels with regard to Health and Safety protocols at any Counties Manukau Health workplace;
- Support relevant Health and Safety associated training and education for all employees;
- Ensure that all training undertaken is suitably recorded and reported so that training gaps may be readily identified and actioned appropriately;
- Ensure that the training requirement status is reported to the Board of Directors at regular intervals;
- Support Health and Safety consultation in the workplace by ensuring any Health and Safety Representatives and any Health and Safety Committee, required by law, are in place and

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that appropriate training and resources are provided to ensure adequate Health and Safety;

- Support the rehabilitation programme where employees are unable to perform normal duties due to work injury or ill health;
- Be directly or indirectly (via appropriate delegation) responsible for the induction of all new employees to the workplace in the policies and practices relating to Health and Safety, including an orientation tour of their workplace;
- Develop reports for achieved Health and Safety targets to be submitted to the Board of Directors;
- Report directly to the Board of Directors on compliance levels achieved under the Health and Safety policies and programmes;
- In consultation with the HR Management, develop executive incident investigation summary reports of incidents, work related illnesses, diseases and environmental harm that require notification to the Health and Safety Regulatory Authority, with a summary of the action that has been taken to prevent recurrence;
- Ensure that consultation with relevant personnel is undertaken regarding any significant incident including environmental harm;
- Ensure that all employees under the control of any Counties Manukau Health workplace adhere to the Health and Safety Policy and Procedures Manual;
- Ensure that all Counties Manukau Health workplaces are maintained in a condition that is safe to employees and visitors and report any defect or non-compliance issue that cannot be fixed locally, directly to the relevant Executive Manager;
- Ensure consultation is undertaken and recorded with employees regarding any changes to Health and Safety, policy and/or procedures that may directly impact their Health and Safety at all Counties Manukau Health workplace;
- Ensure that internal incident reports of incidents pertaining to employees injury or near miss are documented, in line with the Health and Safety Policy and Procedures Manual; and
- Ensure in consultation with the HR Management and relevant Senior Managers that Contractors demonstrate their Health and Safety capabilities before being engaged, that Contractors receive workplace based Health and Safety induction training and that their work is appropriately supervised.

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## Senior Managers

Senior Managers are to ensure:

- All employees under their control adhere to the Health and Safety Policy and Procedures Manual;
- That workplaces under their control are maintained in a condition that is safe to employees and visitors and report any defect or non-compliance issue that cannot be fixed locally, directly to the Executive Management;
- To identify and document workplace hazards utilising the checklists provided on a regular basis;
- That all employees submit all compliance documentation required by a regulatory body or Counties Manukau Health in a timely manner;
- That all plant and equipment under their control is suitably maintained in line with any stipulated maintenance schedule, as required by Counties Manukau Health;
- That consultation is undertaken and recorded with employees regarding any changes to Health and Safety, policy and/or procedures that may directly impact their Health and Safety at any workplace under their control;
- That all employees training records are kept current and training status reports are submitted to the appropriate Executive Leadership Team manager on a regular basis;
- That all employees receive all necessary training to enable them to perform their tasks safely;
- That tasks not covered by the provisions of the Health and Safety Policy and Procedures Manual have been developed with a risk management approach and that risk assessments for those tasks are documented;
- That full attendance by employees at designated training sessions is maintained to ensure suitable knowledge is updated with regard to Health and Safety protocols at the workplace under their control;
- That all employees attend emergency evacuation procedures in accordance with legislative requirements and any emergency preparedness protocols required by any client/customer;
- That all training undertaken to enable employees to perform their tasks safely is recorded;
- That Operational Managers ensure emergency evacuation procedure drills are undertaken and recorded in accordance with legislative requirements and as a minimum, to ensure that these are undertaken annually, to determine whether they work effectively; and
- That all relevant compliance documentation is gathered and records of this information are appropriately filed, to ensure that management at all levels can access the information at all times.

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## General Manager of Human Resources

The GM HR is to ensure:

- All employees have been trained in the policies, procedures and requirements of Counties Manukau Health's Health and Safety Policy and Procedures Manual;
- All Counties Manukau Health workplaces are regularly inspected to ensure that they are maintained in a condition that is safe to employees and visitors and report any defect or non-compliance issue that cannot be fixed locally directly to the Executive Leadership Team;
- That workplace hazards are documented and are submitted to the Executive Leadership Team for review and if required escalation;
- That consultation is undertaken and recorded with employees regarding any changes to Health and Safety, policy and/or procedures that may directly impact their Health and Safety at any Counties Manukau Health workplace;
- That all employees employed for any Counties Manukau Health Project have suitable, documented Health and Safety capabilities before being engaged and that employees undertake all relevant Health and Safety induction training required for any external project or any Counties Manukau Health workplace;
- Ongoing support of Health and Safety consultation in the workplace with all employees by ensuring that all new processes, work practices and changes to any current work process or practice are clearly communicated to employees for comment before the formal implementation of the practice or process;
- That there are sufficient training programmes available to employees to enable them to perform their tasks safely;
- That all employee training records are kept current and training status reports are submitted to the Executive Leadership Team on a regular basis;
- That there are sufficient First Aid Officers for all Counties Manukau Health workplaces, as deemed appropriate;
- That all risks assessments for tasks not covered by the Health and Safety Policy and Procedure Manual are documented and the findings of these assessments are made available to all employees;
- That assistance is provided to management at all levels, where required, to ensure all Counties Manukau Health workplaces remain compliant with their Health and Safety responsibilities; and
- That full attendance at designated training sessions is maintained, to ensure suitable knowledge is attained with regard to Health and Safety protocols at all Counties Manukau Health workplaces.

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## Occupational Health and Safety Manager

The Occupational Health and Safety Manager is to ensure:

- All employees under their control adhere to the Health and Safety Policy and Procedures Manual;
- That the workplace under their control is maintained in a condition that is safe to employees and visitors and to report any defect or non-compliance issue that cannot be fixed locally directly to the Human Resources Manager;
- To identify and document workplace hazards utilising the checklists provided on a regular basis and submit these to the Human Resources Manager for review;
- That all plant and equipment under their control is suitably maintained in line with any maintenance schedule stipulated by Counties Manukau Health;
- That all employees under their control receive all necessary training to enable them to perform their tasks safely;
- That tasks not covered by the provisions of the Health and Safety Policy and Procedures Manual have been developed with a risk management approach and that risk assessments for those tasks are documented;
- That all employees and contractors employed for any Counties Manukau Health task demonstrate their Health and Safety capabilities before being engaged, that contractors undertake any relevant Health and Safety induction training required for the task, prior to allowing them to undertake any work for that task and gather and forward all relevant compliance documentation to the General Manager of Human Resources for processing in a timely manner; and
- That attendance at emergency evacuation procedures, in accordance with legislative requirements, is undertaken on an annual basis.

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# Appendix 1: Health and Safety Representatives

## The election and appointment of Health and Safety Representatives

- Health and Safety Representatives will be elected and/or appointed in accordance with the Counties Manukau Health Worker Participation in Health and Safety Guideline (**WPG**).
- Where appointed, Health and Safety Representatives shall hold office for a period of two years.
- Designated work areas or agreed work groups shall have Health and Safety Representatives as per the processes contained in the Counties Manukau Health WPG and in alignment with the specific risk profile for the work group/area.
- All staff who wish to stand or are nominated to become Health and Safety Representatives for the work area will be required to undertake a selection process to ensure they have the appropriate interest, commitment and understanding to fulfil the Health and Safety Representative's role.
- All elections, where required, of Health and Safety Representatives will be by secret ballot.
- An election is not required if there is only one candidate for the Health and Safety Representative position.
- If there are no candidates then the manager may nominate a Health and Safety Representative.
- The manager and workers, together with any Union representatives may, in good faith, call at any time for further elections or nominations for Health and Safety Representatives.
- Nominations/Elections for Health and Safety Representatives shall be held a maximum of two yearly and Health and Safety Representatives shall have the right to stand for re-election with no time limit on the number of terms a Health and Safety Representative can stand for election.
- The Unions and the Employer shall work together to support the election process for Health and Safety Representatives. If the existing Health and Safety Representative is the only nomination for the role they will automatically be re-appointed with no need to conduct an election.
- When the position of Health and Safety Representative becomes vacant the election and appointment of the replacement Health and Safety Representative will follow the process outlined in the Counties Manukau Health WPG.
- Workers considering standing for the position of Health and Safety Representative will be provided with a copy of the Health and Safety Representative's role description that outlines the role and attributes required in the role.
- If the current elected and/or appointed Health and Safety Representative is not reasonably fulfilling the requirements of the role or is acting in a manner inappropriate to the intent of the Counties Manukau Health WPG, action may be taken to replace the in managing Health and Safety Representative concerned in accordance with appropriate legislative requirements.
- Counties Manukau Health will record and forward the names and designated work areas of all elected Health and Safety Representatives, including any vacancies to the Unions after scheduled elections, with the objective of providing opportunity for those bodies to facilitate communication on vacancies to their members.

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- All workers can access information on the process for Endorsement/Election of a Health and Safety Representative on SouthNet Occupational Health and Safety Intranet Website.

## Training of Health and Safety Representatives

- Each elected Health and Safety Representative is entitled to two days paid leave per year to attend an approved training course.
- All new Health and Safety Representatives will receive induction training on Counties Manukau Health’s internal policy, procedures and systems around health, safety and wellness.
- This will be coordinated by the Health and Safety Advisor and Human Resources Business Partner.

## Specific targets for each Health and Safety Representative:

Health and Safety Representatives are to ensure:

- Safety audits are carried out and any deficiencies are followed-up.
- Other staff in the area are involved in safety audits and/or other Health and Safety issues.
- Health and Safety Committee meetings are attended in person or by tele-conference.
- Feedback on Health and Safety process development and other consultation documents is provided within two weeks.
- A Key Performance Indicator (**KPI**) statement must be recorded in each Health and Safety Representative’s performance plan to ensure that (s)he is given time and support to perform duties.
- Counties Manukau District Health Board, its management and workers may agree from time to time to include additional functions of the Health and Safety Representative.

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## Appendix 2: Process for System Review

This guideline in totality and the system it describes will be reviewed 6 months from the date the guideline is signed off in accordance with this guideline.

The basis for the review will be the targets included in this guideline in totality, including the Worker Health and Safety Participation Guideline and the Due Diligence in Health and Safety Guideline.

The process for the review will be as follows:

1. Senior Managers and Health and Safety Representatives will be asked for specific feedback about the performance of the system and individual Health and Safety Representatives, as well as general feedback;
2. All workers are invited to comment on the system and recommend alterations or improvements;
3. The Health and Safety Advisor/Manager collates all feedback (after a two week consultation period);
4. A forum consisting of the following people review the collated feedback and agree the changes:
  - OHSS Manager (chair);
  - GM Human Resources;
  - Divisional Health and Safety Representative; and
  - Worker Union Delegate.
5. The revised guideline is then signed off by representatives of:
  - Employer (GM Human Resources);
  - Workers (Occupational Health and Safety Manager/Designated Health and Safety Representative); and
  - Union (Union Representative).
6. The revised guideline will then be published via Counties Manukau Health staff communication protocols.

All workers must have the opportunity to participate in the system review but ownership remains with Human Resources and Health and Safety to ensure that the review is carried out.

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## Appendix 3: Definitions

### KPI

A Key Performance Indicator - any specific target or objective in a Performance Plan.

### Health and Safety Representative

Means a worker appointed, as an individual or as a member of a Health and Safety Committee or both, to represent the views of workers in relation to Health and Safety at work.

### Hazard Management

Reviewing on-site hazard register quarterly, checking controls are still working, and all hazards are listed;

Reviewing business unit hazard registers as part of incidents/accidents investigations.

### Accidents and Incidents

Reviewing the incident/accident at the Health and Safety Committee to identify controls to prevent the incident occurring again and managing any significant hazards. This includes providing recommendations for improvement.

### Inductions

Health and Safety inductions of new staff members.

### Emergency Preparedness

Discussing and confirming with the manager that the emergency plan is current, information has been updated and staff are trained in its contents - Emergency Preparedness Plan.

### Worker Participation

- Ensuring regular discussions about Health and Safety happens at the monthly staff meeting.
- Attending Health and Safety Committee meetings;
- Attending the two-day Health and Safety training includes any other training deemed appropriate and relevant to the business;
- Following through on any directives from Health and Safety Committees;
- Coordinating the Health and Safety Annual Calendar and adding the calendar of events into the Health and Safety Representative's own personal calendar for actioning;
- Complying with Counties Manukau Health's Health and Safety policies and procedures;
- Meeting with the manager to discuss trends, accident/incident reports and findings, hazards reports and the outcome of quarterly hazard identification checks and audit findings; and
- Other items as identified in the worker participation guideline.

### Trained Health and Safety Representative

A Health and Safety Representative who has achieved a level of competency in Health and Safety practice specified by the Minister by notice in the Gazette or who has completed an appropriate and approved training course.

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## Health and Safety Committee

Means a committee established to support the ongoing improvement of the Health and Safety of Counties Manukau Health's workers.

## Employer

Subject to sections 3C to 3F of the Health and Safety in Employment Act 1992:

- (a) means a person who or that employs any other person to do any work for hire or reward; and, in relation to any worker, means an employer of the worker; and
- (b) includes, in relation to any person employed by the chief executive or other worker of a Crown organisation to do any work for the Crown organisation for hire or reward, that Crown organisation.

For the purpose of this guideline, employer includes a representative of the employer.

## Employee

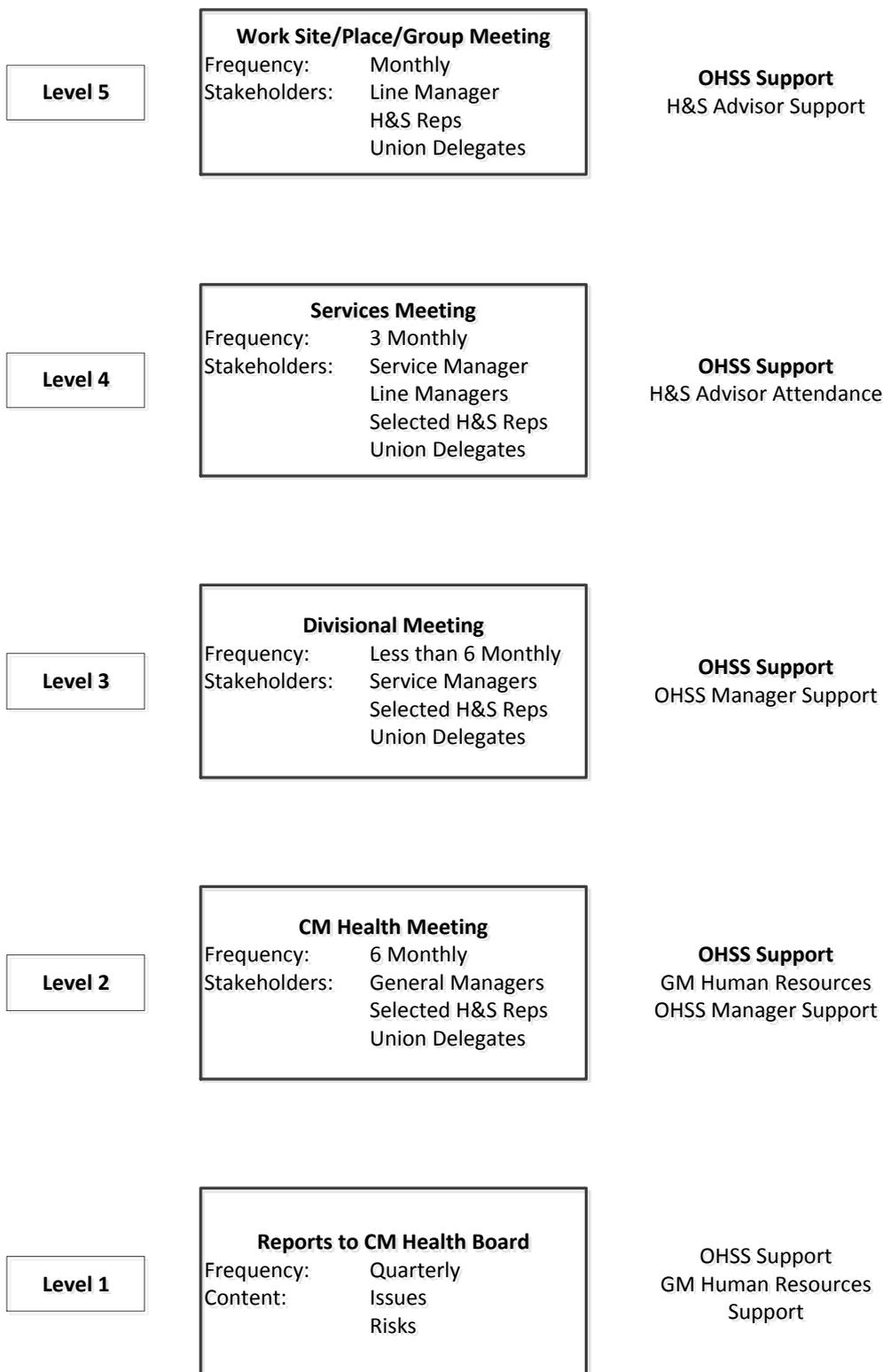
Has the definition as contained in the Health and Safety in Employment Act 1992.

## Hazard Notice

Has the definition as contained in the Health and Safety in Employment Act 1992.

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# Appendix 4: Health and Safety Participation Structure



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# Health and Safety Reform

Counties Manukau District Health Board

February 2016

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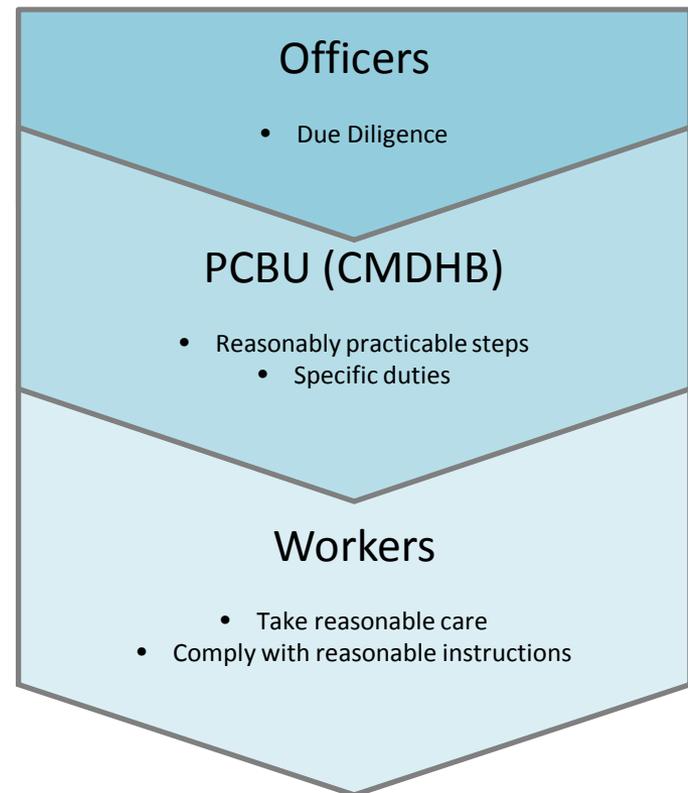
# Summary

New and increased accountability framework

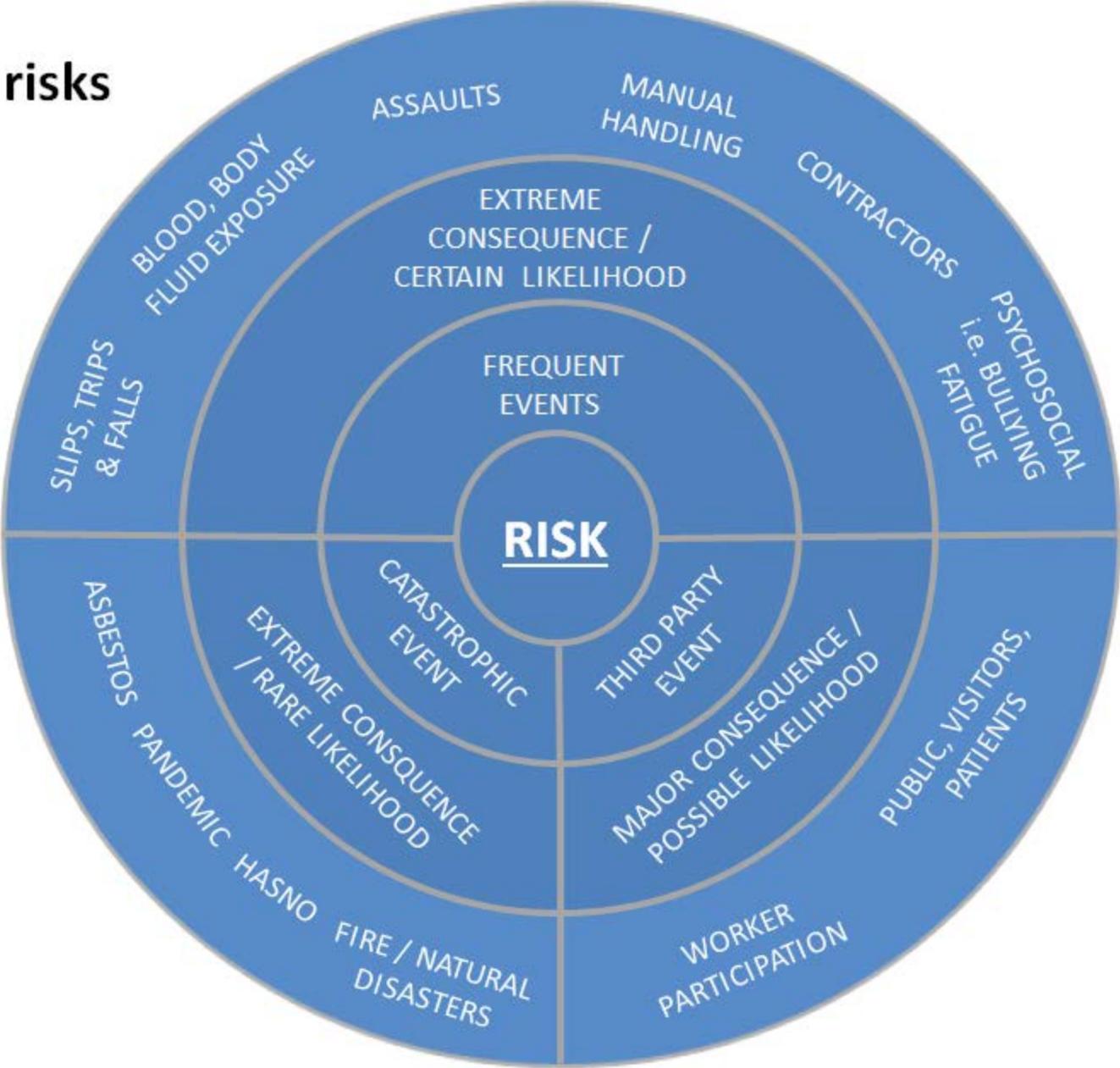
Increased penalties and compliance sanctions

Key focus areas:

- > Due Diligence
- > Risk management
- > Contractor management
- > Worker participation
- > Regulatory change/reporting



# Key risks



# Progress to date

DUE DILIGENCE	RISK MANAGEMENT	CONTRACTOR MANAGEMENT	WORKER PARTICIPATION	REGULATORY CHANGE/REPORTING
<p>H&amp;S Due Diligence Guideline developed</p>	<p>H&amp;S policy in place</p> <p>H&amp;S management framework developed and being implemented</p> <p>5yr H&amp;S plan deployed</p> <p>Designated H&amp;S board member in place</p>	<p>Procurement and contractor management processes continue to be reviewed</p>	<p>H&amp;S Worker Participation Guideline developed</p>	<p>External H&amp;S audit to ID gaps against new framework competed.</p> <p>Hazardous substance audit undertaken. Advisor in place</p> <p>Exec and Board workplace inspections initiated</p> <p>Structured reporting in place to CEO and ELT; Board; Audit, Risk and Finance</p> <p>HR and H&amp;S management meetings w CE (6 weekly)</p>

# Opportunities and next steps

DUE DILIGENCE	RISK MANAGEMENT	CONTRACTOR MANAGEMENT	WORKER PARTICIPATION	REGULATORY CHANGE (penalties, reporting & insurance)
<p>Continuous development and monitoring.</p>	<p>Continue implementation of H&amp;S risk management framework</p> <p>Undertake training re H&amp;S management system, hazard and risk management</p> <p>Engage with HR regarding workplace bullying &amp; harassment</p> <p>Investigate fatigue as an organisational risk</p>	<p>Continue review of procurement and contractor management processes</p> <p>Develop strategy/approach to address gaps</p>	<p>Monitoring worker participation and levels of engagement</p>	<p>H&amp;S capability and governance audit 2016/17.</p>

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## Perspective

CMDHB making significant progress to ensuring it is ready to meet its obligations when the new regulations come in

- > Audit
- > Board/CE support
- > Policies, procedures and practices structured and fit for purpose
- > Worker participation and engagement
- > Risk-based approach

Future work part of ongoing cycle of continuous improvement

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WE GET RESULTS**

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# Counties Manukau District Health Board

## Healthy Food and Beverage Environments Policy

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### Recommendation

It is recommended that the Board **note** that the CM Health Healthy Food and Beverage Environments Policy is now publicly available on our CM Health website, as required by the Ministry of Health.

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**Prepared and submitted by Doone Winnard, Clinical Director Population Health and Stella Welsh, Food Services Manager; January 2016.**

### Purpose

To update the Board on the status of the Healthy Food and Beverage Environments Policy for CM Health, as required by the Ministry of Health.

### Background

In August 2015 the Director-General of Health wrote to DHB CEO's regarding the Minister's expectation that DHBs strengthen their approaches to help reduce the incidence of obesity, encouraging DHBs to show sector leadership by reviewing and/or developing a healthy food policy. There was an expectation that such policies would be made available on DHB websites by 30 December 2015.

Over 2013-14 CM Health worked together with the other Auckland Metro DHBs and Auckland Regional Public Health Service to update our food and beverage environments policies to improve the type and availability of foods and beverages on DHB premises for staff and visitors. Our revised CM Health policy was endorsed by ELT in August 2014 and Stella Welsh, Food Services Manager, has been working with food service providers to ensure their offerings align with the policy.

Over 2015 several other DHBs adopted the Auckland region policy and after the letter was received from the DG in August requiring DHBs to review or develop a healthy food policy, a national network was established to provide a means for information and resource sharing for improving food and beverage environments in DHBs. More recently the Ministry of Health has played a facilitation and support role for this work, as part of the DHB Healthy Food Policies workstream under the Childhood Obesity Plan.

In December 2015, drawing on the principles of the Auckland Metro DHB policies, the DHBs and the Ministry of Health agreed together a set of principles to be the basis for nationally consistent Healthy Food and Beverage Environments DHB policies. The Principles align with the new Eating and Activity Guidelines for New Zealand Adults, which are based on current international evidence. The existing CM Health policy aligns with these principles, which are now available on our website with a link to our policy (<http://www.countiesmanukau.health.nz/for-patients-and-visitors/healthy-food-beverages-dhb-policy/>). Our policy will be further refined as the national DHB/MoH collective progresses this work in 2016.

The Ministry of Health required that DHBs should include their new or updated policy for noting by their Board at the next scheduled meeting following 30 December 2015.

## 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. CEO Report – OIA	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)]	<b>Privacy</b> The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons.  [Official Information Act 1982 S9(2)(a)]
2. Social Investment Board Proposal	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)]	<b>Commercial Activities</b> 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)]
3. Minutes of 2 December 2015	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.  [NZPH&D Act 2000 Schedule 3, S32(a)]	<b>Confirmation of Minutes</b> For reasons given in the previous meeting.
4. Action Items	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.  [NZPH&D Act 2000 Schedule 3, S32(a)]	For reasons given in the previous meeting.
5. Minister's Letter of Expectations	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section	<b>Commercial Activities</b> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.

		9(3)(g)(i)of the Official Information Act 1982.  [NZPH&D Act 2000 Schedule 3, S32(a)]	[Official Information Act 1982 S9(2)(i)]
6. Regional Services	After Hours	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)]	<b>Commercial Activities</b> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.  [Official Information Act 1982 S9(2)(i)]
7. Project SWIFT Update		That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.  [NZPH&D Act 2000 Schedule 3, S32(a)]	<b>Commercial Activities</b> The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities.  [Official Information Act 1982 S9(2)(i)]
8. IS Projects Update		That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.  [NZPH&D Act 2000 Schedule 3, S32(a)]	<b>Commercial Activities</b> 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. Ko Awatea Service Expansion		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)]	<b>Commercial Activities</b> 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)]