# Counties Manukau District Health Board
# Board Meeting Agenda

**Wednesday, 19 October 2016 at 1.30 – 4.30pm, Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland**

| Time | Item |
|---|---|
| 1.00 – 1.30pm | **Board Only Session**<br>- Media & Board Responsibilities |
| | 1. **Welcome** |
| 1.30 – 1.40pm | 2. **Governance**<br>2.1. Attendance & Apologies – Wendy Lai<br>2.2. Conflicts of Interest/Specific Interests<br>2.3. Confirmation of Public Minutes – 7 September 2016<br>2.4. Action Items Register |
| 1.40 – 1.50pm<br>1.50 – 2.00pm<br>2.00 – 2.10pm | 3. **Strategy**<br>3.1. Chair's Report (Verbal Update)<br>3.2. Chief Executive's Report<br>3.2.1. Occupational Health & Safety – Worker Participation (Bev Stone) |
| | 4. **General Business** |
| 2.10 – 2.15pm | 5. **Resolution to Exclude the Public** |
| 2.15 – 2.20pm<br>2.20 – 2.25pm<br>2.25 – 2.35pm<br>2.35 – 2.50pm | 6. **Confidential**<br>6.1. Confirmation of Confidential Minutes – 7 September 2016<br>6.2. Action Items Register<br>6.3. Social Investment Board Update (Sandra Alofivae)<br>6.4. After Hours Services Procurement (Benedict Hefford/Louise McCarthy) |
| | ***Afternoon Tea Break*** |
| 3.00 – 3.10pm<br>3.10 – 3.25pm<br>3.25 – 3.30pm | 6.5. Healthy Together 2020 - Technology Update (Sarah Thirlwall)<br>6.6. Healthy Together Technology – e-Vitals Project Business Case (Sarah Thirlwall)<br>6.7. IS Projects Update (Leanne Elder) |

**Next Meeting: 30 November 2016**
**Room 107, 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) | No Meeting | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Wendy Lai (Deputy Chair) | | ✓ | ✓ | ✓ | × | × | × | | |
| Arthur Anae | | ✓ | ✓ | ✓ | ✓ | - | - | | |
| Colleen Brown | | ✓ | ✓ | ✓ | ✓ | × | ✓ | | |
| Sandra Alofivae | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Lyn Murphy | | ✓ | ✓ | ✓ | × | ✓ | ✓ | | |
| David Collings | | ✓ | ✓* | × | ✓ | ✓ | ✓ | | |
| Kathy Maxwell | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| George Ngatai | | ✓ | × | ✓ | × | × | × | | |
| Dianne Glenn | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | |
| Reece Autagavaia | | ✓ | ✓ | × | ✓ | ✓ | ✓ | | |

*** Attended part meeting only**

# BOARD MEMBERS' DISCLOSURE OF INTERESTS October 2016

| Member | Disclosure of Interest |
|---|---|
| Dr Lee Mathias, Chair | • Chair, Health Promotion Agency<br>• Chairman, Unitec<br>• Deputy Chair, Auckland District Health Board<br>• Acting Chair, New Zealand Health Innovation Hub<br>• Director, healthAlliance NZ Ltd<br>• Director, New Zealand Health Partners Ltd<br>• External Advisor, National Health Committee<br>• Director, Pictor Limited<br>• Director, John Seabrook Holdings Limited<br>• MD, Lee Mathias Limited<br>• Trustee, Lee Mathias Family Trust<br>• Trustee, Awamoana Family Trust<br>• Trustee, Mathias Martin Family Trust |
| Wendy Lai, Deputy Chair | • Partner, Deloitte<br>• Board Member Te Papa Tongarewa, the Museum of New Zealand<br>• Chair, Ziera Shoes<br>• Board Member, Avanti Finance |
| Arthur Anae | • Councillor, Auckland Council<br>• Member, The John Walker 'Find Your Field of Dreams' |
| Colleen Brown | • Chair, Disability Connect (Auckland Metropolitan Area)<br>• Member, Advisory Committee for Disability Programme Manukau Institute of Technology<br>• Member, NZ Down Syndrome Association<br>• Husband, Determination Referee for Department of Building and Housing<br>• Chair, IIMuch Trust<br>• Director, Charlie Starling Production Ltd<br>• Member, Auckland Council Disability Advisory Panel<br>• Member, NZ Disability Strategy Reference Group |

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|---|---|
| Dr Lyn Murphy | • Member, ACT NZ<br>• Director, Bizness Synergy Training Ltd<br>• Director, Synergex Holdings Ltd<br>• Trustee, Synergex Trust<br>• Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)<br>• Member, New Zealand Association of Clinical Research (NZACRes)<br>• Member, Franklin Local Board<br>• Senior Lecturer, AUT University School of Inter professional Health Studies<br>• Member, Public Health Association of New Zealand |
| Sandra Alofivae | • Member, Fonua Ola Board<br>• Director, Housing New Zealand<br>• Member, Ministerial Advisory Council for Pacific Island Affairs<br>• Member, Social Housing Reference Group<br>• Chair, Social Investment Board |
| David Collings | • Chair, Howick Local Board of Auckland Council<br>• Member, Auckland Council Southern Initiative |
| Kathy Maxwell | • Director, Kathy the Chemist Ltd<br>• Regional Pharmacy Advisory Group, Propharma (Pharmacy Retailing (NZ) Ltd)<br>• Editorial Advisory Board, New Zealand Formulary<br>• Member, Pharmaceutical Society of NZ<br>• Trustee, Maxwell Family Trust<br>• Member, Manukau Locality Leadership Group, CMDHB<br>• Board Member, Pharmacy Guild of New Zealand |
| Dianne Glenn | • Member, NZ Institute of Directors<br>• Member, District Licensing Committee of Auckland Council<br>• Life Member, Business and Professional Women Franklin<br>• Member, UN Women Aotearoa/NZ<br>• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust<br>• Life Member, Ambury Park Centre for Riding Therapy Inc.<br>• Vice President, National Council of Women of New Zealand<br>• Justice of the Peace<br>• Member, Pacific Women's Watch (NZ)<br>• Member, Auckland Disabled Women's Group |

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|---|---|
| George Ngatai | • Chair, Safer Aotearoa Family Violence Prevention Network<br>• Director, Transitioning Out Aotearoa<br>• Director, BDO Marketing<br>• Board Member, Manurewa Marae<br>• Conservation Volunteers New Zealand<br>• Maori Gout Action Group<br>• Nga Ngaru Rautahi o Aotearoa Board<br>• Transitioning out Aotearoa provides services and back office support to Huakina Development Trust and also provide GP Services to their people<br>• Chair, Restorative Practices NZ |
| Reece Autagavaia | • Member, Pacific Lawyers' Association<br>• Member, Labour Party<br>• Member, Auckland Council Pacific People's Advisory Panel<br>• Member, Tangata o le Moana Steering Group<br>• Employed by Tamaki Legal<br>• Board Member, Governance Board, Fatugatiti Aoga Amata Preschool<br>• Trustee, Epiphany Pacific Trust |

# BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

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

| 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 notes that Mr Collings has a conflict of interest in regard to the Innovation Hub. He may participate in the deliberations of the Board in relation to this matter because he is able to assist the Board with relevant information, but is not permitted to participate in decision making. |
| 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 noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting. |
| George Ngatai | Community Services Pharmacy Funding Policy | Mr Ngatai declared a specific interest in terms of their GP Service being like to use a local Pharmacy. | 13 August 2014 | That Mr Ngatai's specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting. |

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|---|---|---|---|---|
| Wendy Lai | HBL Business Cases | Ms Lai declared a specific interest in regard to Deloitte's involvement with HBL on this work. | 13 August 2014 | That Ms Lai's specific interest be noted and that she may not participate in either the deliberations or determination of the Board in relation to this matter and is asked to leave the room. |
| Wendy Lai | Ko Awatea Panel Advisory Services | Ms Lai advised that Deloitte have been shortlisted to provide Panel Advisory Services to Ko Awatea. This work does not have any involvement with the APAC Business Case | 5 November 2014 | Noted. Ms Lai advised on the 3 December 2014 that Deloitte have now been selected to work with the Ko Awatea team to improve commercial awareness and increase income levels. |
| 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 noted and that the Board agree 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 noted and that the Board agree 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 noted and that the Board agree 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 noted and that the Board agree 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 noted and that the Board agree 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 2015 | That Mr Collings' specific interest be noted and that the Board agree that he may remain in the room and participate in any deliberations, but be excluded from any voting. |
| 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 2015 | That Mrs Murphy's specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting. |
| Lyn Murphy | MIT Nursing Programme Report | Mrs Murphy is a Lecturer in the Faculty of Business & Information Technology at MIT. | 9 September 2015 | That Mrs Murphy's specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting. |
| Kathy Maxwell | Integrated Pharmacist Services | Mrs Maxwell is a Pharmacist/ Director of Kathy The Chemist Ltd. | 27 July 2016 | That Mrs Maxwell's specific interest be noted and that she may not participate in either the deliberations or determination of the Board in relation to this matter and is asked to leave the room. The Chair permitted Mrs Maxwell to read out a statement prior to her departure. |
| Sandra Alofivae | Social Investment Board | Mrs Alofivae has been appointed Chair of the Social Investment Board. | 27 July 2016 | That Mrs Alofivae's specific interest be noted and that she may not participate in either the deliberations or determination of the Board in relation to this matter, but may remain in the room. |

# Minutes of Counties Manukau District Health Board

Held on Wednesday, 7 September 2016 at 1.30 – 4.30pm Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

| | |
|---|---|
| Present: | Dr Lee Mathias (Chair), Mrs Dianne Glenn, Mrs Sandra Alofivae, Mrs Kathy Maxwell, Apulu Reece Autagavaia, Mr David Collings, Dr Lyn Murphy, Mrs Colleen Brown |
| In attendance: | Mr Geraint Martin (Chief Executive), Mr Ron Pearson (Deputy CEO), Mrs Lyn Butler (Board Secretary) |
| Apologies: | Ms Wendy Lai, Mr George Ngatai, Mrs Colleen Brown (leaving early) |

**1. Welcome**

The Chair welcomed everyone to the meeting. Mr Jarred Williamson, Manukau Courier was in attendance for the public items.

**2. Governance**

2.1 Attendance & Apologies

Noted.

2.2 Conflicts of Interest/Specific Interests

Noted.

2.3 Confirmation of Public Minutes – 27 July 2016

**Resolution**

That the public Minutes of the Board Meeting held on **Wednesday, 27 July 2016**, were taken as read and confirmed as a true and correct record.

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

Mr Collings asked why the Special Board Meeting Minutes were in confidential. The Chair advised that the confidential Minutes would be discussed later in the meeting, as per the Agenda.

2.4 Action Items Register

Noted.

The Chair advised that she had provided a briefing to the Board in the Board Only Session on the recent National Chairs' Meeting on sustainability in the sector.

Mr Martin advised that his presentation was intended as a conversation starter as part of a collective conversation. A good response was received, and a paper will be developed for the next stage. The Chair added that the Northern DHBs are very different to other DHBs in the way they offer services.

**3. Strategy**

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

The Chair advised that a national project is looking at shared services, which will include reviewing where NRA fits with hA.

Management of the Debt Equity Swap Proposal is of concern. The intention is to make financial mechanisms easier for DHBs to manage.

3.2 Chief Executive's Report (Geraint Martin)

The report was taken as read.

Mr Phillip Balmer joined the meeting.

Mr Martin wished to acknowledge Mr Balmer's leadership in achieving the 2015/16 health targets.

Mr Martin has recently been appointed Chair of the ISSP Steering Group. The group will undertake a large and important piece of work, ultimately coming up with a recommendation for RGG. The first step will be to develop a Target Operating Model, look at efficiencies, demography, critical path etc. There are 4-5 workstreams underway. The outcome will be presented to all Boards for their sign off.

Following CMDHB being awarded an 'A' rating for their Investor Confidence Rating, Mr Martin acknowledged the excellent work Mrs Louise Zacest has carried out in this regard.

All Health Targets have been achieved for 2015/16. CMDHB are the only DHB to achieve this result this year, as well as over the last three years.

Treasury have identified CMDHB as the top DHB in their analysis of DHBs performance as at 30 June 2016.

All the above has not been achieved by building more buildings and providing more beds, but by focussing on developing changed models of care. The commitment, diligence and focus of staff has played a huge part in this result. Mr Martin acknowledged Mr Balmer's hard work, particularly in relation to FCT and Diagnostics. Mr Balmer thanked Mr Martin for being a leader that challenges people to be excellent, rather than average, which helps an organisation to have that ambition.

The Chair said that in the future, it would be good to hear patients consistently say that MMH is wonderful and not be surprised by that.

Mr Martin recently attended the SMO Engagement Workshop, where they talked consistently about Primary and Community Services.

Mr Pearson advised that budget had been achieved for the first two months of the year.

Agreement has been reached with Audit NZ on removing the qualification from the Annual Report, which is currently being finalised. The scope of audit has been agreed with Internal Audit. There is a potential exposure to the whole of sector for $30-40M as a result of a change and application of levy. This will be considered at the next Chairs'/CEOs Meeting.

Work is continuing with MoH on Debt Equity, on their requirement to change from a debt to equity model. This will only address part of the solution and is not taking future growth into consideration.
*Mrs Brown left at 2.15pm*

**Resolution**
That the Chief Executive's Report be **received.**
**Moved:** Lee Mathias **Seconded:** Sandra Alofivae **Carried:** Unanimously

3.2.1 Health & Safety Update (Beth Bundy)
The report was taken as read.

Mrs Bundy advised that the new reporting framework is designed to align with legislation. Mrs Kerry Bakkerus is undertaking the risk work.

A recent walkaround audit of MMH was carried out, which Mr David Collings attended. All audit visits are documented. The Chair advised that more Board Members could be involved in these audits next term, and we could move to more of a Wellness Strategy going forward. Mrs Bundy agreed and said that this is currently a national focus, and that an organisational wellness approach is being developed.

**Resolution**
That the Board:
**Receive** the Health and Safety quarterly report for the period ending 30 June 2016.
**Moved:** Kathy Maxwell **Seconded:** Lyn Murphy **Carried:** Unanimously

Mr Collings again referred to the Minutes of the Special Meeting and asked why these were confidential. Following a lengthy discussion, the Chair advised that this topic was a confidential item to be debated by the Board at that time. A public consultation was part of the overall process, so the public were very aware this topic was being discussed. The process does not change the decision made by the Board.

Mrs Alofivae said that Mr Collings had raised these issues numerous times previously at the Special Board Meeting, with appropriate responses being provided at the time. Therefore, these matters did not require further re-litigation at this meeting.

**4. General Business**
None.

**5. Resolution to Exclude the Public**

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

The meeting was re-opened to the public.

The meeting closed at 4.15pm. The next meeting of the Board will be **Wednesday, 19 October 2016** at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board of **7 September 2016** are approved.

Signed as a true and correct record on **19 October 2016.**

Chair ……
Dr Lee Mathias (Chair)

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

| DATE | ITEM | ACTION | DUE DATE | RESPONSIBILITY | COMMENTS/UPDATES | COMPLETE ✓ |
|---|---|---|---|---|---|---|
| 27 July | Chair's Report | The recent National Chairs' Meeting highlighted that the difference between large and small DHBs is increasing. Mr Martin is to present to the October Board on the differences, funding model, etc. | November | Geraint Martin | This has been deferred to November, as Geraint will be overseas for the October Meeting. | |

# Counties Manukau District Health Board
# Chief Executive's Report

## Recommendation

It is recommended that the Board:

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

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

1.0 **Introduction**

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

- **Strategic** – with a special focus on planning for 2016/17.
- **Operational** – including the reports from the Director of Strategic Development, Director of Corporate & Business Services and Director of Ko Awatea.
- **Compliance** – included is the report on Health & Safety.

2.0 **Strategic**

2.1 **Building Momentum in Leadership**

This month we have begun increasing the pace of transformational change.

Last year we:

- Refreshed our strategy (i.e. Healthy Together 2020).
- Ensured we have built as strong and effective delivery 'engine' as possible in the DHB (i.e a high and stable level of operational performance in finance and health targets, and business processes such as the Investor Confidence Rating).
- Identified, following the Gateway Review early in 2016, the organisational changes we needed to implement to ensure we are 'match fit' for delivering change. The three major recommendations were for the appointment of a Director of Transformation, a structure which encourages integration rather than silos and a leadership team that was mobilized to design and deliver change effectively at pace, whilst not losing focus on business as usual.

In this report, I will update the Board on the actions we are taking to address the third action. Having appointed David Lenihan, we are now focussing on the following key points:

- Over the last three months, the management structure has been reviewed to ensure we can deliver integration of services faster and more efficiently. Following wide consultation, I have decided to appoint a Director of Patient Care who will also be the Chief Nurse & Allied Health officer too. The remit for the role will be:

    - **To be the strategic voice for Nursing and Allied Health** across the whole system, not just in hospital care.

- **To focus on taking forward our approach to improving the patient experience.** We will continue to devolve more services into Primary & Community Care and start to transform how the patient interacts with the health system through technology. As a result, we must see the patient experience as not just what happens by the bedside, albeit that is vital, but what happens for the patient across the whole journey of care. This journey will have increasing levels of remote monitoring and virtual care.

- **To co-ordinate redesign of the workforce and training.** Currently, if a patient needs care to stay at home, they may get visits from a wound care nurse, physio and occupational therapist in turn. However, in reality the scope of practice that each clinician has could provide all of the patients' needs in one visit. In this way, we will reduce people involved in care from three to one, with the same outcome, but also freeing up valuable time and resource. The current structure which focuses on professional silos is a major barrier to us achieving this.

- **To work with the current Director of Hospital Nursing, Director of Allied Health and Chief Nurse Advisor, Primary care, to ensure uniform and highest standards of care everywhere.** These three posts will now be accountable directly to the Director of Patient Care, creating a strong focus for clinical leadership.

- **To establish a 'community of expertise'**. This is a working title for a programme of work which intends to mobilise the wider leadership of the DHB in delivering change. It is important that as we move away from siloed to integrated working, we also move away from a purely 'hierarchal', representative leadership structure to one which emphasizes empowerment, autonomy, accountability and networked decision making. Several healthcare and industry case studies have identified this as a critical factor in successful change strategies *(Dr Raina Brands, London Business School 2015).*

Over the last two years, we have refreshed our clinical leadership and built capacity through our management development programmes in Ko Awatea. Consequently, we have strength in depth to mobilize and draw upon.

2.2 **Building Momentum in Transformation**

We have embarked upon a number of initiatives to accelerate the pace and sale of transformative change.

A project is underway to develop our Healthy Together Target Operating Model (TOM). A TOM is an industry tool used to describe how services need to be configured in the future in order to deliver improved outcomes and better performance. The tools are also commonly used in complex transformation programmes in large organisations to help shape and test options. This will become the roadmap by which we will turn our Vision in Healthy Together 2020 into detailed delivery programmes and therefore reality.

For CM Health, the TOM will help answer the following fundamental questions:

(1) What will be different after we deliver our strategy?

(2) What outcomes will have been achieved and how will success be measured?
(3) What will care services look like in the future?
(4) How will they be configured to deliver whole of system integrated care?

We are reviewing our current planning documents (e.g. LTIP, HT2020, SWIFT, etc) and developing the delivery detail behind our three key areas of Population Health & Social Investment, Integration and high quality hospital services. The project is expected to produce the first draft of the TOM in late November 2016. When complete, the TOM will have identified our change priorities and produced a delivery roadmap to 2020.

In parallel to the TOM project, I have launched an initiative to strengthen change leadership across the organisation.

A Commissioning Group has been created. This group will provide whole-of-system design leadership for Integrated Care and will act as the central point for HT2020 design, coordination and prioritisation.

The group will commission a suite of Future Design Programmes for key services. These will be composed of multi-disciplinary teams - from across the whole system - and will help tackle HT2020 design challenges. These networks will garner the expertise of our staff and foster intimate collaboration across primary, community and secondary care.

It is expected that some changes will be made to the existing ELT and Management arrangements as the Future Design plans are deployed.

2.3 **Building Momentum in IT**

We have been building momentum in the Healthy Together 2020 technology stream. A three part framework has been developed to bring structure to our IT transformation.

| Foundation | Innovation | Future |
|---|---|---|
| Healthy Together 2020 Technology | Innovation Partnership | Precision Driven Health research initiatives |
| Clinical Portal and Clinical Data Repository Upgrade | Amadeus Platform | |
| Supporting innovation with Community Health | Social Investment Approach | |
| | NZ Health Inc Partner Data | |

**Foundation**

The focus for Healthy Together Technology is to build a strong IT capability. We have based this on what our clinicians have advised us are essential IT investments for safe and efficient care.

As many of these foundational components are well proven internationally they can be deployed as production ready, scalable, secure, robust solutions.

We are working with Orion and hA at present to upgrade Concerto to Clinical Portal. There are new modules that can be leveraged once Clinical Portal is implemented.

**Innovation**

New technology developments are prolific and consumers and clinicians use these technologies in many aspects of their life, including looking after themselves, interacting with healthcare providers/patients/family/people like me.

Technology is expected to be as disruptive to healthcare as it has been for other industries especially in the empowerment of consumer driven health. Consequently, we need to prioritise innovation in IT.

It is proposed that we establish an innovation group within CM Health operating within the HT2020 Directorate and co-designing with clinicians and consumers.

For example, Orion offer a cloud hosted innovation space (hosted by Amazon Web Services) that enables developing technologies to be explored with clinical, consumer and health manager involvement.

**Precision Medicine**

Precision medicine is about using 'big and complex' data to inform and guide even more personalised decisions in healthcare. This includes genomic data, but can also include data from other sources, including consumer's own information, lifestyle and published literature.

CM Health has signed a partnership agreement with Orion, University of Auckland, WDHB and Canterbury to explore the opportunities to apply precision medicine to disease prevention and treatment.

**NEHR**

Last week several members of ELT attended the NEHR Workshop which reviewed the completed work of the NEHR project which was led by Dr Gloria Johnson working in a Regional capacity. This will now be presented to RGG and will inform the development of the Regional Information Services Plan that is in development. The RISP Project Team is Chaired by me and will draw up the NEHR project as well as SWIFT, other DHB strategies and the Health Strategy to produce the next 5-10 year plan.

2.4 **Social Investment Board & Equity**

An update is included in the confidential Board papers.

## 3.0 Operational

3.1 **Primary, Community & Integrated Care**

The excellent health target results achieved in 15/16 are holding with projected quarter one results showing Heart and Diabetes Checks, Better Help for Smokers to Quit, and immunisations all at or above the 90/95% targets.

In child health, the downward trends in SUDI and acute rheumatic fever rates are continuing and we are on track to achieve the new national health target for child obesity checks. However, child oral health remains a concern and a key focus over the next quarter will be working closely with Waitemata DHB to improve performance of the regional dental service in the Counties area.

22,000 patients with long term conditions are benefiting from the At Risk Individual programme by receiving more planned, proactive care with care co-ordination and goal based care plans. 377 patients have been enrolled in Reablement and 269 have transitioned from Reablement. Acute hospitalisation, ED attendance and re-admission rates have dropped or remained static compared to the equivalent period last year.

3.2 **Hospital Services**

Our focus on delivering high quality, sustainable services continues, with a number of key initiatives and changes, both within Hospital Services and across the organisation, underway to support new and improved ways of delivering healthcare. The Directorate's change in structure to better enable the delivery of integrated care is now bedded down, with the new divisions taking effect in September. Despite this period of change, Hospital Services has demonstrated strong and consistent performance for the first quarter of the 16/17 financial year.

Efforts to ensure we are well placed to maintain delivery throughout the year are reflected both in our delivery to budget, and our elective discharges for the two months are marginally ahead of budget. Overall, our acute volumes are below our anticipated demand, reflecting the mild start to winter and better support services in the community. Preliminary results for the quarter indicate we are maintaining our Emergency Department length of stay (96%) and smokefree advice (96%) performance. Additionally, our transformation and efficiency agenda is progressing well, with associated financial and non-financial benefits being realised. This performance is mirrored in data collected by the Health Roundtable for recently agreed System Level Measures, which places CM Health continuing on par or exceeding our national peers in the areas measured.

**Health Target Summary – 2016/17**

| Target | Current Results | Status by 30 June 2017 |
|---|---|---|
| **Emergency Departments**   | *95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours*<br><br>**September result: 96%** | **ACHIEVE** |
| **Elective Surgery***   | *Elective surgery will increase by an average of 4,000 discharges per year*<br><br>**August result**: **113.5%**<br>**WEIS:** 107.8% (3,891 actual against 3,609 planned)<br>**ESPI2:** 1 FSA breach for August (target of 0)<br>**ESPI5:** 4 breaches for treatment in August (target of 0) | **ACHIEVE** |
| **Faster Cancer Treatment**   | *85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.*<br><br>**August result:** 71%<br>74% performance excluding patient choice related reasons for August.<br>**Note:** 12 breaches in August. Of the 12, 8 were due to capacity related issues at the front end of the pathway. Services have been reviewing patients that breached in August to understand more fully where the capacity issues lie and action plans are being completed. There is moderate confidence that September performance should recover from this August dip.<br><br>**ACTION:** Continue to micro-manage with weekly case reviews, tumour stream reporting, CanTrack system monitoring patient pathways and sustainable systems solutions to ensure pathway reliability. | **ON COURSE** |
| **Immunisation**   | *95% of eight month olds will have had their primary course of immunisation on time.*<br><br>**August result (provisional only)**: 94%<br>**Note:** Maaori tamariki coverage at 87%<br><br>**ACTION**: The immunisation team is currently speaking to families and service providers to identify current problems or gaps in the service and opportunities for improvement. | **ON COURSE** |
| **Raising Healthy Kids****   | *95%of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions (by December 2017)*<br><br>**Result (for 6 months to the end of June 2016): 40%**<br>**Note:** National result (for 6 months to the end of June 2016) of 49% | **NEW TARGET** |

| | | | |
|---|---|---|---|
| **Tobacco**   | **Primary** | *90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months*<br><br>**August result (provisional only)**: 87%<br>**Note:** PHOs are working to improve the gap. | **ON COURSE** |
| | **Maternity** | *90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking*<br><br>**August result (preliminary result only)**: 80%<br>**Note:** Recent DHB category changes due to NCIS has distorted this result. Investigation in progress. | **ON COURSE** |

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

## 4.0 Strategic Development

**Deep Dive – Complex Households and Families: Fanau Ola Service Changes**
The Pacific Health Development and Maaori Health Development Divisions are in the final stages of completing the recruitment of workforce to establish a 'Fanau Ola' and/or 'Whaanau Ora' approach with the existing teams. This has meant some changes in staff to lift the skills and competencies that can work with a smaller and more complex group of households and families. This means, in particular, a direct shift away from paraprofessional workforces (e.g. advocates, cultural support advisors) to highly experienced and qualified professionals with the broad scope of practice (including psychosocial and behaviour change therapies) and skills to work with households and families. The Pacific Division is advertising for nurses interested in training to become Nurse Practitioners in the fields of primary healthcare, child youth and family and potentially mental health. These professions need to be able to provide continuity of care and support similar to cases below.

Six months old K was born with a disease causing bowel obstruction and has been admitted 7 times at Auckland hospital for corrective surgery. K was also admitted at Middlemore Hospital 8 August 2016 due for a chronic respiratory illness. K's 3 year older brother C, was also admitted at Middlemore Hospital twice within the last 12 months with severe life threatening viral wheezing/asthma. C has a history of severe eczema.

K, her parents and her 2 older siblings sleep together in one bedroom. They are currently boarding with the 8 other members of their extended family in a 3 bedroom rental property. K's father works full time and her mum stays home to look after K and her siblings.

Overcrowding is the primary issue of concern for this family. This has had flow on effect to K's broader household and family circumstances - financial and other supports such as transport to take K for all her appointments were also explored. The interventions implemented included:

- Advocacy to Housing New Zealand for prioritisation due to health related concerns.
- Family start agency enrolment.
- Children's family tax credit in receipt (family were not aware of all their available entitlements).

- Husband and extended family organised to provide transport when the children are required to see a GP and attend their outpatient appointments. Family Start can also assist with transport.
- Continue to explore donate lounge suits, dining table, plus chairs and a fridge for the family.
- Explore child care options for C and his brother through ongoing support from family start for the family in the community

Since interventions, HNZC have now allocated a house for this family and they moved in September 2016. There has been a reduction in EC admission for C, and K is now reducing her outpatient hospital visits from once a week to every three months.

Both Fanau Ola and Whaanau Ora teams work with the wider Localities and CHSI programmes and the Social Investment Board to ensure that evaluations assess the wider system impact of such interventions.

**Directorate Highlights**

There are 4 teams that provide 'corporate services' and two direct patient support services (Maaori and Pacific cultural support) in the Strategic Development Directorate. The table below summarises Directorate highlights and risks as at end August.

| **Highlights** |
|---|
| **Strategic Planning**<br>• 15/16 Annual Report currently undergoing Minister assessment. An internal review of the 15/16 planning cycle review for improvement will be completed by end September. 15/16 Annual Plan Q4 report in progress.<br>• Health equity measurement framework in progress (aligned with the Ko Awatea led campaign development and other equity programmes eg Tobacco, Alcohol).<br>• Long term investment plan 2nd draft completed for Treasury assessment; waiting results.<br>• All three population group plans – Maaori, Pacific and Asian – will be published on the CMH website in October. |
| **Communications Channels**<br>• A preliminary assessment to support a new intranet platform has been completed. Discussions with hA have confirmed that a suitable platform exists and is supported. Current focus is on understanding ongoing cost implications, testing functionality against user requirements and a change approach to support good support and engagement from across the organisation. Once this is confirmed, a detailed proposal will be presented to ELT.<br>• A change proposal is with employees proposing a structure that reflects the resourcing demand of Health Together 2020 and its increasing community and stakeholder facing requirements. It also aligns resources to support and enhanced digital function. It is achieved within existing headcount and budget parameters and through vacancy management. |
| **Population Health**<br>• Residential mobility analysis using PHO enrolment data for SIB analytics workstream, scoped and commenced.<br>• Extensive PRIMHD mental health data extract scoped and delivered to external consulting group for use with CM Health Mental Health and Addictions Integration planning team.<br>• Potential numbers of obese and overweight children at practice level provided for Childhood Obesity |

Health Target planning.

- Advice on interpretation of national palliative care modelling for CM Health planning based on review of local mortality and place of death data.
- Modelling to inform Ophthalmology Clinic Business Case and Renal model updated for 10 year plan.
- Support for refinement of MoH virtual diabetes register using TestSafe data – analyses and manuscript provided.

**Risk & Privacy**

- **Risk Management**
  - progressing slower than planned but still focussed on the Roadmap implementation.
  - currently holding risk training and key risk workshops across the business to facilitate completion of risk registers
  - discussions with ELT on the key risks for their directorate in conjunction with Director of Strategic Development.
  - '*Engaged and Effective Workforce*' In-depth review completed with '*Quality of Care*' in progress.
- **Privacy** - a significant amount of time is being spent on privacy breach review and investigation. This will reduce once the process is standardised with other incident investigation processes to ensure objectivity and consistency across the organisation. The programme of work has been divided into 7 streams, all in progress to improve privacy maturity as agreed in our Government Chief Privacy Officer maturity assessment submitted in 03/2016:
  - Governance and Risk Management
  - Assurance
  - Communication Strategy and artefacts
  - Data classification, protection and security
  - Legal, Contracts and Third Parties
  - Policies and Procedures
  - Training

  *Current challenges*:
  - 83 policies with the word 'privacy' - these are currently being reviewed for updating and relevancy.
  - Lack of contracts' database doesn't allow the project team to understand the population of contracts across the organisation. Requirement of the roadmap is to understand the current state of privacy policies and procedures for all contracts, and the assurance as to the compliance with these policies

  *Progress to date:*
  - Privacy Policy has been updated and will be submitted to next Clinical Governance Group for review and approval.
  - Communication Strategy and key messages drafted for roll out.
  - Conversation scheduled with Quality Assurance Team, Legal, HR and H&S to discuss investigation process to understand how we drive consistency and objectivity in the process of incident investigations.

**Maaori Health Development**

- GM, Maaori Health role has been advertised to close mid-September. The recruitment process aims to complete with an appointment before Riki NiaNia leaves on the 18th November.

**Pacific Health Development**

- *AWHI referrals actioned by advocates for home insulation of cold, damp houses and help for*

*babies/children in overcrowded homes.*

- ***Social Worker -*** *supported a number of Pacific families to better deal with social issues that affects their health. These issues included Housing NZ, WINZ, Immigration, housing furniture, writing letters of support for families (ie) to doctors and other professionals. 12 families with housing issues, 7 with financial issues.*
- **Regional Pacific**

  *Samoa* - continued feeding in the co-design five year ILP design document, simultaneously designing the six month extended ILP activity.

  *Fiji* - INFANTS Programme monitoring and evaluation visit is planned and same for the placement holders to CM Health.

  *Niue* - Business as usual for patient and visiting specialist coordination, Niue ambulance project is in pipeline for approval.

  *Kiribati - c*ontract signed off for an extended one year support.

## 5.0 Finance

**Key Highlights/Issues (August 2016):**

- While the monthly result posted a positive variance, our operating performance remains very tight. Provider Arm volumes are slightly down on contract (Acute -1%, Elective -3%). While up on July, ED presentations for August are 7% below the same period last year. A high level of vacancies exist across the organisation and are partially covered by locums, bureau, overtime and casual staff. Outsourcing has been required to meet contracted surgical volumes, primarily due to a shortage in anaesthetic technicians and pending appointment of urology SMO.

- Unfavourable Provider Arm revenue timing differences include a delay in the opening of the retail Pharmacy and unrealised planned revenue savings, mainly offset by additional ACC revenue relating to the ACC arrears initiative.

- Primary, Community and Healthy Together initiatives are progressing slowly on or under budget. Demand driven costs like Aged Residential Care show strong growth so while currently on budget may present a future challenge.

- The current year's capital plan will be finalised in November 2016 following an in-depth multi-year prioritisation against regional and organisational strategic direction. This will be integrated into the TOM. Strategic requirements to invest in IT and physical infrastructure remain a challenge alongside core replacement and upgrade.

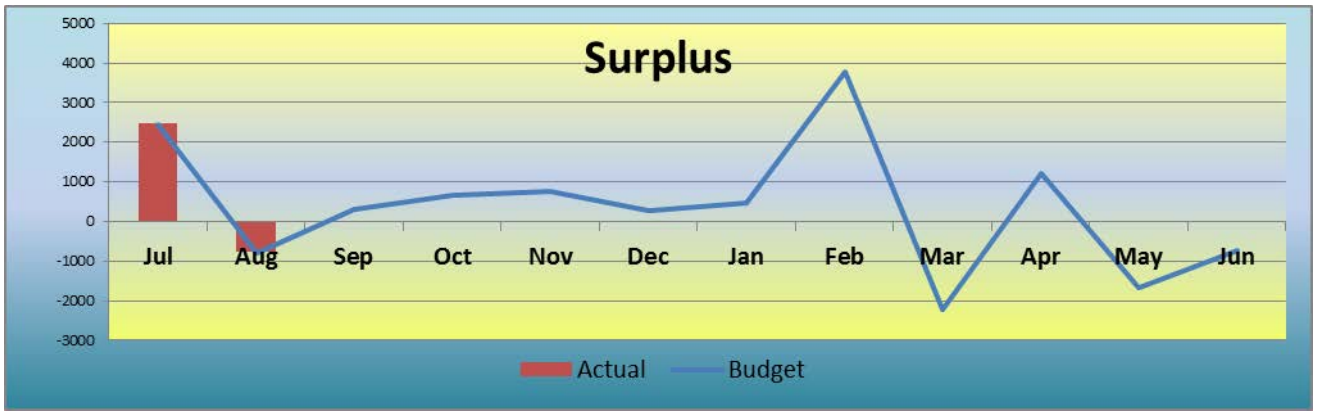
- Annual audit is progressing well and is on track for completion in early October.

- The land sale has now been formally approved by the Minister of Health and we have initiated discussion/negotiations with MBIE in regard to formal transfer/sale.

## FINANCIAL POSITION at August 2016

### Statement of Performance by Operating Arm

| Month August 2016 | | | Net Result | YTD August 2016 | | | | Full year | |
|---|---|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | $000 | Act | Bud | Var. | Last year | Bud | Forecast |
| 2,327 | 2,320 | 7 | *Hospital Provider* | 7,807 | 7,792 | 15 | 6,874 | 41,138 | 41,138 |
| (3,604) | (3,643) | 39 | *Integrated Care* | (7,221) | (7,274) | 53 | (4,196) | (43,592) | (43,592) |
| (1,503) | (1,503) | (0) | *Ko Awatea* | (2,916) | (2,918) | 2 | (2,343) | (17,451) | (17,451) |
| (2,780) | (2,826) | 46 | *Provider* | (2,330) | (2,400) | 70 | 335 | (19,905) | (19,905) |
| 2,267 | 2,243 | 24 | *Funder* | 4,538 | 4,484 | 54 | 2,235 | 26,900 | 26,900 |
| (250) | (208) | (42) | *Governance* | (479) | (416) | (63) | (145) | (2,495) | (2,495) |
| **(763)** | **(791)** | **28** | ***Surplus (deficit)*** | **1,729** | **1,668** | **61** | **2,425** | **4,500** | **4,500** |




### Volume Summary August 2016

### Volumes Other

| Month | | | | | Total WIES | Year to date | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | % | Last. Yr. | | Act | Bud | Var. | % | Last. Yr. |
| 5,806 | 5,992 | -186 | -3.10% | 6,245 | *Acute* | 5,806 | 5,992 | -186 | -3.10% | 6,245 |
| 1,503 | 1,503 | 0 | 0.00% | 1,582 | *Elective* | 1,503 | 1,503 | 0 | 0.00% | 1,582 |
| **7,309** | **7,495** | **-186** | **-2.50%** | **7,827** | ***Total*** | **7,309** | **7,495** | **-186** | -2.50% | **7,827** |

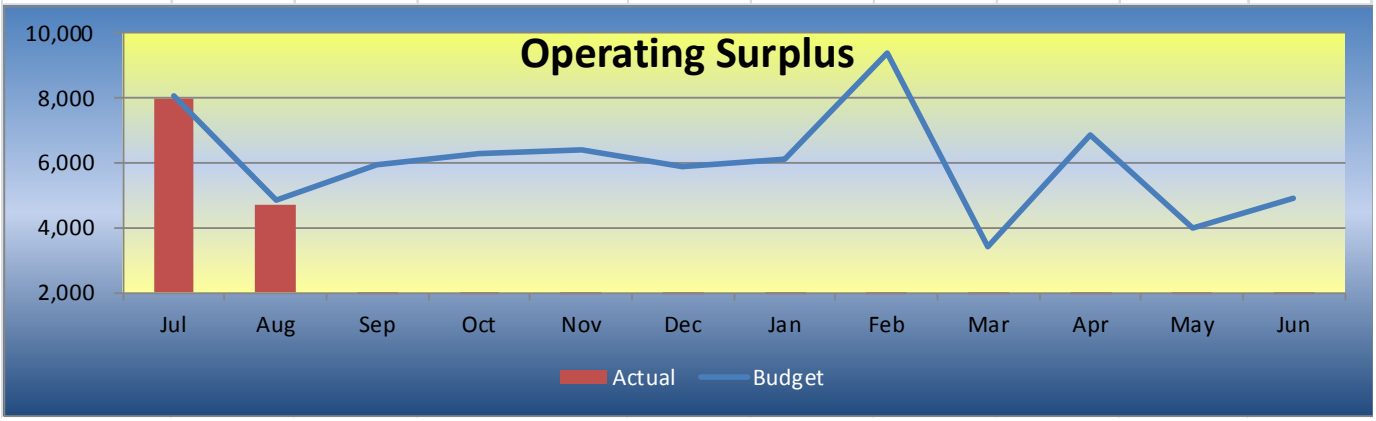
### Discharges

Note that we do not budget for discharges.

| Month | | | | | Year to date | | | |
|---|---|---|---|---|---|---|---|---|
| Act | Last Yr. | Var. | % | | Act | Last Yr. | Var. | % |
| 7,505 | 7,903 | (395) | -5.00% | *Acute* | 7,505 | 7,903 | -395 | -5.00% |
| 1,420 | 1,459 | (39) | -2.70% | *Elective* | 1,420 | 1,459 | -39 | -2.70% |
| **8,928** | **9,362** | (434) | -4.60% | ***Total*** | **8,928** | **9,362** | **-434** | -4.60% |
| **0.82** | **0.84** | **-0.02** | -2.40% | ***Ratio WIES to discharges*** | **0.82** | **0.84** | **-0.02** | -2.40% |

## Statement of Performance

| Month | | | | Year to Date | | | | Full Year | |
|---|---|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | *$000* | Act | Bud | Var. | Last year | Bud | Forecast |
| | | | ***Revenue*** | | | | | | |
| 128,652 | 129,409 | (757) | *Crown* | 256,779 | 258,842 | (2,063) | 244,581 | 1,550,944 | 1,550,944 |
| 2,957 | 3,649 | (692) | *Other* | 6,590 | 7,626 | (1,036) | 6,755 | 43,959 | 43,959 |
| **131,609** | **133,058** | **(1,449)** | ***Total Revenue*** | **263,369** | **266,468** | **(3,099)** | **251,336** | **1,594,903** | **1,594,903** |
| | | | ***Expenses*** | | | | | | - |
| 49,878 | 50,795 | 917 | *Personnel* | 95,671 | 98,873 | 3,202 | 91,412 | 594,801 | 594,801 |
| 1,496 | 1,023 | (473) | *O/S Personnel* | 3,139 | 2,046 | (1,093) | 2,401 | 12,275 | 12,275 |
| 5,540 | 5,521 | (19) | *O/S services* | 10,910 | 11,045 | 135 | 8,735 | 66,731 | 66,731 |
| 54,610 | 55,613 | 1,003 | *Funder Provider payments* | 109,802 | 111,226 | 1,424 | 107,461 | 667,359 | 667,359 |
| 9,403 | 8,790 | (613) | *Clinical Sup.* | 18,701 | 17,296 | (1,405) | 18,350 | 105,242 | 105,242 |
| 5,993 | 6,476 | 483 | *Infrastructure* | 12,473 | 13,050 | 577 | 10,576 | 76,413 | 76,413 |
| **126,920** | **128,218** | **1,298** | ***Operating Exp*** | **250,696** | **253,536** | **2,840** | **238,935** | **1,522,821** | **1,522,821** |
| **4,689** | **4,840** | **(151)** | ***Surplus after operating Exp.*** | **12,673** | **12,932** | **(259)** | **12,401** | **72,082** | **72,082** |
| 2,880 | 2,894 | 14 | *Depn.* | 5,801 | 5,789 | (12) | 5,359 | 34,733 | 34,733 |
| 1,059 | 1,225 | 166 | *Interest* | 2,118 | 2,450 | 332 | 2,118 | 14,700 | 14,700 |
| 1,513 | 1,512 | (1) | *Capital Chg.* | 3,025 | 3,025 | - | 2,500 | 18,149 | 18,149 |
| - | | | *Gain on Sale* | - | | | | - | - |
| **(763)** | **(791)** | **28** | ***Net Surplus*** | **1,729** | **1,668** | **61** | **2,424** | **4,500** | **4,500** |



**Revenue**

| Month | | | | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | $000 | Act | Bud | Var. | Bud |
| 73,567 | 74,099 | (532) | *Provider* | 146,708 | 148,550 | (1,842) | 887,394 |
| 123,738 | 124,593 | (855) | *Funder* | 247,965 | 249,185 | (1,220) | 1,495,112 |
| (66,861) | (66,770) | (91) | *Elimination* | (133,625) | (133,540) | (85) | (801,239) |
| 1,165 | 1,136 | 29 | *Governance* | 2,321 | 2,273 | 48 | 13,636 |
| **131,609** | **133,058** | **(1,449)** | ***Total*** | **263,369** | **266,468** | **(3,099)** | **1,594,903** |

Provider remains unfavourable for the month. The main drivers for the current month's variances are:

**Government Revenue:** Personnel Health Revenue down due to lower billings arising from lower than expected volumes.

**Patient/Consumer Sourced:** Non-resident unfavourable billings offset by increased patient co-payments.

**Other Income:** Unfavourable primarily due to the late opening of the community pharmacy (now scheduled for November/December. There are associated reductions in cost of sales.

**Funder Payments unfavourable:** Impacted by reduced volumes for the month.

**Staff costs (incl Outsourced)**

| Month | | | | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | *$000* | Act | Bud | Var. | Bud |
| 50,400 | 50,941 | 541 | *Provider* | 96,923 | 99,165 | 2,242 | 596,551 |
| 974 | 877 | (97) | *Governance* | 1,887 | 1,754 | (133) | 10,525 |
| **51,374** | **51,818** | **444** | ***Total*** | **98,810** | **100,919** | **2,109** | **607,076** |
| | | | | | | | |
| 15,444 | 16,126 | 682 | *Medical* | 29,619 | 31,166 | 1,547 | 187,010 |
| 700 | 444 | (256) | *Outsourced* | 1,389 | 888 | (501) | 5,330 |
| 16,144 | 16,570 | 426 | ***Total*** | 31,008 | 32,054 | 1,046 | 192,340 |
| 18,373 | 18,308 | (65) | *Nursing* | 35,753 | 36,119 | 366 | 218,404 |
| 231 | 194 | (37) | *Outsourced* | 658 | 389 | (269) | 2,333 |
| 18,604 | 18,502 | (102) | *Total* | 36,411 | 36,508 | 97 | 220,737 |
| 7,338 | 7,323 | (15) | *Allied Health* | 13,641 | 14,103 | 462 | 84,620 |
| 4 | 11 | 7 | *Outsourced* | 7 | 22 | 15 | 133 |
| 7,342 | 7,334 | (8) | ***Total*** | 13,648 | 14,125 | 477 | 84,753 |
| 2,230 | 2,319 | 89 | *Support Personnel* | 4,422 | 4,408 | (14) | 26,267 |
| 22 | 1 | (21) | *Outsourced* | 35 | 2 | (33) | 12 |
| 2,252 | 2,320 | 68 | ***Total*** | 4,457 | 4,410 | (47) | 26,279 |
| 6,491 | 6,718 | 227 | *Management Admin* | 12,234 | 13,076 | 842 | 78,501 |
| 539 | 372 | (167) | *Outsourced* | 1,050 | 744 | (306) | 4,467 |
| 7,030 | 7,090 | 60 | ***Total*** | 13,284 | 13,820 | 536 | 82,968 |
| 49,876 | 50,794 | 918 | ***Internal*** | 95,669 | 98,872 | 3,203 | 594,802 |
| 1,496 | 1,022 | (474) | ***Outsourced*** | 3,139 | 2,045 | (1,094) | 12,275 |
| **51,372** | **51,816** | **444** | ***Total*** | **98,808** | **100,917** | **2,109** | **607,077** |

Provider – personnel costs are favourable for the month reflecting lower hospital volumes, less sick leave and less overtime. This was reflected in most categories of staff.

A level of vacancies exist across the organisation in all personnel categories (including Allied Health) and are partially covered by bureau, overtime and casual staff. While Outsourced Staff costs were up, this was more than offset by lower Personnel costs.

**Outsourced Services**

| Month | | | | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | $000 | Act | Bud | Var. | Bud |
| 3,195 | 3,269 | 74 | *Corporate & Governance Services* | 6,392 | 6,537 | 145 | 37,178 |
| 2,344 | 2,253 | (91) | *Clinical Service* | 4,518 | 4,508 | (10) | 27,892 |
| **5,541** | **5,522** | **(19)** | ***Total*** | **10,910** | **11,045** | **135** | **65,070** |

Offset by hA cost benefit and savings in other expenses.
Clinical Services costs again reflected the lower patient volumes for the month.

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

| Month | | | ***Major Categories*** | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | ***$000*** | Act | Bud | Var. | Bud |
| | | | ***Personal Health*** | | | | |
| 20,876 | 21,186 | 310 | *IDF Personal Health* | 42,104 | 42,372 | 268 | 254,233 |
| 9,001 | 9,005 | 4 | *Pharmaceuticals* | 18,003 | 18,009 | 6 | 108,055 |
| 6,015 | 6,289 | 274 | *Primary Practice Services – Capitated* | 13,821 | 12,578 | (1,243) | 75,468 |
| 582 | 556 | (26) | *Child and Youth* | 963 | 1,111 | 148 | 6,668 |
| 463 | 463 | - | *Adolescent Dental Benefit* | 889 | 926 | 37 | 5,558 |
| 806 | 790 | (16) | *Chronic Disease Management and Education* | 1,513 | 1,580 | 67 | 9,478 |
| 484 | 480 | (4) | *Palliative Care* | 967 | 959 | (8) | 5,756 |
| 199 | 299 | 100 | *General Medical Subsidy* | 498 | 598 | 100 | 3,588 |
| 1,469 | 1,101 | (368) | *Other* | 1,733 | 2,203 | 470 | 13,217 |
| **39,895** | **40,169** | **274** | ***Total Personal Health*** | **80,491** | **80,336** | **(155)** | **482,021** |

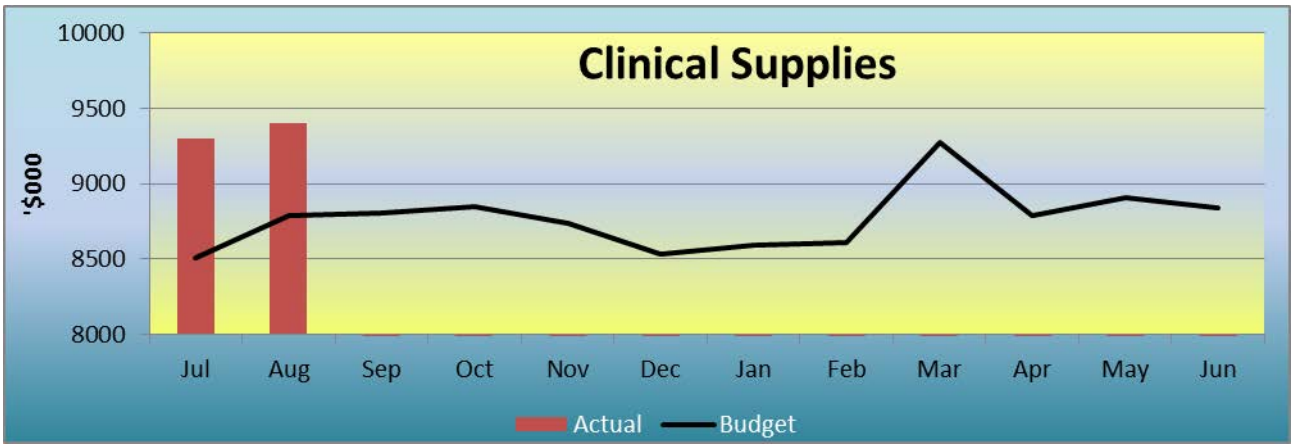
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | ***Mental Health*** | | | | |
| 1,249 | 1,250 | 1 | *IDF Mental Health* | 2,497 | 2,500 | 3 | 14,998 |
| 842 | 890 | 48 | *Community Residential Beds & Services* | 1,680 | 1,781 | 101 | 10,684 |
| 664 | 753 | 89 | *Other Home Based Residential Support* | 1,360 | 1,507 | 147 | 9,040 |
| - | 341 | 341 | *Alcohol & Other Drugs* | - | 683 | 683 | 4,098 |
| 280 | 278 | (2) | *Crisis Respite* | 562 | 555 | (7) | 3,332 |
| 354 | 355 | 1 | *Child & Youth* | 709 | 709 | - | 4,256 |
| 195 | 179 | (16) | *Kaupapa Maori Community* | 373 | 358 | (15) | 2,145 |
| 184 | 1,479 | 1,295 | *Community Service* | 369 | 2,958 | 2,589 | 17,745 |
| 856 | - | (856) | *Other* | 1,603 | - | (1,603) | - |
| **4,624** | **5,525** | **901** | ***Total Mental Health*** | **9,153** | **11,051** | **1,898** | **66,298** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | ***Disability Support Services*** | | | | |
| 4,539 | 4,406 | (133) | *Residential Care: Hospitals* | 9,185 | 8,813 | (372) | 52,876 |
| 1,998 | 1,883 | (115) | *Residential Care: Rest Homes* | 3,818 | 3,767 | (51) | 22,600 |
| 1,642 | 1,741 | 99 | *Home Support* | 3,269 | 3,483 | 214 | 20,897 |
| 1,714 | 1,696 | (18) | *Other* | 3,225 | 3,391 | 166 | 20,348 |
| **9,893** | **9,726** | **(167)** | ***Total Disability Support Services*** | **19,497** | **19,454** | **(43)** | **116,721** |
| | | | | | | | |
| **85** | **103** | **18** | ***Total Public Health*** | **170** | **206** | **36** | **1,233** |
| **113** | **90** | **(23)** | ***Total Maori Health*** | **491** | **181** | **(310)** | **1,085** |
| **54,610** | **55,613** | **1,003** | ***Total Funder Payments*** | **109,804** | **111,228** | **1,424** | **667,358** |

**Clinical Supplies (excluding depreciation)**

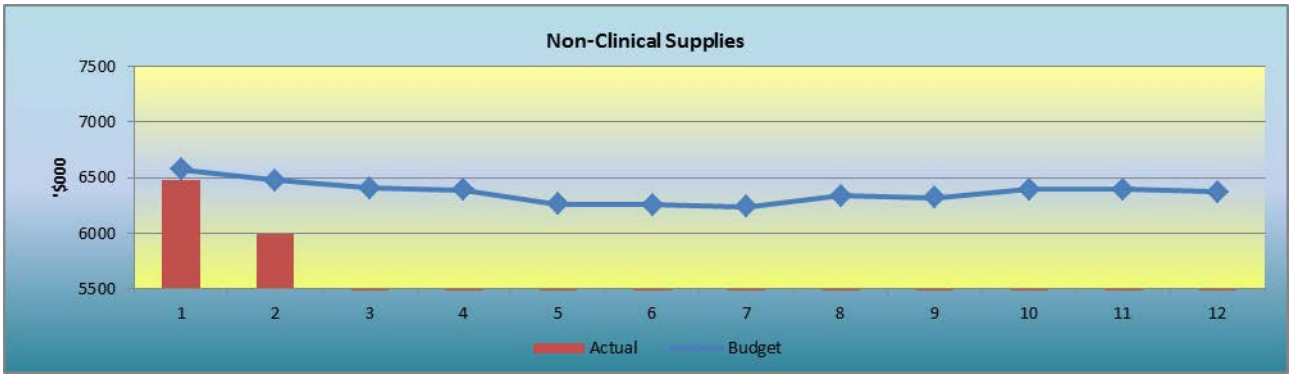
| Month | | | | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | - | Act | Bud | Var. | Bud |
| 3,535 | 3,104 | (431) | *Treatment Disposables* | 6,959 | 6,114 | (845) | 37,160 |
| 833 | 831 | (2) | *Diagnostic Supplies & Other Clinical Supplies* | 1,679 | 1,677 | (2) | 9,955 |
| 1,391 | 1,277 | (114) | *Instruments & Equipment* | 2,576 | 2,511 | (65) | 15,198 |
| 275 | 321 | 46 | *Patient Appliances* | 568 | 628 | 60 | 3,853 |
| 1,341 | 1,547 | 206 | *Implants & Prostheses* | 2,962 | 2,987 | 25 | 18,641 |
| 1,749 | 1,384 | (365) | *Pharmaceuticals* | 3,284 | 2,729 | (555) | 16,532 |
| 279 | 326 | 47 | *Other Clinical Supplies* | 673 | 650 | (23) | 3,902 |
| **9,403** | **8,790** | **(613)** | ***Total*** | **18,701** | **17,296** | **(1,405)** | **105,241** |

Clinical Supplies are unfavourable for the month.
Clinical Support – unfavourable, while costs are only 1% up on the same month last year, significant savings had been budgeted in July which have been realised in other cost categories.



**Non Clinical / Infrastructure (excl depreciation, interest and capital charge)**

| Month | | | | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | $000 | Act | Bud | Var. | Bud |
| 5,701 | 6,214 | 513 | *Provider* | 11,858 | 12,526 | 668 | 73,561 |
| 292 | 262 | (30) | *Governance* | 615 | 524 | (91) | 3,146 |
| **5,993** | **6,476** | **483** | ***Total*** | **12,473** | **13,050** | **577** | **76,707** |




**Depreciation, Interest and Capital Charge**

| Month | | | | YTD | | | Full Yr. |
|---|---|---|---|---|---|---|---|
| Act | Bud | Var. | $000 | Act | Bud | Var. | Bud |
| 2,880 | 2,894 | 14 | *Depreciation* | 5,801 | 5,789 | (12) | 34,733 |
| 1,059 | 1,225 | 166 | *Interest Paid - Debt* | 2,118 | 2,450 | 332 | 14,700 |
| **1,059** | **1,225** | **166** | ***Interest Paid*** | **2,118** | **2,450** | **332** | **14,700** |
| 1,513 | 1,512 | (1) | *Capital Charge* | 3,025 | 3,025 | - | 18,149 |

**Ratios (Provider Arm only)**

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

| | Aug 16 | Jul 16 | Jun 16 | May 16 | Apr 16 | Mar 16 | Feb 16 |
|---|---|---|---|---|---|---|---|
| *Medical* | 21.05 | 19.34 | 24.53 | 21.43 | 21.01 | 21.96 | 19.94 |
| *Nursing* | 24.95 | 23.74 | 23.33 | 24.64 | 24.59 | 25.49 | 24.67 |
| *Allied* | 9.95 | 8.60 | 8.22 | 9.26 | 9.35 | 9.87 | 9.29 |
| *Support* | 3.03 | 3.00 | 3.17 | 3.19 | 3.16 | 3.25 | 2.75 |
| *Management* | 7.67 | 6.81 | 8.61 | 7.89 | 7.33 | 7.42 | 7.17 |
| ***Personnel*** | **66.65** | **61.49** | **67.86** | **66.41** | **65.44** | **67.99** | **63.81** |
| *Outsourced Pers.* | 1.86 | 2.12 | 1.96 | 1.74 | 2.58 | 1.89 | 1.73 |
| ***Total Personnel*** | **68.51** | **63.61** | **69.83** | **68.15** | **68.02** | **69.88** | **65.54** |
| *Outsourced Clinical Services* | 3.19 | 2.97 | 3.72 | 2.81 | 3.51 | 2.42 | 2.77 |
| *Outsourced Corp (hA)* | 4.14 | 4.17 | 3.44 | 3.63 | 3.59 | 3.68 | 3.75 |
| *Clinical Supplies* | 14.09 | 14.02 | 14.71 | 16.28 | 14.42 | 15.38 | 13.62 |
| *Infrastructure* | 13.86 | 14.62 | 10.63 | 12.85 | 12.28 | 13.53 | 13.71 |
| ***Total*** | **103.78** | **99.38** | **102.32** | **103.71** | **101.82** | **104.9** | **99.39** |

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

| | 2017 YTD | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|---|
| *Medical* | 20.2 | 21.2 | 20.9 | 20.7 | 21.2 | 20.5 |
| *Nursing* | 24.3 | 24.5 | 24.8 | 25.1 | 25.5 | 24.7 |
| *Allied Health* | 9.3 | 9.2 | 9.3 | 9.7 | 9.7 | 9.5 |
| *Support* | 3.0 | 3.1 | 3.0 | 2.9 | 2.7 | 2.7 |
| *Man/Admin* | 7.2 | 7.3 | 6.9 | 6.8 | 7.2 | 7.8 |
| *Personnel* | **64.1** | **65.3** | **65.0** | **65.2** | **66.3** | **65.2** |
| *Outsourced Personnel* | 2.0 | 2.0 | 2.0 | 1.8 | 1.8 | 1.7 |
| ***Total Personnel*** | **66.1** | **67.3** | **67.0** | **67.0** | **68.1** | **66.9** |
| *Outsourced Clinical Services* | 3.1 | 2.8 | 2.5 | 2.7 | 2.9 | 2.8 |
| *Outsourced Corporate* | 4.2 | 3.7 | 3.7 | 3.7 | 3.4 | 3.3 |
| *Clinical supplies* | 12.7 | 14.5 | 14.4 | 14.0 | 14.4 | 14.7 |
| *Infrastructure* | 11.6 | 13.1 | 13.2 | 13.0 | 12.4 | 13.2 |
| ***Total*** | **97.6** | **101.4** | **100.8** | **100.4** | **101.2** | **100.9** |
| *Depn* | 4.0 | 3.6 | 3.6 | 3.8 | 3.1 | 2.8 |
| *Interest* | 1.4 | 1.5 | 1.5 | 1.1 | 1.5 | 1.3 |
| *Capital Charge* | 2.1 | 2.2 | 1.8 | 1.7 | 1.7 | 1.7 |

**Balance Sheet**

| | Actual | Budget | Variance | Opening 01-Jul-16 | YTD Movement |
|---|---|---|---|---|---|
| **Current Assets** | | | | | |
| Petty Cash | 11 | 11 | - | 11 | - |
| Bank | 35,522 | 31,235 | 4,287 | 31,793 | 3,729 |
| Trust | 900 | 901 | (1) | 873 | 27 |
| Prepayments | (74) | 292 | (366) | 292 | (366) |
| Debtors | 53,135 | 49,843 | 3,292 | 50,043 | 3,092 |
| Inventory | 1,762 | 1,468 | 294 | 1,468 | 294 |
| Assets Held for Sale | - | - | - | - | - |
| **Total current Assets** | **91,256** | **83,750** | **7,506** | **84,480** | **6,776** |
| **Fixed Assets** | | | | | |
| Land | 176,530 | 176,530 | - | 176,530 | - |
| Buildings, Plant & Equip | 614,189 | 643,914 | (29,725) | 639,736 | (25,547) |
| Investment Property | 1,527 | 1,527 | - | 1,527 | - |
| Information Technology | 4,259 | 4,281 | (22) | 4,259 | - |
| Information Software | 561 | 673 | (112) | 561 | - |
| Motor Vehicles | 4,416 | 4,460 | (44) | 4,416 | - |
| **Total Cost** | **801,482** | **831,385** | **(29,903)** | **827,029** | **(25,547)** |
| Accum. Depreciation | (150,324) | (150,314) | (10) | (144,526) | (5,798) |
| **Net Cost** | **651,158** | **681,071** | **(29,913)** | **682,503** | **(31,345)** |
| Work In-progress | 44,607 | 42,108 | 2,499 | 39,110 | 5,497 |
| **Total Fixed Assets** | **695,765** | **723,179** | **(27,414)** | **721,613** | **(25,848)** |
| **Investments in Assoc** | 37,704 | 38,538 | (834) | 37,704 | - |
| **Total Assets** | **733,469** | **761,717** | **(28,248)** | **759,317** | **(25,848)** |
| **Current Liabilities** | | | | | |
| Creditors | 85,381 | 86,195 | (814) | 85,859 | (478) |
| Income in Advance | 6,195 | - | 6,195 | 1,917 | 4,278 |
| GST and PAYE | 7,107 | 6,696 | 411 | 6,691 | 416 |
| Loans | - | - | - | - | - |
| Payroll Accrual & Clearing | 32,331 | 33,734 | (1,403) | 33,785 | (1,454) |
| Employee Provisions | 91,121 | 88,540 | 2,581 | 87,640 | 3,481 |
| **Total Current Liabilities** | **222,135** | **215,165** | **6,970** | **215,892** | **6,243** |
| **Working Capital** | (130,879) | (131,415) | 536 | (131,412) | 533 |
| **Net Funds Employed** | **602,590** | **630,302** | **(27,712)** | **627,905** | **(25,315)** |
| **Non Current Liabilities** | | | | | |
| Term Loans | 292,500 | 292,500 | - | 292,500 | - |
| Employee Provisions (non current) | 21,062 | 21,669 | (607) | 21,221 | (159) |
| Trust and Special Funds | 895 | 901 | (6) | 873 | 22 |
| Insurance Liability - Non Current | 931 | 931 | - | 931 | - |
| **Total Non Current Liabilities** | **315,388** | **316,001** | **(613)** | **315,525** | **(137)** |
| **Crown Equity** | | | | | |
| Crown Equity | 123,659 | 123,659 | - | 123,659 | - |
| Revaluation Reserve | 219,987 | 246,896 | (26,909) | 246,896 | (26,909) |
| Retained Earnings | (56,444) | (56,254) | (190) | (58,175) | 1,731 |
| **Total Crown Equity** | **287,202** | **314,301** | **(27,099)** | **312,380** | **(25,178)** |
| **Net Funds Employed** | **602,590** | **630,302** | **(27,712)** | **627,905** | **(25,315)** |

**Buildings, Plant and Equipment:** Variance represents a revaluation adjustment post the final MoH return (prior to CFIS).

**Cashflow**

| | Month | | | YTD | | |
|---|---|---|---|---|---|---|
| **$000** | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** |
| **Cash flows from operating activities** | | | | | | |
| Cash was provided from: | | | | | | |
| Crown Revenue | 125,117 | 129,509 | (4,392) | 257,967 | 257,123 | 844 |
| Other | 2,783 | 2,537 | 246 | 6,149 | 5,381 | 768 |
| Interest rec. | 174 | 167 | 7 | 441 | 334 | 107 |
| Cash was applied to: | | | | | | |
| Suppliers | (74,098) | (76,853) | 2,755 | (157,667) | (153,398) | (4,269) |
| Employees | (49,788) | (50,107) | 319 | (94,177) | (97,551) | 3,374 |
| Interest paid | (1,059) | (1,225) | 166 | (2,118) | (2,450) | 332 |
| Capital charge | (1) | (1,512) | 1,511 | - | (2,699) | 2,699 |
| **Net cash from Operations** | **3,128** | **2,516** | **612** | **10,595** | **6,740** | **3,855** |
| **Cash flows from investing activities** | | | | | | |
| Cash was applied to: | | | | | | |
| Fixed assets - Non FMP | (3,600) | (3,233) | (367) | (6,862) | (6,466) | (396) |
| Sale of Asset | - | - | - | - | - | - |
| Investments | - | (416) | 416 | - | (806) | 806 |
| Restricted & Trust Funds | 21 | - | 21 | 22 | - | 22 |
| **Net cash from Investing** | **(3,579)** | **(3,649)** | **70** | **(6,840)** | **(7,272)** | **432** |
| **Cash flows from financing activities** | | | | | | |
| **Cash was provided from:** | | | | | | |
| Debt | - | - | - | - | - | - |
| Other Non-Current Liability | - | - | - | - | - | - |
| **Net cash from Financing** | - | - | - | - | - | - |
| **Net increase / (decrease)** | **(451)** | **(1,133)** | **682** | **3,755** | **(532)** | **4,287** |
| Opening cash | 35,984 | 32,379 | 3,605 | **67,762** | 64,157 | 3,605 |
| **Closing cash** | **35,533** | **31,246** | **4,287** | **71,517** | **63,625** | **7,892** |

| **Summary** | Month | | | YTD | | |
|---|---|---|---|---|---|---|
| | **Actual** | **Budget** | **Variance** | **Actual** | **Budget** | **Variance** |
| **Opening cash** | 35,984 | 32,379 | 3,605 | 67,762 | 64,157 | 3,605 |
| Operating | 3,128 | 2,516 | 612 | 10,595 | 6,740 | 3,855 |
| Investing | (3,579) | (3,649) | 70 | (6,840) | (7,272) | 432 |
| Financing | - | - | - | - | - | - |
| **Closing cash** | **35,533** | **31,246** | **4,287** | **71,517** | **63,625** | **7,892** |

**Commentary:**

Positive cash flow variance of $2.5m was achieved primarily from operations. This simply reflects timing differences with receipts and costs from June impacting the July result and the capital charge payment not due until December 2016. Capital spending was on budget.

| MOH Debtors $000 | Total | Current | 30 day + |
|---|---|---|---|
| Invoiced | 4,307 | 2,660 | 1,647 |
| Accrued | 693 | | |
| **Total** | **5,000** | | |
| *Last month* | *3,892* | | |

**Personnel**

**Costs per FTE** *(Rolling average)*

| | Aug 2016 | Jul 2016 | Jun 2016 | May 2016 | Apr 2016 | Mar 2016 |
|---|---|---|---|---|---|---|
| Medical | 187,475 | 185,826 | 186,163 | 186,263 | 185,474 | 184,917 |
| Nursing | 78,238 | 77,613 | 77,866 | 78,193 | 77,784 | 78,539 |
| Allied Health | 71,546 | 70,744 | 71,193 | 70,869 | 71,060 | 71,419 |
| Support | 52,790 | 52,259 | 52,464 | 52,369 | 51,987 | 52,026 |
| Management/Admin/Clerical | 83,609 | 82,523 | 82,611 | 75,485 | 74,414 | 74,502 |

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

| Counties Manukau | Aug-16 | Jul-16 | Jun-16 | May-16 | Apr-16 | Mar-16 |
|---|---|---|---|---|---|---|
| Accrued FTE (as per MOH template) | 904.7 | 887.7 | 910.4 | 905.4 | 926.6 | 894.1 |
| Annual Leave loading | (79) | (78) | (80) | (79) | (79) | (79) |
| FTE's on holiday | 54.5 | 54.0 | 64.8 | 56.5 | 33.2 | 64.5 |
| Payroll FTE's | 880.0 | 864.0 | 896.0 | 882.5 | 880.6 | 879.4 |
| Contractors / Consultants (FTE equivalent) | 10.0 | 10.0 | 10.0 | 11.0 | 10.0 | 10.0 |
| Vacancy | - | - | - | - | - | - |
| Total | 890.0 | 874.0 | 906.1 | 893.5 | 890.6 | 889.4 |
| Number submitted Jan 09 for 31 Dec 08 | 867.5 | 867.5 | 867.5 | 867.5 | 867.5 | 867.5 |
| Variance | 22.5 | 6.5 | 38.6 | 26.0 | 23.1 | 21.9 |

## 6.0 Ko Awatea

**Purpose**

Ko Awatea is working to fully articulate its products and services for Counties Manukau Health (CMH) and wider, nationally and internationally. It is transitioning to a balanced scorecard approach for performance reporting and working to clarify expectations and targets within that framework.

We note that in the meantime, coverage across functions will be selective; some measures will be reported monthly and others quarterly. The aim is to bring relevant highlights and issues to the Board's attention. As Ko Awatea increases its maturity across these aspects, it welcomes the Board's feedback on the information provided or any requests more detailed information.

**5th APAC Forum, Sydney Australia 12-14 September, 2016**

In brief:

- Nearly 1,400 delegates
- 276 poster submissions
- 52 Ko Awatea International Excellence in Health Improvement Awards
- 500 capacity crowd for gala dinner

The transition to digital poster formats and the trial of enhanced posters was a success. A total 276 were displayed to attendees, generating great interest and competition for the poster awards. APAC received good media coverage, including New Zealand Doctor Magazine, New Zealand Herald, The Listener and the Paul Henry Show.

APAC Forum 2016 has driven a high level of interest in Ko Awatea, providing a number of opportunities, which are now in the Ko Awatea business pipeline. We are moving to quantify these, and follow up with the preparation of proposals.

In November, a full report on APAC 2016 is to be presented to the Board, as is a budget for APAC 2017 to ELT and the Board.

**Strengthening Cross System Collaboration**

**New Zealand Innovation and Improvement Network (NZIIN)**

The New Zealand DHB Innovation and Improvement Network (NZIIN) has been under development since June 2015, and is intended to accelerate the development and uptake of innovation and improvement across the New Zealand health system. Following endorsement by the DHB Executive on 2 August 2016, the NZIIN was presented to the 20 DHB Chairs and CEs on 1 September. Ashley Bloomfield, CEO of Hutt Valley DHB, was nominated and approved as Sponsor of the project. A steering group is being assembled to ensure broader engagement and endorsement across the sector, as well as improve alignment and reduce duplication. Representation is being sought from a broader stakeholder group, including the Health Quality & Safety Commission, Ministry of Health and other influential groups.

The initial 18-month proof-of-concept is funded by the District Health Board surplus through 'Central TAS', a shared services organisation for New Zealand DHBs. In the discovery phase, the project will identify bright spots, insights, and shared challenges across participating DHBs. Subsequently, a trial project/s will be selected and collaboratively undertaken by a subset of

these DHBs. CMH is one of the pioneer participants, and Ko Awatea is providing project management, evaluation and advisory services. TAS is also providing some project support. While we are participating in and supporting the project, it is not – in positioning or in fact – driven by CMH or Ko Awatea.

**Knowledge Access Supporting Evidence-based Practice**

**Health Equity Clearinghouse - New Library Resource to support Health Equity**

The Counties Manukau Health Library has curated a collection of national and international resources, guidelines, toolkits and literature to support the work that CMH is doing to address health inequity in our community**.** The clearinghouse includes links to documents, videos and blogs outlining CMH's programme of work on health equity as well as profiling the strategic programme of the Ministry of Health, the Health Quality & Safety Commission, academic partners and New Zealand NGOs. Full text access to online toolkits and selected readings to promote health equity in New Zealand and internationally are featured, as well as peer reviewed literature and academic and sectoral analysis. In alignment with the CMH Strategy, there is a particular focus on child health. The clearinghouse is updated weekly and is complemented by the CMH Library's clearinghouses on Maaori, Pacific and Asian Health Research.

The Health Equity Clearinghouse is available via the intranet and also externally to our national and international partners via the HealthPoint website.

To promote access to the resource, the CMH Library regularly shares links to the latest updates to the clearinghouse via social media using the #healthequity hashtag on Twitter. In August 2016, the CMH Library Directory of Resources had the second highest page views on HealthPoint with 968 page views.

**Supporting Improvement and Transformational Change**

**Diabetes Care Collaborative (Modified Diabetes Care Improvement Package [DCIP] Programme)**

The Diabetes Care Collaborative builds on the improvement work done by the Manukau Locality - Diabetes - collaborative. The aim of Diabetes Care Collaborative is a 10% reduction in the average HbA1c in patients with poor control of their diabetes (HbA1c >75mmol/mol) by June 2017. Ten general practices which collectively have 33% of the people with poor diabetes control in the district are actively participating in the collaborative. Ko Awatea is providing the expertise in improvement methodology for the collaborative. Key highlights to date:

- Improvement Advisors are visiting all ten practices to provide improvement knowledge, coaching and data analysis.
- Practices have identified areas for improvement and eight of the ten are now testing their change ideas.
- Changes being tested include: deployment of dedicated diabetes nurses, diabetes clinics, use of health coaches, co-designing diabetes care pathways with patients, having difficult conversations with patients about their diabetes and care.

**Faster Cancer Treatment**

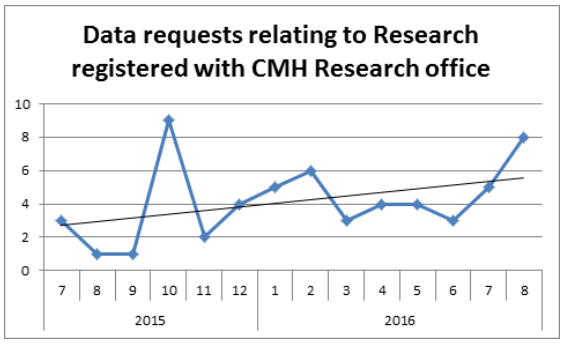
Following four months of solid performance with approximately 80% of patients being treated within the 62-day Ministry of Health target time, there was a dip in performance in August with only 68% of patients (26/38) treated within the 62-day target. Of the 12 breaches, 8 were due to capacity issues.

*Mitigation:* Breaches are being analysed to determine where and why delays are occurring. Ko Awatea Improvement Advisors are also supporting a review of current performance by

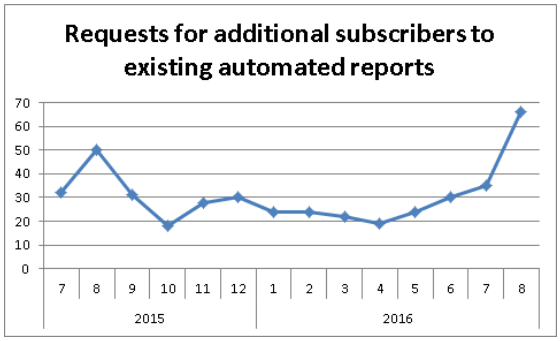
providing data analysis of process performance and supporting the tumour streams to map patient journeys along their pathways to identify where the performance delays occur.

A meeting involving clinical and non-clinical staff from across the tumour streams is scheduled for November to collectively learn and identify opportunities for further improvement and sustainability of changes.

**Data & Analytics Supporting Better Business**




The Research and Evaluation team ran the inaugural Research week in June 2016, with the aim of encouraging and fostering research at CMH. We have seen a slow but steady increase in requests for data relating to Research or Audit that is registered with CMH Research office, which is a positive sign of increasing work in this area.




Last month saw the highest volume of requests by CMH users to have access to existing automated reports. This suggests that the reports are useful to the end user and that more people are utilising data to inform their day to day work.

**Business Development**

Ko Awatea has been awarded the 'Talking Matters' collaborative contract by COMET Auckland; a Council Controlled Organisation of Auckland Council, and also an independent Charitable Trust. COMET support education and skills across Auckland, contributing to the relevant social and economic goals in the Auckland Plan. The project involves an 18 months proof of concept in 3 communities to demonstrate that community action around early oral language is possible and makes a demonstrable difference in families and in the confidence and capability of young children.

## 7.0 Compliance

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

**Executive Summary**

Activities for the month are up-to-date as outlined in the attached Health and Safety Plan.

WorkSafe's ten-year strategy to tackle work-related health was recently launched. The plan approaches health from two directions i.e. the effect of work on health and the effect of a person's health on their work – the latter being a potential cause of

injury, e.g. a fatigued worker. The overall Occupational Health and Safety Plan is being amended to reflect a renewed risk management approach incorporating the above considerations for Occupational Health, which is also aligned with the Wellness Strategy.

Executive/Board workplace inspection was undertaken in the Gastro Department at Middlemore Hospital with constructive engagement and feedback from all stakeholders. David Collings, Board Member, was in attendance.

Related to the community health worker safety risk management work, are the learnings from the Ministry of Social Development (MSD) court judgment relating to the WorkSafe prosecution following the Ashburton tragedy, for failing to keep its staff safe. The summary findings are below, provided only as topical information to the current initiatives. CM Health is reviewing the learnings, as appropriate, which relate to the potential risk our staff encounter when working with the public and the potential risk of violence:

- WorkSafe experts have told the court that controlled access, bulletproof glass and barriers to keep clients and staff separate should be considered
- Since the shooting MSD now has controlled access to their offices, which include:
  - a controlled-access barrier (either external or internal). An external barrier would prevent access to the office and would be controlled by a security guard
  - a zone system - an internal barrier would allow entry to a certain point with further access controlled

There were no notifiable events to WorkSafe in August and September.

# Counties Manukau District Health Board
## Health and Safety Action Plan Update

| H&S System | Objectives Q3 2016 | STATUS September 2016 – Work Completed | Status | STATUS October 2016 – Work Planned |
|---|---|---|---|---|
| **Leadership and Practice** | | | | |
| **Responsibility, Commitment & Legal Obligations** | Engage with stakeholders on inclusion of H&S in recruitment processes.<br><br>KPI and Reporting formats to be finalised | Annual workplan now to be completed and rescoped to reflect the priority risk focus (This work is due for completion in November).<br><br>The Regional Worker Participation Agreement is in its final draft and is pending regional sign off. | | Worker Participation Structure paper is to be presented to the Workforce Education Committee and the Board (Refer to Appendix A).<br><br>The Regional Worker Participation Agreement to be finalised and signed<br><br>ACC Partnership Programme Audit preparations ongoing intensively for 3 day audit in October. |
| **H&S Information, Document Management & Communications** | Prepare communications and information for bi-annual ACC Partnership Programme Audit 2016 | H&S Recognition Award nominations closed on 30 September.<br><br>ACC WSMP Partnership Programme annual update on injury management has been communicated to the organisation, as per compliance requirements.<br><br>Final Flu programme uptake information sent to MoH and the organisation. Final uptake figure – 66% | | Preparations are underway for the H&S Recognition Awards Ceremony.<br><br>Nominations will be reviewed and evaluated in October with the ceremony to take place in November. CM Health CEO and appropriate members from the ELT and Senior Managers to attend.<br><br>ACC WSMP Audit communications will be sent to relevant stakeholders in the organisation |

| Prevention as a Culture | | | | |
|---|---|---|---|---|
| **Hazard/Risk Management** | Support workplace area Hazard Risk Registers development (ongoing process)<br><br>Review of orgnasitonal health and safety critical risk profile | *To include info regarding OHSS Risk Register vs Generic Organisational Risk Register*<br><br>The Community Health Workers Risk project continues to consider escalation processes and how these will align with clinical pathways<br><br>OHSS Systems and Framework Risks have been prioritised | | The Community Health Workers Risk project will continue to investigate the escalation processes. OHSS continues to provide support.<br><br>Generic Organisational Risk Register finalised in preparation of the ACC WSMP Audit.<br>Site Specific Risk Registers will be reviewed with the relevant sites once ACC confirms the sites to be audited. |
| | Moving and handling remains an uncoordinated organisational risk | Director of Hospital Services is still working to identify a GM to lead the steering group | | An external consultant from a tertiary institute will provide ergonomist consultancy support once the GM has been confirmed. |
| **Contractor H&S Management**<br><br>**Safe Design, Procurement & Disposal of Assets** | Develop health and safety contractor management support documentation in consultation with stakeholders<br><br>Commence review to parallel with the Contractor Management work | Contractor Management remains a focus. An external H&S Risk Consultant will support the design of a credible and practical framework that will comply with the new legislative requirements. | | The focus on Contractor Management will be further address in November (due to ACC WSMP audit)<br><br>Awaiting proposal for a deep-dive audit on Contractor Management compliance<br><br>healthAlliance continues to be engaged in the development process. |

| Prevention as a Culture (Continued) | | | | |
|---|---|---|---|---|
| **Wellbeing and Medical Management** | Confirm leadership engagement and commitment to Wellness Strategy<br><br>Identify different Wellness Strategy work streams<br><br>Confirm draft Wellness framework | Wellness strategy has been communicated and discussed with the Director of Healthy Together 2020 to ensure alignment of approach. | | The Wellness strategy is not a focus for October due to the ACC WSMP Audit. |
| **H&S Training & Competency** | Develop health and safety capability building (training) material (ongoing)<br><br>Facilitate health and safety capability building training | Review and update of the organisational Health and Safety Induction booklet pending due to delay in receiving initial draft version.<br><br>OHSS has sought input from external consultants for a proposal on CM Health specific training programme options. | | Organisational Health and Safety Induction Booklet review remains ongoing.<br><br>OHSS to progress CM Health specific training opportunities based on the updated Worker Participation Structure. |
| **Incident Management** | Investigate status of linkages between incident investigation findings and hazard & risk management<br><br>Conduct half yearly incident data analysis and update organisational risk register and generic hazard/risk register if required | Indicent trend analysis is ongoing. | | Incident trend analysis will be finalised in preparation of the ACC WSMP Audit. |

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| **Worker Empowerment and Engagement** | | | | |
| **Employee Consultation & Involvement** | H&S Recognition Programme<br><br>Initiate engagement to scope the establishment of an organisation H&S Committee | Worker Participation Structure draft has been developed with legal compliance requirements. The draft will be presented to the Workforce Education Committee and the Board. | | Worker Participation Structure draft will be finalised once feedback is received from relevant stakeholders. |
| **Audit, Inspection and Performance Measurement** | | | | |
| **Audit, Inspection and Performance Measurement** | Undertake audits as per the health and safety Audit Programme (ongoing)<br><br>Preparation for the full ACC Partnership Programme Audit 2016 (ongoing) | Executive/Board H&S workplace inspection report to be presented and trends identified.<br><br>Bi-annual Workplace Inspection report distributed.<br><br>First Aid Guideline review finalised.<br><br>ACC WSMP Audit preparations were ongoing. | | Next round of Workplace Inspections to be completed in October.<br><br>ACC WSMP Audit preparations is main area of focus, with the audit scheduled for 26-28 October 2016. |

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| | On Track |
| | Possible Roadblock Identified |
| | Delayed |

# Counties Manukau District Health Board
# Occupational Health and Safety
## Worker Participation – September 2016

## Recommendation

It is recommended that the Board:

**Receive** this in-depth topical Health and Safety risk review.

**Prepared and submitted by** Bev Stone, Manager Occupational Health & Safety Service on behalf of Beth Bundy, Director Human Resources.

**Executive Summary**

In-depth Health and Safety risk review – Worker Participation: Failure to participate and sustain an engaged workforce resulting in work environments where health and safety risks are not optimally controlled.

New Zealand recently amended its health and safety laws, with Worker Participation being one of four focus areas. Employers must now demonstrate practices that give their workers opportunities to participate, on an ongoing basis, in improving health and safety.

The New Zealand Government has said: *"When you engage workers in work health and safety everyone benefits. Your business is a healthier and safer place for everyone, and performance and productivity increase. Stronger worker engagement and participation leads to healthier and safer workplaces."*

Quality of Care is the heart and soul of this organisation. Patients expect, and CM Health aspires to provide, 'excellent collaborative, high quality, compassionate and safe healthcare[1]. Research shows that there is a link between staff engagement, efficiency and delivery of quality care, and these principles relate to the management of organisational health and safety for workers, visitors, patients and their families.

This in-depth review provides insight into the requirements for worker participation and highlights the consequences of a compliance breach of a workforce that is not engaged appropriately. These new requirements, as well as the motivation to be constantly improving our practices, has necessitated a review of the worker participation structure for CM Health in the most appropriate and cost effective manner, outlined in the treatment plans section of this paper.

**Purpose**

The purpose of the paper is to provide insights into the legislative requirements for effective worker participation and the potential consequences for the organisation.

| **In-depth Risk Review** | |
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| Risk title | **Worker Participation** |
| Risk owner | Beth Bundy - Director of Human Resources |

[1] Counties Manukau Health People Strategy 2015-2020 'Working Together'

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| Assessment by: | Bev Stone – Occupational Health and Safety Manager |
| Date of assessment | 28 September 2016 |

| **Risk Context** | |
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| Background | The new Health and Safety at Work (HSW) Act extends a PCBU's obligations to workers – defined as individuals who carry "out work in any capacity for a PCBU" – creating a shift from the previous Act's focus on employees to the new Act's "workers". Under the 2015 Act there is a major shift from focusing on employment relationships to looking at the nature of engagement of persons who do work for persons conducting a business or undertaking (PCBUs).<br><br>This change will require PCBUs to re-evaluate how they manage risks in their workplaces and in places where work is carried out for the business or undertaking. PCBUs will no longer be able to restrict their management of health and safety risks to those within their workplaces, who they naturally consider to be workers, but will also have to consider individuals they hire to do work for one off assistance, whose work may raise health and safety issues. This is particularly relevant for complex and large organisations.<br><br>The focus of the HSW Act is to protect workers and other people against harm to their health, safety and welfare by eliminating or minimising risks at work.<br><br>The HSW Act starts by placing duties on various categories of people, and goes on to specify how worker participation should take place. It also covers how the new legislation will be enforced, and the penalties for breaching the requirements.<br><br>Worker participation and representation is viewed as a significant requirement to ensure improved health and safety practice in organisations. It is a means of assisting PCBU's and officers in their duty of eliminating or minimising risks by being informed by the workers who face those risks directly. Everyone is responsible for health and safety and helping one another stay healthy and safe. This is true from a practical perspective, as well as a legal one, and as such every employer needs to make sure workers can contribute to health and safety decisions at work.<br><br>It also means that New Zealand's "she'll be right" attitude is often not good enough.<br><br>There is definitive evidence that better health and safety outcomes are achieved, if all workers take responsibility for ensuring everyone goes home safely.<br><br>The effective way to do this is to engage with workers and have ways for them to participate.<br><br>There is also a significant amount of evidence that shows that engaged workers really do deliver better health care and patient outcomes. |

Engagement and participation are related duties. What is done to meet one duty can help meet the other. Both involve two-way communication – a conversation about health and safety.

- *Engagement* is how a business involves its workers in work health and safety matters and decisions.
- *Participation* practices are the on-going ways for workers to raise health and safety concerns, be part of making decisions which affect work health and safety, and offer suggestions for improving health and safety.

What is reasonable and practical will depend on workers' views and needs, the size of the organisation and the nature of its risks. The law enables flexibility and innovation: the focus is on effectiveness rather than whether any a particular system is in place.

A well-established way to support worker participation is by electing Health and Safety Representatives (HSRs), or setting up a Health and Safety Committee (HSC). Both these processes are also subject to legislative requirements, set out in the Act for how they will work.

All workers who carry out work for a business or undertaking must have reasonable opportunities to participate in improving work health and safety. This includes everyone, from the front line to managers and leaders.

However, when engaging on a matter relating to work health or safety, only those workers who are, or who are likely to be, directly affected by that matter are to be engaged.

Worker engagement, participation and representation duties do not apply to volunteer workers. However, given a business has the same responsibility for the health and safety of all its workers, it can make sense to involve them.

PCBUs must engage and consult with workers:

- When hazards are identified and assessed
- When making decisions about:
    - addressing risks
    - the adequacy of staff welfare facilities
    - monitoring worker health and workplace conditions
    - providing information and training to workers
    - procedures for resolving work health or safety issues
- When determining work groups
- When proposing changes which may affect the health and safety of workers

Businesses must also engage with workers when developing worker participation practices (i.e. ways for workers to participate in improving work health or safety on a day to day basis).

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| CM Health context | The goal of CM Health is to have an engaged workforce with the right skills in the right place at the right time that is reflective of the population that we serve. A resilient workforce that is culturally aware and competent, that embraces diversity and provides 'excellent collaborative, high quality, compassionate and safe healthcare[2].<br><br>To achieve this, CM Health recognises that the involvement of workers in health and safety is critical to the development of an effective and positive health and safety culture, which is aligned with the CM Health People Strategy.<br><br>The objective of the worker participation structure is to ensure CM Health has a worker engagement and participation process that is adaptable and flexible enough to meet the changing needs within CM Health, whilst fulfilling our legislative obligations.<br><br>Health and safety is everyone's personal responsibility and CM 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 at Work Act 2015, supporting Regulations and AS/NZS 4801:2001 (which is used as the benchmark to assess Occupational Health and Safety Management systems for organisations).<br><br>The costs to the organisation are undefined but any costs due to health and safety impacts and injuries are unacceptable and unsustainable in the long term.<br><br>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 health and safety of our people.<br><br>If health and safety is demonstrated by leadership as a priority, overall health and safety performance will improve.<br><br>To grow safety leadership, we must provide opportunities for our workers to learn, share and contribute towards making our workplaces safer.<br><br>In partnering with our workers, we can use the individual and collective influence of division, service and satellite areas to contribute to our work place health and safety practices, which is aligned with our organisational culture.<br><br>This can be done with shared learning and development, i.e. the provision of opportunities for workers, at all levels, to share skills, experiences and resources to overcome common challenges. |

[2] Counties Manukau Health People Strategy 2015-2020 'Working Together'

| Risk Details | |
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| Risk description | **Worker Participation: Failure to participate and engage the workforce on health and safety matters**<br><br>The risk to the organisation is the failure to effectively participate and engage with our workers to gain understanding from those working in the work place, on new and known risks resulting in controls being implemented that may have a direct impact on workers.<br><br>This also compromises our legal responsibility. |
| Risk interdependencies | Should any of the following interdependent risks materialise, our ability to maintain an effective and engaged workforce may be affected.<br><br>• **Capacity and Capability Management**: Misalignment of skills, capacity and performance of workforce, current and forecast to business needs<br>• **Mission and Leadership:** Misaligned focus on executing the DHB's core strategies due to misunderstood health and safety mission/vision and/or poorly articulated goals/objectives, lack of direction, focus and cohesiveness due to lack of leadership<br>• **Financial Constraints**: Inability to absorb costs due to traditional training methodologies<br>• **Business Transformation:** Inability to balance change agenda with business as usual workload demands on staff<br>• **Operational constraints:** Human and time resourcing<br><br>If the prior risks materialised, this may impact staff engagement and potentially affect the following:<br><br>• **Quality of patient care** and our ability to meet the health demands of our community<br>• Increasing negative outcomes relating to **Health and Safety** for all concerned. |
| Underlying causes | The following causes may result in our staff not being engaged or effective:<br><br>• Workload / system pressure<br>• Processes and systems that do not support worker participation and engagement<br>• Challenges of maintaining skills and knowledge of our workers, especially those who have had health and safety training at CM Health's expense<br>• Behaviours of senior leaders that do not support a health and safety culture or the activities / initiatives that workers undertake in a formalised health and safety manner e.g. Health and Safety Representatives<br>• Failure to address inconsistent and unsafe behaviours<br>• Work force pressure taking precedence over health and safety risks<br>• Lack of clarity of roles and responsibilities |

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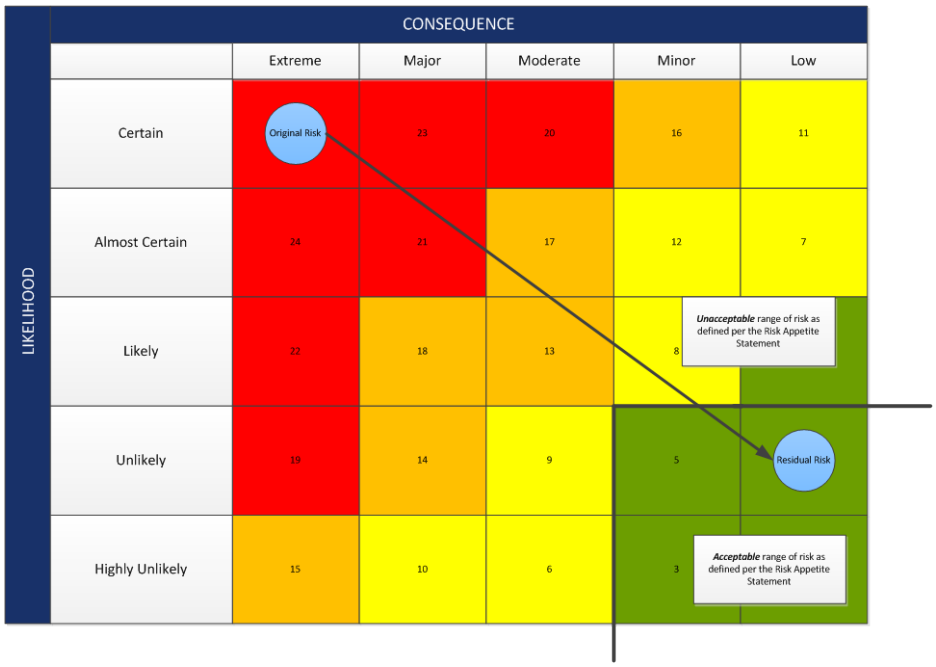
| Risk rating |  |

## Risk Management

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| Current controls | The current controls are historical and have been reviewed against the new legislation.<br><br>As such the risk of a compliance breach remains certain, in the current practices.<br><br>The most significant gap relates to the management and training of Health and Safety Representatives. CM Health has to date provided training that is no longer recognised as an industry standard, i.e. New Zealand Qualifications Authority unit standard.<br><br>CM Health currently has the following worker participations opportunities:<br><br>• Health and Safety Drop-In Forums that provide opportunities for workers to engage in an open forum with members from the Occupational Health and Safety Service<br>• A number of Health and Safety Committees that operate in silos<br>• Joint Consultative Committees where health and safety is a standing agenda item<br>• Focussed risk management groups<br>• Currently 200 Health and Safety Representatives who have had some form of training in the past but now don't meet the legislative requirements<br><br>A Regional Worker Participation Agreement for Health and Safety has been reviewed to reflect the new legislative changes and is currently being finalised. The agreement includes Waitemata, Counties Manakau Health and Auckland District Health Boards (DHB) and designated unions.<br><br>The purpose of the Worker Participation Agreement is to outline the process of worker participation within Waitemata, Counties Manukau, and Auckland DHBs respectively. This agreement sets out a process to: |

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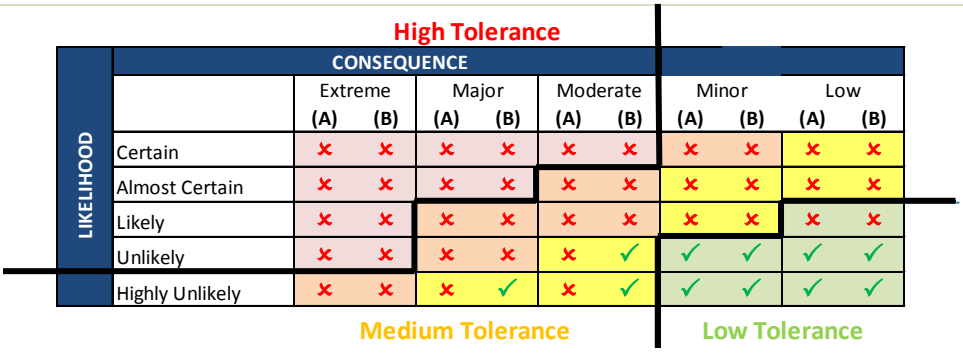
| | • Ensure all workers are provided with reasonable opportunities to actively engage and participate in health and safety within their respective organisation.<br>• Ensure each DHB meets legislative requirements for worker engagement and participation.<br>• Promote cooperation between the Persons Conducting a Business Undertaking (PCBU), Workers and Unions.<br>• Align with existing health and safety systems within each respective DHB. |
| Risk progress | Since 2014, CM Health began making significant progress to ensuring it was ready to meet its obligations when the new legislation was introduced in 2016. These continue and include:<br><br>• **Audit:** A base line audit undertaken by an external health and safety specialist to determine capability and compliance<br>• **Health & Safety Management Framework**: Developed and endorsed by the Executive Leadership Team and Board<br>• **Board and Executive Leadership Team Due Diligence:** This includes endorsement, reporting, engagement and participation<br>• **Policies, procedures and practices:** Are being re-structured and fit for purpose<br>• **Worker participation and engagement** - an initial "Health and Safety Guideline to Due Diligence and Worker Participation" was developed. CM Health consulted with Meredith Connell, external expert legal services, who confirmed the innovative approach was 'best practice'. This work is part of an ongoing cycle of continuous improvement. As a result, the following documents, still to be published, incorporate controls in place to reduce the risk to an acceptable level:<br>  • "Principles for Due Diligence and Worker Participation" developed to provide an organisational structure for ensuring a high standard of health and safety. It includes some general information regarding health and safety operations at CM Health – **Please see Appendix A**<br>  • "Guideline: Application of the Worker Participation Structure in CM Health" which provides guidance on operationalising worker participation – **Please see Appendix B**<br>  • Regional Worker Participation Agreement – Draft due for confirmation and signage before the end of the year – **Please see Appendix C**<br>• **Risk-based approach:** The Health and Safety Management System now focusses on risk and is aligned and incorporated into the organisational risk methodology |
| Risk appetite |  |

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| | A) **Compliance** (Legal and Regulatory / Contractual)<br>B) **Health and Safety and Wellness** (Injury impact)<br><br>We have a **low** risk appetite for issues arising in compliance, unless such risks are highly unlikely and we also have a **low** risk appetite for issues arising from Health & Safety and the wellness of CM Health people. |
| **Risk Assurance** | |
| Assurance | The following assurance activities provide feedback, support and guidance as to the adequacy and effectiveness of implemented controls:<br><br>• Worker Participation is an organisational risk which must be actively managed. It is legislative requirement and enforceable by the regulator i.e. WorkSafe<br>• The current legislative regulations provide clarity around the framework of requirements as a minimum benchmark for compliance<br>• Senior managers are able to provide leadership and direction as their awareness, motivation and skills are increased about health and safety matters affecting workers and the organisation as a whole<br>• A changing organisational work place culture will support workers to be more aware of their rights, and remove the fear of exercising them<br>• Worker participation will support the identification of risks, their controls and implementation<br>• Unions are able to constructively participate and be engaged in health and safety matters<br>• Cost benefit i.e. CM Health currently has tertiary accreditation resulting in a 20% discount on levies. Worker Participation is a criteria for the ACC audit<br>• A variety of professional services both in and out of the organisation are engaged to ensure leading practice, for example Community Health Worker Risk and Bullying and Harassment processes<br>• Legal advice, as appropriate and where required |
| **Treatment Plans** | |
| Controls to be implemented | "The Guideline: Application of the Worker Participation Structure in CM Health" describes the guiding principles of:<br><br>• Consultation<br>• Co-operation<br>• Collaboration<br>• Co-ordination<br>This structure also encompasses the CM Health Values of "Together, Kind, Excellent and Valuing Everyone".<br><br>The following outlines the basic structure options to enable engagement and participation of workers in health and safety at CM Health.<br><br>*Note: Management Representatives are included as it is understood that they will have the authority to ensure corrective action is undertaken at their level of involvement. The number of management representatives cannot exceed the number of worker representatives, as specified in the regulations.* |

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| | • **Worker representation committee structure:** Encompassing 4 levels i.e.<br>  • Work area<br>  • Service<br>  • Divisional<br>  • Management<br><br>• **Worker Representative Roles: Encompassing 2 levels i.e.**<br>  • Work Area Health and Safety Champions who have completed a fit-for-purpose introductory training course, run in-house, to enable them to support their work area manager in regard to operational health and safety. These are workers who have an interest in health and safety but are not nominated or elected<br>  • Service Health and Safety Representatives nominated and elected by the staff in the service to represent the service and who would support the champions. These Representatives require formal industry standard training, if they request to be trained. Otherwise they will be recognised as Health and Safety Champions<br><br>The committee structure should implement a reporting and escalation process to the next level committee to ensure transparency and visibility of issues, risks and activities related to health and safety interventions and activities undertaken by the Health and Safety Champions and Representatives |
| Responsibility | Beth Bundy, Director of Human Resources |
| **Conclusion** | |
| Risk rating justification | The inherent risk rating (before controls) is high, with:<br><br>• The potential for non-delivery of an essential service due to a shortage of workforce supply.<br>• Poor quality services delivered due to staff not being actively and appropriately engaged.<br><br>CM Health has implemented a number of controls to manage the risk with further treatment plans in progress. The residual risk is currently within appetite. |
| Further commentary, key messages and assumptions | **Risk to engagement and effectiveness going forward**<br><br>The success of effectively participating and engaging our workers is dependent on having positive leadership direction and management.<br><br>With the transformation programme of work under review, the current Health and Safety Workplan, which is aligned with the People Strategy and includes the Wellness Framework, may not be aligned or embedded in CM Health's transformational process. This will perpetuate the silo thinking that Health and Safety adds no value to operational and commercial activities.<br><br>There is a risk therefore that a lack of ***timely and clear*** workforce requirements to support the participation and engagement of workers may result in health |

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| | and safety controls being unsupported by those who work with these risks on a daily bases. It may also impact the organisation's ability to have the right participation and skills in the right place at the right time with an adequate and effective health and safety representative workforce which may affect staff engagement and effectiveness overall.<br><br>**Assumption**<br><br>It is assumed that Officers of the Counties Manukau District Health Board as a PCBU will consult with its workers when:<br><br>• identifying hazards and risks in the workplace<br>• making decisions about how to eliminate or minimise those hazards and risks<br>• developing procedures for anything to do with health and safety<br>• making decisions about facilities for workers welfare<br><br>CM Health Board and Executive Leadership Team will have adequate awareness of this organisational risk and provide opportunities for participation and engagement to CM Health workers to facilitate a safe and healthy work force and culture, able to deliver quality patient care. |
| Final conclusion | The aim of the Occupational Health and Safety Management System is to lead a step and culture change in health and safety performance by:<br><br>• Advancing a common vision for Zero Harm / Impact across all levels of the business<br>• Modelling and growing inspirational, highly visible safety leadership<br>• Creating a compelling case for change and a strong workplace safety culture<br>• Sharing skills, experiences, and resources to overcome common challenges<br><br>CM Health is conscious of the need to align worker participation and engagement with any transformation programme and is aware of areas to improve with defined actions to deliver.<br><br>Nationally, CM Health compares favourably against other District Health Boards' health and safety performance. |
| **References** | |
| WorkSafe | 1. http://www.worksafe.govt.nz/worksafe/hswa/working-together/with-other-businesses<br>2. http://www.business.govt.nz/laws-and-regulations/health-safety/creating-an-hs-culture/worker-engagement-participation |

COUNTIES MANUKAU HEALTH

# *Principles for Due Diligence and Worker Participation in Health and Safety*

***October 2016***

# Contents

# *Health and Safety Principles in*

- *Due Diligence and*
- *Worker Participation*

## Contents

The Counties Manukau Health, Health and Safety Principles 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 Principles for Worker Participation in Health and Safety; and
2. Counties Manukau Health Principles for Due Diligence in Health and Safety.

Note: This document should be read in conjunction with the CM Health Guideline: Application of Worker Participation in CM Health.

## Employer Commitment

Counties Manukau Health (CM Health) is committed to demonstrating best practice regarding workplace health and safety. In doing so, it should take all reasonably practicable steps to continuously improve health and safety in the workplace.

Health and safety is everyone's personal responsibility and CM 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 at Work Act 2015, supporting Regulations and AS/NZS 4801:2001 (which is used as the benchmark to assess Occupational Health and Safety Management systems for organisations).

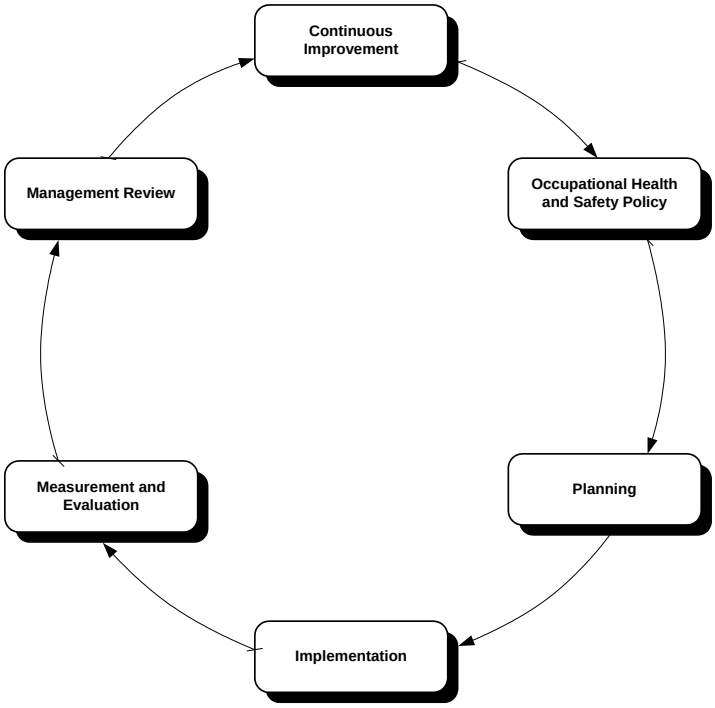
CM Health acknowledges the requirement to engage its workers in health and safety through systems and processes that enable workers to participate effectively in contributing to health and safety in CM Health on an on-going basis.

These systems can include, but are not limited to, the nomination and election of Health and Safety Representatives, the establishment of Health and Safety Committees and the development of other forums to facilitate the involvement of CM Health workers in the management of health and safety.

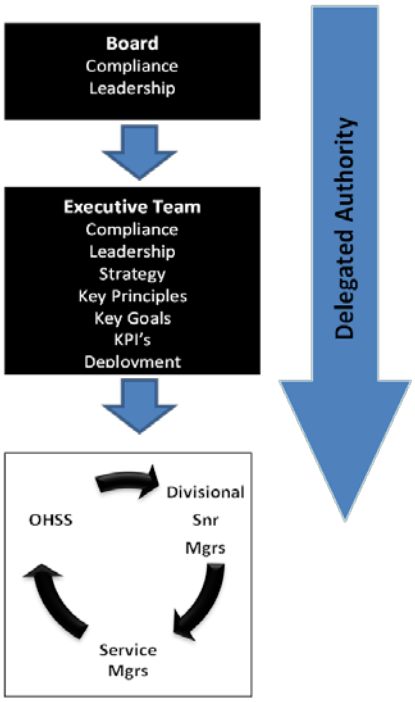
Health and safety should improve with cooperation between CM Health and workers, and where appropriate, with input from Unions representing workers.

The following diagrams provide a simplified overview

## Continuous Improvement




## Delegation of Authority



# Interpretation and Consultation of Principles

This principle should be interpreted:

- consistently with any Regulator issued principles (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 principle has been produced as part of CM Health's commitment to move toward best practice in health and safety management. For the avoidance of doubt:

- All persons subject to these principles understand and acknowledge that all relevant rights and obligations contained in the Health and Safety at Work Act 2015 apply to them.
- Any reference to terminology that is only relevant to the Health and Safety at Work Act shall be interpreted as forming part of CM Health's drive towards best practice.
- Definitions of some specific terms used in these principles are shown in Appendix 3.

## Consultation

This principle 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 principles materials that were available at the time of development and review.

Moving forward, CM Health should consult and cooperate with all relevant organisations with regard to the following health and safety matters:

- Hazard/risk identification and assessment for work carried out for or by CM Health;
- Making decisions about ways to control hazards/risks, 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 CM Health workplace; or
  - Monitoring the health of workers; or
  - Monitoring the conditions at any CM Health workplace; or
  - Providing information and training for workers at any CM Health workplace.

This principle is intended to supplement the regional agreement which has been prepared in consultation with relevant Unions, worker groups and other applicable parties.

# Objectives

The objectives of the CM Health, Health and Safety Principles to Due Diligence and Worker Participation are to:

1. Assist CM Health to achieve excellence in workplace health and safety by drawing on the combined skills, knowledge and experience of all workers;
2. Enable CM Health workers to engage and participate in the development of systems, processes and procedures for managing workplace health and safety;
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 CM Health, Health and Safety Principles to Due Diligence and Worker Participation are:

1. Daily, weekly, monthly or six monthly safety workplace inspections (as deemed appropriate) completed for all areas and as defined by the Divisional Risk Management Plan;
2. All health and safety issues raised by workers are resolved in an appropriate timeframe as determined by appropriate risk assessment in accordance with CM Health risk assessment principles and procedures;
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 prevent incidents, and increase worker awareness of health and safety.

# Health and Safety Policy Statement

COUNTIES MANUKAU HEALTH

## Health and Safety Policy Statement

Counties Manukau Health's commitment to and policy on health and safety at work applies across our entire business.

**Our Commitment**

Counties Manukau Health (CM Health) 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. CM Health is committed to upholding the following:

- Promoting a culture where our workers, and the people with whom we work, share this commitment
- Actively train our officers, managers and workers to understand their responsibilities to develop appropriate policies and procedures that allow everyone to work safely and in a manner which protects themselves, their colleagues and any other person from harm
- Ensuring our managers and workers 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 workers to participate in the review and improvement of the safety management system by involving and discussing with them ways which reduce workplace risks 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 and risks successfully
- Maintaining effective risk, incident and non-conformance reporting and analysis
- Offer appropriate rehabilitation to any worker 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

CM Health values our staff and the people with whom we work, celebrating health and safety initiatives and innovation. The CM Health 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.

Gerrit A. Reuth.

Chief Executive Officer
**Counties Manukau Health**

**Dated** 1 June 2016

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| **Document ID:** | A254043 | **CMH Revision No:** | 2.0 |
| **Service:** | Occupational Health and Safety | **Last Review Date :** | 15/09/2016 |
| **Document Owner:** | Service Manager - Occupational Health and Safety | **Next Review Date:** | 15/09/2018 |
| **Approved by:** | Service Manager - Occupational Health and Safety | **Date First Issued:** | 01/08/2014 |
| **Counties Manukau District Health Board** | | | |

# Duties of Counties Manukau Health

CM Health is a "Person Conducting a Business or Undertaking" (PCBU) under the Health and Safety at Work Act 2015.

CM Health should ensure, so far as is reasonably practicable, that the health and safety of workers and other persons within CM Health are not put at risk from work carried out as part of the operation of any business referred to as part of CM Health.

CM Health has a duty to eliminate risks to health and safety, so far as is reasonably practicable; and if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.

To ensure the organisation fulfils its duties with regard to the legislation, CM Health should:

- Ensure that CM Health workplaces, under its direct control, are maintained so that all workers, visitors and other persons are without risks to health and safety so far as is reasonably practicable;
- Maintain plant and structures that are under the direct control of any CM Health workplace, to ensure that all plant and structures do not present a risk to health and safety;
- Engage workers so far as reasonably practicable and in accordance with these principles;
- Provide and maintain safe systems of work for all CM Health workplaces;
- 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 CM Health workplace;
- Provide adequate facilities for the welfare of workers, at any CM Health workplace, including ensuring access to those facilities;
- 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 CM Health workplace;
- Ensure that the health of workers and the conditions at any workplace under the direct control of CM Health are monitored for the purpose of preventing illness and/or injury of workers arising from any work undertaken by a CM Health workplace;
- So far as is reasonably practicable, maintain all CM Health premises that a worker of CM 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 CM Health and the occupancy is necessary for the purposes of the worker's engagement, because other accommodation is not reasonably available; and
- Undertake work in accordance with the due diligence principles contained in the "Health and Safety Guide: Good Governance for Directors", published by the New Zealand Institute of Directors and WorkSafe New Zealand.

# 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 should:

- 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 health and safety while at work;
- Take reasonable care that their acts, or omissions, do not adversely affect the health and safety of other persons;
- Maintain good housekeeping standards at all times;
- Observe all health and safety warning signs and notices;
- Seek specific instruction regarding the hazards/risks 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 approved for that job; and
- Only operate specified plant and equipment, if properly trained and authorised to do so.

# *Due Diligence in Health and Safety*

## Health and Safety Due Diligence – System Objectives and Targets

### Objectives

The objectives of the CM Health and Safety Due Diligence Principles are to:

- Assist CM Health to achieve excellence in workplace health and safety by drawing on the combined skills, knowledge and experience of its executive;
- Enable CM Health Executive to guide the development of systems, processes and procedures for controlling workplace hazards;
- Provide a mechanism for members of CM Health Executive to exercise due diligence to ensure that CM Health complies with its duties and obligations;
- Enable members of CM Health Executive to acquire, and keep up-to-date, knowledge of work health and safety matters;
- Enable members of CM 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 CM Health Executive to ensure that CM 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 CM Health Executive to ensure that CM 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 CM Health Executive to ensure that CM Health has, and implements, processes for complying with any duty or obligation of CM Health under relevant legislation.

### Targets

The Targets of the Health and Safety Due Diligence Principles are:

- Ensuring the requirements of the health and safety programme are established, implemented and continuously improved;
- Relevant members of the CM 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.

# Health and Safety 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 CM 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 CM Health operations. CM 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 should, 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.

# Board of Directors

As Officers of CM Health, each Board Member of the Board of Directors has a duty to ensure they have sufficient knowledge of CM Health's health and safety.

All Officers of CM Health have specific duties relating to health and safety.
The Health and Safety Guide of Good Governance for Directors, which we are members of, defines these responsibilities as:

As CM Health's appointed administrative control panel, the Board of Directors is accountable for CM 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 CM Health's policy and procedures and legislative principles;
- Ensure that management, at all levels, has sufficient knowledge and training to fulfil their health and safety responsibilities;
- Ensure that all relevant workers have sufficient knowledge and training to ensure compliance with relevant policies, procedures and instructions pertaining to safety in the workplace at all CM Health workplaces;
- Review training summaries and ensure that all CM Health workers 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 workers regarding any changes to health and safety policy and/or procedures that may directly impact their health and safety at all CM Health workplace;
- Ensure that a system is in place to allow relevant workers to consult with management regarding any significant incident, including environmental harm;
- Monitor the progress of health and safety investigations and those reported on CM Health's Incident Reporting 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.

# Executive Leadership Team

As part of CM Health's administrative control panel, the Executive Leadership Team (ELT) is responsible for ensuring that CM Health's health and safety protocols are executed and all relevant documents and information is made available for Board review, as appropriate. To support the facilitation of these duties, the Executive Leadership Team in consultation with Human Resources should 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 CM Health workplace.

The Executive Leadership Team, as defined by Health and Safety Guide of Good Governance for Directors should 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 workers, and others at any CM 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 workers 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 workers regarding any changes to health and safety policy and/or procedures that may directly impact their health and safety at any CM Health workplace;
- Ensure development of training sessions to ensure suitable knowledge is attained by workers at all levels with regard to health and safety protocols at any CM Health workplace;
- Support relevant health and safety associated training and education for all workers;
- 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 that appropriate training and resources are provided to ensure adequate health and safety;
- Support the rehabilitation programme where workers 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 workers 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 workers under the control of any CM Health workplace adhere to the Health and Safety Policy and Procedures Manual;
- Ensure that all CM Health workplaces are maintained in a condition that is safe to workers and other persons, 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 workers regarding any changes to health and safety, policy and/or procedures that may directly impact their health and safety at all CM Health workplace;
- Ensure that internal incident reports of incidents pertaining to workers' 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.

# Senior (General/Divisional) Managers

Senior Managers should ensure:

- All workers under their control adhere to the Health and Safety Policies and Procedures;
- That workplaces under their control are maintained in a condition that is safe to workers and other persons, and report any defect or non-compliance issue that cannot be fixed locally, directly to the Executive Management;
- To identify and document workplace hazards/risks utilising the checklists provided on a regular basis;
- That all workers submit all compliance documentation required by a regulatory body or CM 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 CM Health;
- That consultation with workers is undertaken and recorded 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 workers' training records are kept current and training status reports are submitted to the appropriate Executive Leadership Team manager on a regular basis;
- That workers receive all necessary training to enable them to perform their tasks safely;
- That tasks not covered by the provisions of health and safety policy and/or procedures have been developed with a risk management approach, and that risk assessments for those tasks are documented;
- That full attendance by workers 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 workers 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 workers 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.

# General Manager of Human Resources

The General Manager of Human Resources should ensure:

- All workers have been trained in the policies, procedures and requirements of CM Health's Health and Safety Policy and Procedures Manual;
- All CM Health workplaces are regularly inspected to ensure that they are maintained in a condition that is safe to workers 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 workers regarding any changes to health and safety policy and/or procedures that may directly impact their health and safety at any CM Health workplace;
- That all workers employed for any CM Health Project have suitable, documented health and safety capabilities before being engaged and that workers undertake all relevant health and safety induction training required for any external project or any CM Health workplace;
- Ongoing support of health and safety consultation with workers in the workplace, by ensuring that all new processes, work practices and changes to any current work process or practice are clearly communicated to workers for comment before the formal implementation of the practice or process;
- That there are sufficient training programmes available to workers 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 an adequate number of workers are trained to administer first aid at all the CM Health workplaces;
- That all risks assessments for tasks not covered by health and safety policy and/or procedures are documented and the findings of these assessments are made available to all workers;
- That assistance is provided to management at all levels, where required, to ensure all CM 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 CM Health workplaces.

# Occupational Health and Safety Manager

The Occupational Health and Safety Manager should ensure:

- The reporting on workplace hazards and risks, is submitted on a regular basis to the General Manager - Human Resources for review;
- That all workers under their control receive all necessary training to enable them to perform their tasks safely;
- The delivery of the Occupational Health and Safety Framework and Plan

# Operational (Service/Department) Manager

The Operational Managers should ensure:

- All workers under their control adhere to the Health and Safety Policies, Procedures and CM Health Guidelines;
- That the workplace under their control is maintained in a condition that is safe to workers and visitors and to report any defect or non-compliance issue that cannot be fixed locally, directly to the Divisional Manager;
- To identify and document workplace hazards, utilising the checklists provided on a regular basis and submit these to the Divisional Manager for review;
- That all plant and equipment under their control is suitably maintained in line with any maintenance schedule stipulated by CM Health;
- That all workers under their control receive all necessary training to enable them to perform their tasks safely;
- That tasks not covered by the provisions of Health and Safety Policies and Procedures have been developed with a risk management approach and that risk assessments for those tasks are documented;
- That all workers and contractors employed for any CM 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 for processing in a timely manner; and
- That attendance at emergency evacuation procedures, in accordance with legislative requirements, is undertaken in accordance with regulatory requirements.

# *Worker Participation in Health and Safety*

## Health and Safety Representatives' Responsibilities

**The responsibilities 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 CM 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;
- If requested by a worker in the work group/area, to represent the worker in relation to a matter regarding health and safety, including a complaint
- 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 CM 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 CM 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 CM Health to enable the Health and Safety Representative to perform his or her functions.
  (Personal information concerning a worker should 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 should 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 to be 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.

A Health and Safety Representative does not require prior 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, CM Health should allocate paid time to the Health and Safety Representative to undertake the course and pay the course fees for the person. In addition, the Health and Safety Representative may, on approval from the Executive Management, undertake tasks as specified above.

Only a health and safety Representative who has been trained and holds the relevant qualification as prescribed under the Health and Safety at Work (Worker Engagement, Participation and Representation) Regulations 2016 can issue a Provisional Improvement Notice (PIN) or exercise the powers to order the cessation of dangerous work in their work area.

# Health and Safety Committees

The Chief Executive Officer has overall responsibility for health and safety at CM Health.

## Health and Safety Committee Overview

The Health and Safety Representatives and Health and Safety Committees are mechanisms for enabling worker engagement, participation and input into decision-making processes regarding the health and safety of workers in the workplace.

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 should 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, and codes of practice and that the health and safety policy is reviewed.

The membership of a Health and Safety committee should be dependent upon the organisational level at which the committee is operating. The membership can be made up of, but not restricted to, 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 and it is a regulatory requirement that at least one manager on the committee has the authority to enable actions determined by the committee to be actioned. Other people may be invited to the meeting if their expertise is required.

## Health and Safety Committee Focus

The focus of the Health and Safety Committee should 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 CM 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 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 should:

- 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 CM Health's health and safety policy.

# Health and Safety Committee Structure

## Organisational level

At an Organisation level the committee should include a Board member (optional but best practice), Executive Leadership Team members, Senior Managers and members of the HR team, including the OHS Manager and Health and Safety Representatives from the Divisional Health and Safety Committees.

- The Health and Safety Committee should be chaired by a member of the committee selected by the committee;
- The Health and Safety Committee should be formed by the Health and Safety Representatives from the divisional committees, together with manager representatives from the groups listed above; and
- Minutes should be kept at each Health and Safety Committee meeting.

## Divisional Level

At a Divisional level selected Service Managers and Delegated Health and Safety Representatives from the services within the Division should be represented on the Health and Safety Committee.

- The Health and Safety Committee should be chaired by a member of the committee selected by the committee;
- The Health and Safety Committee should be formed by the Health and Safety Representatives from the work groups within the Division, together with delegated service managers;
- Minutes should be kept at each Health and Safety Committee meeting; and
- A member of the Divisional Health and Safety Committee should represent the Division on the Organisational committee.

## Service Level

At the Service Level, Department Managers and Department work group/area Health and Safety Representatives should form the Health and Safety Committee.

- The Health and Safety Committee should be chaired by a member of the committee selected by the committee;
- The Health and Safety Committee should 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 should be kept at each Health and Safety Committee meeting.

## 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 meeting) is to specifically include health and safety on the agenda.

- The meeting should 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 should 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 CM 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 should:

- Meet periodically, suitable to the size and nature of its coverage area;
- Monitor the health and safety performance of its coverage area. This should include hazard/risk management, risk assessments, technical audits, bi-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 CM 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 activates required of groups by CM Health's health and safety management processes.

These general health and safety activities include:

- Review of hazard/risk 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 at regular intervals, Divisional and Service Committees should be not less than quarterly. The Organisational Committee should meet bi-annually or more frequently if deemed necessary.

## 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.

## Order of business

The order of business shall be presented in an agenda format and (as best practice) should include:

- Apologies;
- Minutes of previous meeting;
- Matters arising from the minutes;
- Health and Safety Plan;
- Incident Management;
- Hazard/Risk 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 should be held by the Health and Safety Committee for a minimum of five years.

## Resignations

Should a representative wish to resign from the Health and Safety Committee a 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 cease, or refuse to carry out, unsafe work

A worker may cease, or refuse to carry out; work that they believe is likely to expose the worker to a serious health or safety risk arising from an immediate or imminent exposure to a hazard. 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.

## Escalation and Problem-Solving Process

In the event that a worker refuses to perform unsafe work, the following steps should be taken:

- The worker should advise both their manager and their Health and Safety Representative immediately;
- If the manager is not available, the worker should notify their manager's authorised deputy.
- If their Health and Safety Representative is not available, the worker should advise the relevant Health and Safety Advisor;
- The worker, Health and Safety Representative and manager should attempt to resolve the matter as soon as practicable;
- The worker may continue to refuse to perform the work until they are satisfied it is no longer likely to cause serious risk to the worker 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
- CM 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.

## Provisional Improvement Notice

A trained Health and Safety Representative may issue a Provisional Improvement Notice (PIN) if a Health and Safety representative reasonably believes that the person is contravening, or is likely to contravene, a provision of the Act or Regulations.
The person is required to;

- remedy the contravention; or
- prevent a likely contravention from occurring; or
- remedy the things or activities causing the contravention or likely to cause a contravention.

However, the Health and Safety Representative should not issue a provisional improvement notice to a person unless he or she has first consulted the person.

A Health and Safety Representative should not issue a provisional improvement notice in relation to a matter if an inspector has already issued an improvement notice or a prohibition notice in relation to the same matter.

If a Health and Safety Representative issues a provisional improvement notice, he or she should provide a copy of that notice to the PCBU of the work group that the Health and Safety Representative represents, as soon as practicable.

When a trained Health and Safety Representative issues a PIN, an Inspector may be notified.

The employer and the Health and Safety Representative should work together in good faith to resolve the issue.

## Approval

Immediately the terms of reference for Health and Safety Representatives are ratified when they are formalised into CM 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 should be made in consultation with the Executive Leadership Team, the Organisational Health and Safety Committee, Health and Safety Representatives and the Union. In some cases, other staff and stakeholders may also need to be consulted.

## General Agreement in Relation to Worker Participation

Notwithstanding the terms of these principles all workers should be provided with a reasonable opportunity to participate effectively in ongoing processes for improvement of health and safety for CM Health.

## Adverse, Coercive and Misleading Conduct

<u>Adverse Conduct</u>
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.

Misrepresentation

False or misleading misrepresentations should 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 revised principles, and the process it describes, should be reviewed at least every two (2) years.

# *Associated Documents*

***Other documents relevant to this policy are listed below:***

| | |
|---|---|
| **NZ Legislation /Standards** | Health and Safety at Work Act 2015<br><br>Health and Safety at Work (General Risk & Workplace Management) Regulations 2016<br><br>Health and Safety at Work (Worker Engagement, participation, and Representation) Regulations 2016<br><br>AS/NZS 4801:2001 Occupational Health and Safety management system<br><br>ACC Workplace Safety Management Practices (WSMP) |
| **CM Health Documents** | Health and Safety Management Framework<br>Health and Safety Management Manual |
| **Other related documents** | Introduction to the Health and Safety at Work Act 2015 – Special Guide, WorkSafe New Zealand, March 2016<br><br>Worker Engagement, Participation and Representation: Good Practice Principles, WorkSafe New Zealand, March 2016<br><br>Health and Safety Guide: Good Governance for Directors, Institute of Directors/WorkSafe New Zealand, March 2016 |

# *Appendix 1: Health and Safety Representatives*

## The election and appointment of Health and Safety Representatives

- Health and Safety Representatives should be elected and/or appointed in accordance with the CM Health Worker Participation in Health and Safety Principles (WPG).
- Where appointed, health and safety Representatives shall hold office for a period of two years.
- Appointed Health and Safety Representative may stand for re-election as many times as they wish.
- Designated work areas or agreed work groups shall have Health and Safety Representatives as per the processes contained in the CM 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 should 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 should 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 should 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 should follow the process outlined in the CM Health WPG.
- Workers considering standing for the position of Health and Safety Representative should 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 CM Health WPG, action may be taken to replace the Health and Safety Representative concerned in accordance with appropriate legislative requirements.
- CM Health should 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.
- All workers can access information on the process for Nomination/Election of a Health and Safety Representative and the list of Health and Safety Representatives are posted on the Occupational Health and Safety Intranet Website (SouthNet).

# 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 should receive induction training on CM Health's internal policy, procedures and systems around health, safety and wellness.
- This should be coordinated by the Health and Safety Advisor and Human Resources.

# 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 should be recorded in each Health and Safety Representative's performance plan to ensure that (s)he is given time and support to perform duties.
- CM District Health Board, its management and workers may agree from time to time to include additional functions of the Health and Safety Representative.

# *Appendix 2: Process for Principles Review*

These revised principles should be reviewed every two (2) years.

The basis for the review should be the targets included in these principles in totality, including the Worker Health and Safety Participation Principles and the Due Diligence in Health and Safety Principles.

The process for the review should be as follows:

1. All workers are invited to comment on the system and recommend alterations or improvements;

2. The Health and Safety Advisor/Manager collates all feedback (after a two week consultation period);

3. A forum consisting of the following people review the collated feedback and agree the changes:
- Occupational Health and Safety Manager (chair);
- General Manager Human Resources;
- Health and Safety Representatives; and
- Worker Union Delegate.

4. The revised principles is then signed off by representatives of:
- Employer (General Manager Human Resources);
- Workers (Occupational Health and Safety Manager/Designated Health and Safety Representative); and
- Union (Union Representative).

5. The revised principles should then be published via CM Health staff communication protocols.

All workers should have the opportunity to participate in the system review but ownership remains with Human Resources and Occupational Health and Safety Service to ensure that the review is carried out.

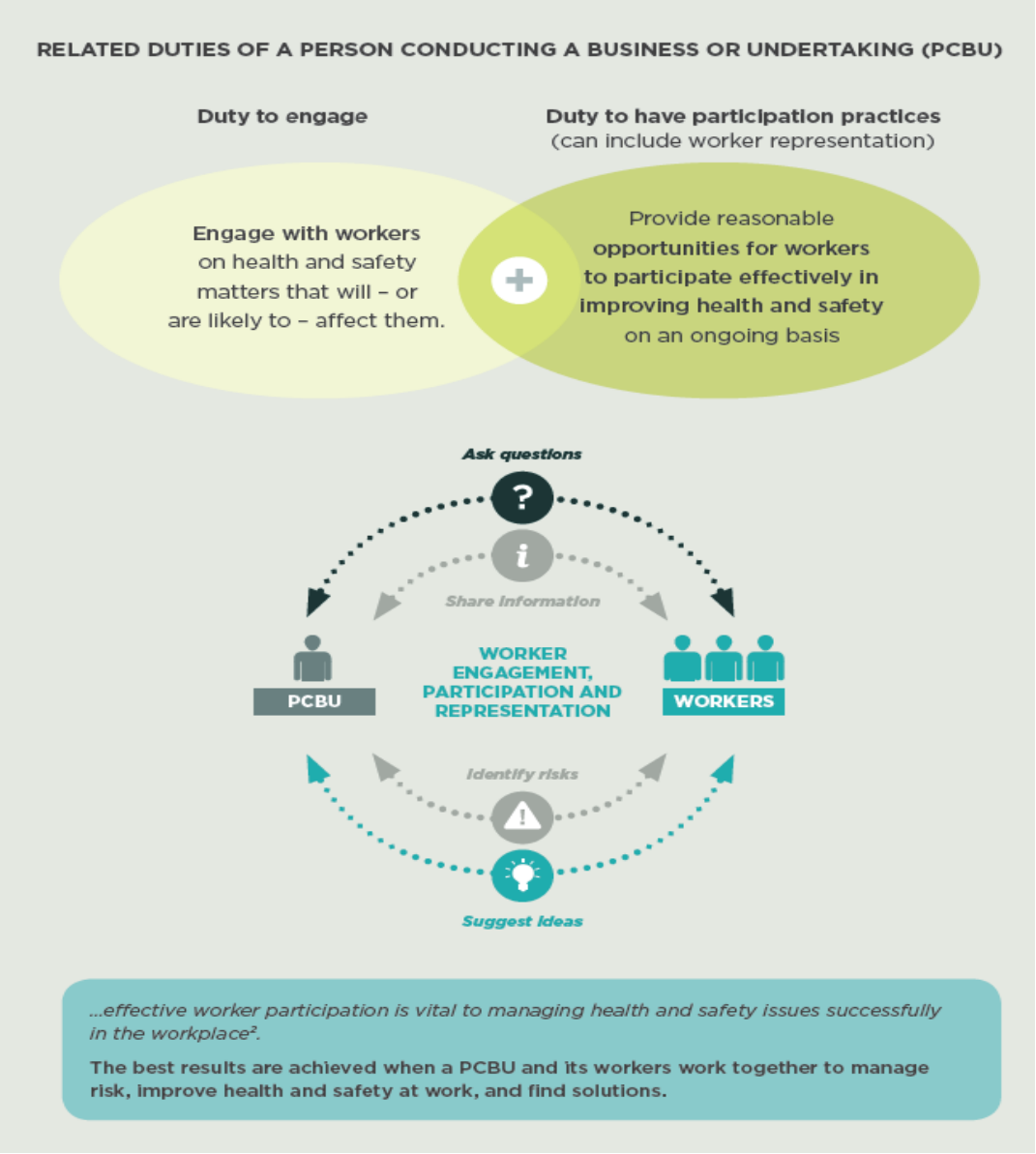
# *Appendix 3: Definitions*

| | |
|---|---|
| **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. |
| **Health and Safety Committee** | Means a committee established to support the ongoing improvement of the health and safety of CM Health's workers. |
| **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. |
| **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 Management** | A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and acting to prevent recurrence. |
| **KPI** | A Key Performance Indicator - any specific target or objective in a Performance Plan. |
| **Near Miss** | An event that could have resulted in harm or loss but did not |
| **Notifiable Event** | Any events that arise from work that result in the death of a person, a notifiable injury/illness or a notifiable incident. |
| **Other Persons in the Workplace** | Examples of other persons at workplaces include workplace visitors and casual volunteers at workplaces. Other persons have their own health and safety duty to take reasonable care to keep themselves and others safe at a workplace. See Section 7 for more information about other persons at workplaces. |
| **Person Conducting a Business or Undertaking (PCBU)** | A PCBU may be an individual person or an organisation. This does not include workers or officers of PCBUs, volunteer associations, or home occupiers that employ or engage a tradesperson to carry out residential work. |

| | |
|---|---|
| **Provisional Improvement Notices (PIN)** | Health and Safety Representatives may issue a Provisional Improvement Notice if they believe that a person is breaking the law, or likely to break the law. The PIN tells the person what the health and safety issue is and can include recommendations to resolve the issue (e.g. by fixing or preventing a problem) by a certain date. However, a PIN should not be issued to a person or business unless they have first been consulted with. |
| **Risk** | The possibility (likelihood) of suffering harm or loss from a hazard. |
| **So far as is reasonably practicable** | Controls are reasonably practicable if it is reasonably able to be done to ensure health and safety, having weighed up and considered all relevant matters, including:<br>How likely are any hazards or risks to occur?<br>How severe could the harm that might result from the hazard or risk be?<br>What a person knows or ought to reasonably know about the risk and the ways of eliminating or minimising it (eg by removing the source of the risk or using control measures such as isolation or physical controls to minimise it).<br>What measures exist to eliminate or minimise the risk (control measures)?<br>How available and suitable is the control measure(s)?<br>Lastly weigh up the cost:<br>What is the cost of eliminating or minimising the risk?<br>Is the cost grossly disproportionate to the risk? |
| **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. |
| **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. |
| **Worker Participation** | Systems and processes that enables CM Health workers to engage and participate in health and safety. |
| **Workplace** | Is any place where work is carried out for or on behalf of CM Health whilst a person is deemed at work. |

| | |
|---|---|
| **Volunteer Workers** | A volunteer is a 'volunteer worker' when:<br>they work for a PCBU who knows they are doing that work or has given consent for it to be done<br>the volunteer does the work on an ongoing and regular basis<br>the work is an integral part of the business or undertaking<br>the work is not:<br>participating in fundraising<br>assisting with sports or recreation for an educational institute, sports club or recreation club<br>assisting with activities for an educational institute outside its premises or<br>providing care for another person in the volunteer's home (eg foster care). |

# *Appendix 4: Health and Safety Participation Structure*




Worker engagement, participation and representation at a glance
Source: WorkSafe New Zealand (2016)

# Guideline: Application of the Worker Participation Structure in CM Health

## Overview

The process to enable engagement and participation of workers in health and safety is a key tenet of the Health and Safety at Work Act (HSWA) 2015. Counties Manukau Health (CM Health) recognises that the involvement of workers in health and safety is critical to the development of an effective and positive health and safety culture.

The objective of the proposed structure is to ensure CM Health has a worker engagement and participation process that is adaptable and flexible enough to meet the changing needs within CM Health, whilst fulfilling our legislative obligations.

## Purpose

This guideline builds upon the requirements of the Health and Safety at Work (Worker Engagement, Participation and Representation) Regulations 2016 and the CM Health - Health and Safety Due Diligence and Worker Participation Guideline and is based on the four guiding principles outlined in these documents, of;

- Consultation,
- Co-operation,
- Collaboration, and
- Co-ordination

This structure also encompasses the CM Health Values of "Together, Kind, Excellent and Valuing Everyone".

**Note:** This guideline must be read in conjunction with the Principles of Due Diligence and Worker Participation in Health and Safety.

## Scope of Use

**This guideline is applicable to** all departments within CM Health. The method used to engage with workers, and enable their participation, is not restricted to the use of health and safety committees, but any organisational forum which involves workers, their representatives (both union and health and safety) and managers. These forums must present the opportunity to raise and discuss issues that affect or may affect the health and safety of workers at CM Health. In addition, it is a forum where corrective actions may be discussed and developed as required.

## Guideline

The following outlines the basic structure options to enable engagement and participation of workers in health and safety at CM Health.

*Note: Management Representatives are included as it is understood that they will have the authority to ensure corrective action is undertaken at their level of involvement.*

*Issues that can't be actioned by the applicable forum are to be escalated to the next level forum.*

*The number of management representatives cannot exceed the number of worker representatives, as specified in the regulations.*

**Worker representation committee structure:**

1. Departmental/Work Area (level 4)
    - No Formal health and safety Committee unless it is requested by worker health and safety representatives
    - All Department/Work areas have health and safety champions elected in accordance with the worker participation regulations
    - Health and safety is a formal agenda item at all staff meetings
    - Managers, workers and worker representatives attend the meeting
    - Meeting frequency not less than monthly

2. Service or Equivalent (Level 3)
    - A Joint Consultative Committee (JCC) or Health and Safety Committee if no JCC is in operation
    - Attended by Service Health and Safety Representatives and Managers
    - Meeting frequency not less than 3 monthly

3. Divisional (Level 2)
    - A Divisional JCC
    - Attended by Management, Union, Health and Safety Representatives (from the Service level committees within the Division)
    - Frequency of meeting as determined by the Divisional General Manager but not less than 3 monthly

4. CM Health (Level 1)
    - CM Health Organisational JCC
    - Attended by Management, Union, Worker and Health and Safety Representatives (as nominated from the Divisional Committees)
    - May also include CM Health Board representative if available
    - Frequency of meeting not less than 3 monthly

**Worker Representative Roles:**

1. Department level – Health and Safety Champions

These would be staff who have completed an introductory training course, run in-house, to enable them support their Charge Nurse Manager (CNM)/Manager in regard to health and safety.

The key role of the Health and Safety Champion is to represent their work area and assist the CNM/Manager with the operational health and safety within the department and would include assisting with;

i) Induction of new staff

ii) Completion of the bi-monthly Health and Safety Inspection

iii) Maintenance of the Department Hazard/Risk Register

iv) Other health and safety related activity as agreed with the Department Manager

2. Service Level – Health and Safety Representative

These would be service Health and Safety Representatives who have been nominated and elected by the staff in the service to represent the service. The service Health and Safety Representatives would support the department Health and Safety Champions. The duties of the Health and Safety Representatives would be;

i) To represent the workers in the work group/area in matters relating to health and safety;

ii) To monitor the measures taken by CM Health, to ensure health and safety within their work group/areas;

iii) To investigate complaints from members of the work group/area relating to health and safety;

iv) If requested by a worker in the work group/area, to represent the worker in relation to a matter relating to health and safety (including a complaint)

v) To inquire into matters that appear to be a risk to the health or safety of workers in the work group/area, arising from the conduct of any CM Health operations;

vi) 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 CM 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;

Additional responsibilities of the Service Health and Safety Representative contained in the HSWA 2015 allow for;

- 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 CM 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;
- Health and Safety Representatives are to be 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; and
- Only a Health and Safety Representative who has been trained and holds the relevant qualification as prescribed under the Health and Safety at Work (Worker Engagement, Participation and Representation) Regulations 2016 can issue a Provisional Improvement Notice (PIN) or exercise his/her powers to order the cessation of dangerous work in their work area.

**Suggested Service Health and Safety Representative numbers:**

| Service | Number of Trained Health and Safety Representatives (Service Health and Safety Representatives) | Department Health and Safety Champions (approx.) |
|---|---|---|
| Mental Health | 4 | 16 |
| ARHOP | 4 | 11 |
| Localities | 4 | 8 |
| SACS | 4 | 16 |
| Manukau Super Clinic | 6 | 19 |
| MACS | 8 | 40 |
| Women's Health | 4 | 10 |
| KidzFirst | 4 | 9 |
| Facilities and Engineering | 2 | 14 |
| Ko Awatea | 2 | 5 |
| **Total** | **42** | **148** |

## References

1. Health & Safety at Work Act 2015
2. Health & Safety at Work (General Risk and Workplace Management) Regulations 2016
3. Health & Safety at Work (Worker Engagement, Participation, and Representation) Regulations 2016
4. Health and safety in Employment Regulations 1995

## Definitions/Description

Terms and abbreviations used in this document are described below:

| Term/Abbreviation | Description |
|---|---|
| **Hazard** | Anything with the potential to cause harm or loss to person, property or environment. |
| **Health and Safety Champion** | 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. |
| **Health and Safety Committee** | Means a committee established to support the ongoing improvement of the health and safety of CM Health's workers. |

| | |
|---|---|
| **Health and Safety Representative** | Means a worker appointed, as an individual or as a member of a Health and safety Committee or both, who has completed the required training, to represent the views of workers in relation to health and safety at work. |
| **Incident** | Any event that could have (near miss) or has resulted in harm, damage or loss, to any person, property or place (including environment). |
| **Joint Consultative Committee (JCC)** | Committee consisting of CM Health managers, staff representatives, union organisers and delegates. |
| **Management Representatives** | CM Health staff holing management appointments participating in the forum |
| **Provisional Improvement Notices (PIN)** | Health and safety Representatives may issue a Provisional Improvement Notice if they believe that a person is breaking the law, or likely to break the law. The PIN tells the person what the health and safety issue is and can include recommendations to resolve the issue (e.g. by fixing or preventing a problem) by a certain date. However, a PIN must not be issued to a person or business unless they have first been consulted with. |
| **Risk** | The possibility (likelihood) of suffering harm or loss from a hazard. |
| **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. |
| **Worker Participation** | Systems and processes that enables CM Health workers to engage and participate in health and safety. |
| **Workplace** | Is any place where work is carried out for or on behalf of CM Health whilst a person is deemed at work. |

## Associated Documents

Other documents relevant to this guideline are listed below:

| | |
|---|---|
| **NZ Legislation & Standards** | Health & Safety at Work Act 2015<br>Health & Safety at Work (General Risk and Workplace Management) Regulations 2016<br>Health & Safety at Work (Worker Engagement, Participation, and Representation) Regulations 2016<br>Health and Safety in Employment Regulations 1995 |
| **CM Health Documents** | Principles of Due Diligence and Worker Participation in Health and Safety<br>CM Health's Health and Safety Management Manual |
| **Other related documents** | |

# WORKER PARTICPATION AGREEMENT FOR HEALTH AND SAFETY

# WAITEMATA, COUNTIES MANUKAU & AUCKLAND

# DISTRICT HEALTH BOARDS AND DESIGNATED UNIONS

Last updated: June 2016

**Introduction**

The aim of the Health and Safety at Work Act (2015) is to provide for a balanced framework to secure the health and safety of workers and workplaces by providing for fair and effective workplace representation, consultation, co-operation, and resolution of issues in relation to work health and safety. This agreement also encourages unions and employer organisations to take a constructive role in promoting improvements in work health and safety practices, and assisting PCBU's and workers to achieve a healthier and safer work environment in accordance with the principles of good faith.

**Purpose**

The purpose of the Worker Participation Agreement is to outline the process of worker participation within Waitemata, Counties Manukau, and Auckland DHBs respectively. This agreement sets out a process to:

- Ensure all workers are provided with reasonable opportunities to actively engage and participate in health and safety within their respective organisation.
- Ensure each DHB meets legislative requirements for worker engagement and participation.
- Promote cooperation between the PCBU, Workers and Unions.
- Align with existing health and safety systems within each respective District Health Board.

**Process**

1**. Existing Health and Safety Systems**

The parties agree that worker engagement and participation is integrated within the respective DHB's existing health and safety systems. Within each DHB the in-house Occupational Health and Safety service has a primary responsibility to provide specialist health and safety advice and clinical services to the organisation. Within each organisation, the Health and Safety Representatives shall be actively supported to participate in the process of improving health, safety and wellbeing.

2. **Health and Safety Representatives and Elections**

The parties acknowledge that Health and Safety Representatives are essential to effective Health and Safety structures.

Health and Safety Representatives will undertake their agreed duties as part of their paid employment.

Health and Safety Representatives will be elected in designated work groups in alignment with the Health and Safety at Work Act 2015. Workers considering standing for the position of Health and Safety Representative should have an interest and ongoing commitment to health and safety in the workplace. This includes a good knowledge of the designated work area and a willingness to participate in Health and Safety Forums and undertake approved Health and Safety training.

Nominations/Elections for Health and Safety Representatives shall be held a maximum of two yearly and 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 another endorsement/election shall be held in the relevant designated work area, following the same procedure as set out above.

Each respective DHB 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.

All workers can access information on the process for Endorsement/Election of a Health and Safety Representative on the respective Occupational Health and Safety Intranet.

3. **Health and Safety Representatives:**

**a) Purpose of the Position**

- A Health and Safety Representative in a designated work group represents the health and safety interests of workers and to carry out those tasks designated by the PCBU to Health & Safety Representatives.

**b) Nature and Scope of Responsibilities:**

| HSAW Act Reference | DHB Health and Safety Representative Role |
|---|---|
| ▪ To represent the workers in the work group regarding health and safety | ▪ Acts as a role model for safe work practice in the workplace.<br>▪ To support the PCBU's performance in managing the HSW Act 2015 |
| ▪ To represent the workers in the work group regarding health and safety | ▪ Maintains workplace health and safety notice board. |
| ▪ To investigate complaints from workers in the work group regarding health and safety | ▪ Works with their manager and their work colleagues to identify new hazards, in accordance with the organisational health |

| | |
|---|---|
| ▪ If requested by a worker in the work group, to represent the worker in relation to a matter relating to health and safety(including a complaint)<br><br>▪ To monitor the measures taken by the PCBU that are relevant to health and safety<br><br>▪ To inquire into anything that appears to be a risk to the health or safety of workers in the work group arising from the conduct of the business or undertaking<br><br>▪ To make recommendations relating to work health and safety<br><br>▪ To provide feedback to the PCBU about whether the requirements of this ACT or regulations are being complied with<br><br>▪ To promote the interests of workers in the work group who have been harmed at work, including in relation to arrangements for rehabilitation and return to work | and safety system.<br><br>▪ Seeks advice and input from the in-house Occupational Health and Safety service in accordance with the organisational health and safety system including ensuring that matters that require attention of the above service are brought to their attention.<br><br>▪ Facilitates communication of health and safety matters in their workplace including provision of health and safety information in their workplace.<br><br>▪ Participates in ACC Partnership Programme Audit process as required by ACC and all representatives are given the opportunity to meet with auditors when there is an opportunity.<br><br>▪ Participates in the development of control measures for significant hazards in accordance with organisational health and safety systems.<br><br>▪ Carries out workplace audits and participates in health and safety improvement actions.<br><br>▪ Plans educational/promotion to staff as agreed by manager and in accordance with organisational health and safety systems.<br><br>▪ Completes health and safety representative training as required.<br><br>▪ Attends forums to communicate health and safety issues. |

4**. Provisional Improvement Notices**

The process for issuing provisional improvement notices (PIN) within each DHB health and safety policy and procedures and is an agreed process using a Worksafe NZ template. The provisional improvement notice procedure requires that the DHB hazard management procedure is followed for all identified hazards and risks and that a PIN is only activated when the situation remains unresolved.

5. **Health and Safety Forums.**

Each DHB has health and safety forums which represent the interests of all parties on health and safety issues.

Forums will operate at levels within the organisational structure of each District Health Board.

“Health and Safety Forums will be held by each DHB, in a manner appropriate to the organisation, and no less than four times per calendar year. The agenda and minutes of forums will be sent no later than seven days prior to, respectively, each forum, electronically to all attendees

**Functions of the Health and Safety Forums:**

The Forums shall include the following agenda components:

a) Relevant H&S issues

b) Discuss service workplace injury and illness including specific incidents as well as incident trends.

c) Provide two-way feedback to management and workers on health and safety issues raised.

d) Discuss health and safety impact of management proposals.

e) Consultation on DHB health and safety policy, as deemed appropriate.

**Organisational Forum**

Health and Safety shall be included in an organisational –wide forum, in accordance with the organisational forum structure of each DHB.

6. **Health and Safety Representative Training**

The parties support the need for effective training of elected health and safety representatives. Elected Health and Safety Representatives shall be provided with a two day or equivalent DHB – selected, NZ Qualifications Authority Unit Standard 29315 as outlined in Sections 70(a) and 85 (a) of the Health and Safety at Work Act 2015. Each DHB leave policy and process shall apply to any leave applications to attend health and safety representative training.

DHBs shall request consultative feedback from Unions on any DHB-designated health and safety rep training course. Union Organisers will be invited to take part in agreed components of any DHB-designated, ministry-approved H&S Rep training course and any such training as agreed between the parties.

**7. Review of Employee Participation Agreement**.

The parties agree to convene on an annual basis for the purpose of monitoring the effectiveness of the Employee Participation Agreement. The Employee Participation Agreement shall be reviewed sooner in

the event that new or amended legislation require this agreement to be updated to reflect those changes.

**DHB Signatories:**

For ADHB _____

Sue Waters, Chief Health Professions Officer, ADHB

For WDHB/CMDHB _____

Fiona McCarthy, Director Human Resources, WDHB/CMDHB

For CMDHB_____

Beth Bundy, General Manager Human Resources, CMDHB

**Union Signatories**:

For NZNO_____

Name

Date

For PSA_____

Name

Date

For MERAS_____

Name

Date

For NAWU_____

Name

Date

For Etu_____

Name

Date

For CNS (APEX &
RDA)_____

Name

Date

For ASMS_____

Name

Date

For EPMU_____

Name

Date

## Counties Manukau Health Board Meeting
## Resolution to Exclude the Public

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

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

| General Subject of items to be considered | Reason for passing this resolution in relation to each item | Ground(s) under Clause 32 for passing this resolution |
|---|---|---|
| 1. Minutes of 7 September 2016 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | **Confirmation of Minutes**<br>For reasons given in the previous meeting. |
| 2. Action Items | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | For reasons given in the previous meeting. |
| 3. Social Investment Board 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.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | **Commercial Activities**<br>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.<br><br>[Official Information Act 1982 S9(2)(i)] |
| 4. After Hours Services Procurement | 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.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | **Commercial Activities**<br>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.<br><br>[Official Information Act 1982 S9(2)(i)] |
| 5. Healthy Together 2020 – Technology Update | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, | **Commercial Activities**<br>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 |

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| | under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | disadvantage, commercial activities.<br><br>[Official Information Act 1982 S9(2)(i)] |
| 6. Healthy Together Technology – e-vitals Project Business Case | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | **Commercial Activities**<br>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.<br><br>[Official Information Act 1982 S9(2)(i)] |
| 7. IS Projects Update | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982.<br><br>[NZPH&D Act 2000 Schedule 3, S32(a)] | **Commercial Activities**<br>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.<br><br>[Official Information Act 1982 S9(2)(i)] |