MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD
Tuesday, 10 December 2019

Venue: Room 105, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

CMDHB BOARD MEMBERS	CMDHB MANAGEMENT
Mark Gosche – Chairman Apulu Reece Autagavaia Catherine Abel-Pattinson Colleen Brown Dianne Glenn Garry Boles Katrina Bungard Paul Young	Margie Apa – Chief Executive Officer Margaret White – Chief Financial Officer Dr Peter Watson – Chief Medical Officer Dr Jenny Parr – Chief Nurse & Director of Patient & Whaanau Experience Dinah Nicholas – Board Secretary

PART 1 – Items to be considered in public meeting

AGENDA

	BOARD ONLY SESSION (8.30 – 9.15am)		
	1.	**GOVERNANCE**	
9.20 – 9.25am	1.1	Apologies	2
	1.2	Disclosures of Interest	3-4
	1.3	Specific Interests	5
	2.	**BOARD MINUTES**	
9.25 – 9.28am	2.1	Confirmation of Minutes of the Meeting of the Board – 31 October 2019	6-14
9.28 – 9.30am	2.2	Action Items Register	15-16
9.30 – 9.35am	2.3	Report on *Draft* Minutes HAC 20 November 2019 – verbal	17-27
9.35 – 9.45am	2.4	Report on Minutes CPHAC 25 September 2019 – verbal (Colleen Brown)	28-37
		2.4.1 Recommendation to the Board	
	2.5	Report on *Draft* Minutes CPHAC 6 November 2019 – verbal (Colleen Brown)	38-45
		2.5.1 Recommendation to the Board	
9.45 – 9.50am	2.6	Report on *Draft* Minutes RDISAC 14 November 2019– verbal (Colleen Brown)	46-54
		2.6.1 Recommendation to the Board	
		Morning Tea Break (10.00 – 10.15am)	
	3.	**DECISION PAPERS**	
10.15 – 10.25am	3.1	Biopsy Capable Mammography Machine (Kathy Pritchard)	55-57
10.25 – 10.35am	3.2	Winscribe Text Business Case (Stuart Bloomfield/Ian Dodson)	58-88
10.35 – 10.45am	3.3	IPM Upgrade & Bed Numbering Business Case (Stuart Bloomfield/Ian Dodson)	89-143
	4.	**EXECUTIVE REPORTS**	
10.45 – 11.00am	4.1	Chief Executive Officer's Report (including Patient Story) (Margie Apa)	144-158
11.00 – 11.10am	4.2	Corporate Affairs and Communications Report (Donna Baker)	159-175
11.10 – 11.20am	4.3	Finance and Corporate Business Report (Margaret White)	176-183
11.20 – 11.30am	4.4	Health and Safety Performance Report (Elizabeth Jeffs)	184-195
11.30 – 11.40am	4.5	2018-19 Quality Accounts (Jenny Parr)	196-199
	5.	**FOR INFORMATION ONLY**	
	5.1	Life Expectancy in Counties Manukau	200-204
	6.	**RESOLUTION TO EXCLUDE THE PUBLIC**	
		Lunch Break & Meet and Greet ELT (11.45 – 12.15pm)	205-207

Board Member Attendance Schedule 2019

Name	Jan	20 Feb	Mar	9 Apr	15 May	26 Jun	July	7 Aug	18 Sep	31 Oct	Nov	10 Dec
Mark Gosche (Chair)	No Meeting	✓	No Meeting	✓	✓	✓	No Meeting	✓	✓	✓	No Meeting	
Colleen Brown		✓		X	✓	X		✓	✓	✓		
Dr Lyn Murphy		✓		✓	✓	✓		✓	X	✓		
Dianne Glenn		✓		✓	✓	✓		✓	✓	✓		
Reece Autagavaia		✓		X	✓	✓		X	X	X		
George Ngatai		✓		✓	✓	X		✓	X	✓		
Catherine Abel-Pattinson		✓		✓	✓	✓		✓	✓	✓		
Katrina Bungard		✓		X	✓	✓		✓	X	X		X
Dr Ashraf Choudhary		X		✓	✓	✓		✓	✓	✓		
Kylie Clegg		✓		X	✓	✓		✓	✓	✓		
Pat Snedden		✓		✓	✓	✓		✓	✓	✓		
Garry Boles *(appointed effective 9.12.2019)*												
Paul Young *(appointed effective 9.12.2019)*												

BOARD MEMBERS' - DISCLOSURE OF INTERESTS
10 December 2019

New items in red italics

Member	Disclosure of Interest
Mark Gosche, Chair	• Trustee, Mt Wellington Licensing Trust • Director, Mt Wellington Trust Hotels Ltd. • Director, Keri Corporation Ltd • Trustee, Mt Wellington Charitable Trust • Trustee, Pacific Information Advocacy & Support Services Trust • Life Member, Labour Party • Life Member, ETU Union • Board Member, Kainga Ora Homes & Communities
Catherine Abel-Pattinson	• Board Member, healthAlliance NZ Ltd. • Member, NZNO • Member, Directors Institute • Co-Chair, National Party Health Policy Committee • Husband (John Abel-Pattinson): o Director, Blackstone Group Ltd o Director and Shareholder, Blackstone Partners Ltd o Director and Shareholder, Blackstone Treasury Ltd o Director and Shareholder, Bspoke Group Ltd o Director, Barclay Management (2013) Ltd o Director, AZNAC (JAP) Ltd o Director and Shareholder, Chatham Management Ltd o Director and Shareholder, GCA Trustee Ltd o Director, MAFV Ltd o Director and Shareholder, Manaia No. 4 Trustees Ltd o Director and Shareholder, Wolfe No. 1 Ltd o Director, Greenstone Motels Ltd o Director and Shareholder, Silverstone Property Group Ltd o Director, various single purpose property owning companies o Director and Shareholder, Abel-Pattinson Trustee Ltd
Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Director, Charlie Starling Production Ltd • District Representative, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited

Dianne Glenn	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • *Past* President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities.
Garry Boles	• TBC
Katrina Bungard	• Chairperson MECOSS – Manukau East Council of Social Services. • Deputy Chair Howick Local Board • Member of Amputee Society • Member of Parafed disability sports • Member of NZ National Party
Paul Young	• TBC
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, District Licensing Committee of Auckland Council • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation • Board of Trustees Member, Holy Cross School
Ken Whelan, Crown Monitor	• Board Member, Royal District Nursing Service NZ • Contracts with Francis Health & GE Healthcare (mainly Australia & Asia) • Crown Monitor, Waikato District Health Board

BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 10 December 2019

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action

Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 31 October 2019

Held at Counties Manukau DHB, Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT

Mark Gosche (Board Chair)
Ashraf Choudhary
Catherine Abel-Pattinson
Colleen Brown
Dianne Glenn
George Ngatai
Lyn Murphy
Pat Snedden
Kylie Clegg

ALSO PRESENT

Margie Apa (Chief Executive)
Margaret White (Chief Financial Officer)
Jenny Parr (Chief Nurse and Director Patient & Whaanau Experience)
Dr Gloria Johnson (Chief Medical Officer)
Ken Whelan (Crown Monitor)
Dinah Nicholas (Board Secretary)
Mere Martin & Cherryl Arnold (Communications Team)
Christina Mallon (Chief Midwife)

APOLOGIES

Apologies were received and accepted from Apulu Reece Autagavaia and Katrina Bungard.

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Mr Steven Stelts attended the public section of this meeting.

WELCOME

The Chair welcomed Christina Mallon to the organisation and acknowledged that in November the Board will be farewelling Dr Gloria Johnson who is retiring.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS

The Disclosures of Interest were noted with the following amendment – Dianne Glenn is now the *Past* President of Friends of Auckland Botanic Gardens.

Specific Interests – Mr Gosche, Mr Snedden and Ms Clegg advised a conflict of interest in relation to Item 3.3 on the Public Excluded agenda for this meeting.

AGENDA ORDER AND TIMING
Items were taken in the same order as listed on the Agenda.

2. BOARD MINUTES

2.1 Minutes of the Meeting of the Board 18 September 2019

Matters Arising:
Ratification of 2020 Board Dates – we no longer have a CMDHB MHAC committee. The DHB was supposed to part of a regional MHAC committee however, Auckland, Waitemata & Northland DHBs have now a combined regional committee leaving CM Health & Waikato DHB to form a southern regional committee. Whilst we try and transition to a southern committee, we need to discuss having an interim local committee with the Manawhenua Board. Ms Apa was asked to follow up with the Manawhenua Board.

Rheumatic Fever – Ms Apa advised that the Ministry of Health have formed a working group who will give the Ministry advice on how this money ($3m) needs to be rolled out. In the meantime, the DHB is still running the throat swabbing programme until June next year.

Resolution (Moved: Pat Snedden/Seconded: Dianne Glenn)

That the Minutes of the Board Meeting held on the 18 September 2019 be approved.

Carried

2.2 Action Item Register
Noted.

2.3 Draft Minutes Hospital Advisory Committee – 9 October 2019
The minutes were noted and taken as read.

3 PRESENTATION

3.1 Middlemore Foundation (Sandra Geange, Chief Executive, MMF)
Ms Geange took the Board through a presentation on the Middlemore Foundation.

- MMF has been a charitable trust associated with CM Health since 1999 and has raised $40m since then for the hospital and the community (40% hospital; 60% community prevention/development).
- FY20 capex list $3.6m includes audiology & ophthalmology equipment, warming units, wheelchairs, ventilators, baby monitors etc.
- MMF is holding reserves for Kidz First Clinical, Spinal & the new Rehab unit and the Burns Unit.

Ms Geange to provide a copy of the MMF prioritised fundraising list to the Board Secretary for distribution to the Board.

Ms Geange & Donna Baker to work on getting better communications/stories out in the New Year.

The Chair thanks Ms Geange for her presentation.

4 EXECUTIVE REPORTS

4.1 Chief Executive's Report (Margie Apa)

The report was noted and taken as read.

Measles – the number of measles cases in South Auckland have reduced for four weeks running. This reduction in confirmed cases has also seen a reduction in the number of ED attendances and inpatient admissions. The Ministry of Health has agreed and secured a vaccine supply to bring forward the MMR0 campaign (0-6months) and there is an on-going conversation whether a 'catch up' campaign would be effective. CM Health is advocating for a catch up campaign and if this does not happen, would consider having a further campaign for our own population.

There will be a national review as part of the normal follow up to a national outbreak and the DHB will also undertake our own review. There is an important lesson nationally around how we organise ourselves around supply.

Patient Safety Week - planning for this year's Patient Safety week (3-9 November) is underway, with various opportunities for all staff. The focus this year will be on *Cultural Safety and understanding implicit bias in healthcare.*

Pacific Presentations to the ED - of the 120,000 presentations to CM Health's Emergency Department in 2018, over a third were from Pacific patients. Of interest, Pacific patients presented at different hours of the day than the rest of the population. The Fanau Ola Team conducted a prospective, observational study of why Pacific patients self-present to the Emergency Department, using the same methodology as a study conducted for the general population in 2009. A structured questionnaire was administered to 340 eligible patients. The majority (97.9%) had a regular GP. The reasons given for self-presenting at the Emergency Department were:

60% Referred by GP, Urgent Care Centre, nurse/Ambulance
14% GP closed
13% Felt their condition was severe to go to their GP
13% Other reasons

Further work is required to better understand the needs of this population and self-presentation behaviour and to understand Primary Care's capacity to see patients.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: Colleen Brown)

That the Board:

Receive the Chief Executive Report for the period ending 31 October 2019.

Carried

4.2 Corporate Affairs and Communications Report (Donna Baker)
The report was noted and taken as read.

Obesity – a number of the deep dives presentations on the impact of obesity on services presented to the Board have continued to generate media interest. The Communications Team are currently facilitating a request by TVNZ's Sunday programme looking at the impact of obesity.

Coffee with a Cop this initiative is continuing to be well attended by DHB staff and the NZ Police see value in it and want it to continue.

Resolution (Moved: Ashraf Choudhary/Seconded: George Ngatai)

That the Board:

Receive the Corporate Affairs and Communication Report for the period ending 30 September 2019.

Carried

4.3 Finance & Corporate Business Report (Margaret White)
The report was taken as read.

The result to 31 August 2019 was $216k favourable. While the overall result is in line with budget, the need for additional clinical capacity is putting pressure on Provider budgets.

The delay in the Mental Health underspend is tied to the rebuild and NGO procurement project.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: George Ngatai)

That the Board:

Receive the Finance & Corporate Business Report for the period ending 31 August 2019.

Carried

4.4 Health and Safety Performance Report
The report was taken as read.

ACC Worker Injury Management Audit – this audit occurs every 18 months and the next one is scheduled in mid-November. Planning and preparation is on track.

2019 Staff Influenza Vaccination Programme – numbers are increasing year on year but there is still some way to go. A review into why we do well in some areas and not in others is underway and will inform the vaccination programme for 2020.

4.4.1 Security Incidents (John Cartwright)

The Board received a report on the current work being undertaken by the Security Team in relation to responding to incidents. A list of prioritised actions, from the Frank Stoks review, will be presented to the Board in due course.

The Chairman noted that it will be important to share the results of the review/s with the staff of ED as it makes a difference to people to know they are being listened to and that people are paying attention.

4.4.2 Increase in Incidents in Tiaho Mai

The new Tiaho Mai facility was designed to reduce aggression and be much safer for staff. It is the view of the Mental Health Service that the increase in violence is related to the proliferation and widespread use of meth-amphetamine and synthetic cannabis however, it is too early to conclude whether this is due to the design of the facility not being effective.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: Pat Snedden)

That the Board:

Receive the Health and Safety and subsidiary reports.

Carried

5. GENERAL BUSINESS

5.1 Board Member Reflections

Board members were asked to reflect on their time on the CMDHB Board:

- Inspirational coming in when the environment was so hard and unpleasant (transition from the old to the new). Leadership was terrific due this time with unity shining through.
- Staff and community commitment was inspirational. Challenges are met positively.
- Having a Pacific Chair and CEO has been a point in history.
- An escalation of issues to the Board has led to open transparent conversatinos.
- Deep dives are meaningful and encouraged.
- LTIP has been one of the best things that has been started.
- RDISAC is posed to do some good things regionally and locally.
- A totall different DHB now to six years ago.
- Strong equity and community focus.
- Have seen a joining of management and the clinical staff.
- Good reporting now, particularly financial.
- Mental Health has come a long way in three years.
- Need to appreciate and celebrate our staff.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Mark Gosche/Seconded: Pat Snedden)

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:

Mr Ken Whelan, Crown Monitor, is allowed to remain for the Public Excluded section of this meeting.

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
Public Excluded Minutes of 18 September 2019 and Actions	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Public Excluded Minutes of the Audit Risk & Finance Committee & the Hospital Advisory Committee	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Travel Management & Procurement Rental Vehicles	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities & Negotiations** 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 and negotiations. [Official Information Act 1982 S9(2)(i)&(j)]

Scott Building Remediation & Extension	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities & Negotiations** 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 and negotiations. [Official Information Act 1982 S9(2)(i)&(j)]
Sale of Parcel B	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities & Negotiations** 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 and negotiations. [Official Information Act 1982 S9(2)(i)&(j)]
Wirihana Development Batter Encroachment	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities & Negotiations** 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 and negotiations. [Official Information Act 1982 S9(2)(i)&(j)]

Second Draft 2018/19 Annual Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confidentiality of Advice by Officials** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and Officials. [Official Information Act 1982 S9(2)(f)(iv)]
Fisher & Paykel Healthcare Research Funding	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Chief Executive's Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Public Interest** The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)(ii)]

Women's Health & Newborn Annual Report 2018-19	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confidentiality of Advice by Officials** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and Officials. [Official Information Act 1982 S9(2)(f)(iv)]
Social Wellbeing 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. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Carried

The public meeting closed at 12.00pm.

THE NEXT MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD WILL BE HELD ON TUESDAY 10 DECEMBER 2019.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 31 OCTOBER 2019.

BOARD CHAIR **DATE**

Counties Manukau District Health Board
Action Items Register (Public)

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
18 September 2019	**Health & Safety Performance Report**	Look into whether 'Mates in Construction' could be something the DHB could sign up to. The MATES programme is an integrated programme of training and support – one without the other is insufficient – and delivers a number of training programmes on site which are aimed at raising awareness about suicide in the workplace, making it easy to access help and ensure that the help offered is practical, professional and appropriate.	10 December	Elizabeth Jeffs	*The new H&S Manager for Facilities will consider this. In early 2019 the HR team has deliver the "R U OK" programme (suicide prevention programme designed by a charity in Australia) to the Facilities team to provide the team with skills to check in with one another and raise concerns with one another. This programme has also been delivered to other services along with the MH101 programme.*	✓
18 September 2019	**CPHAC Minutes 14 August 2019**	Hold a full-Board workshop once the Stage 1 Simpson Grierson report on Maaori Health Services & Outcomes is published to determine the implications for CM Health and design a response to how the DHB will address Maaori health disparities.	2020 – Date TBC	Margie Apa		
7 August 2019	**Life Expectancy in Counties Manukau**	Undertake a stocktake against all the items in the column entitled '*Possible role for DHB*' to see how well we are doing.	10 December	Gary Jackson	*Refer Item 5.1 on today's agenda.*	✓
26 June 2019	**Smokefree Policy**	Vaping/Changes to the Smokefree Policy - when there has been enough shift in evidence and there is a clearer picture around regulation, update the Board on vaping, including the experiences from Mid Central DHB who has recently set up a vaping area on their campus.	13 May 2020	Gary Jackson/ Basil Fernandes		
9 April 2019	**Health & Safety Performance Report**	Aggression & Violence – once there is sufficient data from the Code Orange pilot and other work being undertaken in this area, present a deep dive into this area to the Board.	10 December	Elizabeth Jeffs	*The Clinical Director for ED/MMC is working with the new Service Manager to provide an in-depth analysis of the work and report*	✓

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
					back to the organisation. *This will also be provided to the new People & Culture Board Sub-Committee.*	

Minutes of Counties Manukau District Health Board
Hospital Advisory Committee

Held on 20 November 2019 at 1.00pm
Ko Awatea Room 101, Middlemore Hospital
100 Hospital Road, Otahuhu, Auckland

PART I – Items Considered in Public Meeting

BOARD MEMBERS PRESENT

Dr Lyn Murphy (Chair)
Catherine Abel-Pattinson (Deputy Chair)
Dr Ashraf Choudhary
Colleen Brown
Dianne Glenn
George Ngatai
Kylie Clegg

ALSO PRESENT

Dr Gloria Johnson (Chief Medical Officer)
Dr Jenny Pa[illegible] (Chief Nurse and Director of Patient and Whaanau Experience)
Dr Kate Ya[illegible] (Executive Advisor, CEO's Office)
Avinesh An[illegible]nd (Deputy CEO, Provider)
Teresa Opa[illegible] (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

APOLOGIES

There were no apologies from the Committee for this meeting.

WELCOME

The tour of the Medical Wards commenced at 1.00pm. The meeting commenced at 1.48pm.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

There were no Disclosures of Interest to note requiring update.

There were no Specific Interests to note regarding the agenda for this meeting.

1. AGENDA ORDER AND TIMING

Agenda items were taken in the same order as listed on the agenda.

2. BOARD COMMITTEE MINUTES

2.1 Minutes of the Hospital Advisory Committee 9 October 2019

Ms Brown queried the update on the cost of the measles epidemic, requested at the last meeting. Mr Anand advised an update on the hospital costs would be covered in the Finance report, with a Ministry update provided at the next HAC meeting.

Ms Brown queried the action from the last meeting for Ms Tracy to contact the National Coordination Centre to request that they give consideration to how they could capture data from private screenings. Deferred to later in the meeting when Ms Tracy is present.

Resolution (Moved: Ms Glenn/Seconded: Ms Brown)

That the Minutes of the Hospital Advisory Committee meeting held on 9 October 2019 be approved.

Carried

2.2 Action Items Register – Public

Noted.

2.3 Hospital Advisory Committee Work Plan 2019

The report was noted and taken as read.

2.4 Hospital Advisory Committee Draft Work Plan 2020

The report was noted and taken as read.

As only three of the current Committee members will continue on the Committee next year, it was agreed that this item be deferred to the 11 March 2020 meeting.

Action: Secretariat to add to the agenda of the 11 March 2020 meeting.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Executive Summary

The report was noted and taken as read.

In the absence of Ms Apa, Dr Johnson offered to take any questions.

Ms Glenn requested that Ms Apa send congratulatory letters to Mrs Brebner, Ms Hekau and Dr Watson on their recent achievements. Dr Johnson noted that Dr Watson was awarded his fellowship some time ago, and suggested the dates should be checked before any letters were sent.

Action: Ms Apa to prepare letters of congratulations to Mrs Brebner, Ms Hekau and Dr Watson, after first checking the date Dr Watson's Fellowship was awarded.

Ms Brown asked if the 61 cancers diagnosed through the National Bowel Screening Programme sat within the parameters of what the DHB would have expected. Dr Johnson advised that WDHB and CMHDB are both picking cancers up at a higher rate, but is unaware of how it compares to the original business case. Deferred to later in the meeting when Ms Tracy is present.

Ms Brown asked if the DHB has a set number of women per month that would benefit from assessment and treatment for gynaecological conditions on the various lists. Dr Johnson advised that despite outsourcing and some catch up that was achieved by doing a large number of a particular group, there is still a gap that the DHB is aware of. The DHB also looked at doing some Saturday lists but these would be too expensive due to payment of overtime rates. Dr Johnson advised the DHB is encouraging GPs to make the referral so it has visibility of how big the problem is.

Ms Clegg asked if there was any opportunity to improve the ED target trajectory as we move into summer. Dr Johnson noted that one week in particular showed a marked improvement but this was when the hospital was less busy. The DHB had an early winter peak, and it is hoped that it doesn't get a summer peak as it did last year.

Dr Parr noted that there is now a new management team in place in ED, so have a full complement of people to start working on the issues. The team visited Metro North in Brisbane recently to see their patient flow issues and the IT systems used to support patient flow.

3.1.1 HAC Dashbo
Noted.

3.2 Balanced Sc ecard
The report w s note and t ken as r d.

3.3 Hospital Services Project Portfolio Overview
The report was noted and taken as read.

In the absence of Ms Apa, Dr Johnson noted there was nothing in particular to bring to the Committee's attention, and that reasonably good support from Ko Awatea was now in place for projects.

3.4 Finance Report (Mr Avinesh Anand)
The report was taken as read.

Key points:

- YTD $608k unfavourable to budget.
- Vacancies remain in hard to recruit areas.
- $600k of outsourcing has occurred to meet elective volumes.
- External agency bureau costs have been reducing for the last 4 months. Internal bureau has recruited 39 HCAs and 27 RNs who can pick up additional shifts, significantly reducing the need to use external bureau staff.

Dr Parr noted that internal recruitment has been challenging. The Behaviours of Concern pilot in the ARHOP wards and four general medical wards has reduced demand, with 25% of requests having been declined.

The team is working with families and patients to identify the correct approach and where a watch is requested, a speciality nurse talks to staff and family, assesses requirement, and provides advice. The external bureau may be used if there is a need for specialist expertise that is not available in the internal bureau.

Ms Glenn asked if patients are admitted for dementia. Dr Parr advised they were not, that a patient would need to have a medical condition but could also have long term dementia.

Dr Murphy asked about the level of confidence in diagnosing the difference between delirium and dementia. Dr Johnson advised that the team was picking it up more than previously due to training and prompts that were in place. Both diagnoses are challenging as sometimes the signs can be quite subtle and patients can have both.

Mr Anand provided an update on the Measles epidemic.

Key points:

- The DHB has had 10 clinics (5,749 vaccinations of which 3,200 were at MSC) and ran 9 target school clinics (717 vaccinations).
- ED had 540 presentations with 152 admissions for a total of 475 bed days.
- Provider costs of approx. $800k toward vaccine, nurses and costs within the hospital.
- A consultant has been deferred to Samoa.
- A further report will be provided at the next HAC meeting.

Ms Clegg asked if there had been a higher percentage hospitalised with this outbreak. Dr Johnson confirmed that this appeared to be the case. Dr Murphy asked what impact this experience will have on our anti-vaccine people. Dr Johnson replied that they may not be as complacent as previously. Ms Brown acknowledged the amazing job that had been done, noting that now in the aftermath would be the best time to get some simple messages out in the community in a number of languages. Ms Clegg agreed that the DHB should use the crisis to leverage awareness. Ms Brown asked if any GPs had volunteered to open a clinic in the area. Dr Parr advised it was a whole of sector response and was unaware if that had been offered, but what was core was having the vaccines in the right place, with clear messaging to the public around who was a priority.

Resolution (Moved: Ms Abel-Pattinson/Seconded: Dr Choudhary)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

4. CORPORATE REPORTS

4.1 General Medicine Deep Dive Presentation (Dr Stephen McBride, Ms Catherine Tracy)

Dr McBride provided a presentation to the meeting.

Key points:

- General Medicine provides a range of non-surgical healthcare to adults without limit to any one organ or system/area of knowledge.
- New roster to be implemented 9 December, reverts to 1:3 pattern and is more ward-based.
- Workload is measured in three traditional ways – discharge numbers, acuity and length of stay. The DHBs discharges are 36% higher than ADHB with a similar number of doctors. Acuity is similar to other regional DHBs.

- Measuring of complexity recently introduced which shows the DHBs complexity is the highest of regional DHBs with the trend and rate of increase also far higher.
- Bed capacity constantly exceeded, forcing acute areas to be used to house patients. Projections indicate an additional 16 beds per annum required due to population growth.
- Vulnerabilities: vacancies in SMOs, RMOs and nursing, training threatened as service demands eclipse training opportunities, workload is unsustainable, inadequate capacity.
- Strengths: outstanding staff, active recruitment programme, patient flow improvements and innovation.
- Immediate need to permanently open Ward 17 and facilitate recruitment. Short term need for organisational support for services depended on by General Medicine, ie: cardiology, respiratory, ED. Medium term need for 6th ward with three associated teams.

Dr Murphy thanked Dr McBride for the tour of the medical wards and offered her congratulations for the work being done with the resources available. Dr Johnson suggested that this presentation would be beneficial to the incoming Committee and recommended it be scheduled at one of the early meetings in 2020.

***Action**: Secretariat to schedule a repeat of the General Medicine presentation at one of the early HAC 2020 meetings.*

4.2 Bowel Screening Programme Update (Ms Catherine Tracy)

The report was taken as read.

Ms Tracy provided key points:

- Programme is on track and meeting the targets.
- Still identifying more cancers than the 3-4 cancers per month previously forecast by the Ministry.
- Maaori and Pacific bowel cancer results are tracking very close to rates of Europeans. Ministry have therefore agreed to lower the age to 50yrs for Maaori and Pacific but have not advised a date for when this can start.
- Funding for next year is still an issue and Ministry has been asked when those conversations will start.

Ms Glenn asked how we can increase the uptake by Pacific. Ms Tracy advised that it is a national issue. Locally, the DHB has our community support workers touching base in the community, going to churches etc.

Dr Choudhary asked where the data comes from. Ms Tracy advised the data is provided by the National Coordination Centre based on the packs that are returned to the labs. Mailing details are provided by GPs for this purpose, which is more reliable than using voting databases.

Ms Brown asked whether Ms Tracy had followed up on the action point from the last meeting regarding the inclusion of private screening results. Ms Tracy advised that she took this to the steering group and they in turn have put it to the Ministry. Ms Tracy advised that mention of private testing is made in the kit, which provides a number to ring and advise if private testing has been undertaken.

Resolution (Moved: Mr Ngatai/Seconded: Ms Clegg)

That the Hospital Advisory Committee:

Note and receive the report.

4.3 Patient Flow – Every Hour Counts Update (Dr Mary Seddon)

The report was taken as read.

Dr Seddon provided key points:

- Key messages from visits to sites with a command centre:
  - The culture of patient flow is a real priority.
  - Concept of comprehensive actionable information is critical.
- ED/MMC will continue to work on this with the aim of presenting a business case to the Ministry for funding of a command centre.
- Work continues to improve the electronic discharge summaries assisted by GP focus group with a view to co-design our processes. Recent audit of patients in the Discharge Lounge identified long delays and lack of any conversation with patients or Whaanau to proactively plan for discharge.
- Nurse Coordinators (who do not carry a clinical load) have been trialled, which has improved the average time a bed was empty by 1hr 40 min, resulting in a positive cultural shift and improved morale to nursing staff.
- Referrals to outpatients have issues both from GPs sending data in and for the DHB receiving them and sending data back out. Currently GPs have little access to specialist information so use referral system for advice, which generates a lot of extra work. Reviewing what other 2-way communications can be set up to reduce the number of referrals.
- Two improvement projects planned in ophthalmology – cataract FSA/preadmission and virtual clinics for post Avastin injection.

Dr Murphy asked if whiteboards are provided in each patient room to update the family on likely discharge etc. Dr Parr advised that it is an expectation that there is a whiteboard for all patients, and this is monitored in the Fundamentals of Care results.

Ms Glenn asked what the Committee could do to assist in the development of a patient flow vision. Dr Johnson responded that when an item like this is on an agenda, each Committee member should ensure they are receiving regular updates and are kept well informed.

Resolution (Moved: Ms Glenn/Seconded: Ms Brown)

That the Hospital Advisory Committee:

Note and receive the report.

4.4 Human Resources Report (Ms Elizabeth Jeffs)

The report was noted and taken as read.

In the absence of Ms Jeffs, Dr Johnson noted that there is still a lot of ongoing industrial action by the unions.

Ms Brown queried the level of annual leave. Dr Johnson advised that this tends to build up over the year, then plummets over the summer period.

Resolution (Moved: Ms Brown/Seconded: Ms Abel-Pattinson)

That the Hospital Advisory Committee:

Note and receive the report.

4.5 Equitable Health Outcomes Presentation (Ms Aroha Haggie)

Ms Haggie provided a presentation to the meeting.

Key points:

- The framework for healthcare organisations to achieve equity was presented, namely:
  - Make health equity a strategic priority;
  - Develop structure and processes to support health equity work;
  - Deploy specific strategies to address the multiple determinants of health on which health care organisations can have a direct impact;
  - Decrease institutional racism within the organisation;
  - Develop partnerships with community organisations.
- Ms Haggie noted that equity was not limited to ethnicity.
- Ms Haggie invited the Committee to discuss anything they felt was missing, not as obvious as it should be or are they relevant enough to what the DHB believes our community needs.

Ms Brown expressed concern at the 'one plan one team' statement, where the Maaori Action Plan sits within that and how the community most affected by the inequities will see the change.

Mr Ngatai commented that it comes down to having two plans - one is the Maaori plan which is key, with a second plan for other ethnic and community groups that fall within the equity service delivery as well.

Ms Glenn co[illegible]d on t[illegible] inequit[illegible] interim [illegible], th[illegible] workshop next year on equity, and looking at the 25/75 to give us some direction as to how the DHB addresses equity. Her concern is that this may be more of a talk fest and the DHB should focus on delivering change and delivering equity.

Ms Brown suggested the DHB look at all contracts with Maaori and Pasifika and decide if they could be done better but on a more equitable basis than what other people are doing. If the Ministry is going to look at equity, perhaps look at how it funds community organisations to get on with the work.

Mr Ngatai commented equity meant being fair, and that the DHB needs to look at fairer ways of getting services to vulnerable communities. Mr Ngatai suggested the use of the general practice model, where 5-6 priorities were allocated $x and for every enrolled patient, and get them involved in your community service or practice.

Ms Brown asked what the comment 'work with sector partners to optimise system performance' meant. Ms Brown believes that the majority of people with contracts with the DHB who are practising or delivering in areas of high inequity, already do that.

Ms Clegg would like to see something around learnings from Maaori providers about how to optimise this, to have a learning mentality.

Ms Haggie noted that for a long time there was no statutory requirement, so the mechanisms for accountability have been dependent on the goodwill of the people in the system directing the resources, making management and operational decisions. The notion of 'one plan one team' is that it is orientated to the highest need and the biggest priorities that we collectively see.

Ms Haggie outlined the key points for consideration and the practical steps to be taken from the solid foundations already in place.

Ms Brown queried the involvement of Manu Whenua. Ms Haggie advised they are engaged in our Healthy Together strategy and will be present in other areas. They are working with us currently around the dashboard for Maaori Health.

4.6 Patient Experience and Safety Report (Dr David Hughes)
The report was taken as read.

4.6.1 Safety, Experience, Compliance and Measurement Dashboard (Dr David Hughes)
The report was taken as read.

Dr Hughes provided key points:

- An ethnicity split has been added to adverse events for this year, patient experience survey in terms of overall ratings of excellent and good, and hospital acquired complications.
- National Adverse Events (AE) report is being released 21 November, where the experience of Maaori whaanau and patients who have been affected by AE is discussed.
- Maaori patients are under-represented in AE in a similar way that the DHBs Maaori patients are under-represented in complication rates. NZ European patients have a complication rate of 3%, with Maaori at 1.7%. The two biggest complications that get more frequent with age and have the biggest difference between Maaori and non-Maaori, are the onset of delirium in hospital (over 80 years), and hospital-associated infections (65-79 years). The number of Maaori patients over 80 years in MMH is very low.
- The next stage is to think about what issues affect Maaori more, and whether the DHB is doing enough t[illegible] thos[illegible]

4.6.2 Safety, Expe[illegible]ence, Co[illegible]pli[illegible] Meas[illegible]eme[illegible]t Das[illegible] Varianc[illegible] Report (Dr David Hughes)
The report w[illegible]s taken [illegible] rea[illegible].

Dr Hughes provided key points:

- Rate of staphylococcus aureus bacteraemia (SAB) appears to have increased, but following discussion with infection prevention team, it was determined the rate reflects the total number of SAB, not just in-patient. It appears the growth is in patients coming to hospital with this bacteria already in place.
- Pressure Injuries (PIs) indicates there is significantly reduced variation in the process that we are undertaking around PI.

4.6.3 QSM Local Report
The report was taken as read.

Dr Hughes provided key points:

- Overall results are good, continued struggle with 0-60 minutes before knife to skin. Anything above 95% is acceptable.

Resolution (Moved: Ms Abel-Pattinson/Seconded: Dr Choudhary)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

5. INFORMATION PAPERS

5.1 Emergency Department Middlemore Central (John Cartwright)
The report was noted and taken as read.

5.2 Medicine and Integrated Care (Catherine Tracy)
The report was noted and taken as read.

5.3 Surgery, Anaesthesia and Perioperative Services (Pauline McGrath)
The report was noted and taken as read.

5.4 Central Clinic Services (Ian Dodson)
The report was noted and taken as read.

5.5 Women's Health (Mary Burr)
The report was noted and taken as read.

5.6 Kidz First (Nettie Knetsch)
The report was noted and taken as read.

5.7 Adult Rehabilitation and Health of Older People (Dana Ralph-Smith)
The report was noted and taken as read.

5.8 Integrated Mental Health and Addictions (Tess Ahern)
The report was noted and taken as read.

Resolution (Moved: Dr Choudhary/Seconded: Ms Brown)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Ms Brown/Seconded: Ms Glenn)

That the Hospital Advisory Committee 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
Public Excluded Minutes of 9 October 2019 and Actions	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Facilities, Engineering and Asset Management Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Committee to carry out, without prejudice or disadvantage, commercial activities.
Draft CM Health Adverse Events Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Committee to carry out, without prejudice or disadvantage, commercial activities.

Carried

The Public Meeting closed at 3.13 pm to move to the Public Excluded Meeting, to accommodate the availability of a presenter.

The Public Meeting re-opened at 3.19pm.

Dr Murphy advised she was leaving the Board after 9 years of service, and thanked the Committee for their support.

Dr Choudhary advised that he too would not be returning to the Board.

Ms Clegg and Mr Ngatai advised they had not received notification at this time as to whether their services would be required.

The Public Meeting closed at 4.11 pm.

The next meeting of the Hospital Advisory Committee will be held on Wednesday 11 March 2020.

Signed as a true and correct record of Counties Manukau District Health Board's Hospital Advisory Committee meeting held on 20 November 2019.

28 November 2019

Dr Lyn Murphy
Chair

Date

Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 25 September 2019 at 9.00am – 12.00pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Dr Ashraf Choudhary (Deputy Committee Chair)
Dianne Glenn
John Wong
Katrina Bungard
Apulu Reece Autagavaia

ALSO PRESENT

Fepulea'i Margie Apa (Chief Executive)
Dr Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Gary Jackson (Director, Population Health)
Aroha Haggie (Director, Funding & Health Equity)
Elizabeth Powell (GM, Pacific Health Development)
Dr Kate Yang (Executive Advisor to the CE)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present at this meeting.

WELCOME

The meeting commenced at 9.00am with a welcome from the Chair, Colleen Brown and a prayer from Apulu Reece Autagavaia.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda.

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from Colleen Brown, Dr Lyn Murphy and Elizabeth Powell.

2.2 Register of Interests

There were no amendments to the Disclosures of Interest.
There were no amendments to the Disclosure of Specific Interests.

2.3 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 14 August 2019.

Resolution (Moved: Ashraf Choudhary/Seconded: John Wong)

That the minutes of the Community and Public Health Advisory Committee meeting held on 14 August 2019 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Action Items were noted as being on track.

2.5 CPHAC Workplan 2019

The Workplan was noted as being on target.

Developing a CPHAC Scorecard (Dr Kate Yang)

Due to time constraints, this item will be discussed at a subsequent meeting.

3. BRIEFING PAPER

3.1 **Quarter 4 2018/19 Non-Financial Summary Report** (Parekawhia McLean, Director Infrastructure & Strategy)

The paper was taken as read.

Cervical screening is a gap and CM Health are aware of this.

Pacific/Maaori/Asian health programmes provide another layer of information alongside the Q4 report.

CPHAC likes the list of achievements that we can celebrate and the notification of any issues that the Board can be made aware of.

Ms Apa noted that the deeper analysis of ED and the effect of obesity on results.

CPHAC were interested to know if the Information Desk person has been appointed? And will/is the person assisting with flow?

Dr Choudhary would like to see updated Diabetes data for the North Indian community.

Data is monitored for those patients that go to Accident & Medical clinics and then come to ED of their own volition. After Hours and Emergency have all been very busy this year but we don't have concerns about care being offered at a systematic level. Conversations are being held around better support for Primary Care from CM Health.

Asian Health Plan – CPHAC would like to see the introduction of information in regard to nutrition and healthy living.

Resolution (Moved: Ashraf Choudhary/Seconded: Dianne Glenn)

The Community & Public Health Advisory Committee:

Recommendation to the Board: ask HPA and MOH what they are doing for the South/North Asian communities re diabetes, healthy living, etc.

Received this Quarter 4 2018/19 Non-Financial Summary Report.

Noted and review the results for Quarter 4 progress against draft planned 2018/19 actions and performance expectations, including key challenges and resolution plans for those measures where performance was low.

Noted and review the narrative report of progress against the Pacific Health, Asian Health and Maaori Health Roadmaps, as at Q4 2018/19 (Appendix 2)

Noted the appended Northern Region Health Plan Quarter 4 2018/19 summary report provided by the Northern Regional Alliance (Appendix 3).

Carried

4. UPDATE

4.1 Measles Update (John Cartwright, General Manager Emergency Department & Middlemore Central and Kate Dowson, Programme Manager Primary Care) - verbal

The hospital has been dealing with measles since March 2019 and the situation escalated June/July 2019.

There have been 820 cases in South Auckland (predominantly Pacific and Maaori) in particular for the age groups under 5 and 15-29 yrs. Just under half have been through ED.

From the end of August, CM Health set up a response team. From September there has been a regional response and they have taken comms work and helped with logistics.

Opportunistic vaccination clinics were set up in ED and along the main Middlemore corridor.

Over 30,000 people have been vaccinated in South Auckland by Primary Care, reaching the right people from an ethnicity perspective.

The amount of activity in Primary Care has been huge, dealing with cases and vaccinating.

The hospital provided a 12 bed paediatric isolation area (not required for adults). When required, adults can be managed.

The most complicated cases are U5s and some 10 to 15 year olds.

Staff are working very hard across the board to manage the outbreak both inside the hospital and in the community.

Measles is very infections so increases the need to keep patients out of public areas.

The Regional level is about planning going forward. Looking at modelling, etc.

Comms is currently being provided around how to minimise risk for newborns. ARPHS – their area of expertise is dealing with schools providing them with information.

This outbreak has been a learning curve for all agencies involved.

15-29 is a challenging group as they weren't on vaccinating schedules in other countries. U15 – NIR is used to note who is immunised. O15 are not on a register, so has been difficult to track vaccination status post 15 years old. Work is being undertaken around this.

47% of Pacific live in overcrowded houses: measles is hugely infection. Will be taken into consideration moving forward.

It is important to note that 2 vaccinations make you 99% safe not 100%.

CPHAC asked if there will be a peak and was advised that numbers were down last week and Ms Dowson is waiting for numbers for this week. Too early to call, but staff are hopeful numbers are trending down.

5. PRESENTATIONS

5.1 CM Health Disability Strategy & Workplan (Sanjoy Nand, Chief of Allied Health, Scientific & Technical Professions

Mr Nand showcased the CM Health Disability Strategy & Workplan which highlights the Vision which is 'we are fully inclusive' and include the rights of disabled people, reducing barriers (physical and otherwise) and improve accessibility, information and services. The Regional strategy draws from the NZ Disability Strategy 2016-2026.

CM Health will focus on 5 of the 8 outcome areas: Employment and Economic Security, Health and Wellbeing, Accessibility, Attitudes, Choice and Control.

Mr Nand advised that equity and Maaori Health will feature in the Regional Workplan and will:

- Increase staff awareness through training
- Data and Information – collect and use to guide service design, delivery and care
- Further audit of facilities
- Gain the Accessibility Tick
- Create Webpage on Disability Services
- Strategy to include disability – Infrastructure and Service, Equity Strategy
- Representation of disabled people on committees

Progress for CM Health includes:

- Staff Training around Disability Responsiveness eLearning – Mandatory – 750 staff
- Infrastructure Strategy – to include principles of Universal Design and accessibility
- Co-Design – includes disabled people are involved
- Accessibility Tick programme started

Further work will see CM Health:

- Use previous accessibility audit reports to create a priority list of gaps that still remain
- Include work on facilities in Capital and Infrastructure Plan
- Accessibility Tick – work plan
- Improve recruitment and employment processes for disabled people

- Trial data collection on disabled people – for clinical care purposes
- Further training systems for staff – cultural competency to be included, Autism, training of managers/recruiters
- Develop a Disability webpage
- Information on staff with disabilities - currently no information

An Equal Opportunities policy is to be included in the Recruitment process at CM Health.

Mr Nand is working with external agencies to explore alternative sources of funding in order to be able to create some of the improvements mentioned previously.

Mr Nand ran though positives and areas for improvement that have fallen out of the previous 4 audits of various areas within hospital (3 audits) and 1 external site.

Further Improvements to be made from audits and self-assessment include:
- Disability Parking – may need more and improve existing ATR disability parks
- Improve kerb ramps that are not accessible
- Solution for ticket payment to exit time – 15 minutes not adequate for disabled
- Parking machines – height a barrier for disabled
- Toilets and showers – plan needed for improvement of those not accessible
- Kick boards for accessible toilet doors which require push open
- Doors to wards – need to be self-opening for disabled – currently too heavy
- Lifts - fit tactile floor indicators for some

In summary Mr Nand advised that steady progress is being made at CM Health. The Regional Strategy and Committee Work Plan has been useful for setting direction. Learnings from past audits have been useful to understand how accessible our facilities are and to know where improvements can be made. The Manukau Super Clinic Audit suggests a good level of accessibility. To address some gaps will require significant investment to achieve.

Ms Bungard highlighted the fact that the HealthPassport has not yet been made digital.

Mr Nand advised that the information collected regarding disabled patients relies on Census. Health & Disability Strategy advised that 1 in 4 New Zealanders have some type of disability.

Conversation highlighted the issues faced by those with high BMI, in and around the hospital and at community clinics.

Dr Choudhary thanked Mr Nand for his time and encouraged him to keep up the good work.

5.2 Southern Corridor Planning (Parakawhia McLean, Director of Infrastructure & Strategy and Tony Phemister, NRA, Portfolio Manager, Regional Planning & Service Delivery)

This Corridor programme is 1 of 6 programmes that this Government is leading out around Regional Growth Management Partnerships. Iwi and mana whenua are involved from both the northern and southern parts of the corridor. Will support urban development.

The Corridor itself follows the SH1 Network and the main rail trunkline and from an iwi perspective, the Waikato River. This programme will take a whole corridor perspective – infrastructure, transportation and holistic.

Opportunity for CM Health to influence planning alongside all of the other services involved.

Main drive for national work is the transport corridor, but important to recognise energy, water, sewerage. The desire is there to maximise the opportunities of the corridor.

Drury and Pukekohe plans are now in place.

Over the next 30 years from Pakuranga to Pukekohe will see about an additional 63,000 houses – another 210,000 people. Historically we grow faster than the medium projected growth rate.

Pressure is on to finalise plans and commence building. Main barrier is transport systems. Plans are there but need to be moved forward.

The housing development in Mangere was raised. Ms Apa advised that CM health is aware of the Mangere/Otara developments and felt that it was a timely reminder that whilst the Southern Corridor will have growth we also have density in some of our urban places. Mr Phemister will take this information on board.

Ministry of Health and Treasury are charged with land-banking. Actively working in this area.

Matthew Parr is the Director is writing a letter to Cabinet outlining the health functions that will sit within the corridor. Important that Government understand that kinds of services that will be required.

Thinking about CM Health's role, between now and 20 years' time, how do we cope with current growth? There is an opportunity to look at service development, community hubs? How do we support ED within the current fiscal constraints? This is a secondary conversation that will have to take place.

Work is currently being undertaken on the Primary & Community based strategy that works with PHOs to understand their plans. Parallel process is to look at what these services may look like.

Matt Hannant and his team are having a really good look at this, thinking about what the size and context of both the communities need and the demand that we're seeing and then thinking about how we would phase this work and work it in with other developments that are happening.

There are people within the market, provides, people that we could partner with that are looking at how they can work with CM Health in order to provide new models of care, etc. Health campuses and Health Parks are on the radar for CM Health. There are different phases of integration, co-location being an important first step and then you get true integration making the health journey great for whanau and community.

At the community board level, Health isn't discussed in terms of what may be going on with planning for the future. Ms McLean and Mr Phemister are leading the push to establish a dedicated Social Services.

Dr Choudhary thanked the presenters for their hard work in this area.

5.3 Housing First (Julie Nelson, Chief Executive Wise Group; Carol from People's Project Homeless Service, Hamilton; Fiona Hamilton, Housing First Lead, Auckland)

Homeless people are actually well known and known to multiple services so a joining up approach is required.

No government funding for this project so like minded people could collaborate without heavy reporting requirements.

70% of people that walk through the doors of the People's Project are Maaori.

The presenters have seen some system change in response to this work. MSD has amended some of its practises to assist those in need along with Corrections.

Housing First approach is a step up approach and excludes emergency housing and temporary housing going straight to permanent housing.

Ms Nelson advised that it's important to have the population perspective.

The project has netted amazing information. Sadly, it shows that Maaori are over represented. Prescribed drugs play a large factor in the lives of the homeless.

Data collected shows a wide range of valuable information. 83% of 390 people linked to one criminal incidence. Housing First will collect data going forward on how statistics change for people once housed.

Childhood abuse is a factor for approx. 90% of the 390 people being looked after by the programme.

After four years Housing First knows that it takes:

- Time;
- Trust - the service must do what it says it will do, it must follow through and have integrity, be non-judgmental and treat people with respect and dignity every time;
- Major persistence;
- A team of robust, resilient individuals with skilled leadership to maintain the intensity of service delivery required doing whatever it takes to support a client;
- Responsiveness and agility – a shop front works best because the more complex the more unlikely to attend appointments; and
- Relationships. Research shows that resilience is required to overcome adverse events, relationships increase resilience.

There are parallels between the South Auckland Social Wellbeing Board and Housing First. SASWB has population groups they are working with, including vulnerable mums and family violence. The models are similar, in particular in regard to a joined up approach across agencies.

Action

Presentation to be loaded in the resource centre of Diligent.
Mrs Tafau to get further information from Ms Nelson, another report to go into the Resource Centre.

CPHAC asked what is it that you specifically expect the DHBs to do in regard to homelessness. Ms Nelson believes that we all should do our best to end homelessness. She raised Finland as an example, who have eradicated homelessness and this was achieved outside of Government.

Boarding houses are not permanent homes. Need more housing. Need more access to permanent housing. Allow staff to work differently, be more flexible.

A joined up response is the key to ending homelessness.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Apulu Reece Autagavaia)

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
2.1 Confirmation of Public Excluded Minutes 14.08.19 3.1 Immunisations Incentives Programme 3.2 NGO Contract Savings	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Carried

This first part of the meeting concluded at 11.00am.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING OF 25 SEPTEMBER 2019.

Colleen Brown
Committee Chair

From:	Vicky Tafau (CMDHB)
To:	Dinah Nicholas (CMDHB)
Subject:	Recommendation to the Board from CPHAC - 25 September 2019
Date:	Monday, 02 December 2019 10:54:03
Attachments:	image001.png

Quarter 4 2018/19 Non-Financial Summary Report (Parekawhia McLean, Director Infrastructure & Strategy)

The paper was taken as read.

Cervical screening is a gap and CM Health are aware of this.

Pacific/Maaori/Asian health programmes provide another layer of information alongside the Q4 report.

CPHAC likes the list of achievements that we can celebrate and the notification of any issues that the Board can be made aware of.

Ms Apa noted that the deeper analysis of ED and the effect of obesity on results.

CPHAC were interested to know if the Information Desk person has been appointed? And will/is the person assisting with flow?

Dr Choudhary would like to see updated Diabetes data for the North Indian community.

Data is monitored for those patients that go to Accident & Medical clinics and then come to ED of their own volition. After Hours and Emergency have all been very busy this year but we don't have concerns about care being offered at a systematic level. Conversations are being held around better support for Primary Care from CM Health.

Asian Health Plan – CPHAC would like to see the introduction of information in regard to nutrition and healthy living.

Resolution (Moved: Ashraf Choudhary/Seconded: Dianne Glenn)

-

The Community & Public Health Advisory Committee:

Recommendation to the Board: ask HPA and MOH what they are doing for the South/North Asian communities re diabetes, healthy living, etc.

Received this Quarter 4 2018/19 Non-Financial Summary Report.

Noted and review the results for Quarter 4 progress against draft planned 2018/19 actions and performance expectations, including key challenges and resolution plans for those measures where performance was low.

Noted and review the narrative report of progress against the Pacific Health, Asian Health and Maaori Health Roadmaps, as at Q4 2018/19 (Appendix 2)

Noted the appended Northern Region Health Plan Quarter 4 2018/19 summary report provided by the Northern Regional Alliance (Appendix 3).

Carried

Vicky Tafau

Executive Assistant I Population Health Directorate

Dr Gary Jackson, Director Population Health & Campbell Brebner, Chief Medical Advisor, Primary Care

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values

Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 6 November 2019 at 9.00am – 12.00pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Chair)
Dr Ashraf Choudhary (Deputy Committee Chair)
Dianne Glenn
John Wong
Katrina Bungard
Dr Lyn Murphy
Apulu Reece Autagavaia

ALSO PRESENT

Dr Gary Jackson (Director, Population Health)
Aroha Haggie (Director, Funding & Health Equity)
Dr Kate Yang (Executive Advisor to the CE)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present at this meeting.

WELCOME

The meeting commenced at 9.00am with a prayer from Apulu Reece Autagavaia.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda.

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from George Ngatai, Fepulea'i Margie Apa, Dr Jenny Parr, Elizabeth Powell, Mark Gosche and Campbell Brebner.

2.2 Register of Interests

The amendments to the Disclosures of Interest were noted and will be actioned by Ms Tafau. There were no amendments to the Disclosure of Specific Interests.

2.3 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 25 September 2019.

Resolution (Moved: Dianne Glenn/Seconded: Reece Autagavaia)

That the minutes of the Community and Public Health Advisory Committee meeting held on 25 September 2019 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Action Items were noted as being on track.

CPHAC asked that ARPHS provide a thorough update on Measles – what happened, where are the hotspots and problems, what are they looking forward to in regard to solutions, what will be done with ARPHS and DHBs regionally. The MOH national campaign information should be available for inclusion by the next meeting on 18 December 2019.

2.5 CPHAC Workplan 2019

The Workplan was noted as being on target.

Workplan 2020: Look at the demographic changes and what needs to be done in terms of the changes. The ERP data will be available in the New Year – based on the 2018 census. Determine how much regional planning is going on in Health?

3. DISCUSSION

3.1 **Ministry of Health's Well Child Tamariki Ora Review Update** (Kylie McCosh, Senior Portfolio Manager, Well Child Tamariki Ora and Justine Mecchia, Manager, Well Child Tamariki Ora)

Ms McCosh and Ms Mecchia provided an overview of slides.

CPHAC asked if there has been any research into how multiple referrals works for a new Mum with other children? In the current system this data is not able to be collected. This is part of the current review. The MOH don't understand whether these referral rates reflect the capacity of the current system. Need to consider access for whaanau – no car, multiple jobs.

Action
Ms Ellis was asked to bring Startwell to a subsequent CPHAC – early 2020.

The national picture shows systemic problems in the WCTO programme and how they may be being addressed locally and how can the MOH better support this work at a systems level. The MOH hopes and envisages that the case studies will absolutely inform what some of the models of care may look like moving forward.

The Review is looking at systematic changes to enable better integration between maternity and non-health services. Currently this only happens in an adhoc manner but needs to happen in a more flexible manner.

Additional contacts have dropped which could be attributed to financial pressures. The review will see a targeted approach to whaanau that need follow up.

Reporting systems don't currently talk to each other. CPHAC is concerned over the disconnect, there is a need to focus on this issue. The MOH is aware of this and have this as a priority action as part of the review. There will most likely be a multi-year action plan around this going forward.

IT issues have been highlighted at all of the 21 sector engagements that have been held. The review process has helped in informing a solid case to put forward to the government around the need for investment, particularly in IT and is in fact a critical solution to some of these overarching issues.

Carmel Ellis advised that the due to the large number of Counties Manukau's population living in deprivation the coming changes will be very important in particular in the area of improving health outcomes. Carmel is looking forward to working together with the MOH and other sectors to achieve these results.

A review of the core components will be undertaken. The schedule needs to have a comprehensive needs assessment. If all of these different parts of the programme (0 to 5yrs) are using similar components across the services/clinicians, then that will go a long way to be able to gather what information at the other end. Allowing trust and flexibility for the clinician to tailor what is required for the child/whaanau. A lack of flexibility can drive whaanau to disengage from the programme.

Compliance reporting needs to change to outcome based reporting. Data to be collected from whaanau themselves.

The MOH were clear about the fact that a quality framework will need standards to go alongside and practices will need the autonomy to be flexible in the way they achieve outcomes for the child/whaanau.

Overarching issues include inequality and inequity in outcomes, coverage, access, funding and resources, a lack of information on outcomes, services and delivery wanted by parents/whaanau, a change in focus required based on evidence and Government direction and a need for greater alignment of WCTO outcomes, services and delivery across between services and cross-agency.

Outcomes need to not just focus on the child but the wider whaanau and their social determinants. Programme scope needs to be addressed. Stay as is or transition to a service that follows through to adult hood. Need to provide providers with more guidance around achieving outcomes.

Need to review the assessments undertaken around additional visits.

The following points were identified:

- Whaanau support needs to be better defined and financed.
- Improved focus on relationships – whaanau centred services.
- Cultural responsiveness needs to improve.
- Increased cultural and diversity in workforce.
- Programme enablers: see slide 35.30

What type of Pacific supports does the MOH team currently have in place – at governance there is Maaori/Pacific advice from the DHB perspective. There is advice at the Steering group level. Strong Maaori & Pacific cohort in the team. These staff have been on the road attending all 21 community engagement hui.

CPHAC were advised that a report is due back to the Minister this side of Christmas. The 2018/2019 view is still being updated. The need for a multi-year plan will be put forward, including the advice

that significant investment will be needed. The review will need to be ongoing and the MOH advised that engagement with whaanau will continue.

CPHAC thanked both Ms McCosh and Ms Mecchia for their time and look forward to talking further in 2020.

4. UPDATE

4.1 SUDI Prevention (Christine McIntosh, GP Liasion, Primary Care & Tina Higgins, SUDI Prevention, Child Youth & Maternity)

The report was taken as read.

Unacceptably high rate of SUDI in Counties Manukau. However, we also have a high rate of opportunity to work in this area.

The Prevention Plan involves a large portion of work dedicated to distributing baby beds (pepipods, whahakura) to the community, approximately 1500 per year now. Smokefree is still a focus for CM Health. SUDI post care has also become a focus. The Coroner will now advise CM Health if there is a SUDI in the community. A coroner's case can take 2 to 4 years to close.

We are going to trial a rapid review under the Child Youth Mortality Review Group. As part of this work, are we looking at other social determinants in regard to reasons for SUDI. It is a combination of risk factors, mother smoking in pregnancy, premature birth, etc.

CM Health have created a Risk Tool. Important to impart the risks to the whaanau. Cure Kids have invested in this work, the Safe Sleep calculator – taking this tool, ensuring it will work for whaanau.

Extensive community (including providers) engagement has been undertaken and engagement with Midwifery and Neonates. Good communication between providers is key. A navigator type role was identified as being very helpful.

In order to create the SUDI Protection Care Ecosystem we need to work on:

- Understanding the services;
- Virtual integration of providers;
- Thinking about workflow;
- Minding the 'gaps';
- Distributing baby beds;
- Building the software;
- Implementation planning;
- Contracting with WellChild providers;
- MOU with NGO providers; and
- Monitoring and evaluation.

CPHAC raised Peer Support as a way for parents to feel supported through the process. The Te Rito Ora Peer Support programme could potentially be adapted to fit here.

Training now focuses on motivational interviewing, interviewing in a non-judgemental, motivational manner.

Challenges so far have been around data, the loss of Ko Awatea support to TAP, the complexity of the Survive and Thrive 2025 tool, the capacity of midwifery, the time required for training and ensuring the tool meets requirements for web security and privacy.

The positives include:

- Development of expertise in cloud-based decision support tools has led to successful HPA funding and development of an early pregnancy assessment tool;
- Developed a process to match multiple data from DHB, MOH and NGO's in HealthSafe;
- Development of a strategy to provide a targeted approach to address disparity; and
- This is the first tool of its kind in CM Health (and nationally) to provide an overview of services working with families specifically designed for families with babies at increased need of SUDI protection.

CPHAC thanked Dr McIntosh and Ms Higgins and asked that they return in the latter half of 2020.

Resolution (Moved: Ashraf Choudhary/Seconded: Dianne Glenn)

The Community & Public Health Advisory Committee:

Received the Counties Manukau Health SUDI Prevention Plan 2019/20; and

Noted the progress to date on the work plan for Sudden Unexpected Death in Infancy prevention.

Carried

5. PRESENTATION

5.1 Metro-Auckland System Level Measures (Kate Dowson, Primary Care Programme Manager and Damien Hannah, Project Manager System Level Measures)

Presentation to be shared as an information paper in the next agenda.

The 6 high level aspirational goals with a focus on equity are:

1. Ambulatory Sensitive Hospitalisation (ASH) rates for 0 – 4 year olds;
2. Acute hospital bed days per capita;
3. Patient experience of care;
4. Amenable mortality rates;
5. Youth are healthy, safe and supported; and
6. Babies living in smokefree households at six weeks.

These goals are set by the MOH and each district develops a yearly improvement plan. The concept of everyone working together is working very well. The ALTs are accountable for these measures.

The 19/20 Metro AKL Improvement plan will see the development of a regional plan across all three DHBs. There is an SLM Steering Group made up of members from both Alliance Leadership Teams and each measure has a PHO lead. An implementation group sits underneath this, and close relationships with other groups across the region (e.g. Metro Auckland Clinical Governance Forum). Instead of activities for each measure, we have sets of activities which contribute to 2+ measures. Almost all of the activities are equity focused, and the plan reflects a strong commitment to the acceleration of Maaori and Pacific health gain and the elimination of inequity for Maaori and Pacific peoples.

Where a PHO is currently doing an innovative job in a particular area, they will have the overall lead on that measure.

SLM Milestones: MOH more interested on DHBs focussing on the activities rather than achieving the milestones. Demonstrating working towards achievement is key.

Conversation came back to the data being collected but unable to be shared between services. The data that we collect is shared with the MOH who monitor progress. However, as mentioned MOH's concern is with the activity that is being undertaken in order to show progress. They also advise that they wish for DHBs to ensure that GPs have the relevant information.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Katrina Bungard/Seconded: Ashraf Choudhary)

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
2.1 Confirmation of Public Excluded Minutes 25.09.19 3.1 Primary Care Deep Dive: Development of the CM Primary & Community Care 2025 Strategy.	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Carried

This first part of the meeting concluded at 11.00am.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING OF 6 NOVEMBER 2019.

Colleen Brown
Committee Chair

From: Vicky Tafau (CMDHB)
To: Dinah Nicholas (CMDHB)
Subject: Recommendation to the Board - CPHAC 6.11.2019
Date: Monday, 02 December 2019 11:43:24
Attachments: image001.png

Primary Care Deep Dive: Development of the Counties Manukau Primary and Community Care 2025 Strategy (Matt Hannant, General Manager Primary Funding and Development, Primary Care)

Work is underway to develop a new Primary and Community Care 2025 Strategy as part of the District Health Board's work to refresh the Healthy Together strategy for 2020-2025. The work will be informed by national, regional and local work underway that sets out challenges and strategies in primary and community care.

A set of principles have been developed to guide this work. A small working group is leading the development of the strategy, in collaboration with stakeholders and partner organisations within and outside the District Health Board.

A first draft is due for completion by the end of November to support consultation in December and a Board workshop early next calendar year. This paper describes emerging themes and seeks feedback on all aspects of the process.

The paper shows the timeline and principals that are guiding the work and thoughts moving forward. To date there have been good things achieved with Localities, but where to in the future? There will be a focus on working with local communities on co-design.

Common themes from submissions in Phase One include the need to:

- Support the achievement of equity and honouring Treaty of Waitangi obligations;
- Respecting Iwi Partnerships and matauranga Maaori;
- The needs and rights of the patient / whaanau come first and we must take a whaanau centred approach;
- We want excellent access to high quality care, with the same standard across the district (and region), delivered in ways that are more responsive to our community's needs and using co-design and co-production approaches;
- Promote an environment of performance and accountability;
- Are based on evidence, data and analysis along with promotion of innovation and continuous improvement;
- Willingness to do things differently and where necessary, positively disrupt the status quo and create the correct settings for service transformation; and
- Prioritise, co-design and implement coordinated and integrated primary and community health services.

CPHAC asked why the DHB can't incentivise GPs to move into areas of high need. It was suggested that this is an area where Nurse Practitioners would be able to move into small areas of high need. If we really want to be a disruptor, then focus on looking outside the box in order to really support the needs of these communities. This is where Te Ranga Ora will be able to help support.

Potentially the DHB could step into the PC space and provide the services that are required, but not being provided.

If we just leave it to the market, the risk is that we will keep getting what we've got. Need to

stimulate the market to look a new models of care.

Keen to see the DHB break apart the 15min consultation. Fine for those it works for, but not for high needs populations. Another opportunity for the Nurse Practitioners.

It was noted that there will a) not be enough doctors and b) not enough doctors that will wish to work in those high needs areas. With the funding we have, how do we bundle up with other sectors, how do we learn from the disability sector, where they have more individualised models of care, how do we think more holistically?

Learning the Primary Care business will be a challenging and complex time for the DHB, in order to find what works for the community.

Resolution (Moved: Colleen Brown/Seconded: Dianne Glenn)

The Community & Public Health Advisory Committee:

Noted the update regarding the development of a Counties Manukau Health Primary and Community Care 2025 Strategy as part of the District Health Board wide work to refresh the Healthy Together strategy for 2020-2025.

Fed back to the team on the approach, principles, and emerging themes described in this paper for the evolving Primary and Community Care 2025 strategy.

Recommendation to the Board: that this work is complex and CPHAC felt it would be beneficial for it to be workshopped by the Board.

Carried

Vicky Tafau
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Minutes of the
Regional Disability Support Advisory Committee

Held on Thursday, 14 November 2019 at 1.00am
Senior Citizens Room, Fickling Convention Centre, 546 Mount Albert Road, Three Kings, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Co-Chair)
Jo Agnew (Committee Co-Chair)
Dianne Glenn (CM Health Board Member)
Edward Benson-Cooper (WDHB Board Member)
Judy McGregor (Board Chair, WDHB)
Katrina Bungard (CM Health Board Member)
Michelle Atkinson (ADHB Board Member)

ALSO PRESENT

Samantha Dalwood (Disability Advisor, WDHB)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions, CM Health)
Sue Waters (Chief Health Professions Officer, ADHB)
Tim Wood (Funding & Development Manager, Primary Care, WDHB)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present.

WELCOME

The Chairs opened the meeting at 1.00pm and welcomed all those present.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda.

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from Allison Roe, Catherine Abel-Pattinson, and Gwen Tepania-Palmer, Robyn Northey and Amanda Bleckmann.

2.2 Disclosure of Interests

There were no disclosures of interests to note.

2.3 Disclosure of Specific Interests

There were no special disclosures in relation to today's agenda.

2.4 Minutes of the Previous Meeting

Confirmation of the Minutes of the Regional Disability Support Advisory Committee meeting held on 6 June 2019.

On pages 8 & 9 Ms Atkinson had some amendments which she will email to Ms Tafau.

Resolution (Moved: Colleen Brown/Seconded: Dianne Glenn)

That the minutes of the Regional Disability Support Advisory Committee meeting held on 6 June 2019 be approved.

Carried

2.5 Action Items Register & 2.6 Work Plan (Joint Item Discussion)

Ms McGregor feels that the Work Plan should sit in both areas. We should be cross-fertilising now and not wait for the Ministry of Health. Which work plan? The DSAC Work Plan or the MoH work plan? Which areas does this refer to?

CM Health's new Board will be undertaking an Inequities workshop in early 2020.

Discussion to be held at Board level re where Maaori & Pacific Disability Action Plans sit within the organisations and how they will be actioned.

With the launch of the new Disability Action Plan – it will be interesting to see what sits in there around direction, in particular for Maaori & Pacific. Is this a quote? Someone's comment?

Each Board to sign off an agreement for a community representative from each District to sit on RDiSAC. Mana Whenua representation is also to be included.

Ms McGregor felt that it would be beneficial to focus on 2 or 3 priorities regionally. Structure the meetings a different way in order to allow for a better reporting back (to Board) functionality.

Ms McGregor added - The current Work Plan was drafted at the beginning of 2019 and contains core DHB Strategic Work – communication, websites. There needs to be critical focus in order for RDiSAC to be taken seriously. Would like to see more employment for Disabled persons. The Health & Disability Interim Report states that DHBs are large employers and there is no reason why they can't increase the employment within their organisations. RDiSAC could look to gain Board support to introduce targets that can be reported to the Board. It will be important to see the link with Board Strategy. Look into providing a Dashboard that can be fed to the Boards.

A positive course of action is required going forward in relation to how we report on disability employment.

All three DHBs are on a journey to employ more disabled persons. Making deliberate changes in the system in order to make it easier for disabled people to apply and therefore gain employment at DHBs.

Gaining the Accessibility Tick is relatively easy, but it is keeping the Tick that is difficult. All three DHBs will need to show continuous improvement. They need to be organisations where people feel comfortable discussing their disabilities and feel safe to do so.

It was felt that whilst DHBs are moving in the right direction, employing the key people (Recruitment, etc), driving the change, there is still a disjunction between the Government and the work that is being undertaken at the DHB level.

In order to keep Boards informed of where DHBs are at, informative reporting is required from the RDiSAC.

Next engagement with community could be around presenting what work has been undertaken since the previous community engagement at the end of 2017.

Conversation ensued around clarification that whilst the Committee is the Governance arm sitting across the 3 metro-DHBs, the operationalization of how the work is carried out and in fact, what work is carried out, is very individual in approaches to the application of the Plan.

It is a responsibility of this committee to push recommendations to the Board and then on to the MOH in order to hold them accountable.

Seek clarification around what is the mandate of the committee.

Resolution (Moved: Colleen Brown/Seconded: Jo Agnew)

Recommendation to the Boards: The Interim Report of the Health & Disability System Review states *"Better health, inclusion, and participation of people with disabilities must be a priority for action across the whole health and disability system. Increasing numbers of people are living with disability, and more disabilities are being recognised. The system needs to gear its ability to respond to disability becoming more of a norm.*

The Panel's view is that, as the largest employer in many regions, the system should lead in employing people with disabilities. Boosting employment of disabled people overall may be the single biggest contributor to improving wellbeing of disabled people. Bringing their skills to the workforce in health will also make the sector more responsive, adaptive, inclusive, and reflective of the community."

In light of the above requirement, RDiSAC would like to acknowledge the work that is going on within each DHB and asks Boards to discuss how they would like visibility of the fulfilment of the above obligations. Their preferences should be communicated back to RDiSAC prior to the next meeting on 2 April 2020.

Carried

3. STANDING ITEM

3.1 Metro Auckland DHBs Disability Strategy Implementation Plan 2016-2026 – Progress Report (Samantha Dalwood, Disability Advisor, WDHB)

Resolution (**Moved:** Colleen Brown/**Seconded:** Dianne Glenn)

The Regional Disability Advisory Committee:

Received this progress report.

Carried

4. PRESENTATION

4.1 DHB Accessibility & Disability Update (Adele Thomas, Organisational Development Practice Leader, ADHB)

Note that this information is sitting with Boards. ADHB was the first DHB to be awarded the Accessibility Tick at the end of 2018. The Tick has since been re-awarded in 2019.

In terms of purchasing and procurement, ADHB need guidance around ensuring that disability is considered. Individual DHBs are working with healthAlliance in order to update their policies to include consideration of people with Disabilities. Need to think about how we approach this, preferably in a staged manner, in particular for smaller organisations/NGOs. A proactive programme to take the provider leaders on a journey of understanding is to be considered. Further discussion to be had offline around how DHB's can approach this body of work. Case studies can be helpful in order to help inform organisations.

Working towards de-stigmatisation for organisations, with the Recruitment team holding a 'Confidence in recruiting disabled staff' workshop and a 'Disability confidence for managers' workshop. Hiring Managers are to gain an understanding around disabled people. Workshops have been well received in the organisation.

The recruitment process has been reviewed, implementing more supportive processes. Showing encouragement on website for people with disabilities to apply. Putting current staff with disabilities videos on the website as another way to provide encouragement for disabled people to apply for DHB roles. All job adverts display the Accessibility Tick.

Partner with Be Accessible and get interns through them.

Designed an Accessibility survey for staff. To be launched in December.

Whilst DHBs currently interview Maaori & Pacific applicants automatically, ADHB would like to see disabled people being automatically interviewed as well.

It was noted that that each DHB is looking to mirror the work that ADHB is doing.

RDiSAC congratulated Ms Thomas on the work to date.

Mr Nand advised that on the 2nd of December, CM Health will receive the Accessibility Tick. Waitemata DHB will get theirs on 3 December, which is International Day of Disabled Persons.

5. DISCUSSION

5.1 **Committee Members to discuss the validity of Community Representation** (one representative from each DHB)

Advertise widely. Three different roles and each incumbent to have a different skill set. The subject of Mana Whenua was raised and it was felt there should be representation on the Committee.

5.2 **Complexity of Finding Data about Disabled People:** There is a need for specific questions for Adri Isbister, DDG Disability, prior to her attendance at the RDiSAC meeting in April 2020.

We're not set up in a systematic way in order to be able to collect the data. The way the data is collected needs to be consistent across DHBs and the MoH.

We are required to have a plan for the region, but we don't have a way to collect the data to support what the needs may be in the future. Consistent and accurate data needs to be collected.

A series of questions for Ms Isbister need to be compiled and this will need to happen offline as there is no meeting between now and April 2020. Need a whole of system picture in order to be able to look towards planning for the future.

Questions for Ms Isbister: invite her to 2 parts of the April meeting, both Data and Strategy.

6. DISCUSSION

6.1 Taikura Trust and their role in the Disability Sector (Sonia Hawea, CEO, Taikura Trust)

Sonia introduced Peter Hoskin (Community Engagement Manager), Kelly Norton-Matthews (Support Manager), Sally Clark (Manager, Support & Resources)

Sonia advised that Taikura Trust is moving towards a new direction and will be testing new ways of working.

A recent restructure has flattened the structure. There are now 7 leadership roles and an enhanced service delivery team.

Looking holistically, including social supports as well. Model will focus on where the need is most and will walk the journey alongside the client.

Concerns that they are a demand driven service. Case loads are increasing, for some approx. 480 cases per staff member.

There are 6000 low needs clients so Taikura are looking to become more efficient, asking the right questions in the right way, how do we service this group of people? The Funding team are working on simplifying the funding models to do what? To make it easier for clients?

Taikura is the largest NASC in the country with 11,700 clients, often people with multiple needs. Working towards better consistency for clients. Preparing for how we can support disabled people and their families/whānau around flexible funding conversations.

Improving on eligibility pathways and looking at new ways of engagement. Increasing capability internally in order to be able to meaningfully engage. Will link in with the DHBs more effectively.

Hospital In-Reach roles have been maintained. Interface with Hospital rehab will be worked on, in particular around the discharge planning process.

Taikura have signed an MOU with CM Health around commitment to new ways of working together with the DHB, particularly in the space of how do they best place their staff to work more efficiently and effectively with the DHBs.

Taikura advised that it is the MOH that holds the contracts with support providers, not Taikura. So there is no requirement for support providers to accept Taikura's requests for client support or assistance.

Contracts are inadequate to look after very complex cases. In order to find the appropriate support, this can take a lengthy amount of time that is unacceptable for the client. Because Auckland is seen as too big and too expensive, innovative models/pathways of care that may be delivered in other parts of New Zealand can take time to reach Auckland.

Ms Hawea was asked with the change in Taikura, how do you continue to deliver the services that are still required? As a unit, the three managers have worked together on the pace of the change. Ensuring that nothing is lost on the way, engaging with DHBs in a problem-solving manner. Focus has been around better communication, smoother processes, getting support faster.

Young people transitioning from the education sector is a focus for Taikura. It has been highlighted as a service gap. Currently working with clients on an individual basis. Moving to a more effective model.

Capacity in local areas for people to transition into the community is lacking. There appears to be a lack of awareness from planners around what people with disabilities needs are.

Working together going forward using the collective influence in order to effect change. Taikura is working closely with Fepulea'i Margie Apa in order to get the right information in front of the MOH.

RDiSAC would like the opportunity to meet again with Taikura in 2020 to determine how their new models are working for their clients.

The Regional Governance Group have tried to collect as much data as possible in relation to long term investment planning. As they move into health planning, Taikura sharing data with DHBs in order to be able to better inform the MOH would be hugely beneficial.

Regional Dual Disability Service – Ms Hawea is part of this work as invited by Dr Peter Watson.

CPHAC thanked the team for coming along today and the information they shared and look forward to meeting again in June 2020.

The Co-Chairs thanked the Committee members and staff for their commitment during the year and looked forward to a fresh start in 2020 after a break.

The meeting concluded at 4.00pm.

SIGNED AS A CORRECT RECORD OF THE AUCKLAND METROPOLITAN DISTRICT HEALTH BOARDS REGIONAL DISABILITY SUPPORT ADVISORY COMMITTEE MEETING OF 14 NOVEMBER 2019.

Colleen Brown, Committee Co-Chair

Jo Agnew, Committee Co-Chair

From:	Vicky Tafau (CMDHB)
To:	Dinah Nicholas (CMDHB)
Subject:	2019-11-14 RDiSAC Recommendation to the Board
Date:	Wednesday, 04 December 2019 14:23:53
Attachments:	image002.png image003.png
Importance:	High

Action Items Register & 2.6 Work Plan (Joint Item Discussion)

Ms McGregor feels that the Work Plan should sit in both areas. We should be cross-fertilising now and not wait for the Ministry of Health.

CM Health's new Board will be undertaking an Inequities workshop in early 2020.

Discussion to be held at Board level re where Maaori & Pacific Disability Action Plans sit within the organisations and how they will be actioned.

With the launch of the new Disability Action Plan – it will be interesting to see what sits in there around direction, in particular for Maaori & Pacific.

Each Board to sign off an agreement for a community representative from each District to sit on RDiSAC. Mana Whenua representation is also to be included.

Ms McGregor felt that it would be beneficial to focus on 2 or 3 priorities regionally. Structure the meetings a different way in order to allow for a better reporting back (to Board) functionality.

Ms McGregor added - The current Work Plan was drafted at the beginning of 2019 and contains core DHB Strategic Work – communication, websites. There needs to be critical focus in order for RDiSAC to be taken seriously. Would like to see more employment for Disabled persons. The Health & Disability Interim Report states that DHBs are large employers and there is no reason why they can't increase the employment within their organisations. RDiSAC could look to gain Board support to introduce targets that can be reported to the Board. It will be important to see the link with Board Strategy. Look into providing a Dashboard that can be fed to the Boards.

A positive course of action is required going forward in relation to how we report on disability employment.

All three DHBs are on a journey to employ more disabled persons. Making deliberate changes in the system in order to make it easier for disabled people to apply and therefore gain employment at DHBs.

Gaining the Accessibility Tick is relatively easy, but it is keeping the Tick that is difficult. All three DHBs will need to show continuous improvement. They need to be organisations where people feel comfortable discussing their disabilities and feel safe to do so.

It was felt that whilst DHBs are moving in the right direction, employing the key people (Recruitment, etc), driving the change, there is still a disjunction between the Government and the work that is being undertaken at the DHB level.

In order to keep Boards informed of where DHBs are at, informative reporting is required from the RDiSAC.

Next engagement with community could be around presenting what work has been undertaken since the previous community engagement at the end of 2017.

Conversation ensued around clarification that whilst the Committee is the Governance arm sitting across the 3 metro-DHBs, the operationalization of how the work is carried out and in fact, what work is carried out, is very individual in approaches to the application of the Plan.

It is a responsibility of this committee to push recommendations to the Board and then on to the MOH in order to hold them accountable.

Seek clarification around what is the mandate of the committee.

Resolution (Moved: Colleen Brown/Seconded: Jo Agnew)

Recommendation to the Boards: The Interim Report of the Health & Disability System Review states *"Better health, inclusion, and participation of people with disabilities must be a priority for action across the whole health and disability system. Increasing numbers of people are living with disability, and more disabilities are being recognised. The system needs to gear its ability to respond to disability becoming more of a norm.*

The Panel's view is that, as the largest employer in many regions, the system should lead in employing people with disabilities. Boosting employment of disabled people overall may be the single biggest contributor to improving wellbeing of disabled people. Bringing their skills to the workforce in health will also make the sector more responsive, adaptive, inclusive, and reflective of the community."

In light of the above requirement, RDiSAC would like to acknowledge the work that is going on within each DHB and asks Boards to discuss how they would like visibility of the fulfilment of the above obligations. Their preferences should be communicated back to RDiSAC prior to the next meeting on 2 April 2020.

Carried

Vicky Tafau
Executive Assistant I Population Health Directorate
Dr Gary Jackson, Director Population Health & Campbell Brebner, Chief Medical Advisor, Primary Care

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countiesmanukau.health.nz I COUNTIES MANUKAU DISTRICT HEALTH BOARD

From: Dinah Nicholas (CMDHB)
Sent: Wednesday, 04 December 2019 1:53 p.m.
To: Vicky Tafau (CMDHB) <Vicky.Tafau@cmdhb.org.nz>
Subject: can you send me the RDISAC recommendation for Board please

Dinah Nicholas
Executive Assistant to Margie Apa - Chief Executive
Board Secretary

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Middlemore Hospital, Private Bag 93311, Otahuhu, Auckland 1640
www: cmdhb@org.nz

cid:image001.png@01D1964E.44331930

Decision Paper
Counties Manukau District Health Board
Biopsy Capable Mammography Machine

Recommendation

It is recommended that the Counties Manukau District Health Board:

Receive this request for approval to procure a Biopsy capable mammography machine that was not on the Board approved capital plan for the 2019/20 year.

Note this paper was endorsed by the Executive Leadership Team on 26 November to go forward to the Board.

Note this machine was not prioritised on the 2019/20 capital plan as the system was omitted from the prioritisation process due to the mammography units not being recorded in the Clinical Engineering Services' asset register and missed correspondence. Clinical Engineering is working with the Cancer Screening Services to record all their medical equipment (including all leased equipment).

Note that the BreastScreen service is requesting an urgent replacement of the biopsy capable mammography machine because the existing machine is past its useful life and regularly breaks down. This puts the service at risk as during downtime for this machine there is only 1 biopsy capable machine left in the department to support the busy clinics.

Note at the Quarter 1 Capital Budget and Prioritisation Executive Leadership Team sub-committee meeting held in October 2019, funding through substitution and reprioritisation from the exiting Board approved 2019/20 capital plan was agreed.

Note the capital cost of the Tomosynthesis Machine is $320k and this price has been obtained by healthAlliance procurement through negotiations with the successful vendor from an RFP process held in 2018. Dispensation has been approved by the health Alliance Procurement Board on 15 October.

Note an additional $30k is required to support the installation of the machine (software licence, monitor and workstation).

Note the operational cost of this equipment is $27,000 per annum for a service and maintenance agreement post the 12 month warranty period.

Note that in terms of the Delegated Authority Policy Board approval is require for capital expenditure >$250,000 if it was not on the Board approved capital plan, provided the item can be substituted by substitution funding.

Note that Corporate Finance will look at leasing this machine as a funding option.

Approve the proposal to procure a replacement Biopsy capable mammography machine at a capital cost of $320k and supporting IT infrastructure of $30k and total operational costs of $243k over 10 years (to be funded from the Breast Screening contract with Ministry of Health)**.**

Approve total capital funding of $350k through substitution from the 2019/20 Board approved capital plan.

Delegate to the Chief Executive Officer, authority to sign any relevant contract documentation.

Prepared and submitted by: Kathy Pritchard, Service Manager of Cancer Screening Services and Catherine Tracy, General Manager of Medicine on behalf of Dr Gloria Johnson, Chief Medical Officer.

Glossary

BSCM – BreastScreen Counties Manukau
CAPEX – Capital Expenditure
DHB – District Health Board
ELT – Executive Leadership Team
FSA – First Scheduled Appointment
OPEX – Operating Expenditure

Purpose

The purpose of this paper is to request Board to approve this request for capital expenditure (CAPEX). As per the The Delegated Authority Policy, Board approval is require for capital expenditure >$250,000 if it was not on the Board approved capital plan, provided the item can be substituted by substitution funding.

Executive Summary

This paper is seeking approval for the procurement of a capital expenditure (CAPEX) item over $250,000 that is not on the District Health Board (DHB) FY19/20 approved capital plan. The CAPEX approval is required to lease a tomosynthesis machine from BreastScreen operating expenditure (OPEX) (purchase price $320,000) and for the purchase of supporting information technology (IT) equipment for $30,000. The Capital Budget and Prioritisation ELT Sub-Committee approved the funding for this equipment at the 2018/2019 Quarterly (Q4) meeting.

BreastScreen Counties Manukau (BSCM)has prepared a business case to replace an aging, faulty, biopsy capable digital machine with a tomosynthesis machine with biopsy capability for the November 2019 Asset and Capital meeting. This has been submitted as a contingency project as the machine was omitted from the DHB approved replacement CAPEX list. If this machine is not replaced, the breast imaging service will have only one reliable biopsy capable machine at a time when the service is working with the breast diagnostic service toward addressing its “unmet need” project; the long First Scheduled Appointment (FSA) wait lists for women with symptoms of breast cancer.

Background

The Breast Imaging service and BreastScreen purchased 2 digital machines with biopsy capability, one installed in Sept 2009 and the other in March 2010. The machine that was purchased in 2009 was on the CAPEX replacement list for 2017/18; it was starting to break down regularly and “freeze” during biopsy procedures. This machine was replaced with a tomosynthesis machine in Sept 2018.

The machine identified for this replacement, was purchased in March 2010 and was omitted from the approved 2019/20 replacement list. The machine is also showing signs of aging and similar faults are being noted with this machine as seen in the machine purchased in 2009. The reason that this machine did not appear on the replacement CAPEX lists is that there is not a full list of Breast Services equipment on the current Clinical Engineering’s asset register and missed correspondence therefore the machine was not identified as needing replacement. Clinical Engineering is working with the Cancer Screening Services to record all their medical equipment (including all leased equipment).

BSCM has prepared a business case to replace the machine installed in March 2010 with a tomosynthesis machine with biopsy capability for the November 2019 Asset and Capital meeting. This has been submitted as contingency as the machine was not the 19/20FY approved replacement CAPEX list. This machine has reached the end of its operational life. A range of faults with the machine have been logged 1-2 times per month requiring an engineer to be called and resulting in machine down time. The machine often fails during stereo biopsies and requires a reboot procedure each time, or the need to move the patient to the other biopsy room during biopsy procedures. This has occurred several times and therefore we have no confidence in the stereo biopsy capabilities of this machine, but as we have only one other biopsy capable

machine and full clinics, we still need to use it at times for biopsies.

A recent incident has been documented where patient was under compression ready for a biopsy when the machine failed and it had to be restarted while she was still under compression. This is stressful for both patients and staff who are midway through biopsy procedures. It is essential that there are two reliable biopsy capable machines for the breast services.

Mammography equipment is shared between the breast imaging / diagnostic service and BreastScreen. As discussed, a tomosynthesis machine was leased for the diagnostic service in 2018, it is used for high risk screening cases, for diagnostic cases attending the diagnostic breast clinic and for assessment of women recalled by BreastScreen Counties Manukau.

The breast diagnostic service is currently addressing an "unmet need" in its service; this was outlined to ELT papers in July and November 2019. Growth in demand and increased complexity of cases has resulted in an inability to meet FSA targets and there have been cases of delayed breast cancer diagnosis. A number of short term "band aid" initiatives are being implemented to address the waiting lists. Long term an additional breast clinic is planned, commencing when additional clinic rooms are available through the Manukau SuperClinic facility expansion. It is essential that there are 2 fully functional biopsy capable machines available to support the interim solutions, (an interim half breast clinic and a nurse lead mammography on arrival clinic) and the definitive solution, a third breast clinic as these additional clinics are running at the same time and using the same equipment as BreastScreen screening and assessment clinics. Without approval of this replacement machine, it will not be possible to run the third breast clinic and there will be bottlenecks and increased waiting times in current clinics caused by machine breakdowns or the reluctance of staff to use the older machine for biopsy procedures.

It is proposed to purchase the same model of tomosynthesis machine as the one that was installed in Sept 2018, which was procured through an RFP process. Dispensation for this by the health Alliance Procurement Board was granted on 15 October 2019. The tomosynthesis machine will be leased from ring fenced BreastScreen OPEX. The purchase of supporting IT infrastructure, a radiologist workstation, 5MP monitor and a tomosynthesis licence, a total of $30,000 is required to support the project. There will be an on-going annual Maintenance and Service cost of $27,000 to be funded from BreastScreen's operational budget after a 1 year warranty period.

Proposal

This paper is requesting Board approval of total capital funding of $350k through substitution from the 2019/20 Board approved capital plan. If Board approval is not gained this financial year the procurement of the machine will be delayed significantly, extending the period that the service has just one reliable biopsy capable machine. This will increase the risk already documented on the DHB Risk Register in relation to wait times in the breast diagnostic service and also potentially impact negatively on BSCM's ability to meet screening targets.

The Executive Leadership Team endorsed for this paper to be submitted to the Board for approval at their meeting on the 26 November 2019.

Discussion

A separate further business case has been approved by ELT to address the "unmet need' in the diagnostic breast service. This approved business case has identified that addressing the breast diagnostic "unmet need" is contingent on the procurement of this replacement biopsy capable tomosynthesis machine. This proposal is supported by the Lead Surgeon, Diagnostic Breast Service, the Medical Director, BSCM and the Lead Radiologist, Counties Manukau Health Mammography unit and the Clinical Director, Division of Medicine.

Decision Paper
Counties Manukau District Health Board
Winscribe Text Business Case

Recommendation:

It is recommended that the Board:

Receive the business case for the implementation of Winscribe Text as a replacement for out of support and end of life Soprano Medical Documents (Clinical documents transcription application also known as MedDocs).

Note this paper was endorsed by the Audit Risk & Finance Committee on 20 November to go forward to the Board.

Note that the estimated total capital cost of the implementation of Winscribe Text is $1.171m.

Note that the $1.171m required capital budget is planned to be funded as follows:

- $850k from the 2019/20 Board approved capital plan; and
- $321k from the 2020/21 top sliced Board approved capital plan.

Note that the Winscribe Text application provides a technology platform to enable voice recognition and that the costs of implementing this are excluded from this business case.

Note that the operational costs of implementing Winscribe text is $ 250k over 5 years with $23k additional Opex in 2019/20 and $45k pa from 2012/21 – 2024/25.

Note that Winscribe Text is the regionally preferred solution for dictating and transcribing clinical documents as the result of a request for procurement process in 2018. WDHB are already using Winscribe Text and NDHB are in the business case phase.

Agree the proposal to progress the implement Winscribe Text at a capital cost of $1.171m and total operational costs of $250k over 5 years and, delegate to the Chief Executive Officer, authority to sign any relevant project documentation.

Note that on Board approval, the business case will be presented to the 13 December 2019 Regional Capital Investment Group (RCIG) meeting for their endorsement. Upon endorsement of RCIG, the Operational Framework 2019/20 Policy determines the approval thresholds applying to investments in information systems and communications technology, therefore the business case is required to be approved by the Director-General of Health for investments where the whole of life cost is greater than $1.0 million or the project cost is up to $10.0 million.

Prepared and submitted by: Jenny Pooley on behalf of Ian Dodson, General Manager Clinical Support and Stuart Bloomfield, CIO.

Purpose

This paper seeks to present the preferred option for the replacement of MedDocs with Winscribe Text, a modern technology platform for dictating and transcribing clinical documents.

Executive Summary

Background

Winscribe Digital Dictation and MedDocs are currently used to create and publish clinical documents relating to clinical interactions with patients. Winscribe is already familiar to CM Health clinicians as it is used for digital dictation. This implementation of Winscribe Text enables the dictation and transcription to be completed within the same system. There will be little change to the clinicians using the system for dictation however there will be significant change in workflow for clinical transcriptionists.

Over 30 services currently use these systems to record episodes of care with over 500 templates set up within the system. This system along with Soprano Medical Templates (SMT) form the main systems currently used to electronically record clinical reviews and documentation. The implementation of Winscribe Text will allow the continuation of critical services for clinical staff, transcriptionists and general practitioners.

The key objectives of this project are:

- To replace a platform (MedDocs) that will soon be defunct with a modern, stable and reliable technology platform.
- To ensure documents can be easily viewed from in Regional Clinical Portal across the Northern Region.
- To ensure documents are transmitted to appropriate destinations in a timely manner (e.g. GPs).
- To ensure that any Author can create clinical documents by dictating or typing from any location using a variety of devices.
- Establish a stable platform for the implementation of Voice Recognition in a future project.

This business case proposes to rollout Winscribe Text to all inpatient, outpatient and community areas at CM Health that currently use Winscribe Digital Dictation and MedDocs using a service by service approach over 12 months at a total cost $1.171m. The incremental operational costs are $250k over 5 years.

Regional context

At the time of writing this business case WDHB have implemented Winscribe Text. NDHB are in the business case phase for implementing Winscribe Text. WDHB are using voice recognition and there are significant learnings from their implementation process that CM Health has included within this business case. The key learning from this process was that voice recognition should be implemented separately from the dictation and transcribing process. ADHB are not committed to the implementation of Winscribe Text and are continuing a market scan give the challenges WDHB have faced relating to performance of the application and the time taken for clinicians to become familiar with the software.

Options Analysis

Option 1 - Do nothing – remain using MedDocs
Discounted - MedDocs will no longer be supported by the vendor from July 2020. This is a critical administration system for the documentation of clinical care.

Option 2 – Undertake a new request for procurement (RFP) process seeking an alternative supplier.
Discounted – the previous RFP process was completed in 2017 and general agreement across the region supports that there are no other alternatives within the market at this time. This would not be prudent to undertake this process at this stage however CM Health will continue to monitor the market with regards to alternatives before submitting a business case for implementation of voice recognition.

Option 3 – Implement Winscribe Text.
Preferred – aligns CM Health with WDHB and NDHB, provides an up to date technology solution for the recording and transcribing of electronic clinical records. In addition it provides a modern platform to implement voice recognition technology if agreed that this is the right application at the time of business case writing. The new platform has more flexibility in the template set up which enhances digital document transmission and availability:

- Self-authoring: licenced authors can use templates to create, finalise and transmit documents in real time. This is in scope for any author covered by this project. This will be an increasingly utilised option for younger authors in particular, and clinicians wishing to write and transmit brief notes (e.g. to GPs).

- Flexible document creation: the Winscribe Text application has much more flexibility in document and template creation, including easy use of 'macro' functions (e.g. auto text) which will be particularly useful to 'self authors'.

Enabled, but not in scope of current project

- Voice to text: the platform can support either front end (visible to author) or back end (visible to transcriptionist) voice to text transcription. This uses Dragon Medical software. While it allows transcriptionist free document creation, it incurs a substantial licence fee (current approx. $2000 per author).

- Inclusion of non-Winscribe self-authors. Currently, many staff are self-authoring digital documents using Word. These documents are either not stored in a readily visible repository or not digitally stored at all. These authors could move to Winscribe text and documents would be then stored a part of the digital patient record.

Financial Case

The capital cost of the Winscribe implementation is estimated at $ 1.171m in total.

	0)
Appraisal Period (years)	5
Capital Costs	1,171
Whole of operating life costs	250
Cost benefits analysis of monetary costs and benefits	

Present Value of Economic Benefits	
Present value of costs	(1082)
Net Present Value	(1082)

Sensitivity Analysis

The table below illustrates the potential NPV sensitivity for a +/- 20% (increase/decrease) in benefits and also a +/- 20% (increase/decrease) in costs.
Need to add in this picture

Funding Sources

CMH 2019/20 ICT Board approved Capital Plan	$ 850k
CMH 2020/21 ICT Board approved capital plan	$ 321k
TOTAL	**$1.171m**

Appendix

1. Winscribe Text Business Case.

CM Health

Business case

WinscribeText

Prepared for:	Ian Dodson
Date:	31 October 2019
Version:	1.0
Status:	Released

Document Control

Document Information

	Position
Document ID	
Document Owner	David Newton

Document History

Version	Issue Date	Changes
0.1		Draft
0.2		Draft with additions
0.3		Added requirements, change, benefits information, plans and sign off.
0.4		Major changes
0.6		Major changes after review with Jenny Pooley
0.7		Reviewed by Ian Dodson (in meeting), and reviewed by Mary Neate for benefits.
1.0	31/10/2019	Issued to Jenny Pooley.
1.1	7/11/2019	Minor changes made to document post initial review.

Document Review

Role	Name	Review Status
	Stuart Bloomfield	
	Jenny Pooley	Reviewed October 28th, 30 and 31st. Reviewed post first ELT meeting with minor changes.
	Janet Gibson	Reviewed on 25th, 3rd and 4th of October then on the 28th, 30 and 31st.
	Jenny Parr	
	Brian Yow	
	Tina Sun	
	ISGG	
	ELT	
	Ian Dodson	Reviewed main points on 30th November.

Document Sign-off

Role	Name	Sign-off Date
Project Sponsor	Ian Dodson	
Business Owner	Janet Gibson	
Programme Manager	Jenny Pooley	

Contents

Executive Summary

This business case recommends the replacement of Soprano Medical Documents (SMD, otherwise known as MedDocs) with Winscribe Text, a modern technology platform for dictating and transcribing clinical documents. Orion Healthcare, the vendor for Soprano Medical Documents (MedDocs) has given formal notice to DHBs that they will no longer support this application from July 2020. Implementing a product that is already in use across the region mitigates the potential loss of a critical service. Implementing Winscribe Text future proofs CM Health for voice recognition (VR) capabilities in the future and with VR, further benefits. Winscribe Text is the preferred regional system with WDHB already live and NDHB in the business case approval phase.

Winscribe Text is already familiar to CM Health clinicians as it is used for digital dictation. This project enables the transcription to be completed within the same system. There will be little change to the clinicians using the system however there is some change in workflow for clinical transcriptionists. Over 30 services currently use these systems to record episodes of care with over 1600 templates (500+ in active use) set up within the system.

The implementation of Winscribe Text will allow the continuation of critical services for clinical staff, transcriptionists and general practitioners. The key objectives of this project are:

- To replace a platform (MedDocs) that will soon be defunct with a modern, stable and reliable technology platform.
- To ensure documents can be easily viewed from in Regional Clinical Portals across the Northern Region.
- To ensure documents are transmitted to appropriate destinations in a timely manner (e.g. GPs).
- To ensure that any author can create clinical documents by dictating or typing from any location using a variety of devices.
- Establish a stable platform for the implementation of Voice Recognition in a future project.

This business case proposes to rollout Winscribe Text to all inpatient, outpatient and community areas at CM Health that currently use Winscribe Digital Dictation and MedDocs using a service by service approach over 12 months.

Recommendation:

At the time of writing this business case WDHB have implemented Winscribe Text. NDHB are in the business case phase for implementing Winscribe Text. WDHB are using voice recognition and there are significant learnings from their implementation process that CM Health has included within this business case. The key learning from this process was that voice recognition should be implemented separately from the dictation and transcribing process.

The Strategic Case

MedDocs is a document management system used by transcriptionists in the four Northern Region DHBs and has been used at CM Health since 1998. MedDocs is developed on Microsoft Access software which is considered old technology. The vendor, Orion Health, has announced that it will cease support of this application in July 2020. In anticipation of this happening, the Northern Region DHBs undertook a procurement process for a new document management system in 2018. Winscribe Text was the preferred application. Since then WDHB have implemented the application and NDHB are in the process of achieving business case sign off.

Winscribe Text is provided by the same vendor as Winscribe Digital Dictation which CM Health clinicians already use. This application also has voice recognition dictation functionality. The initial rollout of Winscribe Text at CM Health proposes to replace MedDocs, and a second phase of the project anticipates introducing voice recognition for clinical staff. A number of staff already type their own letters in both SMD (and SMT), which has reduced pressure on transcription staff but can be time consuming. Voice recognition dictation has the potential to save clinical staff time and provides improved flexibility for their dictation workflow.

Alignment to Strategy

Local Context

Implementing Winscribe Text is in line with CM Health's 'Healthy Together' strategy aim of delivering Healthy Services'. Winscribe Text allows CM Health to meet the strategic goals of:

- quality and safety is consistent across care delivery
- reducing clinical variation for a more reliable experience
- optimising care delivery through timely, safe, coordinated and effective care
- infrastructure investment to add capacity

Implementation of Winscribe will enable a reduction in the variation in templates used, standardise set up and provide better visibility of clinic appointments that do not have dictation associated with every episode of care.

Regional Context

WDHB has implemented Winscribe Text as their solution for digital dictation and transcribing. The lessons learnt from the WDHB implementation are informing the CM Health approach.

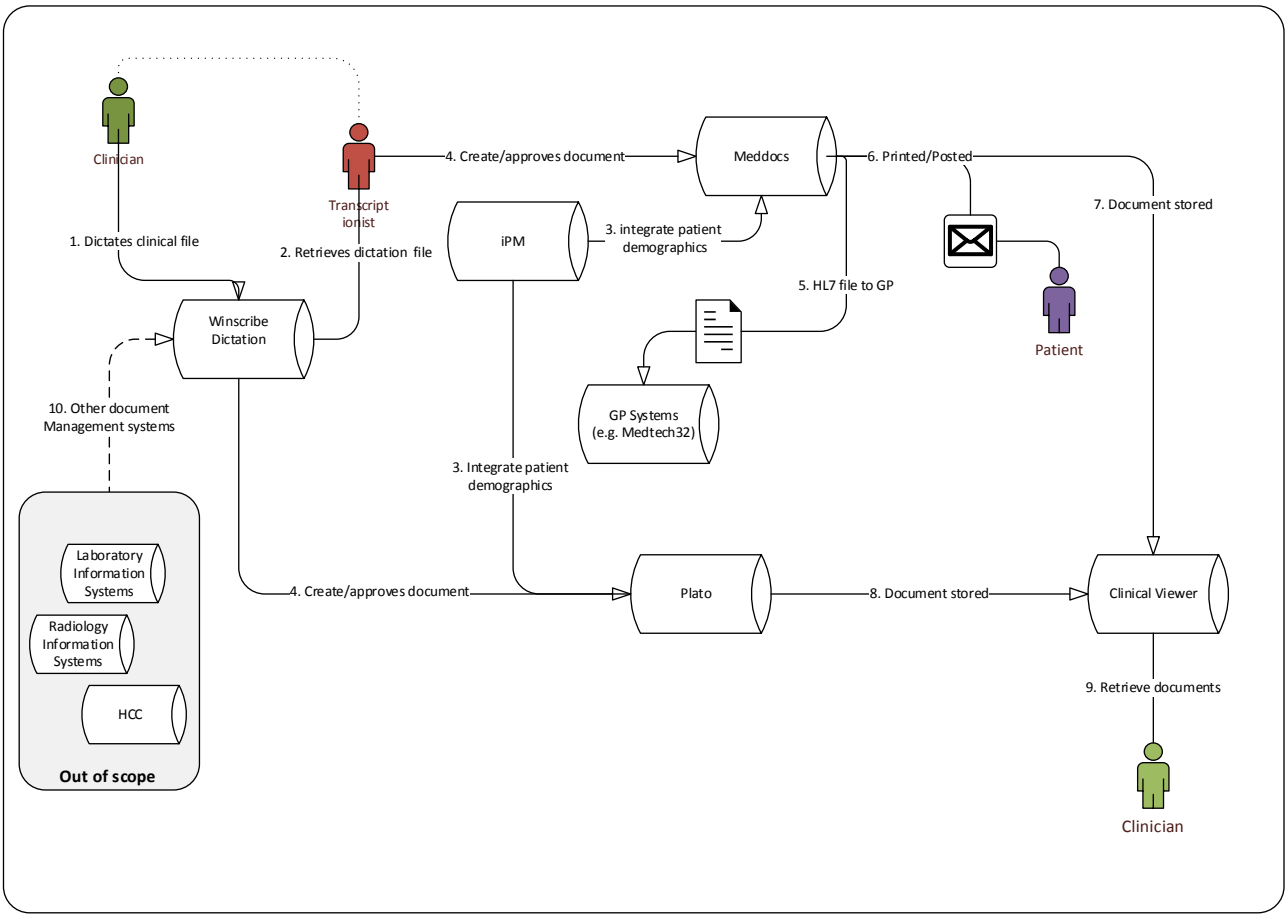
By implementing Winscribe Text CM Health will be aligned regionally as NDHB are also implementing Winscribe Text. This will enable CM Health the opportunity to work with other regional DHBs for future support and development of Winscribe Text.

As Winscribe Text has already been implemented at other WDHB the product is known to health Alliance.

The Need for Investment

The Current State

Winscribe Digital Dictation and MedDocs are used to create and publish clinical documents relating to clinical interactions with patients. The Clinician (known as the 'Author') dictates the document using a microphone, handset or mobile phone app into Winscribe Digital Dictation 4.0. The Clinical Transcriptionist (known as the 'Typist') retrieves this file from the relevant queue and creates the document in MedDocs. The document is then reviewed and approved/validated by the Clinician before being distributed to the patient (as a printed/posted document) and to the patient's GP via Aspire.



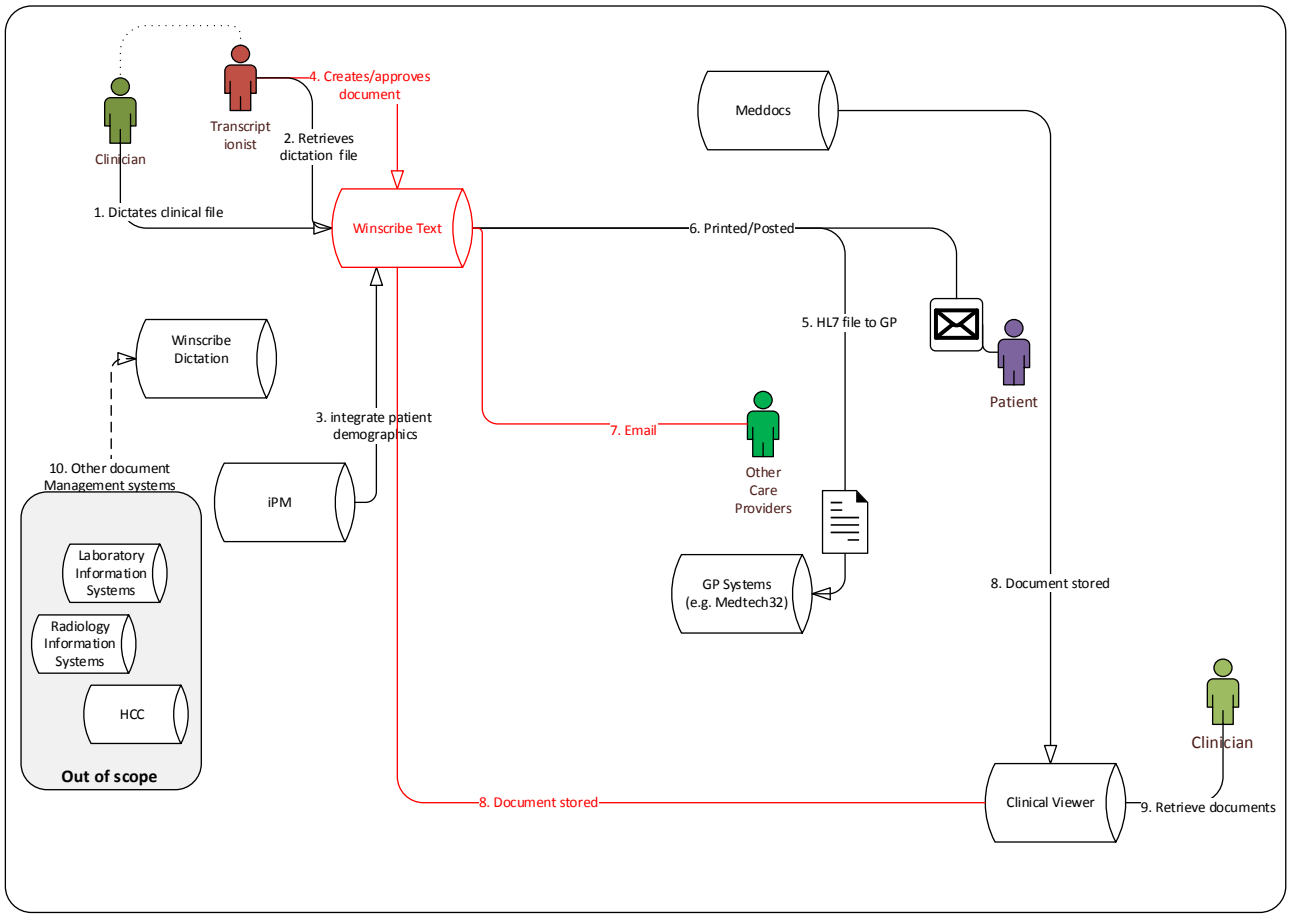
The challenge with the current state is that MedDocs will no longer be supported by Orion Healthcare from July 2020.

Future State

The Clinician will dictate their clinic notes for patients into Winscribe Digital Dictation 4.3. The Clinical Transcriptionist will retrieve the file and create the document in Winscribe Text 10.2. The document is then distributed as per existing functionality.

- Documents will be viewable from Clinical Document Viewer and historic MedDocs documents will remain viewable in the Clinical Documents Viewer ensuring continuity of documentation from one system to the next.
- The option for clinicians to create documents directly using voice recognition will also be available in Phase 2 of the project.

- Templates will be rationalised from 584 templates across the thirty service areas to less than 100 in total.



Future opportunities

In the future, voice recognition can be implemented using Winscribe Text as a potential Phase 2 of this project.

The Case for Change

Winscribe Text will provide a modern, reliable technology platform that will enable CM Health to move away from the reliance on MedDocs. MedDocs will no longer be supported by the vendor, Orion Health from July 2020. Electronic capture of clinical information is critical in ensuring safe and efficient patient care. It is therefore essential that CM Health continue to provide a digital dictation and transcribing service.

Project Scope and Deliverables

Details of the project scope are as follows:

Scope and Users

Implementation of the digital transcription process to the following areas:

- All inpatient, outpatient and community services that currently use MedDocs to create and store documents.

- Services using HCC (Mental Health), Laboratory System (Histology) and PLATO (Orthopaedic, Plastics) will continue to use these applications. Further work is required to better understand if PLATO users can to transition on to Winscribe Text.

Application Deliverables

- Installation of the latest generally available version of Winscribe Text.
- Functional testing, including user acceptance testing.
- Preparation of business continuity plans in case of system outage.

Change Management Deliverables

- Preparation of work flow documentation and modifications to existing protocols/process.
- Communication that ensures everybody has the right level of understanding and required knowledge to use the Winscribe Text solution.
- A review of all templates and transfer of appropriate ones to Winscribe Text.
- Establishment of standardised auto text (snippets) that can be used across all services or by all transcriptionists for various clinicians.

Infrastructure Deliverables

- Installation of Winscribe Text to the following environments:
    - Development.
    - Acceptance (load balanced).
    - Production (load balanced).
- High availability servers and storage with fail over to a different geographic location.
- Security and penetration audit.
- Non-functional (disaster recovery and performance) testing.

Integration Deliverables

- Winscribe Text will integrate with the iPM patient administration system to receive patient demographic, ADT (admission / discharge / transfer) updates.
- An approved / validated document will be passed electronically via HES to Clinical Portal then Aspire integrates to the GP Patient Management System.
- Any document published in MedDocs will be visible immediately after in the Clinical Document Viewer (via Clinical Portal).

Reporting Deliverables

- Reporting that allows the day-to-day monitoring by the Clinical Transcription Service team leaders of the workload to ensure priorities/deadlines are being met:
    - Backlog (hours)
    - Oldest Job (date)
    - Turnaround (working days)
    - Document Breach Summary
    - Provides a listing by functional area of transcribed documents which have breached the target turnaround of 7 days
- Data from the Winscribe database will be made available to CM Health data warehouse.
- Out of the box reports from Winscribe Text.
- Development of a limited number of bespoke reports.

Out of Scope

The following items are specifically excluded from scope:

- Implementation of voice recognition to all services (In a future business case).
- Transfer of any services that are not currently using MedDocs.

Approach

This business case includes the rollout to all CM Health Clinical Services that currently use MedDocs for clinical documentation management. Services will be transitioned on to the new platform over a twelve month period. The Patient Information Services in conjunction with the project team will review all templates and identify commonalities so that templates will have a standardised set up. These forms will then be reviewed by services and compared to existing templates to ensure that any new ones developed are aligned with service requirements.

Clinicians using Winscribe Text will require minimal training as there is little change to the way they dictate into Winscribe Text. Clinical Transcriptionists will require one on one training and support to go live. Training will be provided by a clinical change analyst and patient information services. Super users will be identified for further training to support their colleagues.

Benefits

Winscribe Text has the benefit of enabling clinicians to continue to create, distribute, store and view clinical documents. It eliminates the risk that the current system, MedDocs, will fail after June 2020 when no support will be available. If MedDocs failed the consequences across CMH are likely to be significant. Winscribe Text ensures CMH's continued ability to manage clinical documents using a supported, regional solution.

Although this is essentially a 'like for like' replacement, with new processes similar to current processes, Winscribe Text is expected to deliver additional benefits:

- Enabling the addition of voice recognition technology in the future

Clinician	Current Process	New Process	Expected Benefit
Document management	• Clinical document management system (MedDocs) is operational	Clinical document management system (Winscribe Text) is operational	Moving to a supported, future proofed document management system
Voice recognition	• No voice recognition capability	Infrastructure exists for adding voice recognition capability in future	Future benefits from voice recognition are enabled

Economic Case

Winscribe Text is the preferred tool for digital dictation and transcription of medical documents within the Northern region. Orion Health has indicated there will be no future development of this product and support will be withdrawn from July 2020 therefore the following options were reviewed:

- Option one: Do nothing
- Option two: Initiate a new procurement process
- Option three: Implement Winscribe Text

Critical Success Factors

The key critical success factors (CSFs) for the project have been derived from the core CSFs contained within the Treasury Better Business Case guidance.

Strategic Fit - how well the option meets National, Regional and DHB aims and strategies.

Business Needs – how well the option satisfies the existing and future needs of the DHB and the Health Sector.

Supply Side Capacity and Capability – the ability of the vendors and potential suppliers to deliver the required services and deliverables.

Potential Value for Money - how well the option optimises value for money (i.e., the optimal mix of potential benefits, costs and risks); and ensuring capacity to meet demand while living within our means.

Potential Affordability – the ability of the stakeholders to fund the required level of expenditure.

These CSFs have been used, along with the investment objectives for the project to evaluate the list of possible options.

Options and Conclusions

Option 1 - Do nothing – remain using MedDocs

Discounted - MedDocs will no longer be supported by the vendor from July 2020. This is a critical administration system for the documentation of clinical care.

Option 2 – Undertake a new request for procurement (RFP) process seeking an alternative supplier.

Discounted – the previous RFP process was completed in 2018 and general agreement across the region supports that there are no other alternatives within the market at this time. This would not be prudent to undertake this process at this stage.

Option 3 – Implement Winscribe Text.

Preferred – aligns CM Health with WDHB and NDHB, provides an up to date technology solution for the recording and transcribing of electronic clinical records. In addition it provides a modern platform to implement voice recognition technology. The new platform has more flexibility in the template set up which enhances digital document transmission and availability:

- Self-authoring: licenced authors can use templates to create, finalise and transmit documents in real time. This is in scope for any author covered by this project. This will be an increasingly utilised option for younger authors in particular, and clinicians wishing to write and transmit brief notes (e.g. to GPs).

- Flexible document creation: the Winscribe Text application has much more flexibility in document and template creation, including easy use of ‘macro’ functions (e.g. auto text) which will be particularly useful to ‘self authors’.

Enabled, but not in scope of current project

- Voice to text: the platform can support either front end (visible to author) or back end (visible to transcriptionist) voice to text transcription. This uses Dragon Medical software. While it allows transcriptionist free document creation, it incurs a substantial licence fee (current approx. $2000 per author).

- Inclusion of non-Winscribe self-authors. Currently, many staff are self-authoring digital documents using Word. These documents are either not stored in a readily visible repository or not digitally stored at all. These authors could move to Winscribe text and documents would be then stored a part of the digital patient record.

Financial Analysis of Preferred Option (3)

Financial benefits expected to accrue from this implementation of Winscribe Text over a five-year horizon are summarised as follows:

	$('000)
Appraisal Period (years)	5
Capital Costs	1,171
Whole of operating life costs	250

Analysis of **non-monetary** benefits:	
1	Clinicians continue to have a document management system available
2	Future benefits from speech to text are enabled

Commercial Case

The procurement strategy is to move to the vendor of choice selected through the regional procurement process completed in 2017 leveraging the privacy clause included in this agreement. This aligns CM Health with NDHB and WDHB.

Financial Case

The estimated operational cost of Option 3 is $250,437 over the expected lifespan of 5 years and an initial upfront capital investment of $1,170,830.

Winscribe Text Project cost schedule

Cost Category	Cost Detail	Account categories					
		Hardware	Software/ Licenses	Professional Services	CMH Internal	Other Costs	Grand Total
Project Delivery							
	Discovery and Business Case			56,000			56,000
	Business Analysis			10,000			10,000
	CMH Project Manager			90,000			90,000
	Reporting building			30,000			30,000
10%	Project Delivery Contingency			18,600			18,600
Project Delivery Total		$ -	$ -	$ 204,600	$ -	$ -	$ 204,600
IT Health Alliance							
	Project Management and Solutions Design			340,000			340,000
25%	IT hA contingency	-		85,000			85,000
IT Health Alliance Total		$ -	$ -	$ 425,000	$ -	$ -	$ 425,000
IT Prime Vendors	SBS						
	Hardware (Microphones and headsets	17,500					17,500
	Software Licences		80,192				80,192
	Implementation fees			42,750			42,750
	Training & workshops			4,500			4,500
	Maintenance		17,850				17,850
	Winscribe Text Author User License AM		4,740				4,740
	Winscribe Text Typist User License AM		18,802				18,802
	Clinical Portal Interface			10,000			10,000
	Configuration and testing			1,000			1,000
	Vendor expenses						
25%	IT Prime Vendor contingency	4,375	30,396	14,563			49,334
IT Prime Vendors Total		$ 21,875	$ 151,980	$ 72,813	$ -	$ -	$ 246,668
IT (hA/Prime /Other Vendors) Total		$ 21,875	$ 151,980	$ 497,813	$ -	$ -	$ 671,668
Change Management							
	Change Mgmt & Comms			38,400			38,400
	Clinical Change Analyst			100,000			100,000
25%	Change Mgmt contingency			34,600			34,600
Change Management Total		$ -	$ -	$ 173,000	$ -	$ -	$ 173,000
Backfill Staff-training and set up							
	Backfill typist			18,750			18,750
15%	Backfill contingency			2,813			2,813
Backfill and set up Total		$ -	$ -	$ 21,563	$ -	$ -	$ 21,563
PMO							
	Management				100,000		100,000
PMO Total		$ -	$ -	$ -	$ 100,000	$ -	$ 100,000
TOTAL PROJECT COST		$ 21,875	$ 151,980	$ 896,975	$ 100,000	$ -	$ 1,170,830

Winscribe Text Opex Schedule

Opex per annum		FY20	FY21	FY22	FY23	FY24	FY25	Total
Winscribe Text Typist User License AM		2,370	4,741	4,742	4,743	4,744	4,744	26,084
Winscribe Text Author User License AM		9,401	18,802	18,802	18,802	18,802	18,802	103,411
SBS Maintenance & Support Contract		8,925	17,850	17,850	17,850	17,850	17,850	98,175
Contingeny	10%	2,070	4,139	4,139	4,140	4,140	4,140	22,767
PMO :Project and Portfolio Mgmt								
OPEX estimate (incl. contingency)		22,766	45,532	45,533	45,535	45,536	45,536	250,437

Assumptions: Incremental project costs ONLY

Forecast Profit and Loss Statement (Cash benefits only) Winscribe Text $'000								
Interest Rate (n.a)	**0.0%**	Years						
Project Life Years	**5**	0	1	2	3	4	5	TOTAL
Corresponding Financial Year		FY20	FY21	FY22	FY23	FY24	FY25	
Investment:								
Initial Investment		(851)	(320)	-				(1,171)
Total Investment Outflow		(851)	(320)	-	-		-	(1,171)
Revenue/Benefits (Cash only) Inflow								
Cash		-	-	-	-		-	-
Total Revenue		-	-	-	-		-	-
Operating costs								
Maintenance		(23)	(46)	(46)	(46)	(46)	(46)	(250)
Service charge (Depreciation)			(202)	(242)	(242)	(242)	(242)	(1,171)
Interest		-	-	-	-	-	-	-
Total Operating Costs		(23)	(248)	(288)	(288)	(288)	(288)	(1,421)
Forecast Net Surplus/(Deficit)		(23)	(248)	(288)	(288)	(288)	(288)	(1,421)
Net Surplus/(Deficit) Cumulative		(23)	(270)	(558)	(846)	(1,134)	(1,421)	(1,421)

The key assumptions in the model are:

1. The project duration is estimated at 12 months duration from business case submission.
2. CM Health will be able to use WDHB infrastructure that already exists.
3. The project starts with the set-up of Winscribe Text for CM Health on that infrastructure.
4. Preparation of interfaces to iPM is included in the project duration as a concurrent activity.
5. A 25% contingency is included in the project budget for IT costs, $246,668 for Winscribe Text vendor costs, and 25% contingency for Change Management and 15% contingency on Project Management. Any unknown risks or known accepted risks that do eventuate may results in variation of cost, schedule or quality. Resolution will be sought via the change control process from the steering group.
6. A business change budget is included in the project costs to manage the review and configuration of templates for all services currently using MedDocs.
7. CM Health staff will be made available to undertake training and User Acceptance Testing. Some backfill for the Patient Information Services team has been allowed to enable staff to undertake overtime if required during the implementation period.
8. Support and maintenance costs payable to the vendor are included in operating expenditure
9. These costs are inclusive of pure technology costs (hardware and software licenses), vendor implementation charges, healthAlliance (hA) resourcing charges, CM Health project and change management and subject matter expertise to be backfilled during implementation and rollout.

Proposed funding will be arranged through this business case request for capital funds from the CM Health Capital budgets for FY2019/20 and FY2020/21.

NPV Sensitivity Analysis

In estimating the future state we believe the benefits are likely to be on the conservative side.

Sensitivity Analysis		NPV moves to $('000)
Decrease Costs	-20%	(1,104)
Increase Costs by	20%	(1,552)

With a 25% contingency built into hA costs it is likely the costs are on the prudent side.

Funding sources

CMH FY19/20 IS Capital Fund	$ 850
CMH FY20/21 ICT Capital Fund	$ 321
TOTAL	**$1,171**

Please note: $321k from the 20/21 ICT Capital plan is subject to ELT and Board approval as this plan has not been submitted and approved at the time of writing this business case.

Risks, Assumptions, Issues and Dependencies (RAID)

Title	RAID	Mitigation Strategy
Funding	I	CM Health to consider available funding alongside other Healthy Together 2020 and other organisational investments
Vendor pricing	A/D	Vendor costs are based upon pricing given directly to CMH in October 2017. Based on recent quote, HA procurement to validate costs in line with the regional agreement
hA Pricing	R	hA were unable to provide any cost estimates in the timeframe. CMH PM and HA Portfolio Manager have estimated based on previous projects.
Vendor Design, Build, operational support	R/D	CM Health is dependent on design, build and operational support from the vendor & hA.
Low stakeholder engagement	R	The project will ensure comprehensive engagement with key stakeholders using project change management and communications plans.
Delivery approach	R/A	The project intends to take a phased approach which will ensure that the training and support give to the transcriptionists will be sufficient to not slow down their output significantly.
Variability of work practices between	R/A/D	Ensure coaching and training plans are developed in conjunction with

Title	RAID	Mitigation Strategy
different services.		Patient Information Service Manager and Team Leads
MedDocs support as CM Health transitions to new application post July 2020	D/R	Project will need to negotiate on-going discussions with Orion to ensure that MedDocs will continue to be available for those services not on Winscribe text by July 2020.
Availability of CM Health resources	R/D	Robust project planning and management will take into account resource availability for activities such as business process mapping, training, configuration, testing and go live activities. Funding is requested for adequate resources to support the project.
Availability of vendor resources	R/D	Robust project planning and management will ensure resources and deliverables are timely from healthAlliance, and SBS (vendor). Timing of other upgrades and projects will be taken into consideration. Resources are committed at the contracting phase.
Resistance to change by staff	R	Key stakeholder engagement of Transcriptionist Team Leaders and Service Manager has commenced early to ensure that the service is heavily involved in the development and configuration of the new application. A comprehensive change management strategy will be implemented.
Reporting data from Winscribe Text	R/A	Winscribe Text data will be made available to the CMH data warehouse. This will be confirmed through due the planning stage.
Project Timeline	R	The project duration is estimated at based on the information available at the time of writing.
Vendor Costs	R	hA and SBS deliverables are subject to Statement of Works and approvals.
Budgeted contingency	R	Contingency figures are based on previous HTT programme business case figures
Interface development	R	Solution design will confirm that the technical implementation of the required IT system interfaces is achievable.
Budget scope	R	Any unknowns may eventuate in a variation to the cost, schedule or quality. These will be subject to change control approval from the steering group.
System performance	R	Performance testing may be limited. Non-functional requirements will include performance.
Ease of uptake	A	Winscribe Text digital dictation has been in the organisation for a number of years and there is little change for clinicians dictating into the system.
Report writer availability	R	Availability of CMH report writer resource to develop custom reporting
Suitable hardware for dictation	A	Existing dictation devices in some services is suitable for on-going use. New hardware has been identified for some areas based on feedback and recommendations from the vendor.

Title	RAID	Mitigation Strategy
Templates can be standardised and rationalised	A	The existing 583 templates in use will be rationalised to a number which meet the generic need across the service areas using them. The Clinical Change Analyst will work with services to review templates and ensure that these meet their needs. Any significant changes will be discussed with the Clinical Lead, Service Manager, PIS and Project Manager.
Viewing documents in Clinical Document Viewer (CDV)	A	MedDocs and Winscribe Text documents will be viewable from Clinical Document Viewer. This will be finalised through the solution design process. NB: WDHB are able to do this now.
Exclusion of authors using other document management systems (e.g. PLATO)	A	Those authors dictating into other document management systems will be excluded from the list of authors requiring licenses for the upgrade.
Change in process of editing	R	Once a clinical document has been approved, it cannot be edited but a copy of the letter can be created for editing.

Constraints

Reference	Description
C001	The task of rationalising the templates currently in use will be time-consuming given the volume of templates in use and the need to consult with the business before introducing change.
C002	External factors which impact the success of creating an auditory file will not be addressed by the Winscribe Text implementation. E.g. lack of privacy, background noise, availability of microphones.

Dependencies and Other Initiatives Linked to this Project:

Name	Description
Soprano Medical Templates (SMT)	A number of staff document their interactions with patients using electronic forms which have been created to reduce the pressure on the transcription staff. The system they use is called **Soprano Medical Templates (SMT)** and this is also an outdated piece of software. Orion Health has not yet issued formal notice about when this will be out of support, but it is imminent. CMH will be implementing a system that will replace SMT in the next year. The team for that project will be investigating the best option for clinical staff to continue to type their own documents. This may be use of the new system (Care Pathways), or taking up the option of using the voice recognition feature which is available in Winscribe Text as an alternative. This will be done after the implementation of Winscribe Text. The SMT upgrade also has an impact on future work that is related to Care Pathways.
The Mailhouse Project	**The Mailhouse Project** is looking at introducing a system to send copies of their appointment letters, discharge summaries and copies of clinic letters to patients via email. This automated process will reduce the cost of postage and

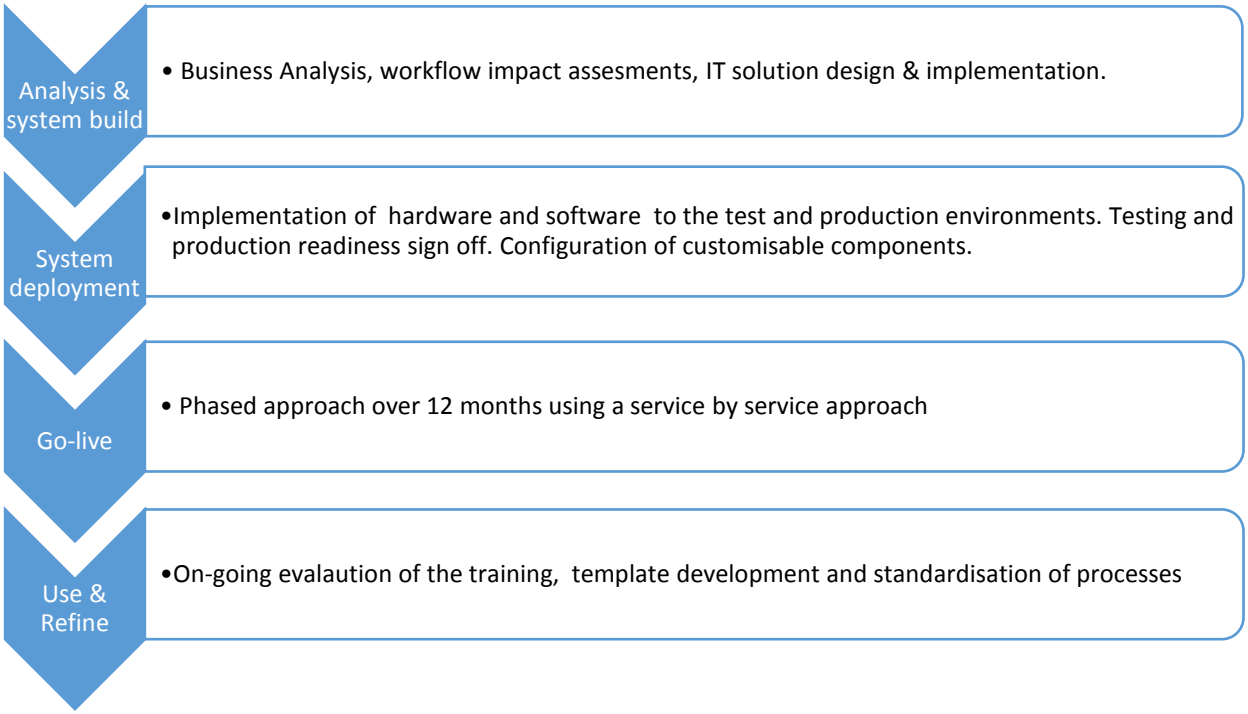
	printing and will save the transcription staff time.
Clinical Portal	The project team who is working on implementing a regional instance of **Clinical Portal** is investigating the option of electronically messaging "copies to" to internal recipients. This would reduce the time transcriptionists spend on printing and inserting letter in envelopes.
Care Pathways Project	**Care Pathways Project** This is a new application from Orion Health, designed to allow multiple clinicians to contribute to one document. The Spinal Unit is a service that has had difficulty effectively storing and maintaining documentation for long-term and complex patients. Care pathways is thought to be a solution for this service, so it will be used as a pilot site for the application.

Management Case

The Winscribe Text project will be delivered as part of CM Health's Healthy Together 2020, Technology Stream. This comprises of a programme of related projects to progress the National and Local digital hospital agenda. It includes diagnostic ordering, medication management, upgrades of key clinical systems and mobility.

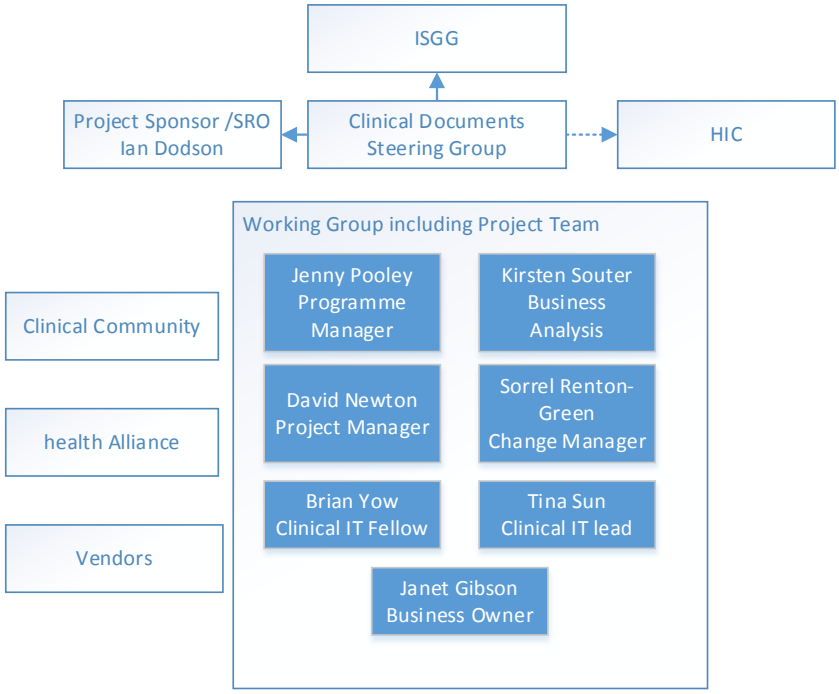
Proposed Project Approach

The diagram below captures the steps taken to prepare and deploy the Winscribe Text solution



Project Governance will be managed through the Information Services Steering Group (ISSG) Executive Leadership Structure and the General Manager of Central Clinical Services will act as Senior Responsible Officer for the project on this Steering Group. This project will be supported by advisory and working groups

(including vendor and customer representatives) who will be empowered to manage the day to day running of the project.



Implementation Strategy: Winscribe Text will be rolled out across all inpatient, outpatient and community services that currently use MedDocs for clinical documentation. A service by service approach will be taken. The speed of implementation wil depend on the number of templates each service requires. Wherever possible the project team will be introducing standardised templates and configuration.

Replacement through joining an established regional solution: CMH will be joining the other Northern Region DHBs in implementing Winscribe Text, with the ability to leverage their knowledge and experience.

Project management framework: The project will be implemented using CM Health's 'Manukau Method' – a standard project management framework currently in use at CM Health and based upon PRINCE2 methodology.

Project management tools: ***Daptiv*** – CM Health's online project tool – will be used to administer project controls (risk, issues, decisions, tasks, plans, milestones, etc.) and will provide regular status reporting as input to governance meetings.

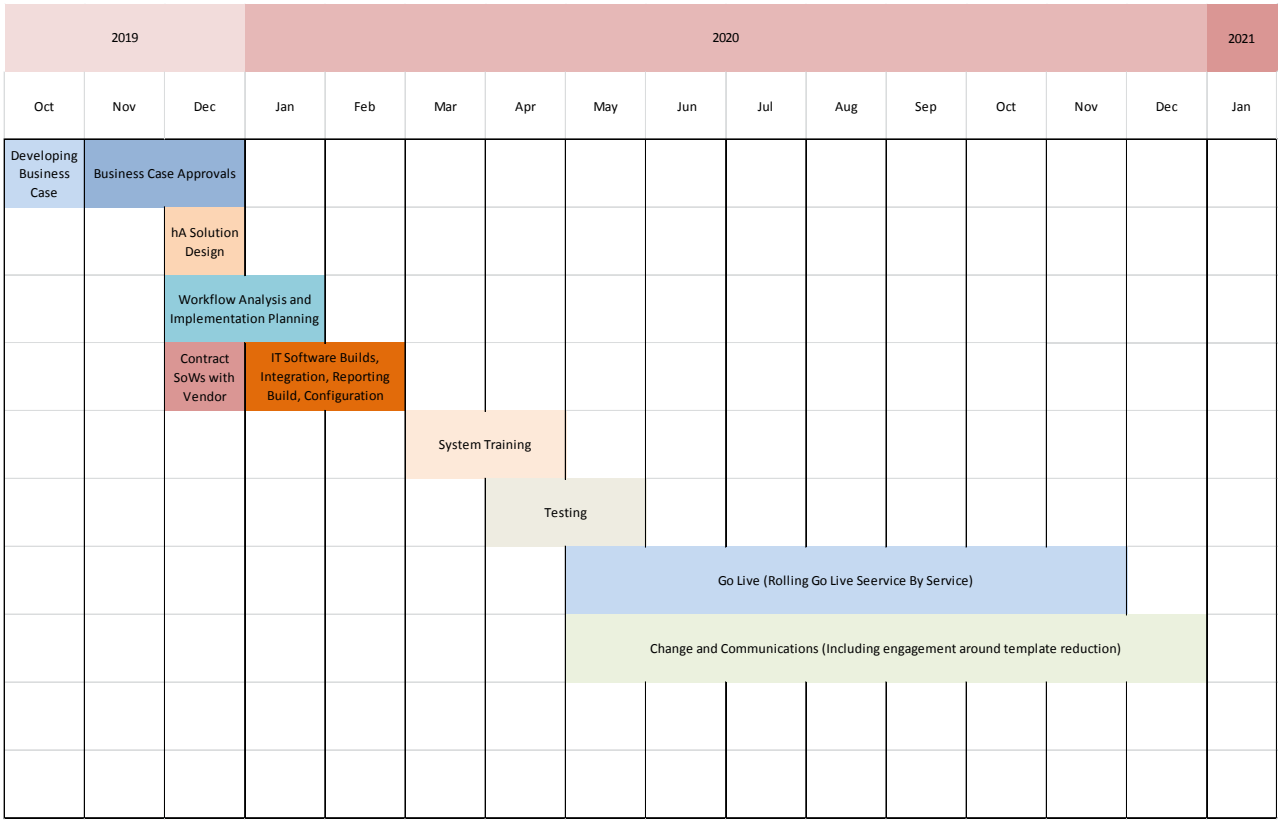
Risk management planning: CM Health already has good risk management processes in place. These defined processes are already a core part of the project management controls in use and are recorded, managed and reported at a project level via Daptiv.

Project timelines: to drive speedy delivery, the vendor and hA have been engaged to prepare for the project. We will commence solution design, workflow analysis and implementation planning immediately following business case approval.

Project Plan and Milestones:

The project is envisaged to take approximately 12 months from business case submission to rollout completion.

Project Timeline



Project evaluation: reviews are a part of the project management methodology and scheduled at the end of each project phase and prior to commencing the next phase.

Contract management: the strategy, framework and plan for dealing with contract change and associated contract management will utilise the existing contract management process in place with health Alliance via hA Procurement team, leveraging the existing Northern Region contract agreement.

Change management

This implementation will utilise and build on lessons learned from previous implementation at WDHB

Organisational change management will be undertaken by CM Health and the project team via Patient Information Services and the Healthy Together Technology Team. As with the introduction of any new technology, there will continue to be complex questions around business process change, integration and transitioning from the current to new systems environment.

Change Management will:

- ensure all impacted stakeholders are identified and engaged
- ensure everybody will have the right level of understanding and will have all the required knowledge and skills to perform the new process
- promote business benefits of the project
- promote and influence desired outcomes and acceptance
- minimise misinformation and resistance
- encourage feedback and input

To achieve these objectives, communications will be: timely, accurate, realistic, consistent, and positive and in accordance with stakeholder requirements (targeted). A series of workshops with key stakeholders will be conducted. They will identify:

- A list of operational processes that will need to be changed
- The number and type of staff affected by the implementation how they will be affected and their expected training needs
- Expectations regarding Winscribe configuration and any integration requirements

Change management activities will be jointly undertaken by the Project Manager, Clinical Change Analyst and Service Manager for Patient Information Services. Such activities will include:

- Involving doctors,nurses, midwives, and Allied Health staff on the project team
- Involving staff in the completion of the 'before and after' survey
- Formalising the identification and management of stakeholder groups
- Involving other clinical services in configuration activities
- Establishing and implementation of a comprehensive communication plan
- Formalising the workflow redesign process
- Involving end users in testing activities (user acceptance testing)
- Conducting a privacy impact assessment
- Training and assessing users with a variety of approaches that will fit into their work schedules
- Providing a high level of go live support and follow up at go live, including trained Super Users

Benefits Management

Benefits realisation management (BRM) will be employed to ensure alignment between project outcomes and the business case.

BRM will identify accountable people, relevant measures and proactive management of benefit realisation with specific milestones post project implementation. This will allow for corrective actions to be made where possible should benefits not be realised according to plan.

BRM process deployed:

1. Define benefit measures for each outcome
2. Identify business performance measure(s) / key performance indicator / key result area that are pivotal to realising the benefit aligned to the areas impacted
3. Determine the business person responsible for the indicator / measure and agree how it will be reported
4. Baseline the current measure and put in place reporting to track these indicators
5. Identify when benefits should start to be released and plan measures aligned to expectations
6. Assess any unintended consequences (dis benefits) and include these in the benefit analysis
7. Review the impact of the plan implementation on the Benefit Measures with relevant business owners and advise / assist them with any adjustments to realise the benefits planned
8. On completion of the plan, ensure BRM continues to sustain the capabilities and realisation of benefits
9. Conduct a post implementation review in conjunction with the sponsor and change lead to determine the final outcome versus plan and detail the lessons learned.

Next Steps

This business case seeks formal endorsement from Executive Leadership Team and Audit Risk and Finance ahead of submission for approval from the CM Health Board to progress the implementation of the preferred option to implement Winscribe Text and joining a shared technology platform with regional DHBs.

Meeting Schedule:

Group	papers due	meeting date
HTT	1 Nov 2019	5 Nov 2019
ELT	8 Nov 2019	12 Nov 2019
AR&F	4 Nov 2019	20 Nov 2019
ISGG	21 Nov 2019	26 Nov 2019
CMH BOARD	29 Nov 2019	10 Dec 2019

Appendix One - Current and Future State Comparison

Process Step	Current State	Future State
1. Dictates clinical file	The Author will dictate their clinic notes for patients into Winscribe Digital Dictation system.	The Author will dictate their clinic notes for patients into Winscribe Text (using Winscribe Professional Dictation).
2. Retrieves dictation file	The Typist retrieves the dictation file from Winscribe Digital Dictation and opens the relevant template in MedDocs to create the document.	The Typist retrieves the file from Winscribe Text and opens the relevant template for the service area.
3. Integrate patient demographics	The NHI number is entered in MedDocs to pull through the patient demographic data from iPM.	The NHI number is entered in Winscribe Text to pull through the patient demographic data from iPM.
4. Creates/approves document	The Typist creates and transcribes the document in MedDocs. When it is transcribed, the document is sent to the Author to check and approve. The approved document is returned to the Typist to accept corrections and distribute the document to Clinical Portal, GP and patient. The Author can edit/approve from Clinical portal.	The Typist creates and transcribes the document in Winscribe Text. When it is transcribed, the document is sent to the Author to check and approve. The approved document is returned to the Typist to accept the corrections and distribute the document to Clinical Portal, GP and patient. The Author can edit/approve from within Winscribe Text or Clinical portal.
5. HL7 file to GP	Once the document is approved, the electronic (HL7) file is distributed to the GP's PMS.	Once the document is approved, the electronic (HL7) file is distributed to the GP's PMS.
6. Printed / Posted	Once the document is approved, the Typist will print/post a copy to the patient. If the document needs	Once the document is approved, the Typist will print/post a copy to the patient. If the document needs to be distributed to other

	to be distributed to other recipients (i.e. 'copies to') these are printed and posted.	recipients (i.e. 'copies to') these are printed and posted.
7. Document Stored	Once the document is approved, it is available in the Clinical Portal, Clinical Document Viewer and Testsafe Concerto	Once the document is approved, it is available in the Clinical Portal, Clinical Document Viewer and Testsafe Concerto.
8. View documents	The Clinician can view all clinical documents relating to a patient's history.	The Clinician can view all Winscribe Text documents relating to a patient's history as well as MedDocs.
9. Other document management systems	Some service areas use Winscribe Digital Dictation to transcribe to other document management systems, e.g. HCC	No change.

Appendix Two – Detailed Business Requirements

Typists- Clinical Transcription Service

Req	Req. Description		
BR 01	A Typist can: • Have a view of the central queue of jobs • See the dictations in their personal queue waiting for transcription/finalisation • Be notified when an urgent job arrives in their queue		
BR 02	A Typist can assign files to their personal folder enabling them to hold their work 'in progress' until they have completed the final approved copy.		
BR 03	The naming convention for a template can be intuitive so the Typist is able to retrieve the required template easily for the service they are typing for.		
BR 04	The Typist can select the correct template for the service and add the relevant auto-text to the document if required.		
BR 05	Any completed/approved dictation is stored and available to the Typist so the Typist can edit a document after it has been published to be subsequently re-issued.		
BR 06	The Typist can assess the 'unapproved' and 'checked' in queues of other Typists to process documents in their absence.		
BR 07	The Typist can access a medical dictionary within the system when transcribing a document.		
BR 08	The Typist can create (and add to) the auto-text file to include terms relevant to the services they support.		
BR 09	Any data fields which have been populated from iPM are clearly visible as external data to the user on the template.		

Team Leaders- Clinical Transcription Service

Req	Req. Description	Priority	Comment
BR 010	Reporting data is available enabling the Team Leader of Clinical Transcription services to identify which templates are being used and the frequency of use.		
BR 011	Template creation, editing and deletion are managed by the Team Leader role within the system.		
BR 012	The Team Leader can see when there is a delay in the service delivery by viewing transcription throughput measures.		
BR 013	The Team Leader can add or remove an author or typist from the system.		
BR 014	The Team Leader can configure groups (of typists) where required, inclusive of groups with secure access to specific templates.		
BR 015	The Team Leader can view the central queue of incoming dictation at all times.		
BR 016	The Team Leader can run a report daily for the 'typist group', 'typist' and the service as a whole to report on the following statistics: ▪ Hours of dictation ▪ Dictation- hours/Count # ▪ Backlog of dictation – hours / Count #		
BR 017	The Team Leader can set up delegation for a user (either Typist or Author) for any absences.		
BR 018	The Team Leader can move a document from one NHI to another if the NHI has been merged or unmerged.		

Authors - Clinicians

Req	Req. Description	Priority	Comment
BR 019	Authors need to be alerted in some way there are documents for them to review and approve on clinical portal.		
BR 020	Authors can configure their settings to meet their preferred style of dictation.		
BR 021	Authors can contribute content to multi-disciplinary documents and view content others have added before a document is approved and published.		
BR 022	Authors can dictate documents when there is no connectivity so the letter file can be transmitted once they are back on the network.		
BR 023	Authors can have access to the clinic list and have a means of identifying those patients they have dictated for so they do not miss a patient nor duplicate any letters.		
BR 024	Authors can select recipients other than the patient's GP to send clinical documents to.		
BR 025	The Service Manager can generate a report for clinic letters which are overdue for review or approval.		
BR 026	Authors can set up approval delegation for any planned absences.		
BR 027	Speech to text is available for Clinicians who want to dictate directly to Winscribe Text.		

Plato Specific Requirements

Plato v8.6 is the document management system used by the Orthopaedics and Plastic Surgery Services. It has been in use since 1992. Clinicians dictate using Winscribe dictation and the clinical documents are created using Plato. The following additional requirements are specific to these service areas:

Req	Req. Description	Priority	Comment
BR 028	Templates can be made available for the following document types: ▪ Operation Notes ▪ Complications		
BR 029	The following reports are able to be generated: • Audit – for Complications • Note for Précis		
BR 030	Operation Notes can be captured for a patient. These include: • Patient demographics – *imported from iPM including patient's GP* • Surgeon(s) • Date of Procedure The following headings are available (but can be deleted if not relevant) • Indication/Findings • Procedure • Post-Op • Free text field They are saved to the patient record.		
BR 031	The Administrator can set up teams for the documents where		

	'teams' are a group of Clinicians working with a patient. Team members can be added or removed by the Administrator. e.g. Street/Geddes/Gordon/Debenham		
BR 032	The typist can reference the team the Clinician belongs to when creating the document but the 'author' of the document (not the complete team) will own the document for release.		
BR 033	Any document with a team reference can identify the author of the file.		
BR 034	Patient summary (précis) reports can be generated providing a history for a given patient inclusive of all clinic letters and operation notes. The user can choose the service area(s) to run the report for.		
BR 035	An author approves the document electronically but can also approve via printed format if required.		
BR 036	All approved clinical documents can be viewed from the Clinical Document Viewer.		
BR 037	Reporting (audit)tools are needed to extract data relating to: • Types of operations • Surgeons • Dates		
BR 038	The complication form for a patient captures: • Date / time (*of entry*) • Location (*defaults to hospital*) • Noted by (*Surgeon reporting*) • Privacy • Category • Description – free text field		

Non-Functional Business Requirements

Req	Req. Name	Req. Description	Priority	Comment
NFR 1	Data Accuracy	The users shall ensure that information being captured for inclusion in reporting is accurate, complete and relevant.		
NFR 2	Presentation of Information	The solution shall ensure that information presented considers the use of a summary/overview page based, as well as tabs, sections, and grouping to maximise user efficiency.		
NFR 3	Access	The solution shall enable the user to see only the information they are authorised to see.		
NFR 4	Privacy	The project shall undertake a privacy impact assessment. To analyse how personally identifiable information is collected, used, shared and maintained, and identify any risks that may arise throughout the delivery of the solution. It shall comply with CMH and regional policies and procedures regarding privacy, auditing, storage and security.		

Req	Req. Name	Req. Description	Priority	Comment
		It shall comply with the Privacy Act. Compliance requirement – sets out how agencies may collect, store, use and disclose personal information.		
NFR 5	End to End Solution Testing	The solution shall ensure that there are sufficient end to end test environments provided to support the on-going support and enhancement of the solution.		
NFR 6	Availability & Reliability	The solution shall be available 24 hours a day, 7 days a week (excluding planned outages).		
NFR 7	Performance	The solution shall respond to user activity within acceptable levels.		
NFR 8	Capacity & Scalability	The solution shall have sufficient capacity and scalability to cater for data being captured and viewed across CMH.		
NFR 9	Scalability	The solution shall be scalable and not restricted to a specific number of data sources, or users.		
NFR 10	Maintainability	The solution shall be easily maintained in order to support efficient correction of defects, and future enhancements.		
NFR 11	End to End Support	The solution shall ensure that there is a support structure in place post implementation. That there are clear lines of responsibility and any required SLAs are in place.		
NFR 12	Continued Solution Support & Enhancement	The project shall ensure that there is a clear and agreed upon pathway for delivery of regular fixes & enhancements. This will include any interfaces between systems.		
NFR 13	Data integration	Requirements shall be defined for data being sourced in real time, near real time and batch.		
NFR 14	Automated Data Source	The solution shall be designed, developed and implemented to automate the sourcing of data into a central repository, i.e. no manual intervention by a user shall be required.		
NFR 15	Data Retention	An agreed data warehouse data retention schedule shall exist before implementation begins.		

Integration

Req	Req. Name	Req. Description	Priority	Comment
IR 01	iPM integration	The templates pull patient demographic data from iPM upon entry of the NHI to the template includes GP details (if known).		
IR 02	Aspire	An approved/ validated document will be passed electronically via HES to Clinical Portal then Aspire integrates to the GP Patient Management System.		

Req	Req. Name	Req. Description	Priority	Comment
IR 03	Clinical Document Viewer	Any document published will be visible immediately after in the Clinical Document Viewer (via clinical portal).		

Reporting Requirements

Req	Req. Name	Req. Description	Priority	Comment
RR 1	Weekly Transcription Update	Provides a listing by Service Area of jobs completed over the reporting period, listed by: • Backlog (hrs) • Oldest Job (date) • Turnaround (working days)		
RR 2	Document Breach Summary	Provides a listing by functional area of transcribed documents which have breached the target turnaround of 7 days		

Decision Paper
Counties Manukau District Health Board
iPM Upgrade and Bed Numbering Business Case

Recommendation

It is recommended that the Board:

Receive the business case for the iPM upgrade to version 13 and the implementation of Bed Numbering in iPM.

Note that this paper was endorsed by the Audit Risk & Finance Committee on 20 November to proceed to the Board.

Note the estimated total capital cost of the upgrade of iPM and the implementation of bed numbering is estimated at $2,373k.

Note that the $2,373k required capital budget is planned to be funded as follows:

- $325k transferred underspend from phase 1 iPM in 2017
- $400k from the 18/19 Board approved capital plan
- $1,050k from the 19/20 Board approved capital plan
- $148k from the 20/21 top sliced Board approved capital plan
- $450k from the regional reprioritisation backlog healthAlliance funding pool

Note that the $450k required from regional prioritised funding is subject to ISSP PSG approval.

Note that there are no additional operational costs as a result of this upgrade or implementing bed numbering in iPM.

Note that the bed numbering module provides a real time bed number for use by other systems and does not provide a fully integrated bed management system. This project will ensure the number is available for Trendcare and Clinical Portal. All other systems integration is out of scope.

Approve the upgrade to iPM version 13 and the implementation of bed numbering at a capital cost of $2,373k from the following funding sources:

- $325k transferred underspend from phase 1 iPM in 2017
- $400k from the 18/19 Board approved capital plan
- $1,050k from the 19/20 Board approved capital plan
- $148k from the 20/21 top sliced Board approved capital plan
- $450k from the regional reprioritisation backlog healthAlliance funding pool

And, delegate to the Chief Executive Officer, authority to sign any relevant project documentation.

Note that on Board approval, the business case will be presented to the 13 December 2019 Regional Capital Investment Group (RCIG) meeting for their endorsement. Upon endorsement of RCIG, the Operational Framework 2019/20 Policy determines the approval thresholds applying to investments in information systems and communications technology, therefore the business case is required to be approved by the Director-General of Health for investments where the whole of life cost is greater than $1.0 million or the project cost is up to $10.0 million.

Prepared and submitted by: Jenny Pooley on behalf of Ian Dodson, General Manager Central Clinical Services and Stuart Bloomfield, CIO.

Purpose

This paper seeks to present the preferred option for the upgrade of iPM, CM Health's core patient information system and the implementation of the bed manager module which provides a bed number to other key clinical applications enabling real time capture of bed occupancy.

Executive Summary

The business case outlines the costs of the upgrade of iPM to the latest available release which ensures CM Health remains on a vendor supported version of this application and is windows 10 compliant. In addition to the iPM upgrade, the iPM Bed Numbering module will be fully configured and rolled out across the organisation in conjunction with a Bed Board application enabling the decommissioning of WIMS, the current bed management application. The implementation of the 'bed board' is a tactical solution to assist with managing the bed booking process and will not provide a fully integrated bed management system.

The upgrade of iPM and implementation of the bed manager module will take approximately 12-18 months from commencement of the project. There are over 90 interfaces to update and test. This business case seeks $2,373k to complete these two phases.

Background

iPM is CM Health's patient administration system, a core IT system that enables the capture of patient demographic information and manages waitlists, booking and scheduling of appointments and procedures. IPM has modules for a wide range of clinical services (ED, Theatre, Outpatients, and Community). It is considered the source of truth for patient demographic information and provides information to over 90 other clinical IT systems. The current support agreement requires CM Health to be two versions behind the latest release. CM Health is now three versions behind and must move to a Windows 10 compatible version of this core administrative system. This is a regional requirement as the region migrates to windows 10 within the next 18 months.

WIMS is the bed management application used by CM Health for over 20 years. It is an in-house developed application built on a Microsoft access database. There are three core modules, one for requesting a bed, one to allocate beds to wards and a third module for allocating beds within wards. Any updates to patient demographic information, admission, discharges and transfers must be done in iPM which then feeds WIMS. This process works well from 0800 – 2000hours when ward clerks are present however outside this time the system does not always reflect a true picture of bed occupancy. This has been highlighted as a priority area for addressing as part of capacity demand management and acute patient flow so that systems accurately reflect the number of patients in beds.

While it is acknowledged that WIMS has been stable and fit for purpose for a number of years, the implementation of more clinical IT systems and the lack of ability to easily extract information out of WIMS for other systems to be able to use and consume is very limiting. The lack of ability to extract information real time has meant that several workarounds for new systems have been implemented (e.g. Trendcare) and other systems that can use the bed information have currently elected not to (e.g. MedChart for prescribing and administering medication).

Regional context

At the time of writing this business case WDHB are also seeking to upgrade IPM to version 13. CM Health will work with healthAlliance and WDHB to ensure lessons are shared and that the projects progress in the most cost efficient way. NDHB are on web pas, a different product by the same vendor that was upgraded earlier this year and ADHB are undertaking a replacement project called the Hospital Administration Replacement Programme (HARP) seeking a new vendor. CM Health has been involved in the procurement process to ensure that any solution identified will meet CM Health's future requirements. CM Health may look to implement this new solution in the future.

Options Analysis

As iPM is an existing application, four options were investigated:

Option 1: Upgrade to iPM version 13 plus bed manager module (providing bed number) – **PREFERRED**
The key benefits of upgrading iPM and implementing the bed manager module are to:

- Ensure CM Health's core patient administration system is on the latest available release and that the organisation remains compliant with the service and maintenance agreement.
- Ensure compatibility with Windows 10.
- Provide a bed number to 'downstream' systems removing CM health's reliance on WIMs, an out dated application used for bed management.
- Implement a tactical replacement for WIMs which reduces reliance on an unsupported application.
- Reduction in administrative workload across services (e.g. discharge patient in one system only which feeds all others, reduction in clinic set up time for clerks).
- Provides future capability to implement web based tools (e.g. online patient portal for booking outpatients).

Option 2: Upgrade to iPM version 13 (no additional modules) – **DISCOUNTED**
The key benefits of this option include:

- Ensure CM Health's core patient administration system is on the latest available release and that the organisation remains compliant with the service and maintenance agreement.
- Ensures compatibility with windows 10.
- Reduction in administrative workload across services (e.g. discharge patient in one system only which feeds all others, reduction in clinic set up time for clerks).
- Provides future capability to implement web based tools (e.g. online patient portal for booking outpatients).
- The challenges include:
- While it is less cost the risk of WIMS compatibility with each new version of iPM remains
- No bed number is available in real time to other clinical systems and the key benefits gained from improved integration with other clinical systems is not realised. This includes the potential benefits to improve capacity demand management of inpatient wards.

Option 3: Implement Bed numbering in existing iPM version – **DISCOUNTED**
The key benefits of this option include:

- Provides a bed number to 'downstream' systems removing CM health's reliance on WIMs, an out dated application used for bed management.
- Implement a tactical solution for the replacement of WIMs reducing reliance on an unsupported application.

The challenges include:

- Organisation remains non compliant with support and maintenance contract.
- Vendor has signalled that version 8 of iPM (current iPM version) will not be supported on Windows 10 which is a significant risk.

Option 4: Do nothing further (cease the feasibility work underway) – **DISCOUNTED**.
This is not an option given the service and maintenance agreement has a requirement to be on a version that is within two releases of the latest version. CM Health is already three versions behind this requirement. In addition, the current version 8 is not supported on Windows 10 which the region is moving to within the next 18months.

All options have a number of benefits and challenges. Option one is the most expensive option however both phases of this option must be completed to ensure a supported version of the application is

available to support windows 10, to provide the bed number for clinical systems that CM Health has or is looking to introduce in the near future (e.g. Clinical Portal, electronic whiteboards, integrated bed management) and to reduce reliance on WIMS.

Option 2 is a more cost effective solution but it does not deliver a critical piece of information (bed number) to other key clinical information systems. It is not clear that WIMS will function correctly on Windows 10. The Acute Patient Flow Programme has also identified that the bed number is essential to provide accurate analysis of the admission, discharge and transfer of patients as current processes require staff to discharge patients from two separate systems. This means that iPM does not always accurately reflect the bed occupancy and doesn't enable efficient bed utilisation.

Options 3 and 4 have primarily been discounted as CM Health must remain compliant with a supported version of this critical administrative system and puts at risk the compatibility with Windows 10. Given the upgrade process takes approximately nine months it is critical that the upgrade to version 13 commences as soon as possible to ensure compatibility with the regional process for Windows 10 implementation estimated for late 2020.

Financial Case

The capital cost of the upgrade of iPM and bed numbering implementation is estimated at $2,373k in total.

	$('000)
Appraisal Period (years)	5
Capital Costs	$2,373
Whole of operating life costs	$2,373
Cost benefits analysis of monetary costs and benefits	n.a
Present Value of Economic Benefits	-
Present value of costs	(2,281)
Net Present Value	(2,281)

Funding sources

CM Health Transfer of underspend iPM upgrade phase 1(2017)	$ 325K
CM Health FY18/19 IS Capital Fund	400
Regional funding (CM Health Portion)	$ 450K
CM Health FY19/20 IS Capital Fund	$1,050
CM Health FY20/21 ICT Capital Fund	$148
TOTAL	**$2,373**

Please note:

- At time of writing only $100k in total (out of an expected $900k) has actually been released to hA at this stage. Assumption that the full regional funding will be made available to hA of which $450k will be apportioned towards the CM Health iPM upgrade costs (or where functionality shared by DHB's will be towards CM Health's benefit)
- The ISSP PSG is being asked to provide assurance that the remainder of this funding will be forthcoming in the 20/21 FY.
- There are no new opex costs as the iPM upgrade and switching on of the bed manager module are included in the existing service and maintenance agreement.

Appendix

1. IPM Upgrade 2019 Business Case.

IPM UPGRADE 2019 BUSINESS CASE

PATIENT ADMINISTRATION SYSTEM UPGRADE AND IMPROVEMENTS

Document Authors	Colin Saunders
Version	**V0.4**
Date	31 October 2019

1. DOCUMENT CONTROL

1.1 REVISION HISTORY

Version number	Version date	Revised by	Sections updated / removed / added
0.1	11 July '19	Colin Saunders	Initial draft
0.2	20 Sept '19	Colin Saunders	Updated draft with financials
0.3	24 Oct '19	Colin Saunders	Included feedback from MM, JP, ID, JG, LV
0.4	31 Oct '19	Colin Saunders	Included PMO costs

1.2 DISTRIBUTION LIST

Name	Title
Lucy Wormald	Change Manager HTT
Janet Gibson	Business Owner-iPM
Jenny Pooley	Programme Mgr HTT
Megan Milmine	Dept. CIO
Lambert Verhaaren	Value & Benefits Mgr.
Stuart Bloomfield	CIO
Ian Dodson	GM

1.3 DOCUMENT APPROVERS

Name	Date of Issue	Signature	Date of Approval
Ian Dodson (Sponsor)			

1.4 CONTENTS

1.5 TERMINOLOGY

Abbreviation	Explanation
iPM	iPatient Manager, Patient Administration System
A& E Data Objects	Carries information from Clinical Portal via SMT and EC Whiteboard to iPM
Mulesoft	Enterprise Application Integration engine
DXC	Vendor supplying and supporting the iPM software application
BAU	Business as usual
WDHB	Waitemata District Health Board
CMH	Counties Manukau Health Board
N-1	Second to last of the most recent version available of a software version
MoH	Ministry of Health
ACC	Accident Compensation Corporation
HTT	Healthy Together Technology IT Programme
DNA / GNA	Did Not Address / Gone No Address
SMT	Soprano Medical Templates
EC Whiteboard	Emergency Care Whiteboard
WIMS	Ward Information Management System

2. DOCUMENT PURPOSE

This business case seeks $2,373K for undertaking a Patient Administration System (iPM) upgrade, enhancing functionality through gaining access to new features whilst ensuring our key enterprise application remains contractually compliant and fully supported.

In addition to the iPM upgrade the iPM Bed Numbering module will be fully configured and rolled out across the organisation in conjunction with a Bed Board application permitting the decommissioning of WIMS.

The business case contains the scope, estimated costs (of development, implementation, on-going operations and maintenance costs), and anticipated benefits offset by any associated risks.

This business case will also provide clarity regarding the approach and high level plans for the deployment. The approach and deployment plan is designed to minimise operational risk, whilst improving solution uptake and benefit realisation.

3. EXECUTIVE SUMMARY

iPM is critical for managing patient administration, demographics and scheduling. Undertaking this project will address risks to critical support for our patient management system, which at the time of writing is 2 versions behind and by late 2019 will be three versions behind and unsupported[1]. In addition implementation will:

- Enable a bed number[2] to be available to downstream systems e.g. TrendCare and Clinical Portal etc.
- Contribute to reduced Administration workload[3] across services, non-clinical support staff and hA.
- Assist with re-bookings and clinic rescheduling (made during clinic restructures)[4]
- Assist MoH data capture requirements for Systematized Nomenclature of Medicine (SNOMED)[5]
- Provide more reliable reporting
- Provide easier access to information
- Enable Outpatient Self-Serve Online Booking Tool[6] that WDHB are currently investigating
- Enable Bed Management[7] and remove the reliance on WIMS
- Ensure compliance with Windows 10 (not currently fully supported)

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[1] Existing commercials with vendors DXC require the system to be maintained to N-1 i.e. within 2 versions of the most recent release. Current version implemented at CMH is v10. Vendors DXC have notified CMH that as by mid 2019 they expect to release version 13 – see appendix 9.1 DXC iPM Roadmap page 30.

[2] Bed numbering will be real-time updated in iPM removing delays due to ward staff manually updating two systems for patient movements (e.g. Discharge where previously patients need to be discharged in both WIMS and iPM) i.e. Real time capability to optimise Bed utilisation due to a "single source of truth"

[3] Potentially saving Clinical Systems Support Team and hA time to set up of 750 hours p.a. (15 hours per week).

[4] This benefits 20 to 40 patients per month that need to be rebooked due to the booking being made during a clinic reschedule made during restructures (approx. 300 restructures per month to update staff status) saving rescheduling time and patient inconvenience

[5] In order to capture data that will provide meaningful analysis for ED attendances MoH propose DHB's report the presenting complaint, procedures and diagnosis using the clinical terminology SNOMED CT to NNPAC for ED presentations. The proposal calls for an early adopters group of DHB EDs to commence in 2019 who will trial the reporting of SNOMED to better refine a National rollout. The early adopters are Auckland, Waitemata, Bay of Plenty, Nelson Marlborough and Canterbury DHBs with National rollout expected on completion of successful trial. Currently CMH are entering ED presentation data in free text format, SNOMED encoding benefits (once fully implemented) are expected to be significant in terms of data and clinical review .

[6] At the time of writing no business case exists for the Outpatient Self-Serve Online Booking Tool yet, however WDHB have recently completed a costs and benefits modelling exercise to support their own business case, of which v13 of iPM is a key enabler – see appendix 9.2 Outpatient Self-Serve Online Booking Tool page 31.

[7] At the time of writing the business case for Bed Management within CMH is currently being developed, v13 of iPM is a key enabler – see appendix 9.4 Bed Numbering

The following table summarises the requirement category and justification criteria for funding:

REQUIREMENT CATEGORY	PRIORITY LEVEL	IMPACT/RISK OF NOT DOING
TECHNICAL: requirement to address unsupported critical systems (iPM and WIMS) and on-going issues related to not being Win 10 certified.	**MUST DO**	**HIGH**
REGULATORY: required to assist MoH data capture requirements for Systematized Nomenclature of Medicine -- Clinical Terms (SNOMED CT) classification Coding for DHB Emergency Departments (ED) in the National Non-admitted Patient Collection (NNPAC)	**MUST DO**	**HIGH**
FUNCTIONAL: Assist with re-bookings and clinic rescheduling (made during clinic restructures) automating a highly manual complex process. Ensures a 'bed number' is easily available to any downstream systems (e.g. TrendCare, Clinical Portal)	**SHOULD DO**	**HIGH**
STRATEGIC: Key enabler for full Bed Management strategy and Patient Flow Tools (self-serve) strategy – both on the ICT Roadmap to be addressed in the immediate term. Enables the implementation of patient flow tools that will provide greater visibility of the true number of beds available.	**MUST DO**	**HIGH**

3.1 RECOMMENDATION

This project recommends investment to upgrade core iPM plus modules as follows:

1. The implementation of iPM Version 13 upgrade, plus
2. Upgrade and modification of any associated data feeds e.g. Mulesoft etc.
3. Upgrade and modification of any key dependent reports e.g. Netezza or the latest data warehouse
4. Configuration of iPM Bed Numbering ready for use
5. Implementation of Bed Board (Replacement of WIMS)
6. Integration with Clinical Portal, ED Whiteboard and TrendCare

4. STRATEGIC CASE

4.1 BACKGROUND

iPM is CM Health's integrated enterprise wide patient administration system that allows every aspect of a patient's journey through the hospital to be managed and tracked within a single system.

It is a Tier 1 application critical for managing all patient demographics and activity such as admission, transfer and discharge, wait list management, outpatient, emergency department and theatre scheduling. If IPM is unavailable then all other clinical IT systems are significantly affected.

The current version of iPM, Version 10, is two versions behind, soon to be three, at which point will be out of support and is not Windows 10 certified.

Use of iPM Version 13 will resolve a large number of historical issues and bugs outstanding from previous versions.

WDHB plan to upgrade their iPM in late 2019 to v13 as a pre-requisite enabler for their 'Outpatient Flow Tools' solution.

A single instance across WDHB & CM Health was explored initially however the cost and workload did not make this a viable option in light of the Northern Regional EHR project seeking to define a regional Patient Administration System. A regional PAS/EHR is not likely to be available for 5-7 years. This upgrade is therefore considered a tactical necessary upgrade.

4.2 STRATEGIC ALIGNMENT

The strategic drivers that this project will deliver against are:

- The Healthy Together – Technology Programme prioritised investment plan.
- By closely coupling the work underway by Waitemata District Health Board (WDHB) to upgrade their iPM instance concurrently with this CM Health upgrade; vendor productivity related savings and lessons can be leveraged and shared. It ensures that while not on the same instance CMH and WDHB remain aligned which assists with other projects in the pipeline as either DHB takes the lead and then can follow.
- Enabler for numbering[7] . Please note: Bed numbering is a prerequisite for bed management and patient flow systems. While this upgrade and implementation of a bed dashboard is an interim solution it is **not** a fully integrated bed management system.
- Enabler for Patient Self-Serve Portal[6]

4.3 CURRENT STATE (existing situation)

The current state needs and problems are described and categorised below.

TECHNICAL NEEDS

CM Health is currently carrying the risk of an unsupported critical application. The reliance on the iPM application (a Tier 1 system) as a key source of patient administration information is demonstrated by the ~90 data interfaces between iPM and other clinical applications[8].

Upgrades to software which interface with iPM are likely to create incompatibility issues if the upgrade does not occur. To view the current application architecture landscape, please refer to section 9.12 Current state Architectural representation page 49.

The current iPM version is relatively stable, however because it is an older version, it lacks the functional updates and fixes resolved in subsequent releases. This is expected to impact on upgrades of other systems which interface with iPM as DXC is unlikely to consider requests for changing the outdated version to accommodate any failures; it is therefore essential to accelerate the upgrade and supportability of iPM.

PROCESS IMPROVEMENT

The key process improvements addressed by this project are listed below – see appendix 9.5 IPM upgrade V12 Benefits review page 39 for further detail:

- Support the export and import of i.PM profiles from one I.PM database to another
    - Repetition of set ups will no longer required by IPM Administrators and Outpatients build clinics etc. which saves time

- The ability to change the Session Status when in Restructure Mode
    - Ability to change the status of a live session from scheduled to on hold or cancelled while clinic is in restructure. Affecting all staff with diary rights (around 55)

- Provides a prompt automatic closure of the referral when closing a waiting list record
    - Major saving for the services, non-clinical support staff and hA, this would help with incorrect selection of referrals which currently requires batch fixing of data

- Disable change to patient address from Home Leave tab
    - Saving incorrect data sent to the MoH impacting on Non Clinical Services for data amendments, Coding, Decision Support

- Disallow updates to personal carer records
    - This functionally ensures the address and phones numbers are not linked once the personal carer is end dated
    - All Staff loading Patient Demographic changes over ~1,000 staff

[8] As at March 2019 hA senior architects performed a review of the hA Reasonable Order of Magnitude (ROM) quote provided to upgrade iPM to v12 – noted at that meeting was:

- ~90 i/f's about 10% are in Mulesoft with [associated] automated [regression] testing scripts (though expected to rise to about ~30 as at completion of the IEP programme)
- Majority of ~90 odd i/f's are direct db views not via JCAPS (which is ~30)

4.4 FUTURE STATE (business objectives)

Upgrading the iPM application to the latest version will ensure CM Health has an up-to-date and well-supported patient administration system that the organisation can be confident will ensure operational continuity.
The updated application will also:

- Provide users with useful functionality that improves productivity, ease of use and process adherence
- Improve patient appointment management
- Remedy previous bugs and system limitations
- Reduce the duplications that can occur during data entry, data entry corrections as well as the requirement for multiple-handling of information
- Reduce the time spent on administrative tasks such as searching out-patient notes or duplicating information allowing more time to be spent on the effective delivery of care.
- Enable the use of web services which can support patient portal tools
- Enable the use of the bed number by other critical applications within the organisation (e.g. TrendCare, Clinical Portal)
- Be Windows 10 fully compatible

Upgrading iPM will enable future installations of other software that have been designed around the most recent versions of iPM, unlocking a constraint that is preventing CM Health from adopting tools to maximize patient progress through the patient journey (e.g. patient flow, bed management, electronic dashboards etc.).

4.5 SCOPE INCLUSIONS

The iPM improvements and upgrade project will include the following if the recommended option is selected:

APPLICATION & MODULES INCLUDED

- Upgrading iPM to the latest available version, including configuring it for relevant use.
- Updating and improving Mulesoft web services, between iPM and Clinical Portal (Concerto) as required for the EC Whiteboard and other applications being affected by the upgrade and inclusion of Bed Numbers within iPM and decommissioning of WIMS.
- Enabling the iPM Bed Numbering module, configuring it for use within CMH
- Deployment of the Bed Board reporting custom solution[9]
- Ability to function within a fully supported technical operating environment.
- Systems, integration, functional testing and user acceptance testing.
- Decommissioning of WIMS

[9] Essentially replaces existing WIMS functionality not included within iPM Bed Numbering e.g. Dr Handover reports etc.

4.6 SCOPE EXCLUSIONS

- Implementation of real-time bed management features are out of scope. Whilst implementation of bed numbering in iPM will improve timeliness of bed occupancy updates it is still primarily a manual process. This project is an enabler for the future state only.
- Development of new bed / room codes are out of scope, i.e. existing numbering and naming structure will remain in place and are expected to be reused.
- Historically CMH undertook an assessment exercise which validated the prior iPM Upgrade BC Bed Management Module that it **did not** fully meet business requirements and added unacceptable levels of administration overhead (See Section 9 for Bed Management De-Scoping Paper) – due to the inclusion of the Bed Board functionality (developed in the prior proof-of-concept phase) administration overhead requirements are expected to remain neutral (no savings expected either) **but** have not been calculated by this paper and any corresponding increase in Opex costs is specifically excluded from scope. Assumption Opex costs remain the same as current state.
- Market research regarding existing market offerings for Bed Management systems[10] is out of scope.
- Any general data cleansing or data change needs are also out of scope.
- The project is responsible for ensuring all existing operational interfaces continue to perform as designed after the upgrade, including those to WIMS (e.g. Clinical Portal and TrendCare etc.). Any development of new interfaces required after this project has been completed is out of scope.
- The project is responsible for ensuring all existing integrated (whether electronic or manual) bed number dependent systems continue to perform as designed after the upgrade. Any implementation of bed numbering as new information components required after this project has been completed are out of scope except for clinical portal(i.e. systems without bed numbers as at time of project initiation will remain out of scope).
- "Cottage industry " reports and queries etc. going direct to the database's (WIMS or iPM etc.) are excluded. Any such services will be responsible for managing any impact on their reports etc. (The project will be responsible for adequate and timely communications to those services to reduce impacts)
- Oracle Driver Update – Current COE desktop image on CMH computers includes Oracle driver version 11.2.0.1 which is not supported with Oracle databases from version 12.2 or higher – required for iPM 13.x. Cost to upgrade client PC's is significant and not included with this project. Assumption is that DXC will certify iPM 13.x with CMH's older version desktop client Oracle drivers until such time as regional funding is available for client device driver updates.
- Windows 10 upgrade testing may not include iPM v13.x – as the project is targeting delivery during 2020 there is an assumption the Windows 10 upgrade project will include the iPM v13.x client software within its remit. Windows 10 testing for the iPM v13.x client software is out of scope.
- A&E Data Objects – there has been a number of attempts to upgrade the A&E Data Objects suite , required for legacy integration, and as at the time of writing the most recent upgrade project is officially on hold. Assumption that current A&E Data Objects version and / or any upgraded version(s) will remain compatible with iPM v13.x. healthAlliance architecture team will be required to consider within their design for this project. Changes required (if any) are not in scope.

[10] N.b. An EIO was conducted 2 years ago looking at bed management and patient flow which identified we needed a bed number turned on in our existing PAS to enable the organisation to benefit from this type of system.

4.7 QUALITY, ARCHITECTURAL AND RISK REDUCTION BENEFITS

Some further benefits of upgrading now will address risks and improve quality as noted below:

- Only the latest and one earlier version (N-1) are supported by DXC. By upgrading to the latest V13.x (expected release mid 2019), CMDHB can be assured of a supported tier 1 system
- This version upgrade will reduce configuration time for future upgrades and provide feature enhancements regularly
- iPM V13 will also support Windows 10, reducing the risk of incompatibility with any dependent systems
- Legacy system WIMS will be decommissioned (which is not fully Windows 10 compliant as it is based on MS Access)

4.8 CONSTRAINTS

CM Health is implementing multiple, simultaneous mission critical application upgrades and replacements (e.g. IEP programme and éclair regional upgrade etc.). This approach is constrained by:

- The capacity of the organisation to accommodate the quantum of change
- The capacity of the resources to deliver the upgrades in an efficient and effective way (including partner and vendor resources, e.g. healthAlliance)
- The timing of Go-Live based on staff availability, especially SME's, constraints for training and other hospital priorities
- The extent of dependent interface testing required given regular, upcoming changes

Technical design constraints will take into account the following principles:

- On completion of project all platforms (dev, test, acc, prod) are to remain in synch and the same version and configuration (specific deliverable)
- All performance requirements for new platforms / infrastructure to 'be the same or better'

These constraints pose risks and will be managed as part of the project risk management process.

4.9 DEPENDENCIES

There are no dependencies on other projects which will affect the ability for this project to proceed

There is a dependency on iPM V13 being available at the due release date (mid to late 2019); otherwise V12 would be deployed to avoid further delays.

There is a dependency on WDHB iPM upgrade for the project to achieve expected costs savings synergies

5. ECONOMIC CASE

As iPM is an existing application, four options were investigated:

Option 1: Upgrade to iPM version 13 Plus Bed Numbering (**Recommended**)

Option 2: Upgrade to iPM version 13 Only

Option 3: Implement Bed Numbering in existing iPM system

Option 4: Do Nothing

5.1 CRITICAL SUCCESS FACTORS

- Actual spend should not exceed budget – minimal risk of overspend
- Clinical risk to be at an acceptable level (agreed by stakeholders)
- The impact of any changes in operation are understood and accepted by the business
- Full operation of all interfaces with other business systems has been tested and the business owners of those systems have agreed that their critical requirements are being met
- All critical functions have a disaster recovery solution available and agreed by the business
- Timing of go-live is agreed with the business process owners – sufficient trained resource available compared to expected demand for services
- Business process owners are comfortable with their ability to maintain service levels
- All business owners are aware of transition support arrangements, how to access assistance, and are comfortable that they can maintain the required service while transitioning
- Support arrangements can cope with the expected level requests for assistance

5.2 OPTIONS ANALYSIS

The following options have been considered:

OPTION 1: FULL INSTALLATION IPM VERSION 13+ PLUS BED NUMBERING (RECOMMENDED)

This is the recommended option and best meets the needs of the business whilst delivering the greatest value. This option will ensure that the technical work is completed in one step, and allow the change impacts on the business to be managed more effectively - albeit over a longer period of time.

This option involves a full technical installation of iPM version 13, upgrading from the current version 10 (without configuring or rolling out any of the existing or new unused features or functionality but including the base installation).

The benefits of this approach are:

- Cost savings from completing both upgrade and Bed Numbering work packets at the same time
- The core application upgrade will be available
- Change management is more effective as the amount of change experienced by the users is managed over time.
- The technical costs and risks are managed effectively.
- Configuration effort and time is reduced by completing both upgrade and bed numbering configuration at the same time (e.g. savings with SME engagement, change management, user testing and end-to-end testing)
- In house iPM functional experts will have time post project to gain any necessary skills to exploit the additional functions and features available
- All systems would be fully Windows 10 compliant

The drawbacks of this approach are:

- Most expensive option

OPTION 2: UPGRADE AND IMPLEMENT ONLY IPM CORE MODULES

This option allows for only the core modules of iPM to be upgraded and implemented. The additional modules such as Bed Numbering etc. would be treated as separate projects and would remain out of scope.

The benefits of this approach are:

- The project will be completed many months earlier
- The change management efforts would be significantly less
- The project costs would be significantly less (the overall project costs would be $1,025k i.e. reduced by approximately $1,348K)

The drawbacks of this approach are:

- The current issues experienced by staff and patients relating to bed numbering and lost productivity would remain unaddressed
- Implementing the functionality in the additional modules (Bed Numbering etc.) as separate projects would create duplication of effort (and cost)
- The opportunity to address business problems using the additional modules would be deferred at best and lost at worst.
- License fees for any un-used modules and support costs continue to be incurred prior to the products being fully utilised e.g. Bed Numbering etc.
- Repeat change management initiatives maybe needed dependent on the extent of change introduced by releasing the additional modules later.
- Benefit realization against unused modules will be slower, due to the gradual release of additional functionality.
- WIMS would eventually require replacing as the Windows 10 project rollouts across the organisation

OPTION 3: IMPLEMENT BED NUMBERING IN EXISTING IPM SYSTEM

This option allows for Bed Numbering to be implemented in the current out-of-support iPM system version 10 plus the decommissioning of WIMS etc.

Upgrading iPM would be treated as a separate project and would remain out of scope.

The benefits of this approach are:

- The project will be completed many months earlier
- The change management efforts would be significantly less
- The project costs would be significantly less (the overall project costs would be $1,449k i.e. reduced by approximately $924K)
- Would deliver critical functionality that will enable other systems to benefit from having a bed number and reduce reliance on an unsupported application (WIMS)

The drawbacks of this approach are:

- IPM version remains out of support
- Full Win 10 compliance not achieved

OPTION 4: DO NOTHING

This option would require ceasing all current work

The benefits of this approach are:

- No further resources would be required
- Conservation of capital that can be redeployed to other uses

The drawbacks of this approach are:

- An important Tier 1 application would remain unsupported and would not address the increasing risk should a catastrophic system failure occur
- It would also render the Phase 1 work to date, as sunk costs
- Many of the drawbacks of options 2 and 3 would still be incurred

NON CASH BENEFITS

Benefit	Description	Term / Freq.	Date benefit expected	Amount
Eliminate duplicate data entry e.g. bed data is currently manually entered into Cap Plan	Expert review of productive minutes saved	On-going	On Implementation	Soft Benefit
Automate currently manual functions e.g. task management requests/workflows	Expert review of productive minutes saved	On-going	On Implementation	Soft Benefit
Radically improve the available integrated management reports and information views e.g. Doctors Patient Location Report	Expert review of productive minutes saved Doctors coming to work early to manually collate data to be able to complete ward rounds	On-going	On Implementation	Soft Benefit
Single source of truth - Bed numbering will be real-time updated in iPM removing delays due to ward staff manually updating two systems for patient movements (e.g. Discharge where previously patients need to be discharged in both WIMS and iPM but impacted e.g. due to clerk not available after hours etc.) "Real time capability to optimise Bed utilisation i.e. single source of truth"	Expert review of productive minutes saved/Patient care improvements / Reduced patient risk	On-going	On Implementation	Soft Benefit
Enable real-time patient data e.g. resolving the time-lag of patient bed location being available to other integrated systems so as to provide better patient care e.g. food and nutrition meal ordering	Expert review of productive minutes saved/Patient care improvements / Reduced patient risk	On-going	On Implementation	Soft Benefit
Enable data history to be retained e.g. patient bed locations, patient shift hand over notes	Expert review of Patient care improvements / Reduced patient risk	On-going	On Implementation	Soft Benefit
Simplify and enable future integration or new systems/functionality that relies on having real-time patient bed location data, for example CMH e Prescribing (Medchart)	Expert review of Benefits to be realised by the business cases for the implementation of new systems/functions	n/a	n/a	n/a
Mental Health Bed Occupancy reporting corrections (see Appendix section 9.13 Mental Health MoH Bed Occupany Reporting correction)		One Time		
Various Technical Benefits (see Appendix section 9.14 technical benefits)		One Time		
Buys us extra time as instead of forcing next min 2 versions upgrade in ~24 months (assumes 1 major ver p.a.) we are jumping from 10 -> 13		One Time		

RECOMMENDED OPTION

Option 1 – Upgrade to Version 13 plus Bed Numbering generates the greatest value for money, resulting from the benefits associated with deploying the new features available in the version.

6. COMMERCIAL CASE

Health Alliance is responsible for managing the vendor contracts required for delivering this project.

6.1 PROCUREMENT STRATEGY

The vendor related costs in the business case are currently based on estimates provided to health Alliance from the vendors DXC (including the additional modules) and realistic allowances for interface development work.

This SoW will be approved by CM Health. The reduced cost to implement in tandem with WDHB iPM upgrade (if any) will be reflected in the SoW costs and arrangement.

6.2 CONTRACTUAL ARRANGEMENTS

The vendors, DXC, will provide a fixed price SoW managed by healthAlliance. Payment will be by agreed terms of the SoW which will specifically be based on agreed milestones. Any changes to price or scope will be managed through the project's change management process.

7. FINANCIAL CASE

To manage risk and conduct a feasibility assessment for the upgrade, the project was segmented into two phases. Phase 1 of the project is anticipated to be completed by ~Dec 2020 with Phase 2 being run in parallel and implemented immediately thereafter to minimise change impact to the organisation and take advantage of savings achieved by reduction in duplicated resources (both for CMH and also hA as they implemented WDHB iPM upgrade):

Phase 1 iPM Upgrade v13.1	$ 915k
Phase 2 Bed Numbering	$1,339k
PMO	$ 120k
Total both phases	**$2,373K**

SUMMARY OF TOTAL PROJECT COSTS AND FINANCIAL FORECAST

As this is purely a compliance project, no economic benefits are expected to accrue from implementing the recommended Option 1 iPM upgrade plus Bed Management, capital costs are summarised below:

iPM 2019 H/L Project cost schedule

Cost Category	Cost Detail	Account categories: Hardware	Software/ Licenses	Professional Services UPG	CMH Internal	Professional Services BN	Grand Total
Project Delivery				196,000		503,320	699,320
	10% Project Delivery Contingency			19,600		50,332	69,932
Project Delivery Total		$ -	$ -	$ 215,600	$ -	$ 553,652	$ 769,252
IT hA				543,100		302,640	845,740
	10% contingency	-		54,310		30,264	84,574
IT hA Total		$ -	$ -	$ 597,410	$ -	$ 332,904	$ 930,314
IT DXC				49,222		56,320	105,542
	25% contingency			12,306		14,080	26,386
IT DXC Total		$ -	$ -	$ 61,528	$ -	$ 70,400	$ 131,928
IT (hA/Prime /Other Vendors) Total		$ -	$ -	$ 658,938	$ -	$ 403,304	$ 1,062,242
Change Management				32,000		159,160	191,160
	25% contingency			8,000		39,790	47,790
Change Management Total		$ -	$ -	$ 40,000	$ -	$ 198,950	$ 238,950
Backfill Staff-training and set up						159,140	159,140
	15% contingency					23,871	23,871
Backfill and set up Total		$ -	$ -	$ -	$ -	$ 183,011	$ 183,011
PMO					120,000		120,000
PMO Total		$ -	$ -	$ -	$ 120,000	$ -	$ 120,000
TOTAL PROJECT COST		$ -	$ -	$ 914,538	$ 120,000	$ 1,338,917	$ 2,373,455

***Please note: Costs are Indicative and subject to confirmation following analysis and high level design

OPTION 1 (V13 UPGRADE PLUS BED NUMBERING)

- Estimated cost: Total initial (one off) investment cost of $2,373k with annual operating project costs (including depreciation and interest) of $475k p.a.
- NPV is negative at ($2,281k) over the five year project life.
- IRR is n/a
- Profit/Loss is forecast to produce a deficit over the five years of ($2,373k) as it excludes cost avoided benefits and also includes depreciation ($2,373) and interest charges ($0).

7.1 FUNDING SOURCE

$ 325k transferred from the underspend of phase 1 iPM upgrade in 2017;
$ 400k from the 2018/19 Board approved capital plan;
$1,050k from the 2019/20 Board approved capital plan;
[11]{ $ 148k from the 2020/21 top sliced Board approved capital plan;
$ 450k from the regional reprioritisation backlog healthAlliance funding pool

$2,373k Total

7.2 BUDGET

All budget funding details, including whole of life costs for option 1 both phases, the change management costs and assumptions, and separate operating cost breakdowns are provided in the appendix, see section 9.3 Detailed costs breakdown.

7.3 PROFIT & LOSS STATEMENT

Annual costs associated with Option 1 total $475k p.a. detailed as follows:

- Annual maintenance costs from Health Alliance to support the iPM upgrade including modules and interface maintenance, $0k p.a. i.e. no change to current maintenance and support costs
- Annual depreciation costs of $475k p.a. where the capital cost is amortised over 5 years which is the period used for the useful product life.
- Interest charges are n/a i.e. zero rated

[11] Note as at time of writing only $100k in total (out of an expected $900k) has actually been released to hA at this stage. Assumption that the full regional funding will be made available to hA of which $450k will be apportioned towards the CMH iPM upgrade costs (or where functionality shared by DHB's will be towards CMH's benefit - the $450k required from regional prioritised funding is subject to ISSP PSG approval.

7.4 NPV AND SENSITIVITY

OPTION 1 (V13 UPGRADE PLUS BED NUMBERING)

	Option 1: iPM + BN $('000)
Appraisal Period (years)	5
Capital Costs	2,373
Whole of operating life costs	2,373
Cost-benefit analysis of monetary costs and benefits	n.a
Present Value of Economic benefits	-
Present Value of costs	(2,281)
Net present value	(2,281)

Sensitivity Analysis		NPV moves to $('000)
Decrease Costs	-20%	(1,825)
Increase Costs by	20%	(2,737)

7.5 FINANCIAL ANALYSIS

The capital investment evaluation for each option is summarised below with all details and calculations available under section 9.9 Financial profit and loss statements.

OPTION 1 (V13 UPGRADE PLUS BED NUMBERING)

- Estimated cost: Total initial (one off) investment cost of $2,373k with annual operating project costs (including depreciation and interest) of $475k p.a.
- NPV is negative at ($2,281k) over the five year project life.
- IRR is n/a
- Profit/Loss is forecast to produce a deficit over the five years of ($2,373k) as it excludes cost avoided benefits and also includes depreciation ($2,373) and interest charges ($0).

OPTION 2 (V13 UPGRADE ONLY)

- Estimated cost: Total initial (one off) investment cost of $1,025k with annual operating project costs (including depreciation and interest) of $205k p.a.
- NPV is negative at ($985k) over the five year project life.
- IRR is n/a
- Profit/Loss is forecast to produce a deficit over the five years of ($1,025k) as it excludes cost avoided benefits and also includes depreciation ($1,025k) and interest charges ($0).

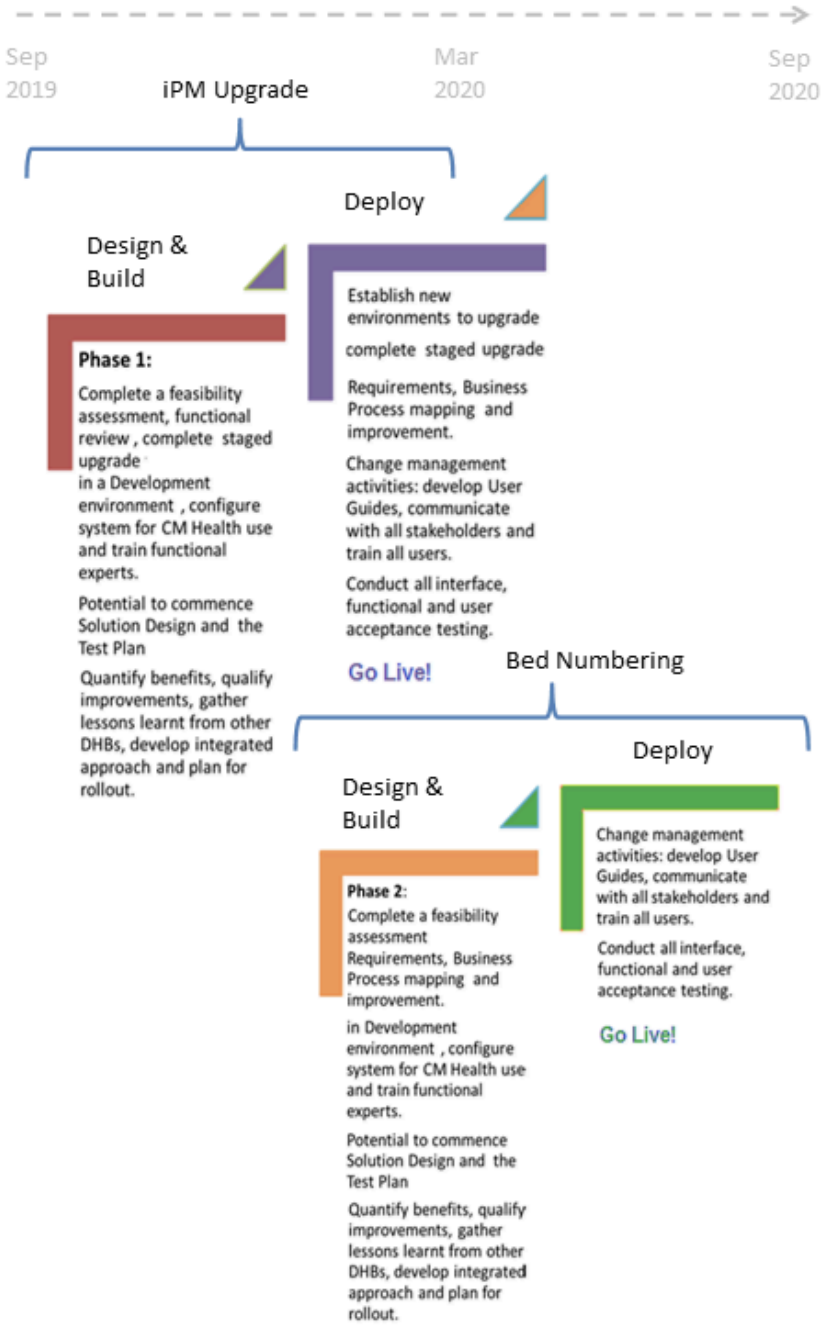
OPTION 3 (IMPLEMENT BED NUMBERING IN EXISTING IPM SYSTEM)

- Estimated cost: Total initial (one off) investment cost of $1,449k with annual operating project costs (including depreciation and interest) of $290k p.a.
- NPV is negative at ($1,393k) over the five year project life.
- IRR is n/a
- Profit/Loss is forecast to produce a deficit over the five years of ($1,449k) as it excludes cost avoided benefits and also includes depreciation ($1,449k) and interest charges ($0).

8. MANAGEMENT CASE

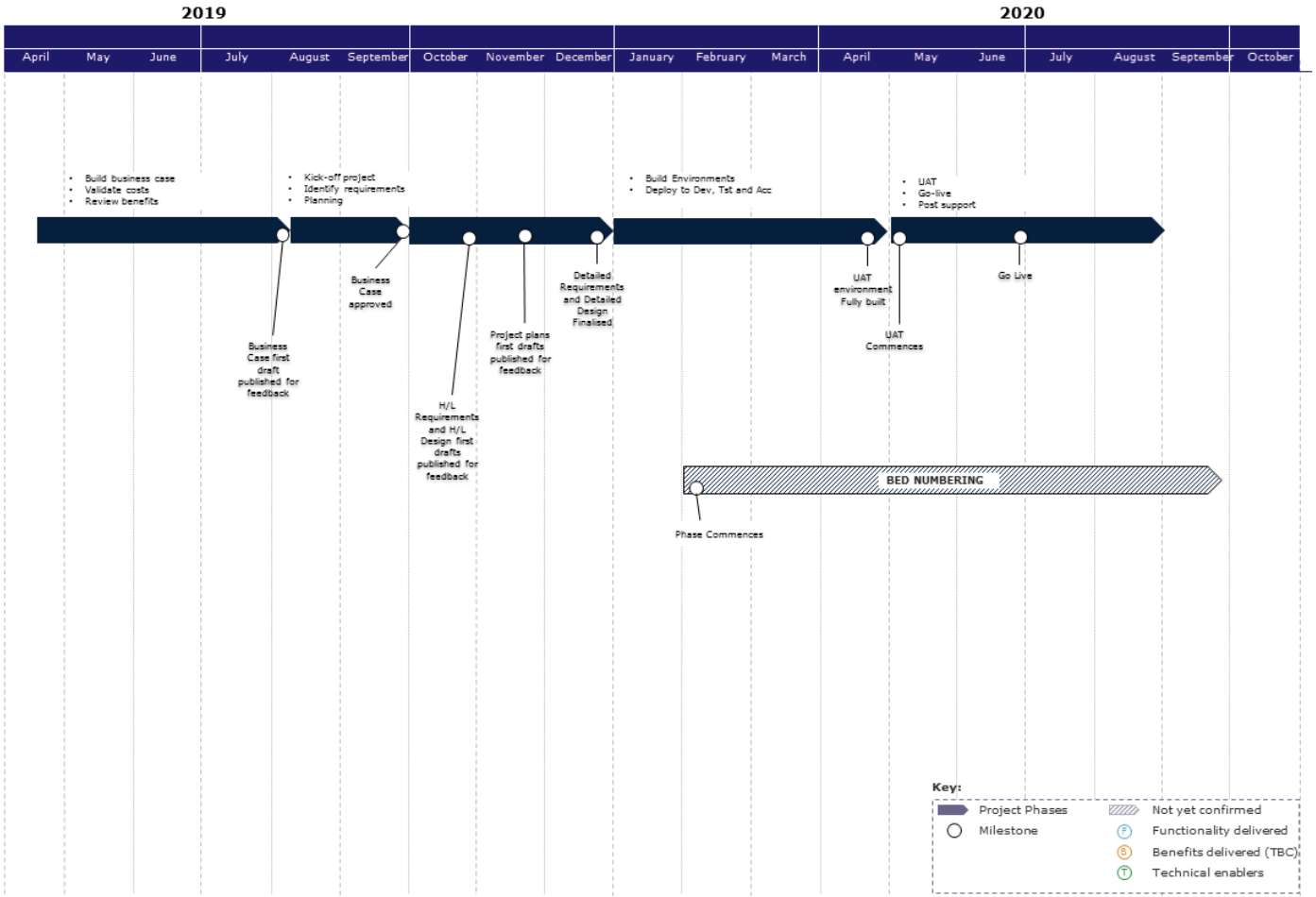
Achievement of the project relies heavily on internal and vendor subject matter experts being available and collaborating to design, test and deliver the best outcomes.

The diagram below summarises the scope breakdown and timelines associated with this project in order to achieve the required outcomes whilst managing the risks, timelines and costs of delivery.



THE HIGH LEVEL TIMELINE

The indicative high level timeline is provided below with key milestones available under Section 8.6.
Note that further refinement will be required once details such as resource assignment, the Solution Design, new features required, and effort are better understood.



RISK MANAGEMENT

The achievability of this project is dependent on effective identification and management of inherent risks, associated with user engagement, training, resourcing, and technical challenges.

A working risk register and associated management and governance reporting will be used to effectively manage all risks. Monthly Risk review meetings and weekly status updates will ensure new risks and mitigation actions are applied.

Assumptions will be tested to identify new risks and where needed, will be escalated.

Lessons learnt by other DHBs during their recent upgrades will be integrated into project resource, schedule, and risk mitigation plans.

PHASING

To manage risk and conduct a feasibility assessment for the upgrade, the project has been segmented into two phases.

Phase 1: Upgrade iPM:

- Conduct a functional review and understanding of iPM legacy version
- Establish the Development environment allowing configuration of CM settings and relevant testing of the upgrade pathway to occur
- Provide assurance that iPM latest version functions with integration layer, SMT and EC White Board, with particular focus on A&E Data Objects (the interface between iPM and ED Whiteboard)
- Training to up skill functional and technical experts regarding the new version
- Establish an upgrade appreciate the amount of time and effort required
- Assess and confirm the user change impacts, needs and plan for managing these
- Deploy and update the technical environment so it meet requirements for the upgrade (if any)
- Seek learnings from other DHBs who have upgraded to more recent versions and integrate lessons into CMDHB plans.
- Establishment of the infrastructure and environment required (e.g. Test) as per solution design
- Configuration and testing (functional, system, integration and non-functional) of iPM latest version so it meets acceptance criteria
- Effective user readiness creation for go-live

- Deployment of the agreed modules

Phase 2: Bed Numbering:

- Conduct a functional review and understanding of legacy bed numbering compared to iPM Bed Numbering module and proposed new custom application Bed Board capability

- Establish the Development environment allowing configuration of bed numbering settings and relevant testing of the bed board feature

- Provide assurance that bed numbering module and bed board functions with integration layer and dependent down-stream systems etc.

- Training to up skill functional and technical experts regarding the new capability

- Assess and confirm the user change impacts, needs and plan for managing these

- Deploy and update the technical environment so it meet requirements

- Seek learnings from other DHBs who have implemented new bed numbering processes and integrate lessons into CMDHB plans.

- Configuration and testing (functional, system, integration and non-functional) on iPM latest version so it meets acceptance criteria

- Effective user readiness creation for go-live

- Deployment of the bed numbering module and bed board capability

- Clinical coaches perform ward / service assistance throughout the go-live period and for a short time after

8.1 APPROACH

The following sections clarify the approach on how the project will be delivered to minimise risks and maximise outcomes.

PROJECT MANAGEMENT

CM Health will appoint a project manager from the Healthy Together Technology team to implement and deliver this project, to ensure that internal Patient Information Services resources can focus on testing and training.

The project manager will work with the appointed hA project manager and any other vendor project managers.

The project management approach will use the standard upgrade process with the following overall stages for the iPM Upgrade:

- Assessment and analysis: determine what changes are contained in the upgrade and what the change management implications will be for implementation.
- Build: establish the development, test and production environments
- Test: conduct functional, integration and user acceptance testing
- Implementation

8.2 PROJECT STEERING COMMITTEE

The project will come under the Healthy Together transformation governance structure.

The project Steering Committee will involve the following members:

Name	Job Role	Project Role
Ian Dodson	General Manager	Project Sponsor
Janet Gibson	Service Manager, Patient Information	Business Owner
Jenny Pooley	Programme Manager	Technology Enabling Change
Colin Saunders	CM Health Project Manager	Business Project Manager
Candice Webley	hA Project Manager	Technical Project Manager
Lucy Wormald	Change Lead	Business Change Manager
TBD	DXC Project Manager	Vendor representative
Karen Nelson	hA Portfolio Manager	

8.3 STAKEHOLDERS

The stakeholders consulted during the development of this business case and a detailed list of all stakeholders is provided in Section 9.4.

All the GMs, their services and all Surgical Services will be impacted.

8.4 DELIVERABLES

Deliverable	Description
Project Management	
Business Case	Justification for undertaking the iPM Upgrade and Bed Numbering work
Project Plan	Overall description of the project
Timeline	Map of key phases, activities and tasks across time
Issues Register	Register of key issues and resolutions
Risk Register	Register of key risks and mitigations
Change Register	Register of key changes to the project scope or activities
Decision Register	Register of key project decisions
Benefits Register	Register of key benefits of the project
Change Management Plan	Identification of project stakeholders; the stakeholder engagement plan including communications planning and delivery; identification of training

	needs and training plan
Assessment and analysis	
DEV Environment	Sandpit for assessment and analysis of iPM legacy version
Configured iPM	Configuration of iPM to current level
Test Plan	Plan that describes the testing approach
Test Scripts	Functional, Integration and User Acceptance Test Scripts
Training Plan	Description of the training required to ensure users are familiar with the upgraded iPM application
Testing	
Test Environment	Functioning test environment with all integration points active
Configured iPM	Configuration of iPM to current level
Issue Register	Register to capture, describe, categorise and track resolution of issues and bug fixes within the iPM V10.0 application.
Functional Testing Approved	Confirmation by the Test Manager that functional testing is complete.
Integration Testing Approved	Confirmation by the Test Manager that integration testing is complete
Web Services Interface Testing Approved	Confirmation by the Test Manager that web services interface testing is complete
User Acceptance Testing Approval	Confirmation by the Test Manager that user acceptance testing is complete
Training delivery	Confirmation by Business Owner that training delivery is complete
Implementation	
Go Live and roll back plans	hA developed plan for implementation
Production Environment	Production environment is ready for Go Live
Post Go Live Support	
Post go-live support	Resources and processes to support users in initial post go live period.

8.5 ASSUMPTIONS

The following assumptions apply:

- Contingency of 10% has been applied for all vendor estimates excepting for DXC which have a 20% figure applied[12]

- Project commences October 2019
- Phase 2 project commences by Mar 2020. A later start may result in additional costs
- Project is costed on the basis of whole of life

- Savings of 50% of CMH PM, BA and CL roles based on combining both phases into one project with phase 2 commencing as soon as practical and with go-live of Phase 2 immediately after Phase 1 (i.e. so to the organisation change impact is one seamless event)

- Interface testing costs (technical and business) remain within estimate parameters
- No errors found in Functional or Interface testing that requires a patch upgrade from DXC
- Limited additional configuration required for V13+ of iPM
- Vendor costs remain within estimate parameters
- CMH testing resource costs remain within estimate parameters
- No impact to down-stream systems not discovered

- Project is decommissioning WIMS. Project is not replacing all WIMS functionality (e.g. handover and travel sheets etc. which are in TrendCare – no allowance for implementing these modules has been allowed for within this business case).

- WIMS informatics reporting will be replicated by the project (DW team to recreate) e.g. Bed visibility, Capacity and Occupancy reports

- Project will re-create bed request, bed booking (bed is 'booked' / reserved) and bed allocation, bed moving functions (currently in WIMS) within the custom iPM bed form and custom Bed Board functions created as part of the proof-of-concept phase – both assumed to be fit for purpose and scalable to robust solution

- Current data model and implemented CMH bed number data taxonomy will remain the same e.g. multiple locations in ED where there are one bed per virtual location (currently managed by ED Whiteboard) will remain the same, i.e. new iPM bed numbering will follow existing data taxonomy assumption this structure has been deliberately chosen to support downstream functionality or existing reporting (where data values are sometimes hard coded). Project will not change or correct historical data taxonomy.

- General approach will be “Like for like” as much as possible. No changes to locations or bed numbering or workflow where ever possible. Exceptions to this will be managed by change request so that we can track the cost (e.g. of fixing enshrined historical decisions etc.)

- Oracle Driver Update – Current COE desktop image on CMH computers includes Oracle driver version 11.2.0.1 which is not supported with Oracle databases from version 12.2 or higher – required for iPM 13.x. Cost to upgrade client PC’s is significant and not included with this project. Assumption is that DXC will certify iPM 13.x with CMH’s older version desktop client Oracle drivers until such time as

[12] Previous iPM upgrade project had significant vendor costs overrun, extra contingency has been applied to attempt to address this risk

regional funding is available for client device driver updates.

- Windows 10 upgrade testing may not include iPM v13.x – as the project is targeting delivery during 2020 there is an assumption the Windows 10 upgrade project will include the iPM v13.x client software within its remit. Windows 10 testing for the iPM v13.x client software is out of scope.

- A&E Data Objects Replacement project doesn't impact (either completes beforehand or delivers post this project)

- A&E Data Objects – there has been a number of attempts to upgrade the A&E Data Objects suite , required for legacy integration, and as at the time of writing the most recent upgrade project is officially on hold. Assumption that current A&E Data Objects version and / or any upgraded version(s) will remain compatible with iPM v13.x. healthAlliance architecture team will be required to consider within their design for this project. Changes required (if any) are not in scope.

- Mailhouse Project (sending the iPM letters to patients by email) will not have an impact e.g. SME resource contention etc.

- Note as at time of writing only $100k in total (out of an expected $900k) has actually been released to hA at this stage. Assumption that full regional funding will be made available to hA of which $450k will be apportioned towards the CMH iPM upgrade costs (or where functionality shared by DHB's will be towards CMH's benefit)

- Historically CMH undertook an assessment exercise which validated the prior iPM Upgrade BC Bed Management Module that it did not fully meet business requirements and added unacceptable levels of administration overhead (See Section 9 for Bed Management De-Scoping Paper) – due to the inclusion of the Bed Board functionality (developed in the prior proof-of-concept phase) administration overhead requirements are expected to remain neutral (no significant savings expected either) but have not been calculated by this paper and any corresponding increase in Opex costs is specifically excluded from scope. Assumption Opex costs remain the same as current state.

8.6 MILESTONES

Below are the estimated milestones and dates for both phases of the project:

Milestones	Estimated Date
INITIATE - Project start	05/2019
INITIATE – Initial analysis, scoping and develop business case	06/2019
INITIATE - Funding approach confirmed	09/2019
INITIATE – Submit Business Case	09/2019
INITIATE – Approval to commence	10/2019
PLAN – Design and Detailed Requirements Commenced	09/2019
PLAN – New development environment stood up	10/2019
PLAN – iPM latest version installed in new Development environment	11/2019
PLAN – Configuration of core iPM complete	12/2019
PLAN – Final Solution Design complete and approved by TAGG	12/2020
PLAN – Configuration of new iPM modules complete	02/2020
EXECUTE –New Test and UAT environments stood up	03/2020
EXECUTE – iPM configured on new Test and UAT environments	04/2020
EXECUTE – iPM functional testing complete	08/2020
EXECUTE – iPM interface testing complete	06/2020
EXECUTE – UAT testing complete	08/2020
EXECUTE – User Training complete	08/2020
EXECUTE - Go-live	09/2020
CLOSE – Handover to BAU support complete	10/2020
CLOSE - Post implementation review accepted	11/2020
CLOSE – Phase 1 end	12/2020

8.7 CHANGE CONTROL

PROJECT CHANGES:

Changes in scope and/or price of the project will be managed using the standard CMH project change management processes. These processes will include the raising of a change request followed by approvals through the predefined governance structure (which will be established during the Implementation, Phase 1).

TECHNICAL CHANGES:

Change control will be managed using the standard health Alliance change control processes.

8.8 ORGANISATIONAL CHANGE MANAGEMENT

Change management activities will be a concurrent process throughout the upgrade project and will facilitate co-design of rules as appropriate. The activities will encompass stakeholder analysis and engagement, some internal testing to understand change impacts, training development, delivery, and communications.

Project management and change management are integrated activities that will happen in unison throughout the project lifecycle.

The change team will collaborate with the Hospital Services Technology Programme Manager, the Project Manager, the Sponsor, the Business Owner and other key stakeholders, other project team members, Ko Awatea, Human Resources, healthAlliance, and vendors in the following areas:

1. Assisting with the development for the case for change
2. Ensuring both the patient/consumer and workforce voices are heard and considered through the principles of co-design
3. The identification of improvement opportunities resulting in process mapping – current state and future state
4. Understanding the impact of the change on the patient/consumer and workforce
5. Planning for change, managing change and reinforcing change
6. Communication planning and delivery
7. System and process training needs including materials and delivery
8. Workforce development needs around workplace culture and values
9. Workforce capability considerations – up skill, reskill, new skills
10. Workforce capacity planning
11. Ensuring an appropriate support model is in place for system go-live and its warranty period
12. Post implementation review

The following activities, whilst an integral part of project delivery which the change team will contribute to, are not being managed by the change team:

1. System user acceptance testing (UAT)
2. UAT script development
3. UAT execution
4. Business continuity planning
5. Disaster recovery planning

6. Benefits realisation

Details of the change management costs can be found in the Appendix.

8.9 BENEFITS MANAGEMENT

Benefits realisation management (BRM) aims to ensure the alignment between project outcomes and business strategies.

To be successful, BRM requires people accountable, relevant measures, and proactive management.

BRM process:

- Identify the investment outcomes. Staff satisfaction and improved quality of work and rework saved.
- Define benefit measures for each outcome. A time and motion study could be completed however the efficiency improvements are considered at the individual level to be very small and a staff satisfaction survey may be more appropriate.
- Identify when benefits should start to be released and plan measures aligned to expectations. Benefits are expected to be released as rules and modules are employed.
- Assess any unintended consequences (dis benefits) and include these in the benefit analysis. Training and set up time has been estimated, however the screen differences are considered minimal.
- Collect current benefit measure data to have a quantitative basis for decision making.
- Plan the new or changed capabilities necessary to realize the benefits.
- Implement the plan.
- Review the impact of the plan implementation on the Benefit Measures and use insights to improve realisation of benefits.
- On completion of the plan, ensure BRM continues to sustain the capabilities and realisation of benefits.

8.10 RISKS

The iPM project risk register is a living inventory and will be updated weekly to actively raise and manage all risks to the project.

Risks which have been identified are managed using standard project management practices and can be viewed in more detail under Section 9.11 Risk register-open risks.

8.11 POST PROJECT EVALUATION

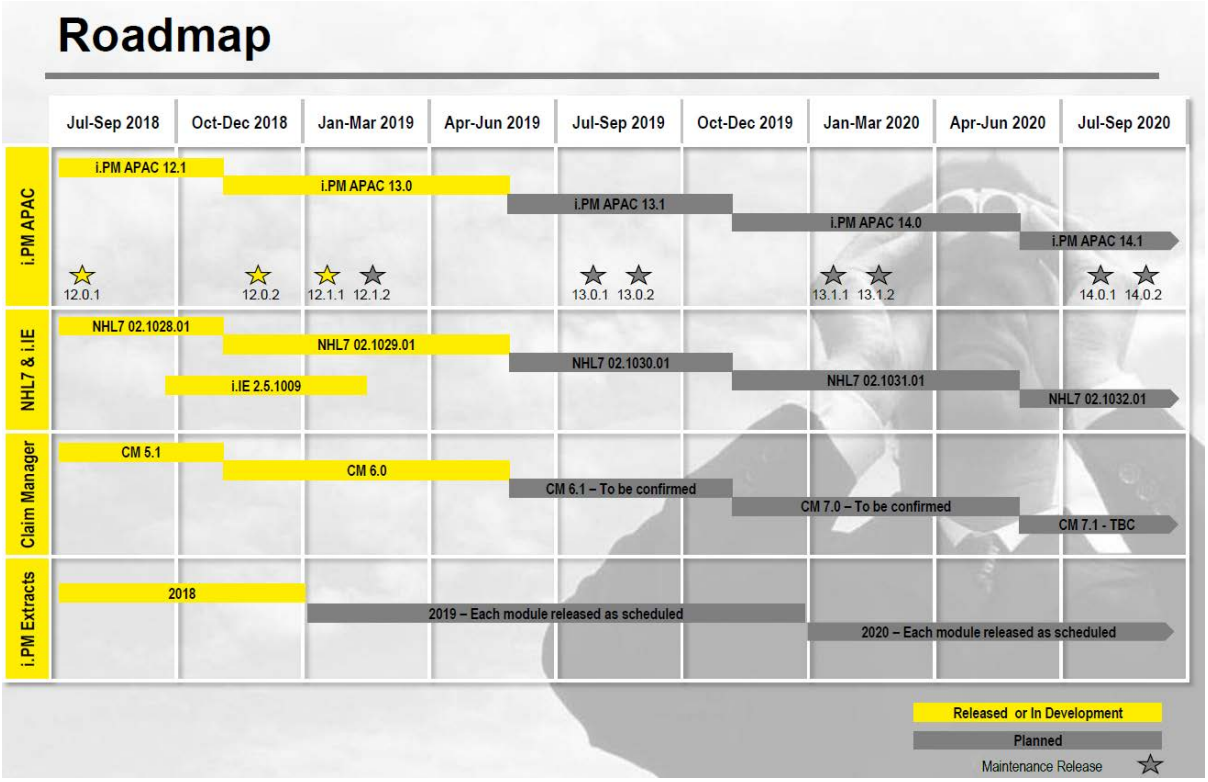
Post project evaluation will include:

- Assessment of whether the project benefits and critical success factors have been achieved
- Identification of any outstanding items (risks, activities or issues) to be handed over to the business as usual operational team
- Communication of project closure to stakeholders

A project closure report will be submitted to the project governance group.

9. APPENDIX

9.1 DXC IPM ROADMAP



9.2 OUTPATIENT SELF-SERVE ONLINE BOOKING TOOL

WDHB is currently undertaking a series of initiatives to enable a suite of applications "Outpatient Flow Tools" of which the "Outpatient Self-Serve Online Booking Tool" a.k.a. "Integrated Online Booking System" is a key component (other components include Patient Check-in Kiosks and a new Appointment Letter system). Significant benefits are expected upon completion.

In 2017 WDHB completed a business case to support the above, quote "The project will include a bi-directional HL7 integration between the new online booking tool and iPM. Appointment creation, changes, deletions etc. will be provided from iPM to the online booking systems in real time and against 'to be agreed' Business Logic – actions can be automatically generated by the system to manage […] appointment[s]…"

Key to enabling the above is the completion of upgrades relating to both iPM (to v13) and A&E Data Objects (WDHB's integration interface layer), both of which are required dependencies for their proposed Outpatient Flow Tools, specifically the Integrated Online Booking System.

Included herein is a copy of the WDHB business case:

S 3.2.1 Outpatient Flow Tools - Business

9.3 DETAILED COSTS BREAKDOWN

iPM 2019 Project cost schedule Option 1 Upgrade and Bed Numbering								
		Account categories						
Cost Category	Cost Detail	Hardware	Software/ Licenses	Professional Services UPG	CMH Internal	Professional Services BN	Grand Total	
Project Delivery								
	Discovery and Business Case			25,000			25,000	
	Business Analysis			32,000		126,540	158,540	
	CMH Project Manager			59,800		132,940	192,740	
	Test Lead			36,000		65,280	101,280	
	Test resources			43,200		130,560	173,760	
	Development					48,000	48,000	
10%	Project Delivery Contingency			19,600		50,332	69,932	
Project Delivery Total		$ -	$ -	$ 215,600	$ -	$ 553,652	$ 769,252	
IT Health Alliance								
	Project Management			88,400		26,000	114,400	
	Solution Design			21,000			21,000	
	Security Review			1,300			1,300	
	Tech Leads & Engineers			208,000		16,720	224,720	
	SOE & Packaging and Deployment			24,000			24,000	
	DBA			35,200		65,120	100,320	
	Development			48,000		100,000	148,000	
	Testing			79,200		22,000	101,200	
	Implementation Support			38,000		40,800	78,800	
	Training					32,000	32,000	
10%	IT hA contingency	-		54,310		30,264	84,574	
IT Health Alliance Total		$ -	$ -	$ 597,410	$ -	$ 332,904	$ 930,314	
IT DXC								
	Consulting			49,222		56,320	105,542	
25%	IT DXC contingency			12,306		14,080	26,386	
IT DXC Total		$ -	$ -	$ 61,528	$ -	$ 70,400	$ 131,928	
IT (hA/Prime /Other Vendors) Total		$ -	$ -	$ 658,938	$ -	$ 403,304	$ 1,062,242	
Change Management								
	Change Mgmt & Comms							
	Clinical Change Mgr			32,000		159,160	191,160	
25%	Change Mgmt contingency			8,000		39,790	47,790	
Change Management Total		$ -	$ -	$ 40,000	$ -	$ 198,950	$ 238,950	
Backfill Staff-training and set up								
	Clinical Lead					119,140	119,140	
	Coaching team					40,000	40,000	
15%	Backfill contingency					23,871	23,871	
Backfill and set up Total		$ -	$ -	$ -	$ -	$ 183,011	$ 183,011	
PMO	Assurance							
	Management				120,000		120,000	
0%	PMO contingency							
PMO Total		$ -	$ -	$ -	$ 120,000	$ -	$ 120,000	
TOTAL PROJECT COST		$ -	$ -	$ 914,538	$ 120,000	$ 1,338,917	$ 2,373,455	

***Please note: Costs are Indicative and subject to confirmation following analysis and high level design

9.4 BED NUMBERING

Bed Management is currently included in the CMH FY19/20 HTT capital plan, though at the time of writing no approved business case exists, and as such no clear solution has been recommended, however Bed Numbering within iPM is a necessary pre-requisite before bed management can be further considered by the DHB.

A copy of the concept paper, approved at HTT steering 2018 is included here:

Concept Paper_Draft 08122017_Enable iPM

The following iPM system issues and bugs, with regards to Bed Numbering functionality, are addressed and resolved within versions 11, 12 and 13 (required if CMH decides to turn on the Bed Manager module within the iPM implementation):

- Run time error and i.PM closes when performing bed transfer in Bed View in APAC 10.1.0
- Some users are unable to use the new drag and drop functionality within Ward view
- Missing some bed numbers from historic inpatient stays.
- i.PM death applications server does not end date the bed stay record when auto-discharging the patient causing error in bed view.
- Patient seems to be occupying two beds at the same time if you do an Admission To Ward then do a Provisional Transfer, Then swap Bed with other patient, and then do the transfer again to another bed of the same ward or different ward.
- In Bed View Summary panel, incorrect counts is displayed while refreshing, later it displays correctly.

9.5 IPM UPGRADE V12 BENEFITS REVIEW

(As provided by Lambert Verhaaren 17/6/19)

IPM upgrade V12 Benefits review V1.dc

Top 5 benefits

Enhancement	Brief Summary	Conclusion	Frequency	Users Impact	Impact time
1) To support the export and import of i.PM profiles from one I.PM database to another ***Version 13***	This functionally ensures exporting and importing profiles between the three environments, at present you need to replicate all three databases in Production, Acceptance and Development individually.	Major saving as setting up profiles is time consuming	All new requests for **New Wards** two in 2018, two in 2019, **New specialties** 1 in 2018, 1 in 2019 **New Contacts**, **Upgrades** when this occurs, **Rules engine** updates, Outpatient set ups, On-going requests	Repetition of set ups will no longer required IPM Administrators, Outpatients build clinics 1 day saving per job, Rules engine, Contacts, Wards, LDDI's	Too difficult to estimate possibly 15 hours per week.
Potentially saving Deborah/Beverly and hA time to set up of 750 hours p.a. (15 hours per week).					
2) For ability to change the Session Status when in Restructure Mode	able to change the status of a live session from scheduled to on hold or cancelled while clinic is in restructure	This change will be most beneficial as it means if a clinic has been put into restructure and a cancellation request is subsequently received, the request can be processed without having to wait for the next working day (after the restructure has been run) to process the cancellation.	currently such requests have to be held over until the next day, when clinic is out of restructure	affects all staff with diary rights (around 55), but mainly affects Clinic Analyst (3 staff)	means work can be done on request instead of held to next day, saving potential error and time.
This benefits 20 to 40 patients per month that need to be rebooked due to the booking being made during a clinic reschedule made during restructures (approx. 300 restructures per month to update staff status). Saving rescheduling time and patient inconvenience					
3) To provide a prompt automatically close the	This functionally ensures referrals can	Major saving for the services, non-clinical support staff and hA, this would help with	*** Waiting information from Rosie	Schedulers, Service reporting review	Too difficult to estimate

Enhancement	Brief Summary	Conclusion	Frequency	Users Impact	Impact time
referral when closing a waiting list record ***Version 13***	be closed automatically when the waiting list closes	incorrect selection of referrals which requires fixing of data			
Potentially over a million referrals that need to be looked at and possibly closed. This would be a one off exercise? (Deborah/Beverly?).					
4) To disable change to patient address from Home Leave tab	This functionally ensures no updates when a patient provides another address when going on home leave	Saving incorrect data sent to the MoH impacting on Non Clinical Services for data amendments, Coding, Decision Support	Too difficult to estimate	Every staff member who puts a patient on home leave and records another address	Too difficult to estimate
This benefits patient address accuracy and potential rework and DNA flow on effects however total additional time is too difficult to estimate.					
5) Disallow updates to personal carer records	This functionally ensures the address and phones numbers are not linked once the personal carer is end dated	Saving staff time when incorrect information is against a personal carer	Too difficult to estimate	All Staff loading Patient Demographic changes over 1000 staff	Too difficult to estimate as staff do not know it has occurred and does not update until next patient registration is verified.
This rule will prevent rework and benefits patient address accuracy and DNA flow on effects however total additional time is too difficult to estimate. Could be 10 per week?					

9.6 HA SOW

CMH iPM Upgrade - Statement of Work Sc

9.7 CN 2019 NCAMP NNPAC ED SNOMED V4.0

In order to capture data that will provide meaningful analysis for ED attendances MoH propose DHB's report the presenting complaint, procedures and diagnosis using the clinical terminology SNOMED CT to NNPAC for ED presentations.

The proposal calls for an early adopters group of DHB EDs to commence in 2019 who will trial the reporting of SNOMED to better refine a National rollout. The early adopters are Auckland, Waitemata, Bay of Plenty, Nelson Marlborough and Canterbury DHBs with National rollout expected on completion of successful trial.

cn_2019_ncamp_nnpac_ed_snomed_v4.0.docx

9.8 FINANCIAL OPERATING COSTS

OPERATING COSTS-OPTION 1

iPM 2019 Operating cost schedule							
Opex per annum	FY19	FY20	FY21	FY22	FY23	Total	Total
	No incremental Opex required						
OPEX estimate (incl. contingency)							
Assumptions:	Incremental project costs ONLY						

9.9 FINANCIAL PROFIT AND LOSS STATEMENTS

OPTION 1-FINANCIAL PROFIT AND LOSS

Forecast Profit and Loss Statement (Cash benefits only)
iPM Upgrade and Bed Numbering Option 1

$'000

Interest Rate (n.a)	**0.0%**			Years					
Project Life Years	**5**			1	2	3	4	5	TOTAL
Corresponding Financial Year		FY20	FY21	FY22	FY23	FY24	FY25	FY26	
Investment:									
Initial Investment		(1,934)	(440)	-					(2,373)
Total Investment Outflow		(1,934)	(440)	-	-	-	-	-	(2,373)
Revenue/Benefits (Cash only) Inflow									
Cash									-
Total Revenue		-	-	-	-	-	-	-	-
Operating costs									
Maintenance		-	-	-	-	-	-	-	-
Service charge (Depreciation)				(475)	(475)	(475)	(475)	(475)	(2,373)
Interest (n.a)		-	-	-	-	-	-	-	-
Total Operating Costs		-	-	(475)	(475)	(475)	(475)	(475)	(2,373)
Forecast Net Surplus/(Deficit)		-	-	(475)	(475)	(475)	(475)	(475)	(2,373)
Net Surplus/(Deficit) Cumulative		-	-	(475)	(949)	(1,424)	(1,899)	(2,373)	(2,373)

9.10 STAKEHOLDERS

The following stakeholders have been identified to date.

Name	Role	Reason
Beverly Higham and other members of Clinical Systems Support Team	Functional Specialists	Selection of included features Testing of Application
Deborah Johnson	Administration Clerk	Data accuracy
John Cartwright	MMC GM	Impact on their service
Anne Anderson	Radiology Services SM	Impact on their service
Rebecca Lawn	Pharmacy SM	Impact on their service
Catherine Tracy	Medicine GM	Impact on their service
	Medical Acute Care SM	Impact on their service
Kevin Palmer	Business Manager - Accident Insurance & Eligibility	Impact on their service
Donald Mikkelsen	Laboratory Services SM	Impact on their service
TBA	Emergency Care Department SM	Impact on their service
TBA	Clinical Risk & Quality Manager	Impact on their service
TBA	Department of Medicine SM	Impact on their service
TBA	Department of Medicine SM	Impact on their service
Sally Urry	Breast Screening Medical Director	Impact on their service
Ross Boswell	Biochemistry CD	Impact on their service

Interface Owners

TBA	Middlemore Central IS Manager	Impact on Capplan
TBA	Charge Nurse	Impact on Colposcopy
TBA	Urology SM	Impact on NBRS
Verena Nadlang	Clinical Coding Manager	Impact on Patient bookings
Michelle Neustroski	Functional Specialist PIS	Impact on MCIS
Kevin Palmer		Impact on ACC online
Fiona Perry		Impact on AGFA RIS
Jovan		Impact on ePharmacy
Rosie/Nuve		Impact on data warehouse
David Bunkall		Impact on Delphic AP & LIS
TBA		Impact on Wims Scan
TBA		Impact on Cardio Server
Albert Lee		Impact on Éclair
Diana Dowdle		Impact on Feedback monitor pro
Paula Nes		Impact on HCC (ARMHIT)
TBA		Impact on PETS
TBA		Impact on iPM NHI
TBA		Impact on iPM Web
TBA		Impact on ProVation
Suzy Barber		Impact on Pyxis

STAKEHOLDERS AND CONSULTATION

The approach to stakeholders and consultation is to use existing forums to identify Champions for each area. The Champions will form an informal network and enable the project team to access all relevant personnel easily without the need for mass e-mails and large workshops.

The table below shows the stakeholder groupings, numbers and likely concerns / interests.

Group	Number of People	Interest / Concerns	People Consulted to Date
Clerical staff	1,000	Time taken, changes to process, quality of care improvements	
Nurse practitioners	1,000	Time taken, changes to their process, quality of care improvements	
Interface owners	40	Integrity of data transfers into other systems	
Heads of Department	40	Impact on their service	
Patient Information Team	9	Changes to their process	Janet Gibson, Deborah Johnson, Beverly Higham
Ko Awatea team	175	Process improvement opportunities, communications, training	

Engagement Process

Extensive functional, integrated, and interface testing will be conducted to minimise business risk and to identify any changes that result in business processes or data fields that may impact services. Through the detailed design phase, all areas impacted will be consulted with via the existing links with Ko Awatea. This should avoid duplication and make maximum use of existing knowledge and work to date.

The primary communication method will be via Champions, existing team meetings, and morning handovers (low-key approach). This will be supplemented with booklets, FAQ's and possibly e-learning materials and screen video's that explain what any changes are.

It is envisaged that there will be an intensive training period of 2 weeks prior to go live to ensure all users are familiar with the changes. Over the go-live period it is envisaged that floor walkers, Champions and super users will provide support covering 30 wards over 3 shift operations.

We aim to provide the test environment to local Champions / interested users and socialise the updated system once the configuration is finalised.

Non Counties Consultation To date

In addition to the above list of stakeholders, the planning and budgeting activities underpinning this business case have been undertaken in consultation with the following individuals and groups:

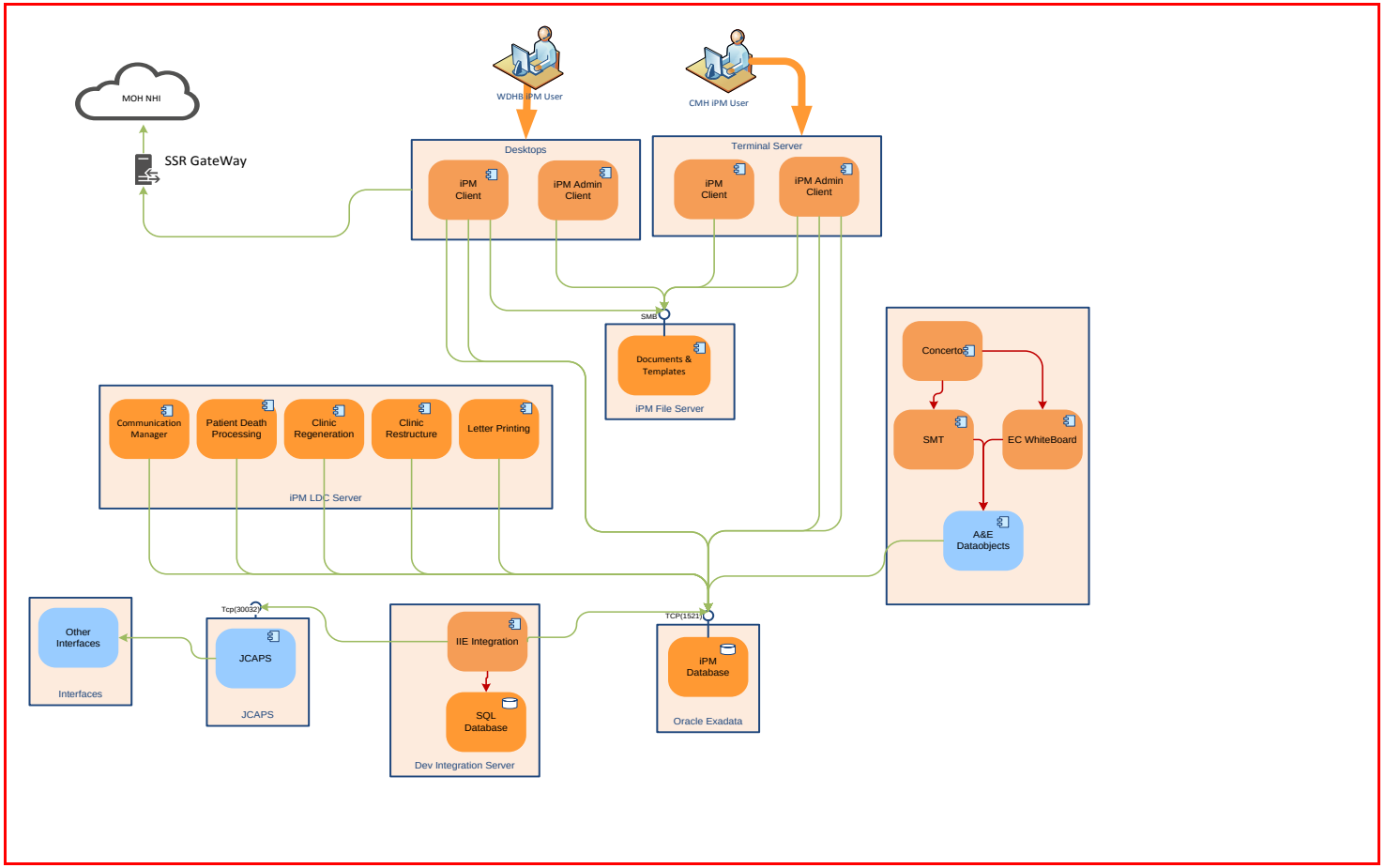
- Health Alliance

9.11 RISK REGISTER-OPEN RISKS

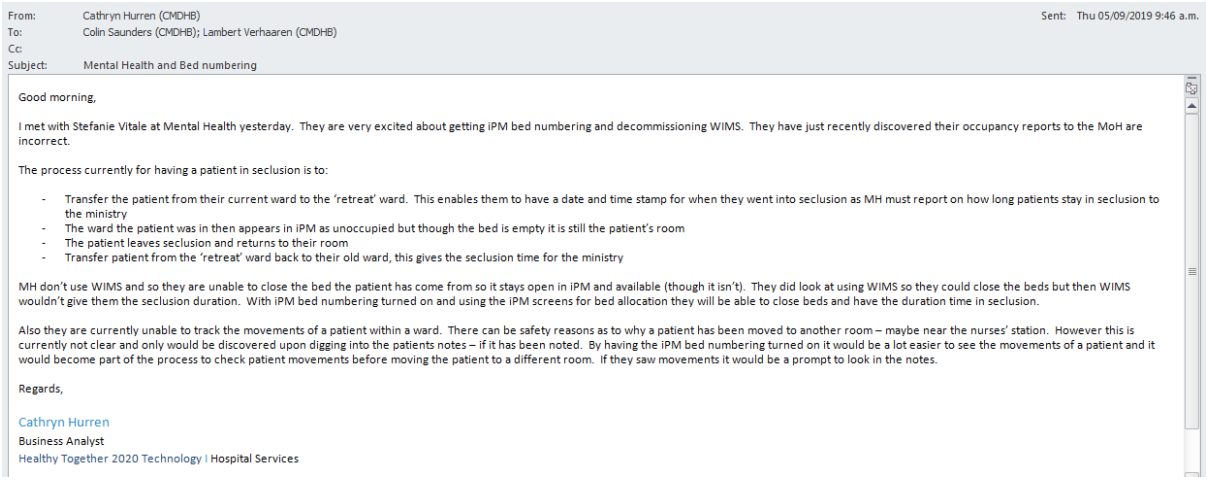
Risk	Probability (H/M/L)	Impact (H/M/L)	Owner	Risk Management Strategy
RESOURCES: There is a risk that the Functional Specialists are over committed working on competing projects	H	H	Business Owner	Project Sponsor to prioritise projects and progress requests for additional resource
VENDOR SUPPORT AND RELIABILITY: DXC may not provide the level of support required. Historically there have been some concerns regarding reliability and responsiveness	M	H	hA Project Manager	To monitor and raise concerns as required. Need to ensure direct support available during test and during cut-over.
TIMELINE: There is a risk that implementing will extend the project delivery timeframes out post Sept 2020.	H	H	CM Project Manager	Discuss with Business Owner, hA technical team what options are available to pull the upgrade delivery date forward.
VERSION AVAILABILITY: The release date for V13 is currently mid to late 2019. If this slips or includes significant bugs, this may create slippage of the schedule and go-live.	L	H	hA Project Manager	Regularly check with vendor on release dates for confirmation. Adjust schedule if agreed and within tolerance of delay period.
STAKEHOLDER CONSULTATION: There is insufficient consultation to develop business rules, therefore the rules may create direct or indirect disbenefits, change management challenges or be discovered late.	M	H	CM Project Manager	Ensure that the key stakeholders and SMEs are identified in time
REDESIGN REQUIRED: Upgrade and new modules may introduce significant changes to design	M	H	hA Project Manager	To re-assess once solution design completed and V13 details known. Architect to make allowance for any technical changes proposed for V13 in advance.
Oracle Driver Update – Current COE desktop image on CMH computers includes Oracle driver version 11.2.0.1 which is not supported with Oracle databases from version 12.2 or higher – required for iPM 13.x. Cost to upgrade client PC's is significant and not included with this project. Assumption is that DXC will certify iPM 13.x with CMH's older version desktop client Oracle drivers until such time as regional funding is available for client device driver updates.	M	H	hA Project Manager	Ensure DXC certification
Windows 10 upgrade testing – risk may not include iPM v13.x – as the project is targeting delivery during 2020 there is an assumption the Windows 10 upgrade project will include the iPM v13.x client software within its remit. Windows 10 testing for the iPM v13.x client software	M	H	hA Project Manager	Ensure Windows 10 project includes in scope

is out of scope.				
A&E Data Objects – there has been a number of attempts to upgrade the A&E Data Objects suite , required for legacy integration, and as at the time of writing the most recent upgrade project is officially on hold. Assumption that current A&E Data Objects version and / or any upgraded version(s) will remain compatible with iPM v13.x. healthAlliance architecture team will be required to consider within their design for this project. Changes required (if any) are not in scope.	M	H	hA Solution Architect	Ensure hA architect considers in design phase and liaises with A&E Data Objects project manager

9.12 CURRENT STATE ARCHITECTURAL REPRESENTATION



9.13 MENTAL HEALTH MOH BED OCCUPANY REPORTING CORRECTION



From: Cathryn Hurren (CMDHB) Sent: Thu 05/09/2019 9:46 a.m.
To: Colin Saunders (CMDHB); Lambert Verhaaren (CMDHB)
Cc:
Subject: Mental Health and Bed numbering

Good morning,

I met with Stefanie Vitale at Mental Health yesterday. They are very excited about getting iPM bed numbering and decommissioning WIMS. They have just recently discovered their occupancy reports to the MoH are incorrect.

The process currently for having a patient in seclusion is to:

- Transfer the patient from their current ward to the 'retreat' ward. This enables them to have a date and time stamp for when they went into seclusion as MH must report on how long patients stay in seclusion to the ministry
- The ward the patient was in then appears in iPM as unoccupied but though the bed is empty it is still the patient's room
- The patient leaves seclusion and returns to their room
- Transfer patient from the 'retreat' ward back to their old ward, this gives the seclusion time for the ministry

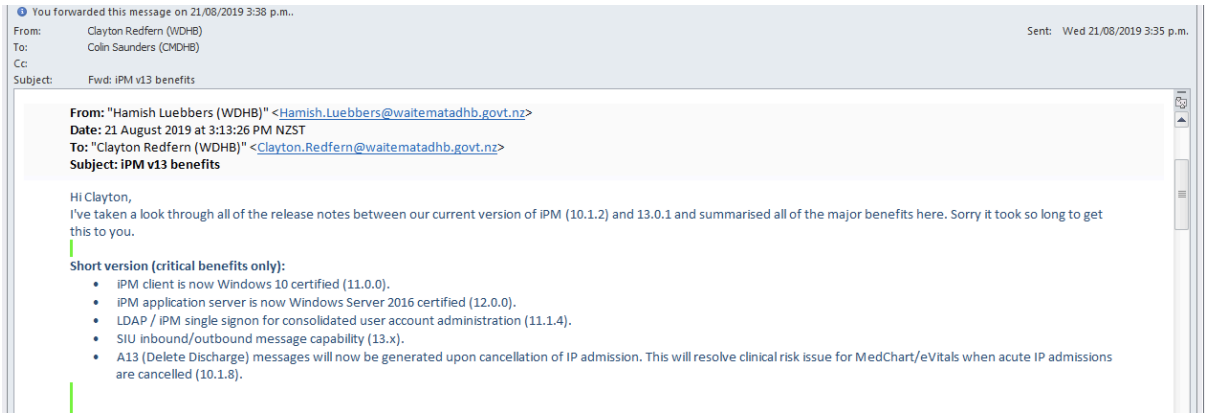
MH don't use WIMS and so they are unable to close the bed the patient has come from so it stays open in iPM and available (though it isn't). They did look at using WIMS so they could close the beds but then WIMS wouldn't give them the seclusion duration. With iPM bed numbering turned on and using the iPM screens for bed allocation they will be able to close beds and have the duration time in seclusion.

Also they are currently unable to track the movements of a patient within a ward. There can be safety reasons as to why a patient has been moved to another room – maybe near the nurses' station. However this is currently not clear and only would be discovered upon digging into the patients notes – if it has been noted. By having the iPM bed numbering turned on it would be a lot easier to see the movements of a patient and it would become part of the process to check patient movements before moving the patient to a different room. If they saw movements it would be a prompt to look in the notes.

Regards,

Cathryn Hurren
Business Analyst
Healthy Together 2020 Technology | Hospital Services

9.14 TECHNICAL BENEFITS



You forwarded this message on 21/08/2019 3:38 p.m..
From: Clayton Redfern (WDHB) Sent: Wed 21/08/2019 3:35 p.m.
To: Colin Saunders (CMDHB)
Cc:
Subject: Fwd: iPM v13 benefits

From: "Hamish Luebbers (WDHB)" <Hamish.Luebbers@waitematadhb.govt.nz>
Date: 21 August 2019 at 3:13:26 PM NZST
To: "Clayton Redfern (WDHB)" <Clayton.Redfern@waitematadhb.govt.nz>
Subject: iPM v13 benefits

Hi Clayton,
I've taken a look through all of the release notes between our current version of iPM (10.1.2) and 13.0.1 and summarised all of the major benefits here. Sorry it took so long to get this to you.

Short version (critical benefits only):

- iPM client is now Windows 10 certified (11.0.0).
- iPM application server is now Windows Server 2016 certified (12.0.0).
- LDAP / iPM single signon for consolidated user account administration (11.1.4).
- SIU inbound/outbound message capability (13.x).
- A13 (Delete Discharge) messages will now be generated upon cancellation of IP admission. This will resolve clinical risk issue for MedChart/eVitals when acute IP admissions are cancelled (10.1.8).

Information Paper
Counties Manukau District Health Board
Chief Executive's Report

Recommendation

It is recommended that the Board:

Receive the Chief Executive's Report for the period 1 November 2019 – 10 December 2019.

Prepared and submitted by: Margie Apa, Chief Executive Officer

Introduction

This report covers the period from 1 November 2019 – 10 December 2019.

News and Events

Pictured above: Phil Turner from Access Advisors (left) presents CM Health Board members and staff with the Accessibility Tick

Counties Manukau Health receives the Accessibility Tick

Kicking off celebrations to mark the International Day of People with Disabilities, Counties Manukau Health (CM Health) was presented with the Accessibility Tick. The Accessibility Tick is a public recognition of an organisation's on-going commitment to making their workplace accessible and inclusive for people with disabilities. This marks our commitment to continuing to make our organisation more accessible to people of all disabilities by adopting a plan of actions which will be implemented over the next few years.

Statistics from the NZ Census show 1 in 4 people have some sort of disability. As a healthcare organisation, CM Health is committed to changing the disparities that exist for disabled people, including through employing more people with disabilities and making CM Health workplaces more accessible and welcoming for people with disabilities.

Support for Samoa: Measles

Counties Manukau Health is taking a lead as part of a medical emergency response to the measles outbreak in Samoa. CM Health's involvement has been primarily through the Ministry of Health's NZ Medical Assistance Team (NZMAT) and through the Ministry of Foreign Affairs (MFAT). In addition, other agencies are providing support to the terrible situation in Samoa.

CM Health has a long-standing partnership with many of the Pacific islands and has been working alongside Samoa since 2007. I would like to commend our colleagues who have headed across to Samoa to care for the unwell and prevent further spread of the disease.

Pictured above: Some CM Health colleagues travelling to Samoa to give assistance

Stage 1 Completion of Scott Building Recladding

Pictured above: Counties Manukau Health and Hawkins staff marking the end of Re-clad Stage 1

On the 7th November 2019, CM Health marked the completion of Scott Building re-clad stage 1 with a blessing by our Kaumatua, Tumu Tikanga and Kuia. This is an important milestone and shows progress of work to date as we upgrade and address leaky building damage to the Scott Building. This is a significant, three-year programme of work due for completion towards the end of 2021. Our primary focus is keeping patients, staff and visitors safe. Thank you to staff and patients who have demonstrated understanding and patience as we progress with this important work.

Happy Diwali

Pictured above: CM Health staff celebrating Diwali festival

Our staff consistently tell us that one of the best things about working at CM Health is the diversity and cultural richness of colleagues and patients. In recognition that many staff members celebrate Diwali, the festival of lights, CM Health hosted a sustainable Diwali-at-work competition this year. Judging criteria focused on waste reduction and leaving no trace. The winning team was Te Rawhiti (Mental Health & Addiction) who held a shared lunch served on banana leaves. After the staff enjoyed the food, they fed their plates to composting worms, so that they too could enjoy a meal. The staff also upcycled empty tuna tins to use as tea light holders and cut out laminated paper to create Rangoli patterns, to be kept and reused again next year.

Neonatal Week

Pictured above: Staff celebrating Neonatal Week

Neonatal Week kicked off this year with a morning tea with home-baking from staff. Patient whaanau were invited to come and korero about what is important to them and what our teams can do to further support them on their journey.

Neonatal Nurses Week started in 2016 when it was known as Neonatal Nurses Day, to recognise the thousands of neonatal nurses who work tirelessly to save babies. This year, the National Association of Neonatal Nurses (NANN) has expanded Neonatal Nurses Day to an entire week, September 9 – 15, to acknowledge neonatal nursing contributions.

Kidz First Neonatal Care provides Intensive Care (Level 3) and Special Care (Level 2) services to infant patients and is an integral part of the continuum of services delivered by the Kidz First and Women's Health Divisions of Counties Manukau Health.

Fisher and Paykel Healthcare Donation

Above: Members of the CMDHB Board and executive team with Fisher & Paykel Healthcare Board and executive team at the signing the research funding agreement. Front row from left, Michael Daniell Director F&P Healthcare, Sanjoy Nand acting-CEO CM Health, Lewis Gradon CEO F&P Healthcare and Vui Mark Gosche Chair CMDHB.

Fisher and Paykel Healthcare have offered a research grant of $1.5m to CM Health over the next ten years. I am excited about making a difference to our community through the careful use of this resource – including research in to Maaori health and obesity. The funding has potential to positively impact our community by furthering understanding of vulnerable populations and healthcare access. A call for Expressions of Interest for this funding will be made in the New Year.

Counties Manukau Living Smokefree Team recognised

CM Health Living Smokefree Service was acknowledged in the 2018/2019 National Smokefree outcomes by the Ministry of Health for the best quit rate, best quit rate for Maaori, best quite rate for Pacific, best cost per quitter and best impact score nationally. Congratulations to the Living Smokefree Team.

The Living Smokefree Service works in partnership with local providers and Quitline, to ensure staff, patients and the wider community are offered free, convenient, local and culturally appropriate support. The range of support on offer includes: Face to face meetings, home visits/phone contacts, group programmes and drop-in clinics. Call 0800 569 568 (option 6) or text message NOW to 590 for more information and support.

Patient Feedback

Every month, Feedback Central receives verbal and written feedback from throughout the organisation. The Feedback Central team works hard to co-ordinate fair, simple, speedy, efficient patient and whaanau centred resolution of all feedback – both good and bad – working in partnership with services across Counties Manukau Health. I want to share with you some messages received from patients these past two months.

"Manukau SuperClinic 1st floor - from the outset the help, care and assistance from all staff, doctors, nurses, cleaning, and physio staff has been great. I'm very grateful and appreciative to have had my operation in this hospital and then to have received the help needed to get me going again. Thanks team."

"These past couple days/nights have been very comfortable and enjoyable for not only me but my partner. All nurses and doctors, all staff that took care of my partner made his stay and experience here a memorable one. Every staff member we came across was always friendly and welcoming. Thank you so much for everything!! We are truly grateful for the experience here with all staff."

"Ward 32 thank you to all the staff. They are wonderful and deserve a box of chocolates. Thank you for looking after mum."

"I am very pleased with the staff of ward 33. I would like to thank the nurses, the caregivers, the cleaners and the tea lady for a welcoming environment. As a patient I am blessed to be taken care by such a good team. Thank you for everything. I would like to thank the tea lady for her kindness that puts a smile on my face in the morning, to Elena for being a great nurse at night for Fatima for good work as well for the MIT student for helping our (*sic*) while all I can say is that through the past ward 33 east is the best. Keep up with the good work and keep on driving because without yous (*sic*) I wouldn't be here today once again thank you and God bless."

"It has been a pleasure being a patient at Manukau SuperClinic. It's a job well done in every way from day one till discharge. Calling out for help was even a plus. Staff make everyone feel at home, keep it up. Cleaning was very spotless."

"I would like to give thanks to all the doctor's and the nurses start from the ED department, then the short stay ward and ward 9 and also the surgery recoveries department and also the orderly last but not least the nurses from post-surgical unit thank you very much from the bottom of my heart GOD BLESS you all."

"What amazing teams; I am truly impressed about the way your staff upheld your core beliefs. At no point did I feel unheard. I was overwhelmed by the care and dedication your staff showed not only to me, but patients around me. I am astounded by the amazing bedside manner - these teams are really a great credit to you and your community. This was my first time in hospital and having surgery. A big thank you to your staff for making the experience less anxiety-filled, and would almost say that minus the pain, it was an enjoyable experience."

"Excellent feedback for staff members who take their time to make us feel safe and looked after - nothing was ever too much trouble and at the same time their sense of humour made you feel more relaxed and cheerful. Everything was carefully explained and I felt involved in treatments - nothing was 'dished out'! Great nurses and physio's and people who bring meals and 'cuppas' - thank you."

"I would like to say many thanks for the awesome treatment I have had from all staff on Ward 33 East each time I stay here I think life could not be better."

"My experience has been very delightful; staff are so kind and patient, also very helpful with letting me know how to cope. I only pushed my buzzer once and my nurse was here so fast. Thanks for being so attentive, patient and caring. Also very well-spoken and very neatly dressed - immaculate presentation all round. There are no improvements to be made as you offer the best care and facilities."

“To all the staff at Manukau SuperClinic Plastics who have looked after my father - a big thank you. Everyone has been so kind and supportive and explained everything well and we cannot thank you enough.”

“To Ward 8 - I'd like to thank all the team for their help, especially the anaesthetic Dr Dave for being so nice and gentle through his job and all his support team for being so brilliant. I'm very impressed by them. To my daily nurses, thank you all so very much for being so kind. You all do your job so well. I'm grateful for all your help and support. Thank you for being available, providing the services that you currently do. I benefited and appreciate what you offer.”

Our People

Retirement farewell for Dr Gloria Johnson, Chief Medical Officer

Pictured above: Dr Gloria Johnson (centre, in yellow) surrounded by CM Health Board members and colleagues from CM Health and the region wishing her farewell

It is with mixed emotions that we bid Dr Gloria Johnson farewell for her retirement. Gloria started her role as Chief Medical Officer in January of 2012, before taking on the role of Acting Chief Executive Officer during a challenging time. In September last year, she went back to her role as Chief Medical Officer and I am grateful to have had her support in my Executive Leadership Team. We will miss her astuteness, her heart for the people and her sense of humour. We wish her all the best for her retirement.

Welcome to Pauline McGrath, General Manager SAPS

From Left: Parekawhia McLean, Sue Shipperlee, Pauline McGrath, Whaea Taui, John Kenealy

We welcomed back Pauline McGrath, as General Manager of Surgery, Anaesthesia and Perioperative Services (SAPS) to Counties Manukau Health (CM Health). Pauline was previously a Service Manager of Lab Services and Infection Prevention & Control at CM Health, before taking on leadership roles in Australia and Ireland. She joins John Kenealy, Clinical Director of SAPS and completes the next steps in changes to leadership structure outlined in the decision document released earlier this year. I would like to acknowledge and thank Sue Shipperlee, Service Manager Elective Services & Urology, for her hard work as acting-General Manager during this time of transition.

Welcome to our University of Auckland first year nursing students

Pictured above: First year nursing students from the University of Auckland

This week we had the pleasure of welcoming first year nursing students from the University of Auckland. Nurses are an integral part of our clinical team and CM Health is committed to supporting development of this important workforce.

Welcome to new House Officers

Pictured above: Postgraduate Year 1 House officers joining Counties Manukau Health

Congratulations and haere mai to the 59 newly qualified doctors joining the CM Health whaanau. These house officers will be working across a range of services at Middlemore Hospital and Manukau SuperClinic over the course of the year.

Appointment to the Health Quality Safety Commission Board

Jenny Parr, Chief Nurse and Director of Patient & Whaanau Experience, was appointed by Associate Minister Honourable Jenny Salesa to the Health Quality Safety Commission Board for a three year term.

Metro Auckland coming together for our Nursing Workforce

The Directors of Nursing of the three Metro Auckland District Health Boards and the Heads of School of four of the five tertiary institutes who educate nurses in the metro-Auckland region met for the first time in October. The meeting provided an opportunity to start a discussion about collaboration and streamlining approaches, including to placements and to documentation.

New Entry to Practice

Two hundred and twenty interviews were scheduled and held for applicants into our New Entry to Practice (NETP) and specialty practice in October. All candidates were welcomed by our Kaumatua and provided with paid parking vouchers and a small gift.

Staff and Patient Workshops

The Patient Experience Lead and Clinical Nurse Director for Maaori Health jointly facilitated workshops for staff and patients with the help of seven co-facilitators. 'In Your Shoes' was a Patient Feedback session for staff and patients and and opportunity to patients and their whaanau to provide feedback on the care they received from one or more of CM Health services. It demonstrates our commitment to build on what we do well and learn what we could do better. In addition to this, 'In Our Shoes' staff only workshop provided an opportunity for staff to talk about their experiences. The facilitators were from the Pacific Health Team, Maaori Health, and the Patient Experience and Patient Safety and Quality Assurance Teams, attended by 25 patients and 30 staff. The patients were Maaori and Pacific (20) and Asian (5). The staff members that attended were all frontline staff and included Allied Health.

Te Ao Maramatanga Conference 1-2 October 2019

Several CM Health colleagues presented at the conference for Te Ao Maramatanga, College of Mental Health Nurses. Sione Vaka was the Keynote speaker, Hineroa Hakiaha was Cultural Convenor, and Samantha Musson and Rachael Muir also presented. Anne Brebner, Clinical Nurse Director of Mental Health and Addiction, also received a fellowship to the College.

Pictured above: Anne Brebner receiving her Fellowship for Te Ao Maramatanga from Dame Margaret Bazley, Suzette Poole and Chrissy Kake; CM Health represented at Te Ao Maramatanga conference

Teei Kaiaruna – supporting Maaori and Pacific workforce

Teei Kaiaruna, a Clinical Pharmacist at Middlemore Hospital of Maaori and Cook Island Maaori origin, has been recognised for her work encouraging Maaori and Pacific students to enter careers in healthcare.

"I can't emphasize enough that culture is a significant strength. Culture has a huge influence on health" she says. Teei also believes that Maaori and Pacific pharmacists have a special role to play in supporting patients who choose to use indigenous medicines with more mainstream medicine. In addition to mentoring students, Ms Kaiaruna co-hosted Maaori and Pacific Island (MAPAS) students on a tour of Pharmacy at Middlemore to learn about different healthcare jobs.

CM Health is committed to developing, recruiting and retaining our Maaori and Pacific workforces to reflect the populations we serve. We stand behind the Maaori Workforce Position Statement by Tumu Whakarae (national Maaori General Managers/Directors), which states:

1. All DHBs will actively grow their Maaori workforce to achieve a Maaori workforce that reflects the proportionality for their Maaori population, particularly, but not limited to, all clinical professions.
2. All DHBs will set in place steps to significantly and meaningfully realise cultural competence for all clinical staff, the Board and other staff groups that have regular contact with patients and whaanau.
3. All DHBs will measure and report on the recruitment and retention of Maaori staff in clinical and non-clinical occupations.

Other initiatives to develop, recruit and retain Maaori and Pacific workforce include hosting Grow Your Own Workforce (GOOW) Steering Group, establishing Health Science Academies for high school students and supporting tertiary institutions with recruitment activities.

In addition to Teei, I would like to acknowledge and thank the numerous staff who support workforce development through mentoring, volunteering and speaking with students.

Sustainability

Counties Manukau District Health Board approved our Environmental Strategy in 2012 and set a target to reduce our carbon footprint by 20% by the end of 2017. At that time we became members of the Certified Emissions Measurement and Reduction Scheme (CEMARS), an organisation which provides independent advice and audits the work programme each year to assess reduction in carbon levels. We received the results from the eighth independent audit of the organisation's carbon footprint for Middlemore Hospital and Manukau Health Park site in September 2019 and we are able to report a result of **26% reduction in our carbon emissions against baseline for the 2018 calendar year.**

The CM Health Board approved the next stage of the Strategy for Environmental Regeneration in December 2018 with the following agreed target:

> *To achieve **zero carbon emissions by 2050** the Environmental Advisory Group has developed an Action Plan. For each project identified on the Action Plan, we provide below the scope, operational feasibility, an estimated cost/benefit and associated risks.*

I have asked Pauline Hanna, General Manager of Infrastructure and Performance, to highlight some of our sustainability initiatives in place to achieve this target.

1. Energy Saving Initiatives

a) Heating, Ventilation and Air Conditioning

We are now able to measure the energy expenditure at the Manukau SuperClinic on a more systematic basis, so we are reviewing and continually revisiting the energy consumption of the heating, ventilation and air conditioning systems. As a result we have lowered energy costs at the site. Reducing unnecessary use of these systems has seen a 50% reduction in energy wastage at the SuperClinic.

b) Lighting

The Facilities, Engineering and Asset Management Division (FEAM) Division is continually undertaking lighting upgrades and as lights need replacing, new and more efficient light emitting diode (LED) systems

are replacing older less efficient fluorescent tubes. There is also an increasing focus on water conservation, which ultimately reduces energy.

c) Data to inform Energy Improvements

Energypro has been used as a tool to account for all carbon activities to capture the most recent carbon footprint. This proved to be highly beneficial in terms of time saved, improved data accuracy and enhanced credibility.

d) Built environment

The short term aim of this focal area involves developing and adopting regenerative building principles. Remediation of existing buildings also presents many opportunities to focus on environmental, health and community outcomes. Specific refurbishment specifications would help prevent further environmental and health impacts as there is compelling evidence in the favour of minimising the number of chemicals used in furnishing material.

2. Supply chain and procurement

The northern region District Health Boards have formed a Regional Environmental Sustainability Procurement/Supply Chain Strategic Group to provide guidance on environmentally responsive activities. There is an emphasis on developing national procurement guidelines which will assist in making a larger impact in supply chain and procurement practices, in alignment with Ministry of Business, Innovation and Employment (MBIE)'s Government Procurement Rules 4th edition which came into force 1 October 2019.

3. Hand-driers

High speed hand dryers were installed in designated public bathrooms at Middlemore Hospital and Manukau SuperClinic. We will report back the savings on paper towels, cleaner time and costs associated with waste disposal and transportation.

4. Waste

There are several initiatives to recycle waste and divert greater volumes of waste away from landfills, to help reduce waste related emissions and lower existing landfill costs. By recycling more, employees also increasingly feel empowered to make change. The Food-Waste-to-Plate project remains a key project for the environmental steering group which incorporates composting organisation food waste from the main food service areas at the Manukau campus. Our long term aim is to send zero waste to landfill, this is in line with the zero carbon aim by 2050.

We have also recently introduced Meat Free Mondays in the staff cafes at Middlemore and the Manukau campuses with success.

5. Transportation

A working group is exploring non-vehicle options for staff to get to and from work. The options involve increasing the:

- utilisation of public transport;
- number of employees who use rideshares; and
- the number of employees who cycle to work (safely).

In the longer term, CM Health will be able to participate in the development of an integrated cycle infrastructure working with key organisations and stakeholder across our region. In doing so, employees and visitors will be able to opt out of car travel in favour of more active modes such as cycling and walking.

Health Focus

The Emergency Department at Middlemore Hospital is the largest Emergency Department in Australasia, with 118,000 patients having being seen in the past financial year.

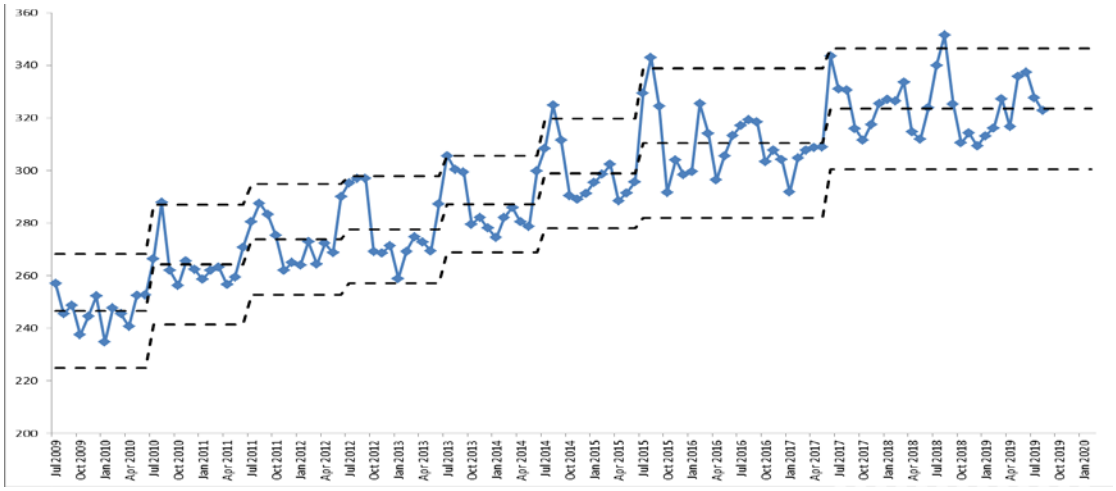
I have asked Dr Vanessa Thornton, Clinical Director of our newly formed Emergency Department-Middlemore Central division, to provide background on immediate demand pressures on ED and to list current initiatives to improve care.

Shorter Stays in Emergency Department National Health Target

The Emergency Department (ED) is the interface between community and the hospital's in-patient facility, and thus has dependency around the community services, department efficiency and in-patient capacity. Our performance against the Shorter Stays in ED (SSED) target has been challenging in the last 18 months despite the average presentations remaining static. It is important to note that the SSED target is a hospital wide target as it reflects activity across the system. When the ED is overcrowded with patients and flow is reduced in and out of the hospital system then the workload is higher for nursing staff in the ED.

The decline in performance for SSED started in 2017 as numbers of presentations outstripped the resources in ED and capacity flow through to the inpatient areas. Figure 1 illustrates the rising presentations to ED. A number of issues have been identified in the last 12 months and initiatives have been developed with the expectation of improved performance in 2020.

Figure 1 - ED presentations since 2009



Current initiatives

1. Governance and leadership

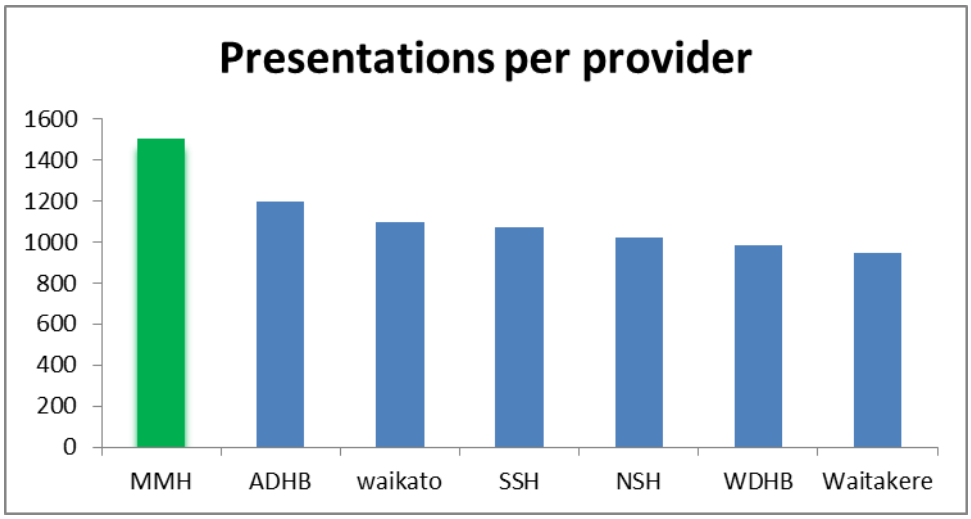
Change in governance has resulted in a new division, ED-Middlemore Central (ED-MMC), in an attempt to improve the flow across the system. Furthermore a new service manager for Emergency Medicine started this month. A new nursing structure has been developed with a Clinical Nurse Director across the division.

2. Staffing

Decision makers: As noted below in Figure 2, the number of decision makers in ED benchmarked with other EDs is much lower. An increase in House Officers and Clinical Nurse Specialist provision in ED has been approved and we are currently recruiting to these positions.

Unfortunately we are unable to recruit into the 2.2 Full Time Equivalent (FTE) Medical Officers of Special Standing (MOSS) / Fellow positions. We have a contingency to increase numbers of providers in December, through extra Registrars being allocated to Middlemore Hospital ED in the first half of 2020 until the MOSS vacancies are full.

Figure 2 - Presentations per provider or decision maker (includes all doctors, nurse practitioner and clinical nurse specialists)



3 Improvement in efficiency

Reduce demand

a. Emergency Q – approximately 400 presentations per month are redirected to urgent care. Please note these are the low acuity patients. This is helpful but by default this leaves the highly complex patients remaining in the ED.
b. Addition of a Receptionist – reducing demand on triage nurses by answering general queries by approximately 10 per hour. This reduces the queue time for those patient presenting to ED for clinical care, but does not show in metrics as this occurs before registration/triage
c. Working with the regional afterhours network (Patient Access to Urgent or Afterhours, also referred to as PAUA) and St John ambulance to reduce ambulance transfers to ED
d. Primary options of acute care (POAC)

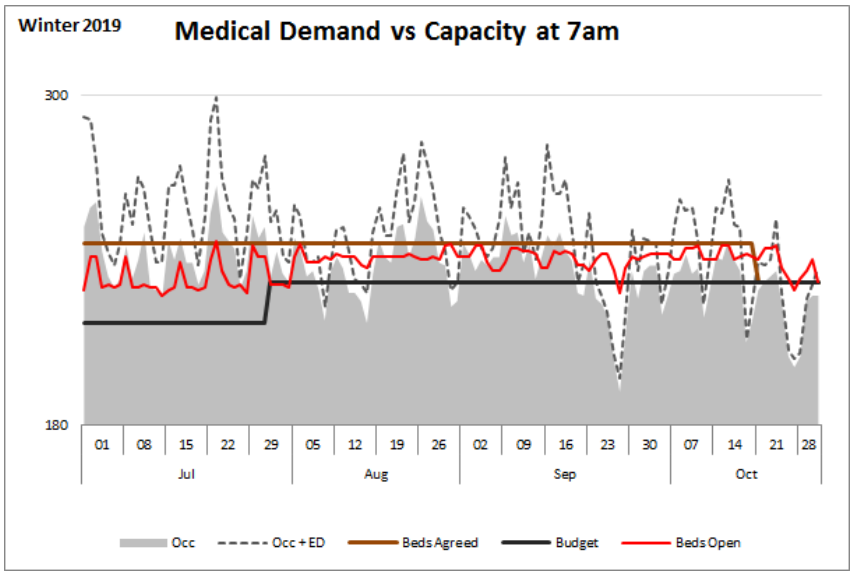
Improve efficiency

a. Senior doctor and nurse led triage to ensure patients are being seen in the right place at the right time. We aim to improve quality metrics such as time to antibiotics, decrease unnecessary diagnostics and lessen double handling for some patients.
b. Clerical team have had many unnecessary task removed to focus on early registration to facilitate senior lead triage
c. Orderlies as part of the team and improved provision over 24/7. Increase provision of orderlies after hours has been initiated.
d. Choosing wisely – reduced X-rays for cellulitis and one off intravenous antibiotics
e. Dedicated discharge cleaner in acute ED – turnaround of bed spaces sped up to ensure timely use of spaces.
f. Altered admission booklet to better reflect the workflow in ED
g. Bundles of care: reinvigorate after learning's from initial pilot
    - Asthma
    - Fractured Neck of femur
    - Hyperemesis
    - Dental - toothache
    - Cellulitis
h. Internal professional standards across divisions in relation to "time to be seen" by specialty teams in ED

Streamline admits

Work with the bed utilization stream of the acute flow project and Middlemore central. Occupancy of the hospital is a key to improving flow from the Emergency department and results in access block for ED. The graph below demonstrates occupancy exceeding beds over a number of weeks in winter resulting in patient's waiting in ED. (Access block) Occupancy must be considered in the SSED to ensure timely admits to the ward, particularly in medicine. Please note Figure 3 occupancy in the hospital over the winter period.

Figure 3. Hospital occupancy over the winter period



Work undertaken by the duty managers in our division

- Increase visibility of available beds across the hospital
- Timely allocation of beds
- Review meeting structure , reasons and outcomes
- Clear process to follow for duty managers

Work undertaken across the Every hour counts project

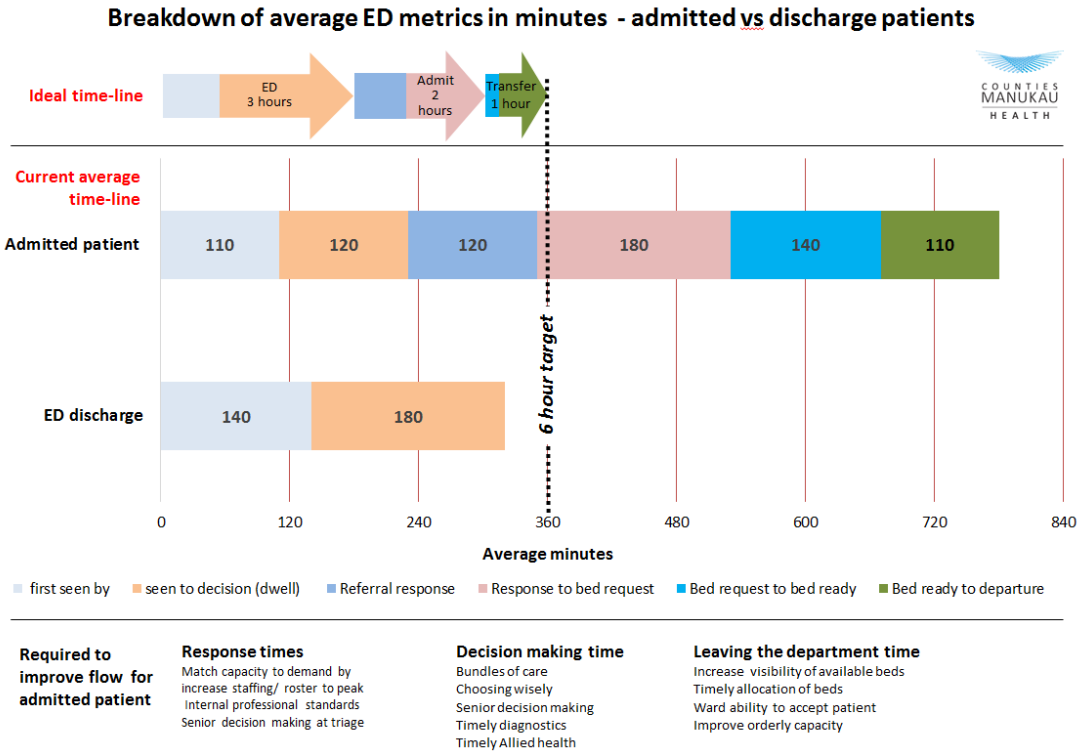
- Timely discharges (medical and surgical)
- Command centre to view bed availability across the wards
- Access to diagnostics particularly MRI

Summary

Whilst demand has not increased in the last 12 months the demand had exceeded the resources 18 months ago. A number of initiatives are underway to ensure that the patient's presenting to ED receive timely care.

Figure 4 demonstrate the areas to focus our attention on. The deployment of command centres will reduce the time waiting for a bed to become available.

Figure 4 - Break down of time spent in ED



Required to improve flow for admitted patient

Response times
Match capacity to demand by increase staffing/ roster to peak
Internal professional standards
Senior decision making at triage

Decision making time
Bundles of care
Choosing wisely
Senior decision making
Timely diagnostics
Timely Allied health

Leaving the department time
Increase visibility of available beds
Timely allocation of beds
Ward ability to accept patient
Improve orderly capacity

Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 30 September-15 November 2019.

Prepared and submitted by Donna Baker, General Manager Communications and Engagement and Parekawhia Mclean, Director Strategy and Infrastructure.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 30 September – 15 November 2019.

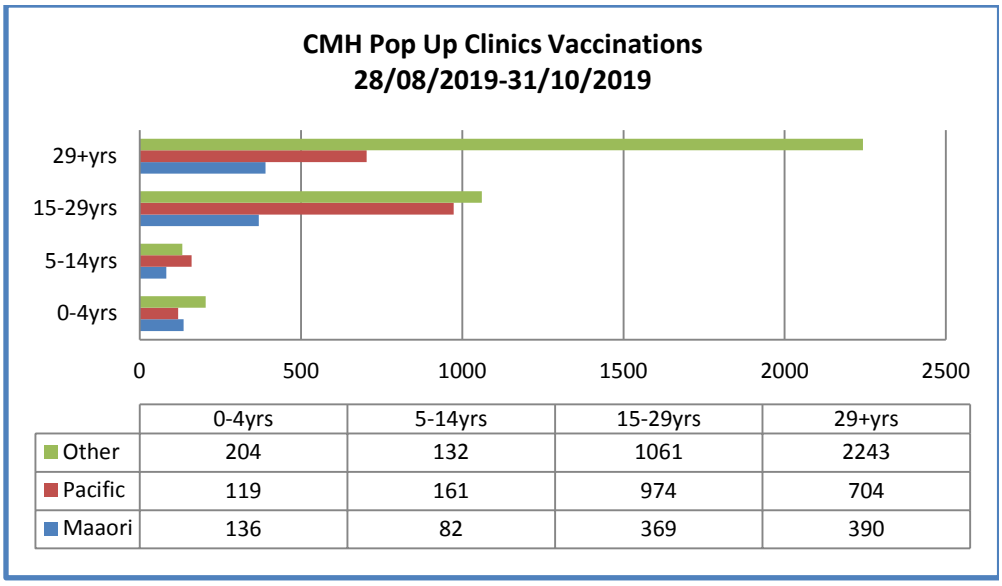
Annual Health Select Committee Review

The Official Information Act specialist continues to collate material in preparation for the Annual Health Select Committee review hearing, with a total of 365 questions received from Parliament. A regional (metro-Auckland) hearing is confirmed for 12 February 2020.

Measles Campaign Update

There is on-going interest in Measles following CM Health district reaching 1000 cases in October, and the outbreak in Samoa. Queries have been facilitated by Communications, including an interview with Kidz First Paediatrician, Dr Jocelyn Neutze with NZ Doctor. Other queries were referred to the regional incident management team who co-ordinated responses for metro-DHBs.

The campaign continues with our key messages for our staff and community, utilising our current collateral suite to support those messages. We have partnered with Plunket and distributed flyers to Early Childhood Centres regarding community clinics aimed at our pepi (6-11 months). We have continued to raise awareness about vaccination with the wider community.



	0-4yrs	5-14yrs	15-29yrs	29+yrs
Other	204	132	1061	2243
Pacific	119	161	974	704
Maaori	136	82	369	390

External Communications

Proactive Media

CM Health website featured on-going proactive articles promoting measles vaccinations and the plans put in place for strike action by union affiliated groups. Other stories included Middlemore pharmacist mentoring young Maaori and Pacific students, our new Chief Midwife, students touring the hospital to learn about health jobs and a successful first year for new primary care mental health model.

Mangere Birthing Centre

A response was prepared to address concerns raised by NGO Mangere Birthing Centre about being forced to close over Christmas due to CMDHB not engaging its services. The response noted that the DHB has no current contract for service nor is involved with decisions of the NGO; has primary birthing units in the district that provide capacity to meet the needs of mothers; and does not have resources to fund over and above current requirements.

Obesity

There has been continued interest in obesity stories in the media focused on women's health and radiology services. Communications has worked to facilitate a number of responses including interviews with Clinical Director Women's Health and Director of Population Health.

Strike Action

Communications provided support through contingency planning and with material for strike action undertaken by APEX-affiliated unions, including Radiographers, Psychologists, Sonographers and Medical Lab Workers. A number of media queries were also facilitated.

Proactive Releases/Website Stories
October

- Middlemore pharmacist mentors young Maaori and Pacific students
- DHBs ask ERA for facilitation to end MIT strikes
- CM Health plans for strike action
- Temporary management of MMR vaccine in metropolitan Auckland
- New Chief Midwife excited about role ahead
- Students tour Middlemore Hospital to learn about health jobs
- Successful first year for new primary care mental health model
- Results for 2019 DHB Elections
- Holidays Act compliance project

November (up to 15th November 2019)

- Scott building reclad marks milestone
- Cameras document stroke journey at CM Health
- Long term solutions to obesity key to CM Health planning
- Families at heart of Bereavement Care Services
- CM Health providing highest level of care Neonatal Unit
- ED Specialist receives ACEM Award

OIA

Agencies have 20 working days to advise a decision on release of information requested under the OIA. This means that there is a rolling response from receipt in one month to response in next month. Requests will vary in their complexity, scope and considerations.

October 2019 saw an overall increase in new request numbers. OIAs received and responded to in October were mainly media derived, with further queries after releases. For some of these cases, media statements and follow-up interviews with clinical leads were provided via Communications to support information released.

Human Resource matters were common requests (use of external consultants, outsourced personnel, staff measles cases, bullying/ harassment cases and employee turnover). In addition, there continue to be questions on the Measles response, and on-going industrial action (medical imaging and psychology)

The recent CM Health website upgrade has enabled introduction of enhanced 'sort and search' features across the proactively published responses to some OIA requests on the website. We are also working to include standard responses available and updated routinely to some recurring queries, (such as Eligibility costs and debts), rather than repeatedly responding to similar request via OIA processes.

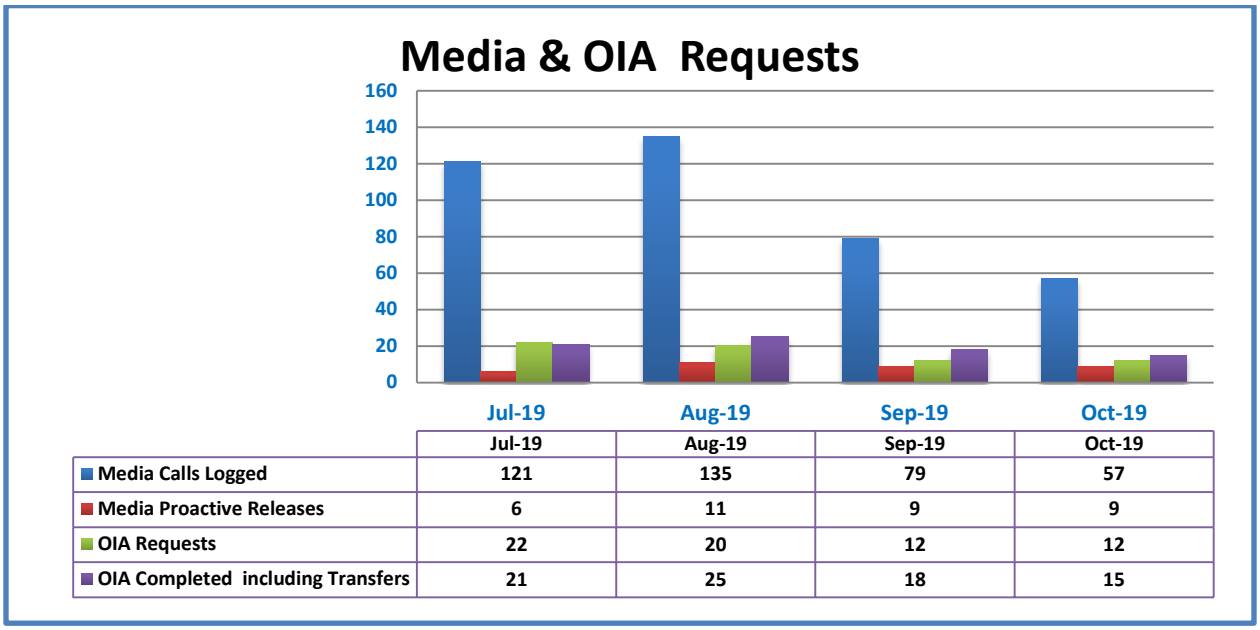
We are seeing a marked increase in the number of Written Parliamentary questions being forwarded to DHBs for rapid responses - within 48-hours. In October, 12 were processed via the OIA function, although most related to measles outbreak response, and were regionally coordinated.

More information on the OIA process and a form to submit requests is available:

- https://countiesmanukau.health.nz/about-us/official-information-act-requests/

Copies of recent OIA releases on common topics are also now on the website.

- https://countiesmanukau.health.nz/about-us/official-information-act-requests/publicly-released-oias/



	Jul-19	Aug-19	Sep-19	Oct-19
Media Calls Logged	121	135	79	57
Media Proactive Releases	6	11	9	9
OIA Requests	22	20	12	12
OIA Completed including Transfers	21	25	18	15

Routine Sector Communications

The Christmas edition of Connect+ is currently in progress. One of the leading stories for this edition is a farewell from departing Chief Medical Officer, Gloria Johnson. There will also be Christmas messages from across the organisation, and 12 days of Christmas tips and messaging on keeping safe this holiday period.

Internal Communications

Scott Building-Milestone for CM Health

We marked a key milestone by celebrating completion of Stage 1 of the project, including a blessing by Mahaki Albert, our Kaumatua and Aunty Taui and words of congratulation from our acting CEO Sanjoy Nand: '*…..This celebration is simply a recognition of all those that have been involved right from the early days of mock ups that were done 3-4 years ago including designing methodologies, which are still being refined, to ensure success of a project that has, to our knowledge, never been done anywhere in the world. Recladding a live hospital with patients and staff occupying the building is a huge call'.*

Franklin Community Hospital

The first Franklin Community Hospital working group met in October, attended by Communications. We will continue to support the group and the GM Penny Magud, through key messaging that will be sent out to staff and the wider community.

CM Health Staff Awards 2019

As part of the final Staff Forum on 4 December, we will be celebrating staff who have been nominated by colleagues for exceptional service demonstrating our values. Each award winner will receive a $250 voucher (from our sponsors), and a certificate. Our CEO Fepulea'i Margie Apa will be presenting these awards, and will name and present the award to the 'Supreme Winner'. We have worked with the HR team and the Special Projects team to promote and support the CM Health Staff Awards.

'Get it off your chest'

Employee Survey 2019 - 26 November - 13 December 2019. Results available end January 2020.
The employee survey will be managed by external providers and will recur every two years. A communications plan has been developed with the Director of HR and team to ensure the survey is promoted/communicated to encourage staff to complete the survey. Everyone is being asked to take part in this survey. It is anonymous; no one will be able to view individual responses. There will be survey clinics for anyone without a DHB email address. Collateral suite has been produced to promote and encourage staff to participate.

Review of the Holidays Act 2003

A regional response was sent out to all DHB staff. The internal communications team worked with the HR team, Auckland and Waitemata DHBs, and healthAlliance, to produce timely communications in line with public announcements on the day.

Staff Safety

***Security Staff Meetings*:** Sessions have been held at the Spinal Unit, Pukekohe Hospital and Papakura Birthing Unit.

Coffee with a Cop: The October 'Coffee with a Cop' was held at Pataka Place, Middlemore Hospital. It is a very successful collaboration with staff and the public. These sessions allow opportunities to ask our community police questions and have a general conversation. Both staff and public are becoming familiar with seeing our community police friendly faces around the hospital. Another session is planned for early December, as part of the Staff Security Campaign.

Health and Safety Committee: The staff safety campaign communications plan has been presented to the Health and Safety Committee by the GM Communications & Engagement, supported by Internal

Communications. We have received approval to use the *'It's not Okay'* national campaign materials as a focus for building on our own campaign.

Patient Safety Week

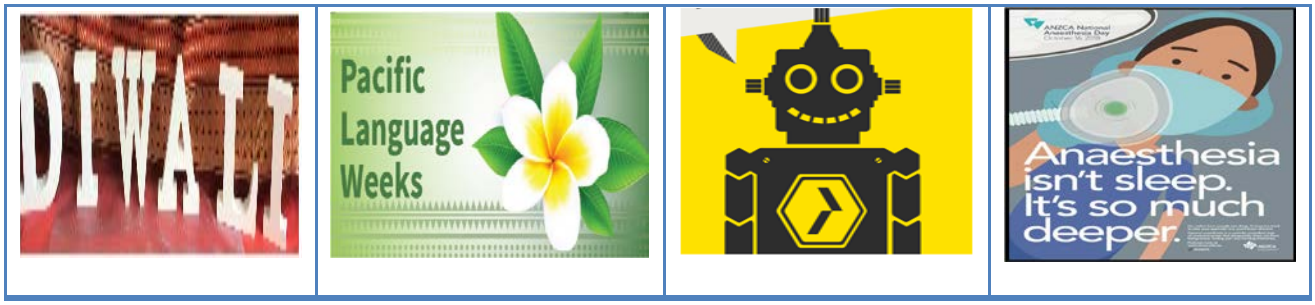
The theme of Patient Safety Week 2019 is to encourage health professionals to examine their own biases and how they affect the health care they provide. Internal Communications attended working group meetings and developed messaging utilising various channels to promote the modules and *'Patient Safety Week'*.

The HQSC and ACC have developed three video learning modules:

- Module 1: Understanding and Addressing Implicit Bias
- Module 2: Te Tiriti o Waitangi, Colonisation and Racism
- Module 3: Experiences of Bias

Campaigns & Promotions

Throughout October a number of promotions were celebrated. Internal Communications supported these with promotional material across all channels.



Diwali Festival Week-Asian Health Gain

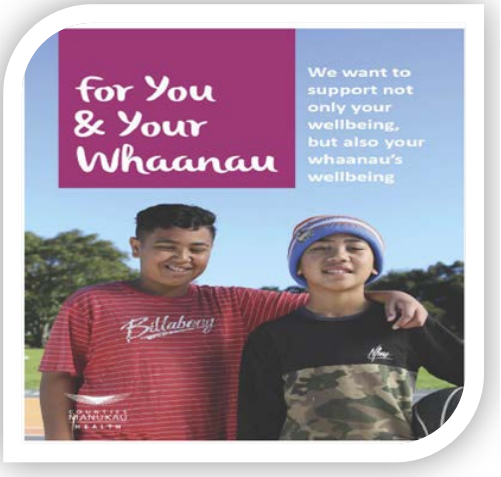
The Stakeholders & Community team and the Internal Comms team worked together, with Asian Health Gain Advisor Kitty Ko, Sustainability Manager Debbie Wilson and Charge Nurse Manager Ruth Prakash to promote a sustainable Diwali across CM Health.

Your Wellbeing Programme

Internal Comms have supported the People and Professional Development Team on the formal launch of the *Your Wellbeing Programme***.** The programme has been designed specifically for the 'Cleaning, Waste Orderlies and Orderlies Services Team'. The formal launch of this programme was on 20 November 2019. Staff celebrated the event in great style.

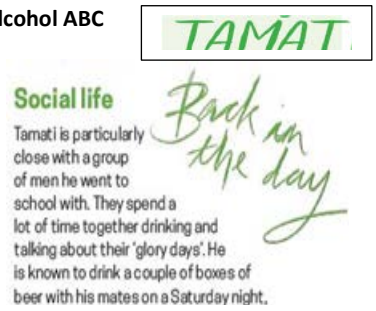
Videography, Photography and Design

Examples of some of the work produced by our design and video teams.



Videos

Business Unit	Content	Channels
	**Staff Safety Video** Another instalment of helpful hints video by our community Police was produced reinforcing the keep safe messages	Paanui, Internal Digital Channels
	See what Margie has to say about Kidz First and their fantastic efforts during the measles outbreak, cutting the ribbon at the recently re-opened Tree House crèche and more.	Paanui
Maaori Workforce – Allied Health	Videos currently being produced profiling two of our Maaori staff in the Allied Health team: ***Speech Language Therapist**; Renee Taylor video filming on 21 November 2019 ***Clinical Pharmacist**;Teei Kaiaruna TBC	Social media channels, website, internal channels, and for student and events.
Pukekohe Birthing Unit	Filming and editing are now complete; sign-off is in its final stages for the final video in a set of three.	All three videos to be shown at the Women's Health and Newborn Annual Report 2018-2019 launch 5 November 2019.
Mental Health; Procurement Hui	Procurement Hui, two videos were produced capturing the Poowhiri and consultation Hui to support the procurement process for Maaori and Pacific providers.	These videos are available on the CM Health Vimeo site and on GETS.
Breast Screening Programme 	Videos with Whaanau Ora social worker Moana Houia-Poka and Samoan interpreter Vaelua Lamb, throughout October for Breast Cancer Awareness Month	Social media channels, website, internal channels.

Spinal Unit	Patient Story; AJ Pouoa patient experience.	Presentation to Board
Cervical Screening Programme (Nov)	A short call to action video with Temira Mataroa – as part of the campaign collateral suite.	Social media channels, website, internal channels.
Alcohol ABC 	Three workforce development videos have been produced supporting staff to have conversations with their patients about their drinking. The interaction is between ED nurse Opal and her patient, Tamati. The character of Tamati is based on one of the AHM personas developed earlier in the year.	Social media channels, website, internal channels. Videos 01.Me, 02.Them, & 03.You  ***Tamati on Screen***

Community and Stakeholder Engagement

Bowel Screening Programme

Numbers for Pacific participation are lower than other ethnicities. We have put together a second phase comms plan that focuses on Pacific whaanau.

MEDIA	DIGITAL	LOCAL & SOCIAL MEDIA	COLLATERAL
Interview spots across Nov/Dec on Pacific radio – 531 PI and Radio Samoa in English, Tongan and Samoan	Digital ad running for a month on Kaniva Tonga News in English and Tongan	Proactive story with a patient that has experienced the programme in progress	Pull-up banners with local champions for events/expos

Cervical Screening Programme

HPA New Campaign in Development – Start to Screen campaign 'Give your cervix some screen time'

HPA in partnership with MoH is developing a behaviour change campaign, targeted at women aged 25-29 years, to encourage increased awareness and participation in cervical screening. The campaign is due to be in market in early 2020. We have developed a local communications plan which aligns with the national campaign.

CMDHB Campaign	CMDHB Campaign	CMDHB Campaign	CMDHB Campaign
SOCIAL MEDIA Four social media tiles with key messages. Network with social media influencers that can share content across their channels	**VIDEO** Video with Temira Mataroa a short call to action video	**LOCAL MEDIA & WEBSITE** Proactive story with a patient that has experienced the programme	**COLLATERAL** Update current collateral Pull-up banners with local champions for events/expos

Promoting Good Sexual Health

There has been a significant increase in the rates of Syphilis in Auckland, including South Auckland. ARPHS requested support with their communications strategy, particularly for our Pacific population, to raise awareness of Syphilis and the campaign for sexual health. Test, Treat, Talk.

Congenital Syphilis

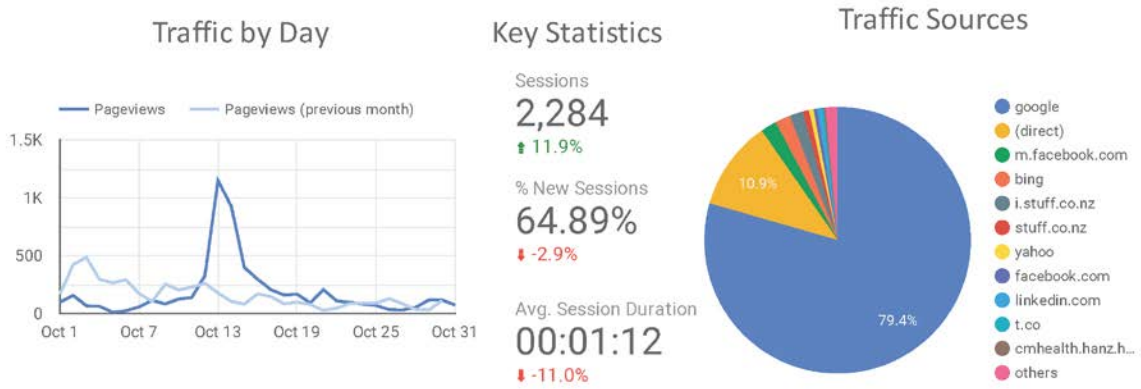
In parallel, CM Health's Child, Youth and Maternity team have requested, communications support to raise the awareness of congenital syphilis for pregnant women and babies. The two priority audiences

for this messaging are midwifes to encourage them to screen pregnant women for the test; and in our population to raise awareness of the dangers to baby of Congenital Syphilis.

Digital Channels

Website (www.countiesmanukau.health.nz**)**
As we look at key metrics for our news and media releases for October we see that the majority of traffic was sourced organically, was unique, and had a heavy interest in the DHB election results.

News / Media Release Readership



Popular Articles

	Page Title	Pageviews	% Unique Pageviews	Avg. Session Durati...
1.	Results for the 2019 DHB Elections | Counties Manukau Health	2,329	57.84%	00:01:18
2.	Successful first year for new primary care mental health model | Counties M...	329	87.54%	00:00:17
3.	Visitor car park rates increase at Middlemore Hospital | Counties Manukau ...	201	80.6%	00:02:23
4.	Students tour Middlemore Hospital to learn about health jobs | Counties Ma...	114	71.93%	00:01:03
5.	New Chief Midwife excited about role ahead | Counties Manukau Health	85	91.76%	00:00:25
6.	Page not found | Counties Manukau Health	84	94.05%	00:00:54
7.	Middlemore pharmacist mentors young Maaori and Pacific students | Count...	62	70.97%	00:00:30
8.	Measles vaccinations being offered to patients and whaanau at Middlemore...	60	88.33%	00:01:12
9.	Plans in place for Strike Action | Counties Manukau Health	45	82.22%	00:00:06
10.	CM Health plans for strike action | Counties Manukau Health	32	78.13%	00:00:00
11.	UPDATED - Temporary management of MMR vaccine in metropolitan Auckla...	32	87.5%	00:00:01
12.	Counties Manukau Health opens new Tiaho Mai Mental Health Unit | Counti...	32	87.5%	00:01:07
13.	Free Mental Health First Aid for Counties Manukau | Counties Manukau Hea...	31	77.42%	00:01:21
14.	News - By Communications Team | Counties Manukau Health	31	83.87%	00:00:14
15.	New Mental Health Team for Pukekohe | Counties Manukau Health	30	90%	00:02:02
16.	Free APP helps parents of preterm babies | Counties Manukau Health	30	63.33%	00:01:58
17.	New Tiaho Mai service gets thumbs up from staff and users | Counties Man...	29	86.21%	00:01:38
18.	Get vaccinated against measles now | Counties Manukau Health	26	88.46%	00:02:06
19.	New approach to primary mental health and addictions care | Counties Man...	26	96.15%	00:00:52
20.	Holidays Act compliance project | Counties Manukau Health	23	60.87%	00:00:39

Figure 1Web Site Data Metrics from Google Analytics

Social Media

We see a mixed month for our October metrics, with a decrease in numbers on Facebook and Instagram, but an increase on LinkedIn. With fewer posts about Measles we start to see messaging celebrating our staff and their diversity reach high levels of engagement across all channels.

	Total Followers	Follower increase	Messages Sent	Impressions	Impressions per Post	Engagements (incl. post clicks)	Engagements per Post	Post Clicks
CM Health Facebook	17,702	0.70%	49	152,803	3,118	6,335	129.29	14,938
CM Health Instagram	671	4.92%	28	9,218	329	573	20.46	222
CM Health LinkedIn	7,834	2.08%	14	24,337	1,738	2,476	176.86	1,704

Figure 2 Summary of Reach and Engagement Metrics for each social media channel

Audience Growth

	Totals	Change (vs. last growth)
Total Fans	28,962	
New Facebook Fans	123	-62.84%
New LinkedIn Followers	160	5.00%
New Instagram Fans	33	-43.10%
Total Fans Gained	316	-41.59%

Figure 3 Audience Growth Overview by social media channel CM Health Facebook

CM Health Facebook

October was a good period for positive messaging about our staff. We see very high engagement rates on Coffee with a Cop and Diwali messaging. We also see high engagement rates on content related to National Anaesthesia Day.

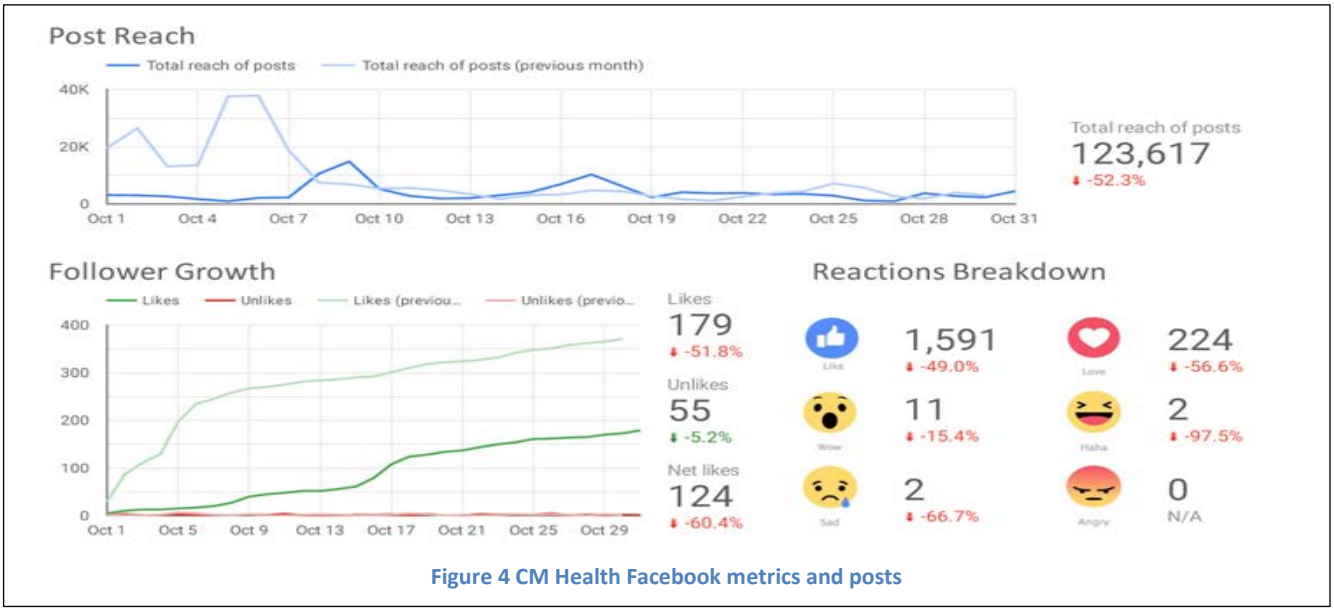


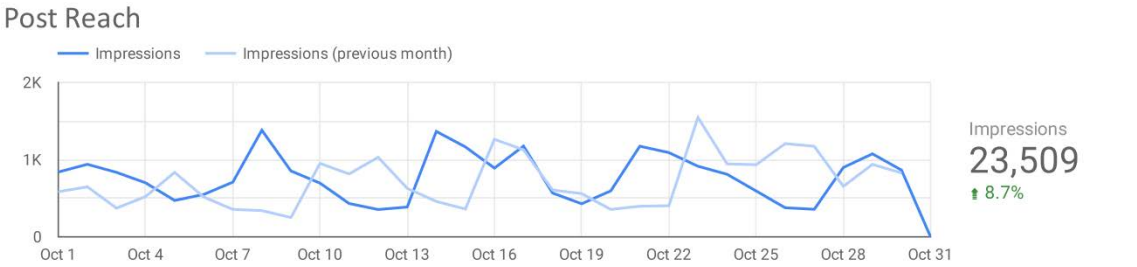
Figure 4 CM Health Facebook metrics and posts

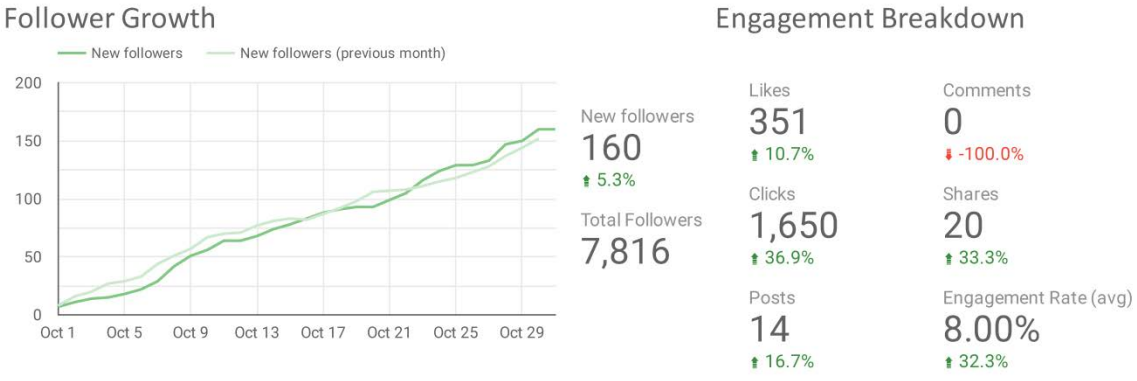
Posts by Engagement Rate

Date	Post message	Media	Rea...	Likes	Comments	Shares	Engagement Rate
Oct 16	Another great 'coffee with a cop' session is happening now at Paataka Place, Middlemore Hospital🎉☕. The cops are here until 1pm – if you're around why not come down for a korero/chat and ask them any questions you may have.		4,307	102	11	1	25.93%
Oct 21	We're celebrating Diwali here at Counties!🙌🎉 Diwali, the Festival of Lights, signifies the triumph of light over darkness, good over evil and renewal of life. Staff are celebrating with colourful decorations and costumes and the staff cafeterias have a delicious meat-free menu on offer today! The Diwali-inspired menus are available at both Manukau SuperClinic staff cafeteria and at Middlemore Hospital.		4,267	104	6	5	19.5%
Oct 11	Around 60 Health Science Academy students visited some of our teams yesterday exploring several health disciplines, including learning how to intubate a mannequin named Bob, during a recent tour of Middlemore Hospital. It's great to see so many rangatahi interested in health! Participating departments were: Anaesthetic Technicians, the Play Specialist Service, Population Health teams, Acute Allied Physiotherapy, Tiaho Mai Mental Health Unit, Ophthalmology and Diabetes Retinal Screening, Cardiac Investigation Unit, the Laboratory and Pharmacy - thanks to all the teams involved! Programme WAT		3,927	107	5	2	18.61%
Oct 25	Happy Diwali! Thanks to all our amazing staff who participated in the celebrations this week - we've had fantastic outfits, delicious food, beautiful decorations and time spent together to celebrate. 🎉🎉		3,601	95	3	3	17.25%

CM Health LinkedIn

This period was a good growth period for LinkedIn. Similar to Facebook we see content celebratory of staff, and recruitment content performing well on this channel. Our post welcoming our new students was a stand-out, achieving an amazing 35% engagement rate.





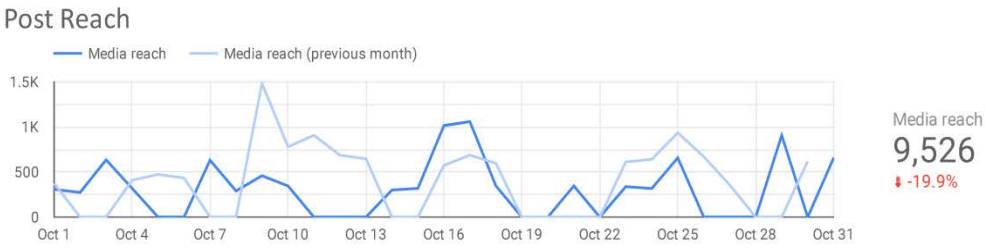
Post Breakdown

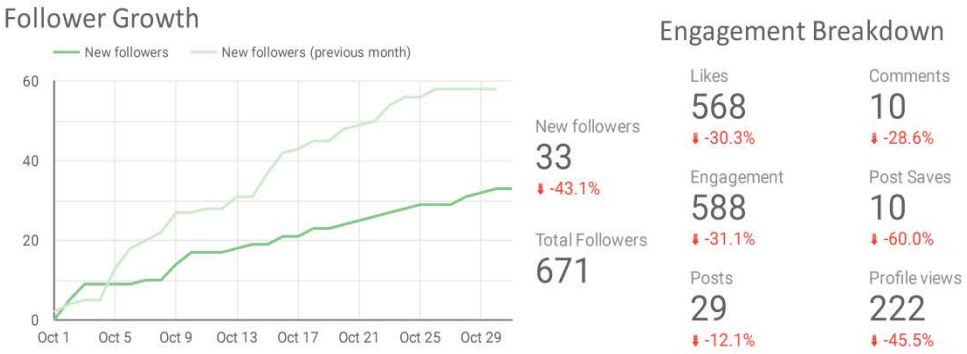
Update title	Created	Impressions	Video views	Clicks	CTR	Reactions	Comments	Shares
Are you our next Chief Medical Officer? We're looking for an experienced and... All followers	10/16/2019	1,180	-	45	3.81%	10	0	5
Teei Kaiaruna is on a mission to ensure more Pacific and Maaori people become... All followers	11/3/2019	37	-	0	0%	0	0	0
Our Chief Nurse and Director of Patient and Whaanau Experience Dr Jenny Parr spoke ... All followers	10/31/2019	827	-	51	6.17%	9	0	0
A big welcome to our 59 new starters who attended our Raahiri/Welcome to CM... All followers	10/31/2019	1,410	-	475	33.69%	18	0	0
Haere ra and farewell to our amazing final year physiotherapy students who spent 2... All followers	10/30/2019	628	-	32	5.1%	11	0	0
Join the team! We're seeking applications from exceptional Radiographers with... All followers	10/28/2019	540	-	12	2.22%	6	0	0
MIT students create a garden to help mental health All followers	10/28/2019	896	-	21	2.34%	18	1	2
Mobile devices release clinical time at Counties Manukau Health All followers	10/22/2019	1,732	-	112	6.47%	43	2	7
Do you want to help make a difference? Our Consumer Council represents the... All followers	10/21/2019	962	-	10	1.04%	10	0	1
"We get to walk with women and their whaanau through the most important... All followers	10/20/2019	1,766	-	59	3.34%	23	1	1
Nau mai, haere mai/ welcome to our first year nursing students! This week we had... All followers	10/16/2019	1,841	-	94	5.11%	45	1	2
Last week around 60 students visited Middlemore Hospital exploring several... All followers	10/14/2019	2,015	-	498	24.71%	35	0	1
Are you an exceptional, experienced individual looking to make your mark at... All followers	10/13/2019	1,337	-	63	4.71%	8	1	0
Join the team! Counties Manukau Health in Auckland, New Zealand is currently seekin... All followers	10/8/2019	1,098	-	13	1.18%	9	0	2
Last week we welcomed 55 new starters at the 'Raahiri | Welcome to CM Health' eve... All followers	10/7/2019	2,029	-	393	19.37%	17	0	0
The college of emergency nurses recently held their annual conference in Hamilton.... All followers	10/1/2019	2,970	-	98	3.3%	74	3	0

Figure 5 CM Health LinkedIn metrics and posts

CM Health Instagram

We saw a dip across the board on Instagram in October. While our top posts performed well, and with numbers consistent with what could be considered 'good', this highlights the need for a strategy that treats Instagram differently to our other channels. (The strategy is under development)





Posts by Engagement Rate

Date	Media caption	Media	Reach	Likes	Commen...	Saves	Engagement Rate
Oct 16	It's National Anaethesia Day today and to celebrate, we have a wonderful team of specialist and trainee anaesthetists, anaesthetic technicians and pre-admission clinic nurses in the main reception at Middlemore Hospital and Manukau SuperClinic until 3pm🎉. The team will inform you about what anaesthesia entails – it's not just a sound sleep; it's a carefully controlled state of unconsciousness. While you're there, ask any questions you have and have a go with some of the specialised equipment. And – you can have a korero/chat with our Advance Care Planning team who are joining them today. See you there! #NAD2019		380	45	5	0	13.16%
Oct 21	We're celebrating Diwali here at Counties! Diwali, the Festival of Lights, signifies the triumph of light over darkness, good over evil and renewal of life. Staff are celebrating with colourful decorations and costumes and the staff cafeterias have a delicious meat-free menu on offer today! The Diwali-inspired menus are available at both Manukau SuperClinic staff cafeteria and at Middlemore Hospital. #diwali #TeamCounties		346	39	0	0	11.27%
Oct 23	It's Occupational Therapy (OT) Week! Shout out to all our amazing OT's! Did you know - there are over 140 OTs working across the DHB, each contributing expertise in addressing occupational issues across a range of patient populations. If you're around Middlemore Hospital today, come visit the team at their OT Week stand in the glass corridor - they're here until 2pm. #otweek2019		338	37	0	0	10.95%
Oct 18	Fakaalofa lahi atu! Happy Vagahau Niue Language Week! 🎉 Staff had a lovely time celebrating Niuean language week together today – there was a presentation about Niue and some useful phrases, followed by a song and dance session which everyone loved! Thank you to everyone who joined us and everyone who helped make this such a special event. #niuelanguageweek #teamcounties		347	33	1	1	10.09%
Oct 31	A big welcome to our 59 new starters who attended our		341	33	0	1	9.97%

1 - 20 / 29

Figure 6 CM Health Instagram metrics and posts

News/Media Listening

Peaks

- 15 October: Incident at Middlemore Train Station
- 19 October: Occupants of serious car crash taken to Middlemore Hospital.
- 21 October: Serious assault in Mangere, victim in serious condition in Middlemore Hospital.
- 29 October: Diwali house fire, victim in Middlemore Hospital.

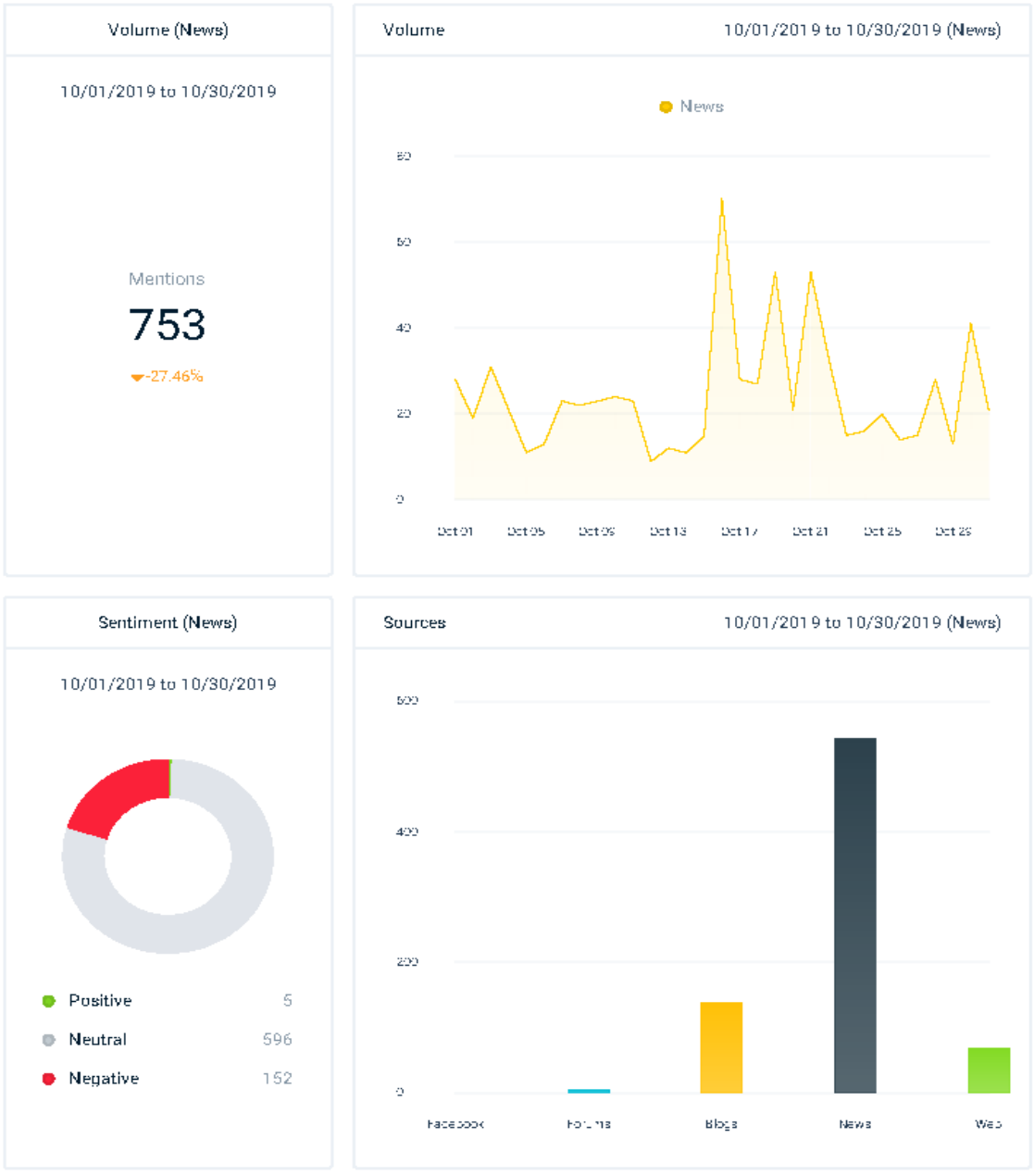
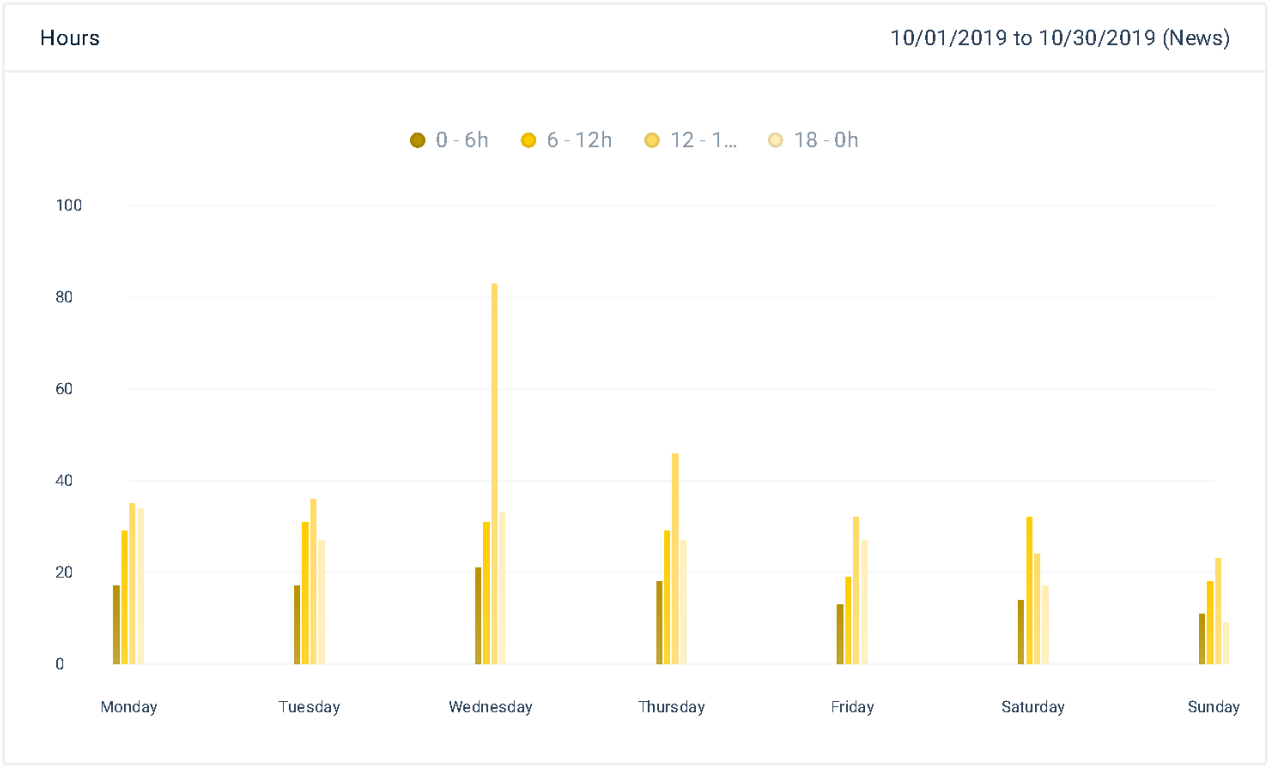


Figure 7 news volume, sentiment and sources



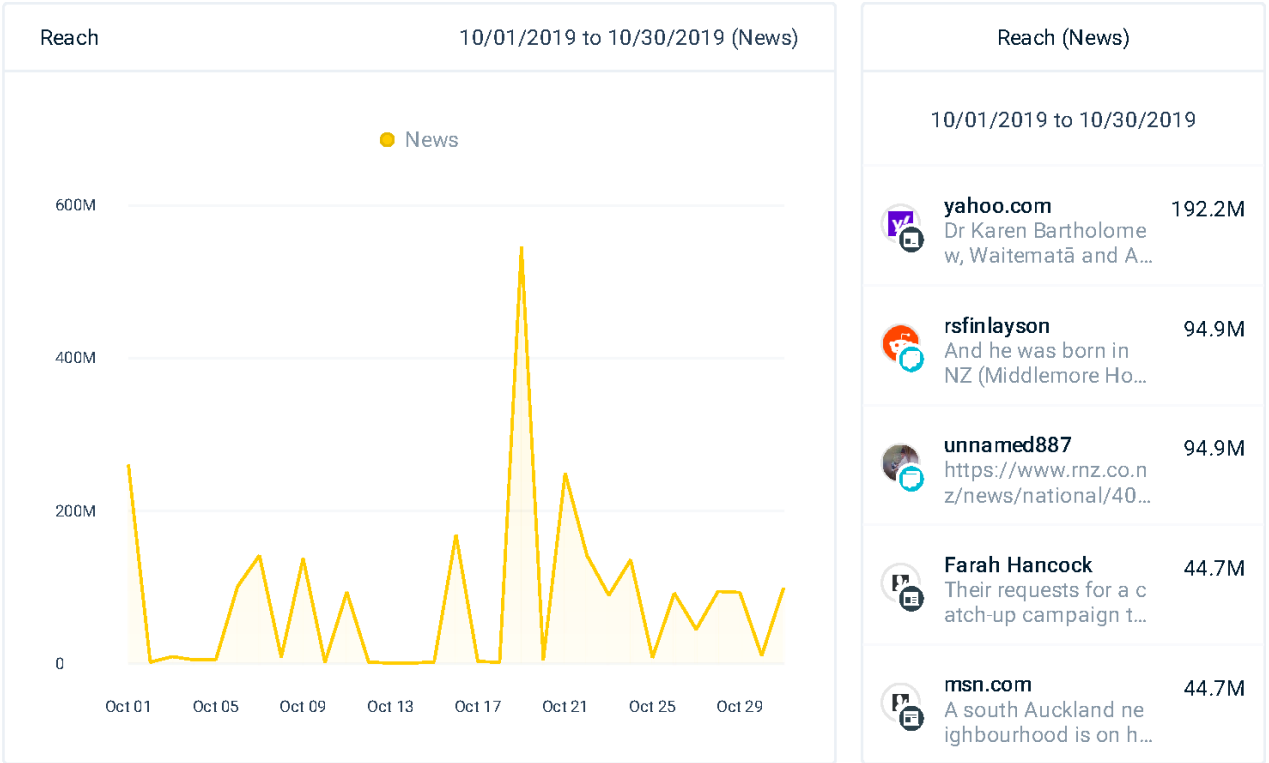


Figure 8 hours and reach

Figure 9 influence, topics, and weekdays

Confidential
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation:

It is recommended that the Board.

Receive that this paper noting that it presents an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 20 November 2019.

Submitted by: Margaret White – Chief Financial Officer

Glossary

ACC	Accident Compensation Corporation	MOH	Ministry of Health
CHC	Chronic Health Conditions	NTS	National Technology Solution
HOP	Health of Older People	PHO	Primary Health Organisation

Purpose

The purpose of this paper is to provide the Board with an overview of the latest available financial position.

1. Key Messages

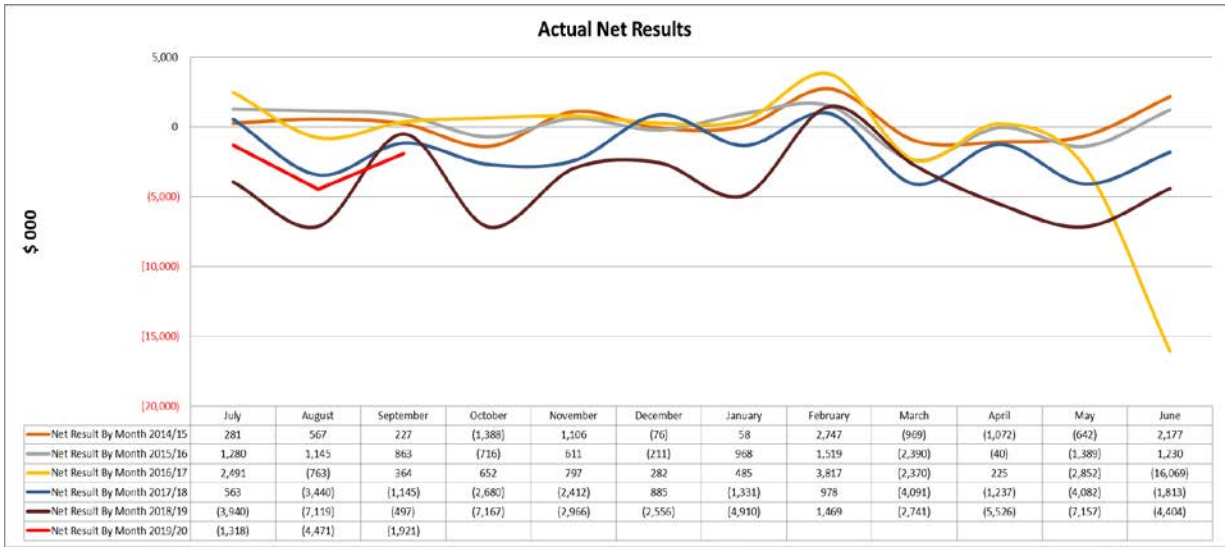
- **CMH 2019/20 YTD Result:** The YTD result reflects growing clinical pressure in a number of areas, largely offset by vacancies. Review of Clinical Service plans in quarter two will inform 2020/21 and outer year investment alongside other strategic priorities. Please refer to separate paper re refresh of Healthy Together strategy and 5 year financial plan.
- **2019/20 Savings Plan:** September has seen a improved performance against the 2019/20 savings target. Work continues to accelerate projects. The EY financial sustainability review due for completion mid November will provide additional avenues for strategic improvement. Updates will be provided in due course.

2. Summary Result and Financial Commentary for the period ended 30 September 2019

Table 1: Summary month and YTD result by division for the period ended 30 September 2019

Net Result	September 2019						Full Year	
	Month			Year to Date				
	Act	**Bud**	**Var**	Act	Bud	Var	Bud	Fcast
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Provider	(4,787)	(4,765)	(22)	(16,616)	(16,008)	(608)	(76,877)	(77,485)
Funder	3,297	2,998	299	9,527	8,993	534	40,769	41,303
Governance	(430)	(209)	(221)	(620)	(675)	55	(2,487)	(2,432)
Surplus/(Deficit)	**(1,921)**	**(1,976)**	**55**	**(7,709)**	**(7,690)**	**(19)**	**(38,595)**	**(38,614)**

Figure 1: Consolidated Net Result (By Month)



	July	August	September	October	November	December	January	February	March	April	May	June
Net Result By Month 2014/15	281	567	227	(1,388)	1,106	(76)	58	2,747	(969)	(1,072)	(642)	2,177
Net Result By Month 2015/16	1,280	1,145	863	(716)	611	(211)	968	1,519	(2,390)	(40)	(1,389)	1,230
Net Result By Month 2016/17	2,491	(763)	364	652	797	282	485	3,817	(2,370)	225	(2,852)	(16,069)
Net Result By Month 2017/18	563	(3,440)	(1,145)	(2,680)	(2,412)	885	(1,331)	978	(4,091)	(1,237)	(4,082)	(1,813)
Net Result By Month 2018/19	(3,940)	(7,119)	(497)	(7,167)	(2,966)	(2,556)	(4,910)	1,469	(2,741)	(5,526)	(7,157)	(4,404)
Net Result By Month 2019/20	(1,318)	(4,471)	(1,921)									

Commentary on DHB Consolidated Financial Performance

Provider **-** The Provider Arm produced a $22k unfavourable result against budget for September 2019 (YTD $608k unfavourable) to budget.

September has seen an increase in Planned Care volume activity, driving cost increases for the month, particularly in outsourced clinical services and clinical supplies. YTD vacancies continue across the system in difficult to recruit to positions. Cover has been provided by locums, bureau, overtime, casual staff and additional outsourced clinical services. Delayed implementation of savings programmes has reflected unfavourably on the YTD result.

Funder **-** The Funder Arm is $299k favourable (YTD $534k favourable) to budget driven mainly by Mental Health and HOP underspends.

Governance **-** Governance Arm is $221k unfavourable (YTD $55k favourable). The months result reflects provisioning for unbudgeted consultancy costs in relation to OIA (to be part recovered from NRA/Region), Ernst Young (EY) review and AON actuarial valuation associated with the 30 June Holidays Act provision.

Table 2: Consolidated Net Result (Cumulative YTD)

Net Result	September 2019						Full Year	
	Month			Year to Date				
	Act $000	Bud $000	Var $000	Act $000	Bud $000	Var $000	Bud $000	Fcast $000
Revenue								
Crown	153,186	149,355	3,832	453,892	448,066	5,826	1,792,291	1,798,117
Other Revenue	3,093	3,449	(355)	9,939	10,274	(335)	40,471	40,136
Total Revenue	**156,280**	**152,804**	**3,476**	**463,832**	**458,341**	**5,491**	**1,832,763**	**1,838,253**
Expenses								
Personnel	57,205	58,732	1,527	173,436	178,088	4,652	724,892	720,272
Outsourced Personnel	1,806	852	(954)	5,212	2,566	(2,646)	10,246	12,892
Outsourced Services	7,250	7,051	(199)	21,557	21,120	(437)	84,058	84,495
Funder Provider Payments	66,820	64,453	(2,366)	198,035	193,360	(4,675)	768,641	773,316
Clinical Supplies	11,634	10,369	(1,265)	33,604	30,927	(2,677)	123,725	126,371
Infrastructure	7,475	7,231	(245)	21,490	21,693	203	86,687	86,483.82
Operating Expenditure	**152,190**	**148,687**	**(3,503)**	**453,334**	**447,754**	**(5,580)**	**1,798,250**	**1,803,829**
Operating surplus	**4,090**	**4,117**	**(26)**	**10,498**	**10,587**	**(89)**	**34,513**	**34,424**
Depreciation	3,209	3,267	58	9,801	9,801	-	39,203	39,203
Interest	-	-	-	-	-	-	-	-
Capital Charge	2,802	2,825	23	8,406	8,476	70	33,905	33,835
Net Surplus/(Deficit)	**(1,921)**	**(1,976)**	**55**	**(7,709)**	**(7,690)**	**(19)**	**(38,595)**	**(38,614)**

Commentary on DHB Consolidated Financial Performance

Month Result – Major variances to budget are described below:

Revenue is favourable to budget by $3.5m (2.3%) reflecting:

- $3.0m additional PHO practice revenue, matched by additional costs;
- PHO IDF quarterly wash-up funding shortfall $323k due to no price/vol. uplift in budget;
- Recognition of YTD Planned Care volumes delivered to contract in September, $828k.

Operating Expenditure is unfavourable to budget by $3.5m (2.3%) reflecting:

- ($954k) additional Outsourced Personnel costs to cover vacancies in difficult to recruit to positions as well as unplanned leave across the Hospital Services, mainly in Mental Health and Facilities Services. Additional approved resource was required in Opthalmology and Gastro to address waitlists;
- ($199k) additional Outsourced Services primarily reflects the Ophthalmology Mega Clinic initiative to reduce waitlists and additional outsourcing of surgical procedures to meet Planned Care target;
- ($2.4m) Provider Payments; mainly additional funded PHO payments (matched by additional revenue $3.0m), HOP underspend trend continues $472k;

- ($1.3m) Clinical Supplies Increased pharmaceutical drug spends of ($157k) driven by Gastro and Renal Services, increased volumes of hip & knee procedures resulting in implant costs overbudget by ($293k) plus unrealised target savings for the month of ($629k);

  Part offset by favourable variances of:
- $1.5m Personnel favourable due to vacancies across the whole of the DHB.

Year to Date Result – Major variances to budget are described below:

Total Revenue is favourable to budget by $5.491m (1.2%) reflecting:
- $5.4m additional PHO practice revenue plus Pay Equity funding, all matched by additional costs;
- Pharmacy $415k additional Retail revenue, offset in cost of goods sold;
- Additional revenue $282k for PCT drugs in Clinical Haematology; offset in Pharmacy drug costs.

  Part offset by unfavourable variances of:
- Non Resident revenue lower than expected ($213k);
- Unrealised target savings ($440k).

Operating Expenditure is unfavourable to budget by $5.58m (1.2%) reflecting:
- ($2.6m) additional Outsourced Personnel costs to cover vacancies in difficult to recruit to positions and unplanned leave across the Hospital Services, in particular Mental Health and Facilities Services. YTD Additional approved resource was required in Opthalmology and Gastro to address waitlists;
- ($437k) additional Outsourced Services reflect the Ophthalmology Mega Clinic initiative to reduce waitlists and additional outsourcing of surgical procedures to meet Planned Care target;
- ($4.7m) Provider Payments; mainly additional PHO ($5.3m) and Pay Equity payments($445k) matched by additional revenue offset by underspends in HOP $605k, Mental Health $166k, Localities $85k and Smokefree $79k;
- ($2.7m) Clinical Supplies Increased volume related pharmaceutical drug spends of ($719k) in Gastro and Renal, additional laboratory volumes relating to the measels epidemic ($213k), unrealised YTD target savings of ($1.9m);

  Part offset by favourable variances of:
- $4.7m Personnel favourable due to vacancies across the whole of the DHB.

3. Statement of Financial Position as at 30 September 2019

Table 3: Statement of Financial Position as at 30 September 2019

	Act $ 000	Budget $ 000	Var $ 000	Aug-19 $ 000	Movement $ 000
Current Assets					
Petty Cash	8	8	-	8	-
Bank	19,368	11,934	7,434	17,336	2,032
Trust	846	843	4	848	(2)
Prepayments	3,385	742	2,643	3,120	265
Debtors	64,351	52,937	11,414	53,780	10,571
Inventory	8,884	8,868	16	8,973	(89)
Assets Held for Sale	5,320	5,320	-	5,320	-
Total current Assets	**102,162**	**80,652**	**21,511**	**89,385**	**12,777**
Fixed Assets					
Land	193,430	193,430	-	193,430	-
Buildings, Plant & Equip	658,943	676,435	(17,492)	674,874	(15,931)
Information Technology	2,223	2,064	159	2,223	-
Information Software	2,060	1,724	336	2,060	-
Motor Vehicles	1,708	2,122	(414)	1,723	(15)
Total Cost	**858,364**	**875,775**	**(17,411)**	**874,310**	**(15,946)**
Accum. Depreciation	(64,878)	(80,205)	15,327	(76,597)	11,719
Net Cost	**793,486**	**795,570**	**(2,084)**	**797,713**	**(4,227)**
Work In-progress	32,070	36,741	(4,671)	26,379	5,691
Total Fixed Assets	**825,556**	**832,311**	**(6,755)**	**824,092**	**1,464**
Reversionary car park interest	1,934	1,934	-	1,934	-
Investments in Assoc	55,829	56,466	(637)	55,829	-
Total Assets	**985,481**	**971,363**	**14,119**	**971,240**	**14,241**
Current Liabilities					
Creditors	104,782	97,766	7,014	94,587	10,195
Income in Advance	13,091	9,480	3,611	11,835	1,256
GST and PAYE	18,892	16,853	2,039	17,267	1,625
Payroll Accrual & Clearing	29,737	27,681	2,056	27,604	2,133
Employee Provisions	193,892	194,474	(582)	192,939	953
Total Current Liabilities	**360,394**	**346,254**	**14,138**	**344,232**	**16,162**
Working Capital	(258,232)	(265,602)	7,373	(254,847)	(3,385)
Net Funds Employed	**625,087**	**625,109**	**(19)**	**627,008**	**(1,921)**
Non-Current Liabilities					
Employee Provisions	35,353	35,353	-	35,353	-
Trust and Special Funds	836	836	-	836	-
Insurance Liability	1,035	1,035	-	1,035	-
Total Non-Current Liabilities	**37,224**	**37,224**	**-**	**37,224**	**-**
Crown Equity					
Crown Equity	414,820	414,820	-	414,820	-

Revaluation Reserve	393,379	393,379	-	393,379	-
Retained Earnings	(220,336)	(220,314)	(19)	(218,415)	(1,921)
Total Crown Equity	**587,863**	**587,885**	**(19)**	**589,784**	**(1,921)**
Net Funds Employed	**625,087**	**625,109**	**(19)**	**627,008**	**(1,921)**

Commentary on Major Variances:

- Closing bank was $7.4m favourable to budget in September. Net cash flows from operations (revenue, expenses and payroll) was $3.7m favourable to budget for the month (refer cash flow variance explanation for further details).

- Prepayments were $2.6m higher than Budget due to timing of invoices, in particular insurance pre-paid for the year.

- Debtors were $11.4m higher than Budget due to timing of invoices to both Ministry of Health and ACC, including late catch-up invoices that would have been accrued.

- Net fixed assets are below Budget by $6.8m due to the timing of capital spend.

- Creditors are $7m above Budget due to timing of invoices and accruals.

- Income In Advance was higher than Budget by $3.6m largely due to timing of revenue recognised in the month.

- The favourable working capital variance to Budget in August of $7.3m is mostly attributable to the timing matters detailed above, mainly capital spend.

4. Statement of Cash Flows as at 30 September 2019

Table 4: Statement of Cash flow for the period ended 30 September 2019

	Month			YTD		
	Act	Budget	Var	Act	Budget	Var
	$ 000	$ 000	$ 000	$ 000	$ 000	$ 000
Cash flows from Operating activities						
Cash was provided from:						
Crown Revenue	129,863	137,881	(8,018)	408,387	413,647	(5,260)
Other	17,020	14,768	2,252	47,342	44,242	3,100
Cash was applied to:						
Suppliers	(85,134)	(89,946)	4,812	(272,468)	(269,663)	(2,805)
Employees	(54,119)	(58,733)	4,614	(171,955)	(178,088)	6,133
Interest paid	-	-	-	-	-	-
Capital charge	-	-	-	-	-	-
Net cash from Operations	**7,630**	**3,970**	**3,660**	**11,306**	**10,138**	**1,168**
Cash flows from Investing activities						
Cash was applied to:						
Fixed assets	(5,691)	(6,111)	420	(12,596)	(18,332)	5,736
Investments	-	-	-	(363)	(1,000)	637
Interest received	82	150	(68)	299	450	(151)
Restricted & Trust Funds	-	-	-	(6)	-	(6)
Net cash from Investing	**(5,609)**	**(5,961)**	**352**	**(12,666)**	**(18,882)**	**6,216**
Cash flows from Financing activities						
Cash was provided from:						
Sale of Asset	9	-	9	48	-	48
Equity injection	-	-	-	6,248	6,248	-
Net cash from Financing	9	-	9	6,296	6,248	48
Net increase / (decrease)	**2,030**	**(1,991)**	**4,021**	**4,936**	**(2,496)**	**7,432**
Opening cash	17,343	13,932	3,411	14,437	14,437	-
Closing cash	**19,373**	**11,941**	**7,432**	**19,373**	**11,941**	**7,432**
Reconciliation Summary						
Net Surplus/(Deficit)	**(1,921)**	**(1,976)**	**55**	**(7,709)**	**(7,690)**	**(19)**
Add/(Less) non-cash items						
Impairment of Intangibles	-	-	-	-	-	-
Depn and Amortisation of assets	3,209	3,267	(58)	9,801	9,801	-
	1,288	1,291	(3)	2,092	2,111	(19)
Add/(Less) items Classified as Investing or Financing activities						
Interest received	(82)	(150)	68	(299)	(450)	151
Gain on Disposal	11	-	11	72	-	72
Add/(Less) Movements in Financial Position items						
Debtors and Other Receivables	10,836	-	10,836	14,057	-	14,057
Inventories	(89)	-	(89)	16	-	16
Creditors	3,187	2,829	358	4,241	8,477	(4,236)

Employee Entitlements	(7,521)	-	(7,521)	(8,873)	-	(8,873)
	6,413	2,829	3,584	9,441	8,477	964
Net Cash flow from Operations	**7,630**	**3,970**	**3,660**	**11,306**	**10,138**	**1,168**

Commentary on Major Variances for the year:

- Revenue from the Crown and other revenue were $3.6m favourable to budget YTD mainly due PHO practice revenue variances (offset by additional expenditure).

- Payments to suppliers were $2.8m higher than budget mainly as a result of variations to the planned timing of supplier payments in the budget (offset by additional revenue).

- Employee Payments were $6.1m favourable to budget representing the timing of the payment of payroll accruals and vacancies.

- Fixed Assets $5.8m favourable to budget representing the delayed timing of capital spend for major capital projects.

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period ending 30 September 2019.

Prepared and submitted by: Kathy Nancarrow, Occupational Health and Safety Manager, and Elizabeth Jeffs, Director Human Resource.

Glossary for Monthly Performance Scorecard and Report

Lost time incidents	Any injury claim resulting in lost time.
Lost time injury Frequency Rate	No of lost time Injuries per million hours worked. **LTIFR (Lost Time Injury Frequency Rate)** = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.
Injury Severity Rate	Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked. **LTISR (Lost Time Injury Severity Rate)** = (Number of Lost Hours / Hours Worked) x 1,000,000.
Notifiable Injury/illness	(a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations. (b) any admission to hospital for immediate treatment (c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance (d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals. (e) any other injury/illness declared by regulations to be notifiable.
Notifiable Incident	An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident.
Notifiable Event	Death of a person, notifiable injury or illness or a notifiable incident.
Pre-Employment	Health screening for new employees.
Worker	An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer.
Reasonably Practicable	Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk.

Glossary

ACC	Accident Compensation Commission
ARF	Audit, Risk and Finance
ASRU	Auckland Spinal Rehabilitation Unit
BBFE	Blood and/or Body Fluid Exposure
CCS	Central Clinical Services
DHB	District Health Board
EAP	Employee Assistance Programme (Counselling)
ELT	Executive Leadership Team
EMIC	Emergency Medicine & Integrated Care
F&E	Facilities and Engineering
HR	Human Resources
HSNO	Hazardous Substance New Organisms Act
HSR NZQA	Health and Safety Representative New Zealand Qualifications Authority
HSWA	Health and Safety at Work Act 2015
IRS	Incident Reporting System
JCC	Joint Consultative Committee
LTI	Lost Time Injury
MH	Mental Health
MMC	Middlemore Central
OHN	Occupational Health Nurse
OHP	Occupational Health Physician
OHSS	Occupational Health and Safety Service
PHCS	Primary Health & Community Services
PEHS	Pre-Employment Health Screening
SAP	Surgical, Anaesthesia & Perioperative
SPEC	Safe Practice and Effective Communication
WellNZ	Injury Management Third Party Administrator

Purpose

The purpose of the Health and Safety report is to provide monthly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Counties Manukau District Health Board.

Executive Summary

Notifiable event and WorkSafe notification

There was no notifiable event in September 2019.

Incident Reporting in September

September incidents decreased from 144 in August to 124. Of the 124, 26 related to BBFE incidents which decreased slightly from 27 in August. There was a slight decrease in aggression and violence incidents of 24 compared to 25 in August but not at a dissimilar level to other months. The 'other category' has a continued trend of staff either hitting into stationery/ falling/ moving objects and lacerations/ cut/ tear. The remainder of the incidents is spread across the remaining incident types, moving and handling with an increase in from 13 in August to 18 and an increase in slips, trips, falls incidents of 15 compared to 13 in August 2019. Incident reporting has been added to the Occ Health & Safety plan as a targeted communication topic for February 2020

Current Issues Update

ACC Accredited Employer Injury Management Audit

The ACC audit was scheduled for 18th and 19th November and Tertiary Accreditation was awarded. The audit includes worker injury claims which are managed by the Counties Manukau Case Manager and third party provider, Wellnz. This year's audit is focused on injury management. A further audit will be scheduled for late 2020 and will include safety management practices.

Worker Participation Agreement

Following implementation of the Worker Participation Agreement, the H&S team is carrying out a review of the Counties Manukau Health H&S Representatives across the DHB. H&S Reps training will form part of this review. Elections are underway for 4 H&S Reps who will attend the Executive Health and Safety Committee meetings each month as representative for the wider H&S Reps team.

Safe365

This is an online safety management tool being implemented across the organisation. Information about Safe365 is now available on Paanui. Facilities and ARHOP are using the system with KidzFirst Community and KidzFirst Inpatient to pick up the work from the pilot and begin full use of the system. Other areas of organisation are currently being set up on training sessions scheduled for December.

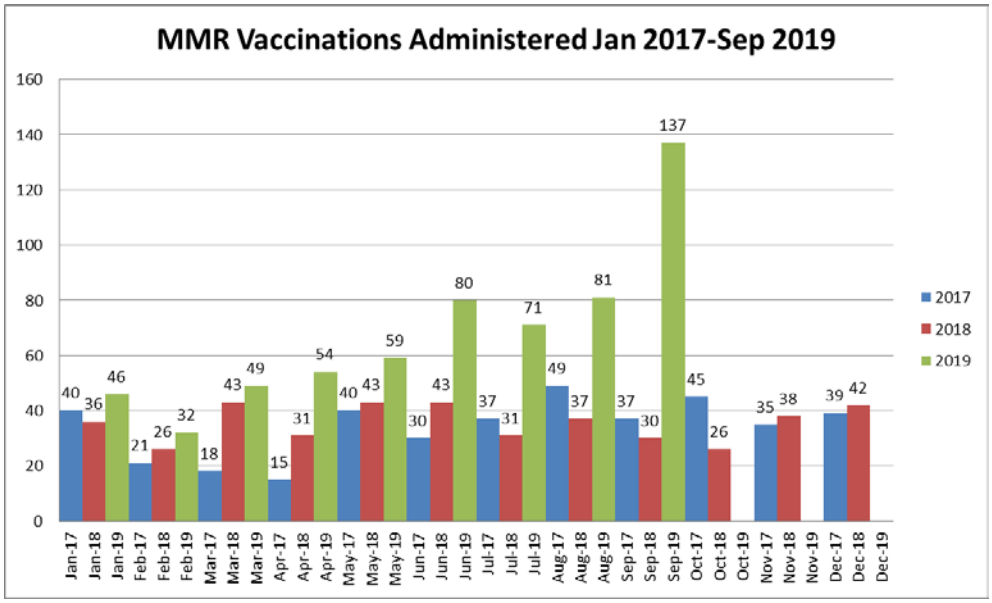
2019 Staff Influenza Vaccination Programme

The Staff Influenza Vaccination Programme came to an end on 30 September with the Counties Manukau completion rate of 67% tracking behind the National target of 80%. Final vaccination numbers for Maternity were 58%, ARHOP 74% and Kidz First 75%.

Planning is now underway for the 2020 campaign. The Occupation Health Team are currently preparing a project plan in conjunction with key stakeholders across the DHB and sourcing vaccinations with the provider. A paper will be presented to Board in the February on the 2020 Flu Campaign including learnings from this year's campaign.

Measles Outbreak

- The Occupational Health and Safety team have been notified of an additional Registered Nurse from ED who contracted measles during the height of the outbreak despite having evidence of being vaccinated.
- The graph below reflects the increase in MMR vaccinations given in the OHSS clinic in 2019 when compared to the previous 2 years. In the year to date, 609 MMR vaccinations have been provided by the OHSS with 137 of these being administered over the month of September.



Graph 1 MMR Vaccinations 2019

Six (6) Counties Manukau staff contracted measles during the outbreak comprising of 2 Clinical, and 4 non-clinical staff members. Of the 6, one caught the disease from a colleague in a non-clinical setting. 16 staff were stood down as a result of being potentially exposed to measles.

Health and Safety Performance Scorecard

Lagging Indicators – Sept19		Actual	Target	Last Month	Status
Reported Incidents	Counties Manukau staff	124	~	144	↓
	Contractors	2	~	3	↓
	Visitors	5	~	2	↑
Injury Claims	New claims registered	43	~	35	↑
	Open claims	283		234	↑
	Lost Time claims	1	<5	0	↑ 🟢
	Lost Time Frequency Rate (LTIFR)	10.55	<10	11.05	↓ 🔵
	Lost Time Severity Rate	419.85	<630	629.33	↓ 🟢
	Claims costs for September (to date)*	$60,411	~	$59,536	↑
* Claims costs are adjusted as additional treatment is required					
Critical risk incidents	BBFE	26	~	27	↓
	Aggression & Violence	24	~	25	↓
	Patient Moving & Handling	18	~	13	↑
	Slips, Trips, Falls	15	~	13	↑
Leading Indicators – Sept19					
Pre-employment	Health screening	100%	100%	100%	~ 🟢
Clinic appointments	Dr & Nurse clinics	493	~	467	↑ 🔴
Vaccinations	2019 Staff flu vaccination uptake	67%	80%	66%	↑ 🔴
	Other vaccinations (dTap, VZV, HepB, MMR)	373	~	285	↑ 🔴

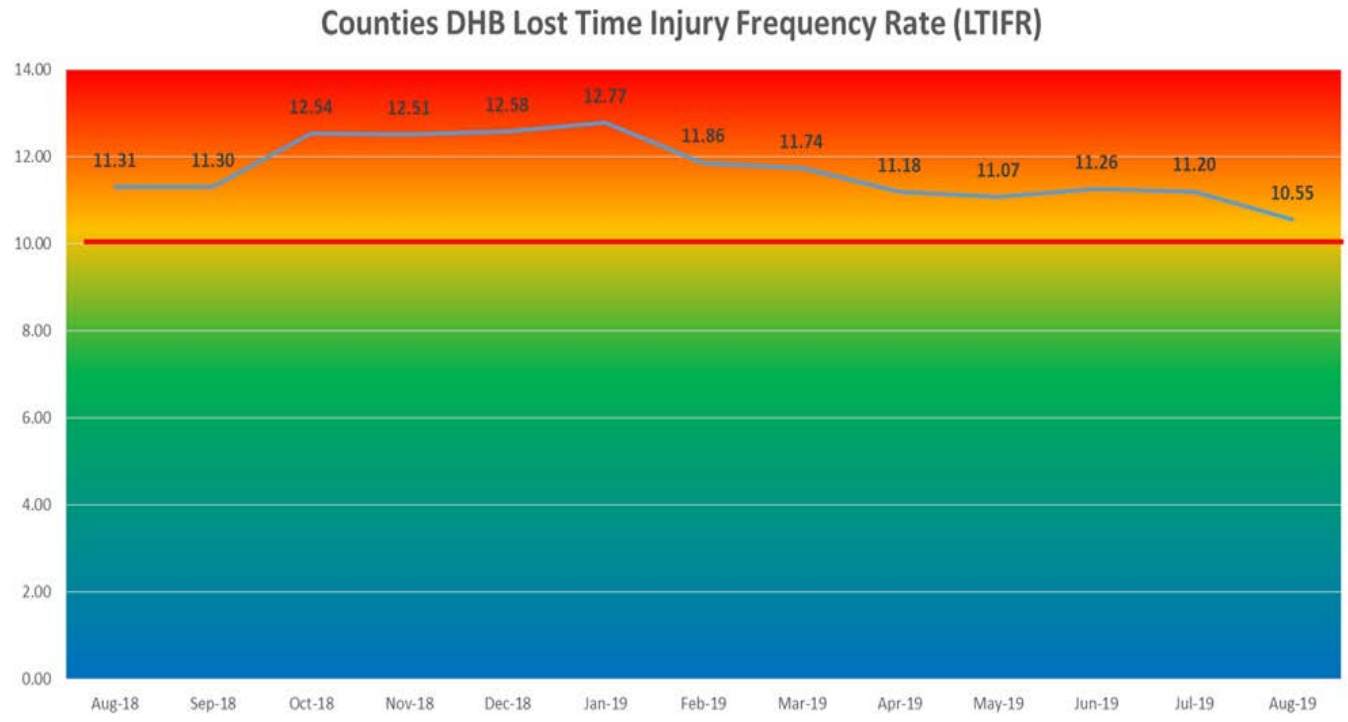
Achievement Criteria		Rating	
On target or better		Achieved	🟢
95-99.9%	0.1-5% away from target	Substantially achieved	🔵
90-94.9%	5.1-10% away from target*	Not achieved, but progress made	🟡
<90%	>10% away from target**	Not achieved	🔴

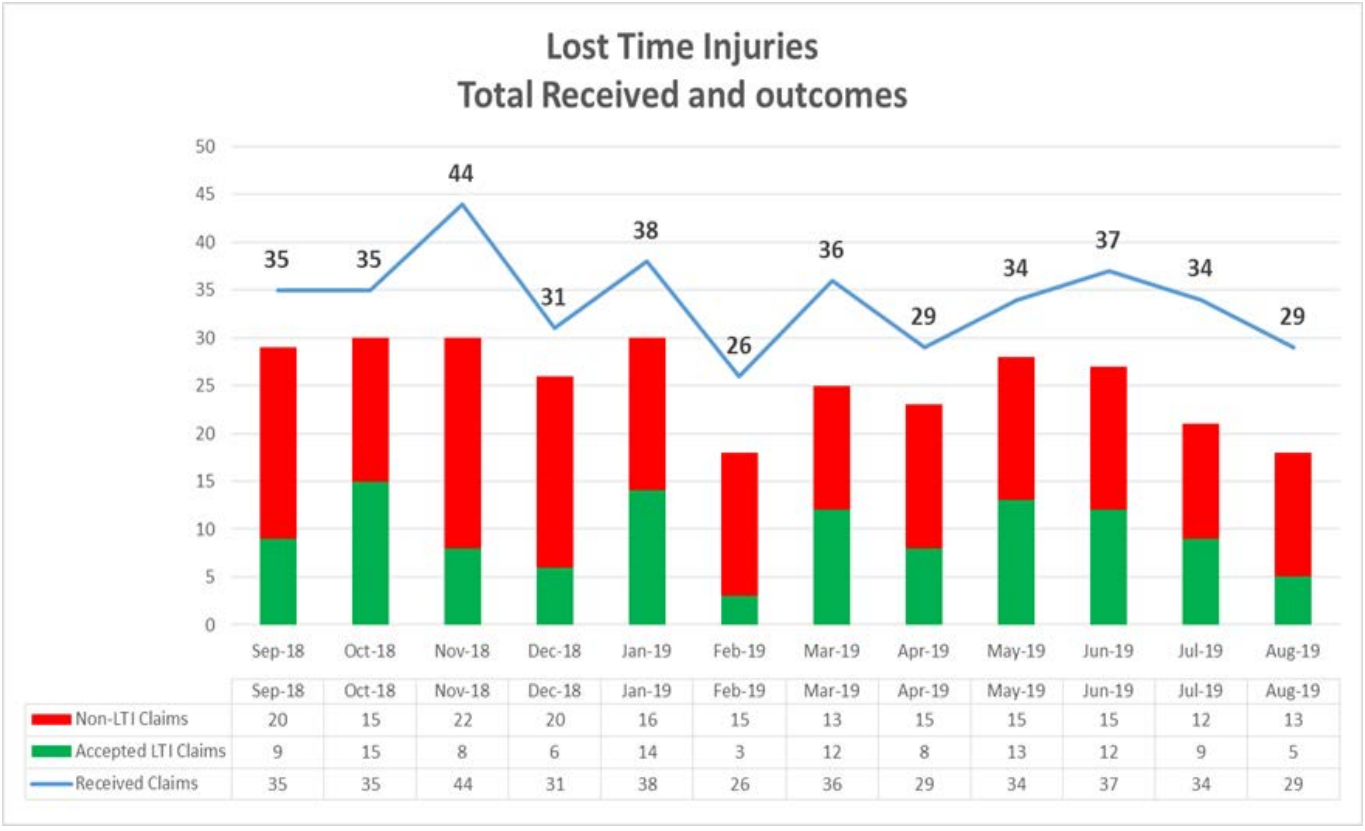
Indicators in Blue	**Comment**
LTIFR	• 12 month rolling average figure remains above the target at 10.55 (vs target of 10). It remains consistent with August figure.
Indicators in Red	**Comment**
Dr & Nurse clinics	• Increase in Occ Health clinic appointments when compared to August figure of 467. The measles outbreak was a contributing factor.
2019 Staff flu vaccination uptake	• As at 30 September 67% of staff vaccinated against national target of 80%. • The Staff Influenza Vaccination Programme came to an end on 30 September 2019.
Other vaccinations	• Increase in other vaccinations administered during the month of September when compared to August figure of 285. • Significant increase in MMR vaccinations administered due to measles outbreak (refer to *Graph 1 MMR Vaccinations 2019).*

LTIFR

The LTIFR rolling average figure is 10.55 and remains reasonably constant.

Discussions and action by WellNZ in backdating the correct LTI figure to appropriate months still to be completed to represent the monthly totals more accurately. The 12 month rolling figure continues to be a more accurate gauge of performance rather than individual month results.





Injury Claim Data

INJURY CLAIM DATA				
Total: Injury Claim Report for September 2019				
Lost days	**Treatment cost (excludes Wellnz costs)**	**Weekly compensation costs (80% of salary)**	**Staff cover cost**	**Total**
Number of lost days for month	$ total for month	$ total for month	$ total cover cost for month	Total $ cost for month
337.29	25,057.72	62,401.39	18,986.21	106,445.32

Key Health and Safety Risks

CM Heath Key H&S risks management update, including key initiatives to reduce/manage risk.

Key	
	Risk is well managed –all significant actions complete
	Risk is well managed - some minor actions to be completed
	Risk is being managed and has some significant actions underway
	Risk is being managed and has some significant actions yet to progress

Risk: Occupational Health & Safety - Aggression and Violence	
Previous Report Action	**Current Action**
• Dr Frank Stocks has undertaken an assessment of CMH environments with regards to security/ safety, including interviews with individuals. • Report and recommendations expected next month.	• Report has been received and is under review by OHSS Manager.
Risk: Contractor Management	
Previous Action Point	**Current Action**
• Facilities have developed an induction video for contractors and staff which will be released in October.	• Awaiting publication.
Risk: Occupational Health and Safety - Safe Moving and Manual Handling (Cleaners and Orderlies)	
Previous Action Point	**Current Action**
• Feedback being collated, but is at a glance positive to using a game based form of learning.	• Arranging for new OHSS Manager to see demo and meet with game producer to establish if this offering is suitable for CM. • An analysis of all sprains and strains from all MH incidents in September has be carried out and results will determine the actions for 2020.
Risk: Blood and Body Fluid Exposure (BBFE)	
Previous Report Action	**Current Action**
• Awaiting data analysis (delayed with OCC Health nurses focused on Measles).	• A review was carried out to assess BBFE incidents which reaffirmed the process in place for initial contact is working well. • Ongoing BBFE reviews have been added to the Occ H&S annual planner.

Risk: Occupational Health and Safety - Slips, Trips and Falls	
Previous Report Action	**Current Action**
• No significant change.	• A review of STF incidents has been completed, high incident months have been added to Occ H&S annual planner for initiatives and targeted actions to be undertaken in 2020.
Risk: Compliance - Health & Safety Training Framework	
Previous Action Point	**Current Action**
• On-going development underway.	• To be considered in the Occ H & S annual plan for 2020.
Risk: Wellbeing – Employee Health and Wellbeing Programme (stress, fatigue, depression)	
Previous Action Point	**Current Action**
• Health checks for staff - Pilot sessions being offered to staff at Middlemore in October in collaboration with MIT. • Flu campaign – 67% of staff have been vaccinated which is 5,112 people.	• Flu campaign came to an end – 67% of staff have been vaccinated which is 5,133 people. • Wellbeing initiatives are currently being established for the 2020 year and will be added to the Occ H&S annual planner.
Risk: Physical environment (ventilation, lighting, noise, equipment)	
Previous Action Point	**Current Action**
• Facilities undertaking remedial work.	• On-going action with Safe365 being implemented in Facilities.
Risk: Compliance - Worker Participation	
Previous Action Point	**Current Action**
• On-going.	• Following the finalisation of the Worker Participation agreement, a detailed review has commenced to confirm H&S Reps are in place for all areas of CM and what training has been completed with H&S Reps. The Occ H&S team will establish a plan for on-going support and engagement with H&S Reps.

Reported Incidents

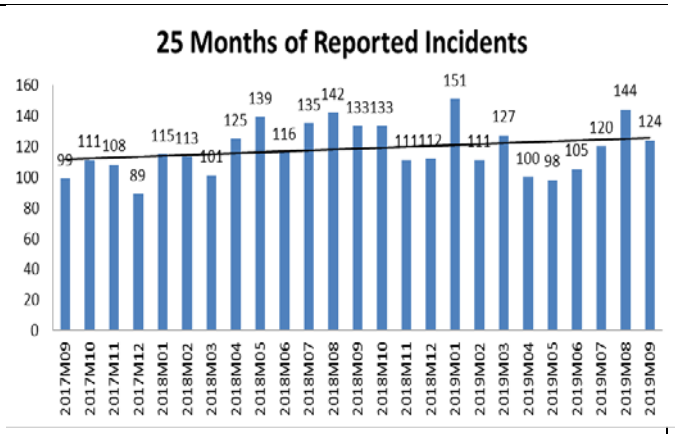
Rolling year-on-year monthly comparison:

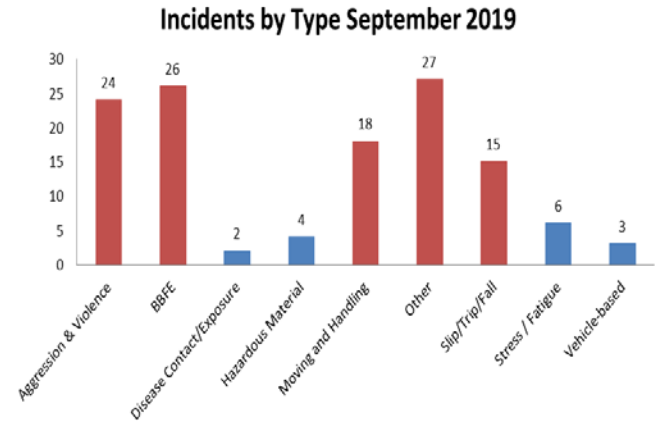
Previous 13 months – 117.4
Current 13 months – 121

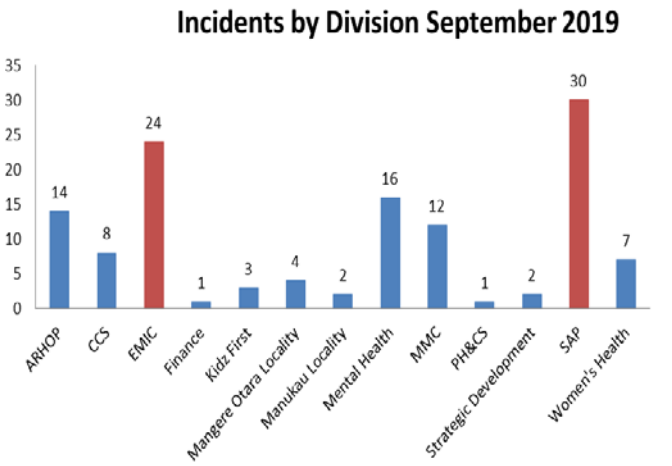
September monthly figures year on year appear to be consistent with a decrease in September 2019. Overall the average has increased which represents the increased reporting on A&V, M&H, BBFE and Slip/Trip/Falls incidents.

Key Observations:

- **Other (27):** Significant increase from the August figure of 40.
  Causation profile:
  - Hitting stationary/falling/moving object: 10
  - Laceration/cut/tear: 6
  - Bite/sting by insect/spider: 2
  - Crushed/ pushed/ stepped on: 2
  - Cleanliness of facility: 1
  - Emergency collapse: 1
  - Entrance/exit blocked/obstructed: 1
  - Hit/bitten/scratched by person unintentionally: 1
  - Property damage/ vandalism: 1
  - Theft: 1
  - Unauthorised access/trespass: 1
- **BBFE (26):** Remains in top three incident rates. Slight decrease from the August figure of 27. OHN investigating trend/causation through follow up with services and individuals. Highest incidents continue to occur within SAP service reviewing causation factors to identify areas for improvement.
- **Aggression and Violence (24):** Remains in top three incident rates. Slight decrease from August figure of 25. ED is continuing to capture incidents within the Code Orange initiative with higher risk incidents being reported within Riskpro.
- **Moving and Handling (18):** Remains in top three incident rates. Increased from the August figure of 13. MMC and EMIC have the highest number of incidents at 4 per service.
- **Slip/Trip/Fall (15):** Slight increase from August figure of 13. 4 of the reported incidents occurred within SAP services. Wet weather conditions and busy periods within the hospital can be the contributing factors to the increase in reported incidents.





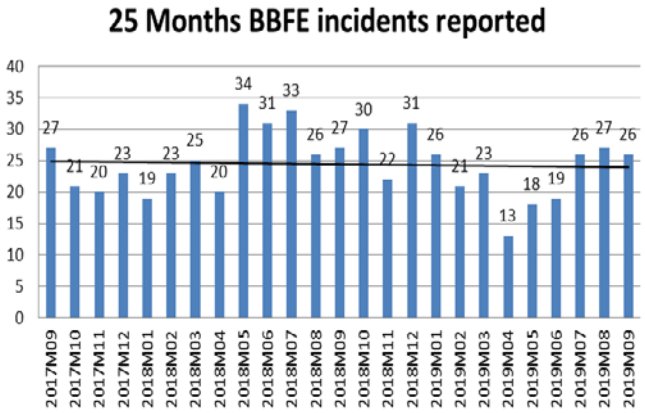


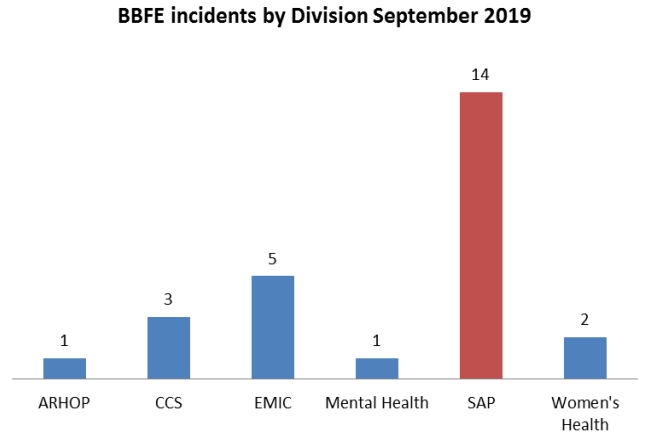
BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly comparison:

Previous 13 months – 25.3
Current 13 months – 24

- BBFE incidents remain consistent when compared with the last 25 months of reporting: 27 (2017) and 27 (2018).
- SAP service continues to have the highest number of incidents at 14, with follow up discussions happening with the service. EMIC has the second highest number of reported incidents at 5.
- OHSS tracking trends and following up with services to reduce reoccurrence.
- Causation profile:
  - Inattention/ distraction: 13
  - Acts of others: 3
  - Job factor: 3
  - Defective tools/ Equipment: 2
  - Improper work techniques: 2
  - Bypassing safety devices: 1
  - Fatigue/ Tiredness: 1
  - Other: 1



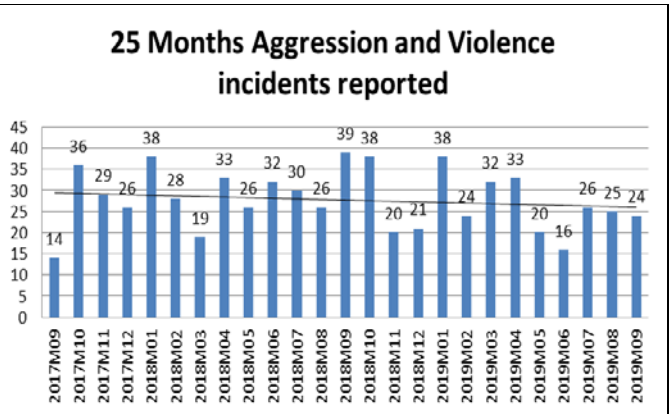


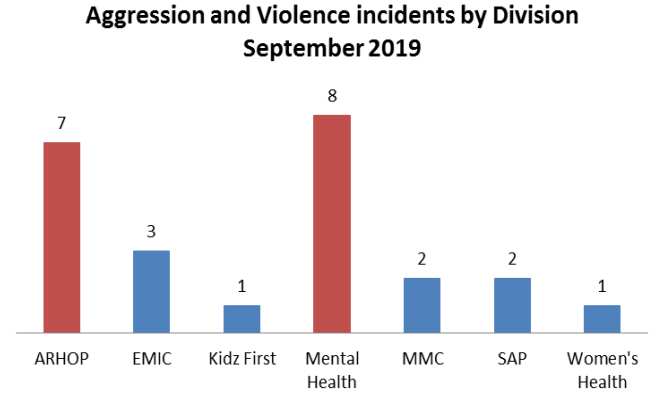
Aggression and Violence

Rolling year-on-year monthly comparison:

Previous 13 months – 29
Current 13 months – 27.4

- Aggression and Violence incidents significantly higher than last 25 months: 14 (2017) and significantly lower than last 13 months of reporting: 39 (2018).
- ED tracking 'Code Orange' trial working with Security Services to better control elevated behaviour.
- MH services have the highest number of reported incidents at 8, with initiatives identified between services, security and H&S to raise awareness and address immediate issues. ARHOP has the second highest number of reported incidents at 7.
- Causation profile:
  - Assault – physical: 9
  - Behaviour – inappropriate: 5
  - Behaviour – harassment: 3
  - Assault – verbal/gesture: 2
  - Behaviour – aggressive/ threatening: 2
  - Behaviour – violent: 2
  - Disorderly person: 1



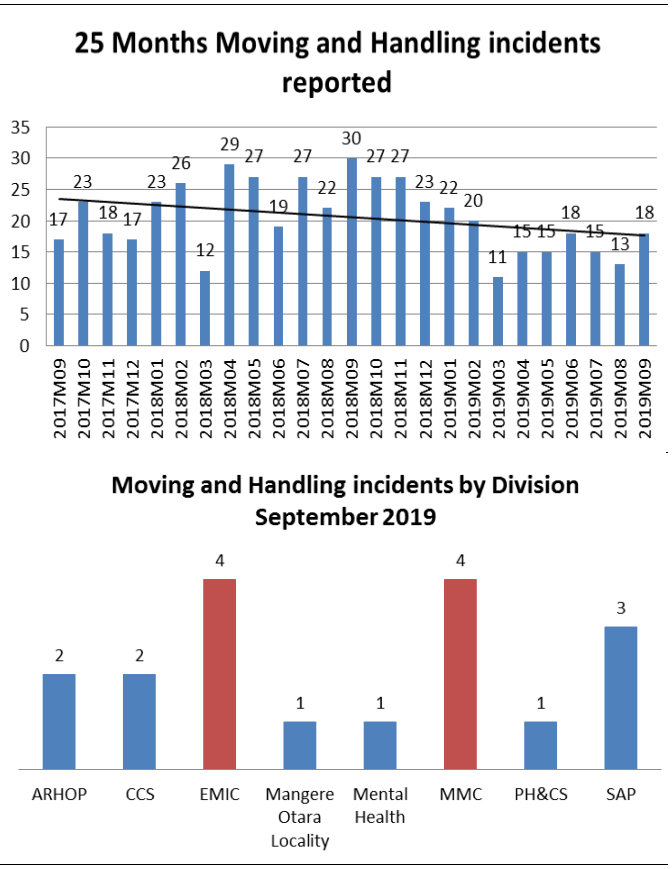


Moving and Handling

Rolling year-on-year monthly comparison:

Previous 13 months – 22.3
Current 13 months – 20

- Moving and Handling incidents consistent with last 25 months: 17 (2017), higher than August (13) and significantly lower than last 13 months of reporting: 30 (2018).
- MMC and EMIC have the highest number of incidents at 4 per service.
- H&S team working with non-clinical teams to review M&H training requirements.
- Causation profile:
  - Awkward position/ posture: 5
  - Lifting/ handling/ carrying: 5
  - Action/behaviour of employee or patient/affiliate: 4
  - Load size/ weight/ assistance unavailable: 3
  - Equipment malfunction/ faulty: 1

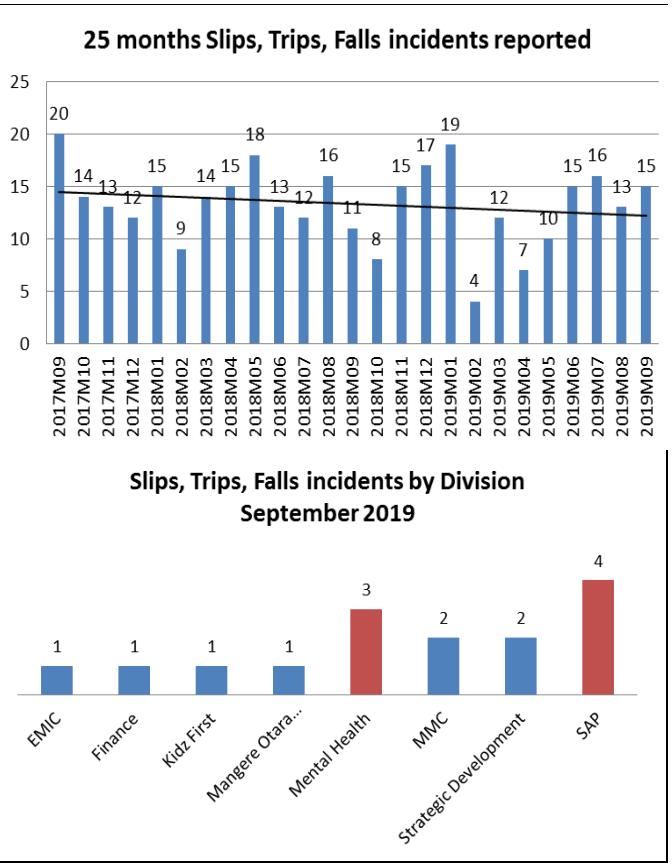


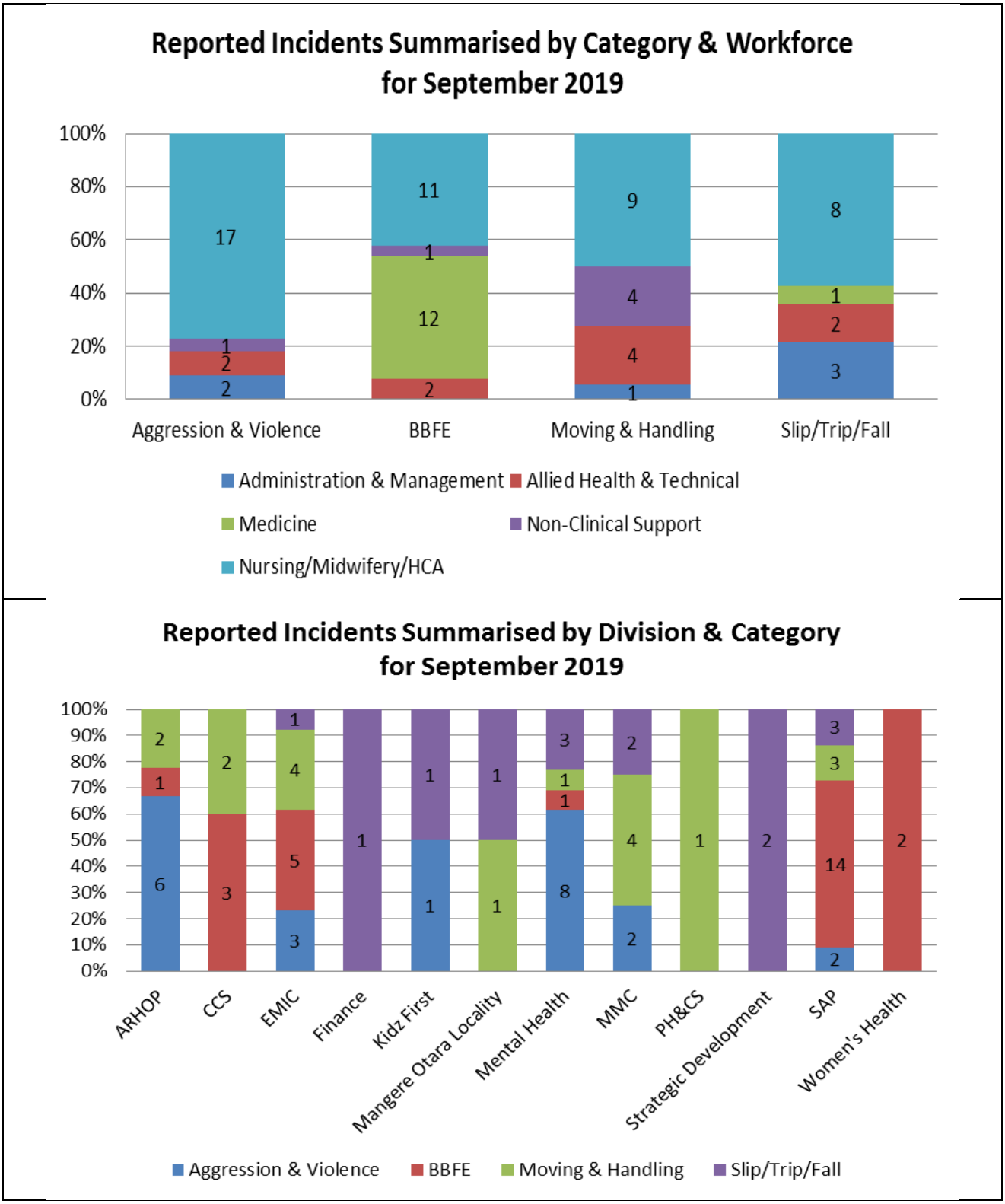
Slips, Trips and Falls

Rolling year-on-year monthly comparison:

Previous 13 months – 14
Current 13 months – 12.5

- Slips, Trips and Falls incidents significantly lower when compared with the last 25 months: 20 (2017) and slightly higher than the last 13 months: 11 (2018).
- SAP services have the highest number of reported incidents at 4 and Mental Health services have the second highest number of reported incidents at 3.
- Causation profile:
  - Slipped/ tripped/ stumbled: 7
  - Surface – slippery/ wet/ uneven: 3
  - Action/behaviour of patient/ visitor: 2
  - Human factors: 2
  - Equipment malfunction/faulty: 1




Reported Incidents Summarised by Category & Workforce for September 2019
100%
80%
60%
40%
20%
0%
17
2
1
2
11
1
12
2
9
4
4
1
8
1
2
3
Aggression & Violence
BBFE
Moving & Handling
Slip/Trip/Fall
Administration & Management
Allied Health & Technical
Medicine
Non-Clinical Support
Nursing/Midwifery/HCA
Reported Incidents Summarised by Division & Category for September 2019
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
ARHOP
CCS
EMIC
Finance
Kidz First
Mangere Otara Locality
Mental Health
MMC
PH&CS
Strategic Development
SAP
Women's Health
Aggression & Violence
BBFE
Moving & Handling
Slip/Trip/Fall

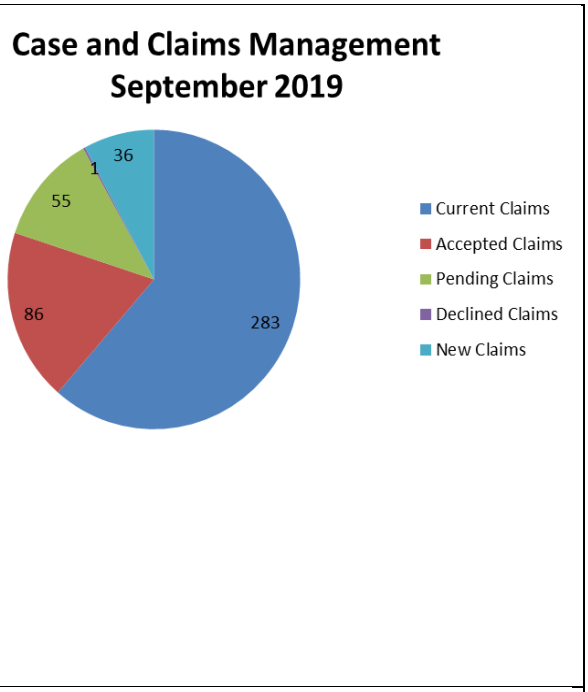
Case and Claims Management:

The Injury Management claims rated as high risk are managed through Wellnz or low risk through the Injury Case Manager at CMH.

Total open claims for September period at 283 have increased from 234 as reported in August 2019. The ratio of accepted and pending remains the same at approximately 64% indicating more than half of the claims are more complex to assess and may require referral to OHP for confirmation.

CMH is currently at Tertiary level in the ACC Accredited Employers Program. The Injury Management audit is underway in November 2019

Noted that the declined cases remain the same to 1 noted in August 2019.

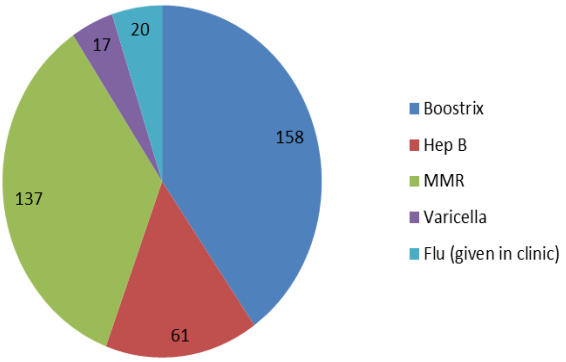


Vaccinations:

Vaccinations administered as part of the pre-employment screening and staff influenza vaccination programme has resulted in full utilization of OHN clinics.

Staff Influenza Vaccination Programme came to an end on 30 September 2019.

September was a busy month with MMR Vaccinations; 137 (*refer to graph 1 in current issues update*)

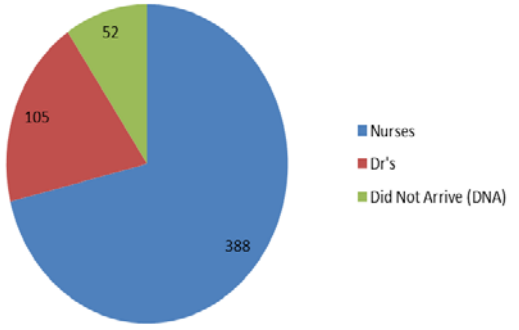


Clinic Appointments:

OHP appointments are high, with 105 Dr clinics and 388 Nurses clinics over September.
Full clinics delivered services to:

- Staff returning from injury (RTW/Fitness to work) together with ergonomic evaluations in service.
- Increase in referrals/complexity of cases resulting in longer close out periods.
- OHN clinics are full with PEHS vaccinations

Staff non-attendance at clinic appointments has increased to 11% of total appointments. OHN follow up phone calls to identify key reasons for DNA with illness and workload being contributing factors.



Counties Manukau District Health Board
CM Health Quality Accounts 2018/19 Draft Content

Recommendation

It is recommended that the Board:

Receive the log of Quality Account submissions and review the online content. The link to view the Quality Accounts online is https://countiesmanukau.health.nz/about-us/quality-accounts.

Note the progress and current gaps and advise on additional information needed.

Prepared and submitted by: Jo Rankine Patient Experience Lead on behalf of Jenny Parr, Chief Nurse, Director of Patient and Whaanau Experience.

Purpose

The purpose of this paper is to provide the Board with a final draft of the 2018/19 Quality Account content pending a few more late submissions and minor formatting.

Background

Historically the content selection process for inclusion in the Quality Accounts has been largely self-selected and submitted in an unstructured format resulting in Accounts that were not well aligned to strategy or fully representative of performance and challenges. The development of the Accounts has also been labour intensive due to the lack of clarity about expectations, resulting in rework. A fresh approach was proposed for the 2018/19 Accounts to align them with current strategy and priorities and publish an online version that was more accessible to stakeholders.

Originally it was a requirement of the Health Quality and Safety Commission (HQSC) for DHB's to produce and annual Quality Account but in 2017 it became optional. The Accounts do provide an opportunity to demonstrate the DHB's transparency, accountability and quality to the public and the Ministry and many DHB's continue to publish them. In 2018 a draft 2017/18 Accounts was reviewed by ELT and it was decided to not publish them as it was felt that the Accounts were not particularly reflective of the organisation's performance and challenges.

Discussion

A template was developed to guide submissions for 2018/19 which has been very helpful in improving the overall quality of submissions.

The Accounts do require some further minor edits to resolve formatting issues and upload any further late additions. The attached Log of Submissions identifies the remaining gaps.

Appendix

1. Log of submissions received.

SECTION	title	Contributor	ELT Sponsor	Uploaded
Opening statement	CEO / Chair intro	Donna Baker	Margie Apa	Y
	CH Health - a diverse pop	Doone Winnard	Margie Apa	Y
	Living our Values	Elizabeth Jeffs	Margie Apa	Y
Priorities	Priorities for 2018/19	Alanna / Marianne Scott	Margie Apa	Y
	Key achievements	Alanna / Marianne Scott	Margie Apa	Y
	Immunisation / Breast & Cervical Screening / ASH rates / Diabetes / Oral Health	Alanna / Marianne Scott	Aroha / Campbell	Y
Performance	Certification	Lesa Freeman	Jenny Parr	Y
	IANZ Accreditation Laboratory results	Pam Rowe	Gloria Johnson	Y
	IANZ Accreditation Radiology results	Gwendoline Lawrence	Gloria Johnson	Y
Patient Safety and Clinical Effectiveness	Patient Safety Week	Lesa Freeman	Jenny Parr	Y
	HQSC markers	David Hughes	Gloria Johnson	Y
	Otago Dental School business case	tbc	Margaret White	Y
	Adverse Events	David Hughes	Gloria Johnson	Y
	Falls Group	Lesa Freeman	Jenny Parr	Y
	Infection Prevention Control	Terry Rings	Gloria Johnson	Y
	Restraint Minimisation	Karyn Sangster	Jenny Parr	Y
	Deteriorating Patient	Lesa Freeman	Gloria Johnson	Y
	Pressure Injuries	Lesa Freeman	Jenny Parr	Y
	Plan of Care Project	Lesa Freeman	Jenny Parr	Y
	Care Compass	Lesa Freeman	Jenny Parr	Y

	Amber/Faster Cancer Treatment / Infusion Centre	Anne Marie Wilkins	Gloria Johnson	Y
	Leadership Walkarounds	Jacqui Wynne Jones	Jenny Parr	Y
	E Vitals project update	Sally Dennis	Jenny Parr	Y
	ISP / iSNAP	Megan Milmine	Stuart Blomfield	Y
	E Prescribing	Sanjoy Nand	Gloria Johnson	Y
	Medication Safety /Opiod Collaborative?	Anne Blumgart	Sanjoy Nand	Y
	PAR Team Call for Concern?	Alison Pirret	Jenny Parr	Y
	Infection Prevention and Control (incl CRO and hand hygiene)	Terry Rings	Gloria Johnson	Y
	Non-acute Flow project	Mohammad Alshadiefat	Mary Seddon	Y
	Acute Flow Project	Bernie County	Mary Seddon	Y
	CCDM / Trend Care implementation	Bobbie Pene	Jenny Parr	Y
	Every Hour Counts	Tracey Popham	Mary Seddon	Y
	Every Dollar Counts	Tracey Popham	Mary Seddon	Y
Service specific initiatives	Mental Health Tiaho Mai rebuild	Tess Ahern	Gloria Johnson	Y
	SAPS Opthamology /	Terry England	Gloria Johnson	Y
	- Enhanced primary care	tbc	Campbell Brebner	Y
	- Registered nurse prescribing	Karyn Sangster	Jenny Parr	Y
	- Urgent and unplanned care	Matt Hannat	Campbell Brebner	Y
	- Community Central /Hospital	Penny Magud	Campbell Brebner	Y

	in the Home project			
	Primary Care Safety in Practice	Campbell Brebner	Campbell Brebner	Y
Patient Experience	Consumer Council report	Renee Greaves	Jenny Parr	Y
	Food quality	Ian Dodson	Jenny Parr	Y
	Feedback Central implementation	Diana Dowdle	Gloria Johnson	Y
	Libby - Boredom Busting	Renee Greaves	Jenny Parr	Y
	Revisiting Visiting (IYS)	Jo Rankine	Jenny Parr	tbc
	Towards a Health Literate System	Siniva Sinclair	Gary Jackson	Y
	Fundamentals of Care	Lesa Freeman	Jenny Parr	Y
	Protected meal times	Lyndee Allan	Jenny Parr	Y
	Patient Stories for the Board and clinical teaching	Renee Greaves	Jenny Parr	Y
4 People Capability requested	Workforce - ethnicity, diversity	Elizabeth Jeffs	Elizabeth Jeffs	Y
	New Grad Employment / Increasing Maaori and Pacific / Mental Health workforce	Hayley Clarke	Elizabeth Jeffs	Y
	Welcome Day revamp	Jenny Powell	Elizabeth Jeffs	Y
	Good Employer report	Marie Townsley	Elizabeth Jeffs	Y
	Undergraduate Education	Wendy McKinstry	Jenny Parr	Y
	Ko Awatea Learn	Kim Wiseman	Mary Seddon	Y
5 Facilities Development	Facilities projects implemented	Anton Verner	Parekawhia McLean	Y

Counties Manukau District Health Board
Potential Actions to Improve Healthy Life Expectancy and Reduce Inequities for the Counties Manukau Population

Recommendation

It is recommended that Counties Manukau District Health Board's Board:

Receive this paper for their information.

Note this paper was requested as follow up to the paper *Life Expectancy in Counties Manukau – 2018 update*, received by the Board at its 7 August 2019 meeting.

Prepared and submitted by: Dr Gary Jackson (Director, Population Health Directorate).

Background

This paper follows the *Life Expectancy in Counties Manukau – 2018 update*, received by the Board at its 7 August 2019 meeting. Life expectancy is a key metric for monitoring the overall progress of the health of the population. Data is updated annually as mortality data becomes available. Recent years have seen improvements continuing for our population, and in New Zealand generally, but trends in some countries have reversed. To continue this improvement, the previous paper outlined measures that central government and the DHB might need to do. This paper compares current Counties Manukau DHB activity with the suggestions made for DHBs – a self-assessment if you will.

In looking at actions to improve healthy life expectancy we also need to address areas of ill health such as mental health and musculoskeletal conditions. These impact morbidity and quality of life to a greater extent than length of life per se. We also note the importance of investment early in the life course to provide equitable opportunities for positive life outcomes.

The DHB works closely with our public health unit, ARPHS, on health protection and promotion matters. They undertake a variety of functions on our behalf, in particular regulatory aspects of tobacco and alcohol control as well as communicable diseases and environmental issues, plus healthy public policy functions. Our input to the regional programme Healthy Auckland Together is mediated through ARPHS.

The Board's Strategy Refresh currently underway provides an ideal opportunity to test the mix of treatment and prevention activities undertaken by CM Health. There may be a need to strengthen preventive activities for the 2020-2025 period including a deliberate work programme that supports the achievement of strategic goals and objectives such as equity and health literacy. It will be important for the Board and Executive to continue to engage strongly with the Ministry about the roles of Government and the Ministry of Health in these areas. Regionally there is a push for more such central leadership on alcohol harm and healthy weight.

DHB Self-Assessment

The table below is reproduced from the life expectancy paper. It was titled: 'Potential actions to consider to further improve healthy life expectancy and reduce equity gaps may include:'. Here we add a fourth column, 'self-assessment', where we compare current and planned DHB activity against that suggested, highlighting areas of potential gain.

Areas of interest	Possible role of government and/or Ministry of Health	Possible role for DHB	*Self-assessment of DHB actions*
Tobacco control	• Further strengthening legislation and regulation including tobacco excise increases • Raising smoking age • Enhancing Smoke Free Environments Act • Guidelines/expectation that every health service contact is an opportunity to support behavioural change.	• Engagement with local intersectoral work to enact smoke free policies (e.g. with Council and Local Boards) • Strong culturally appropriate smoking cessation support services • Enhanced evaluation and support of long-term outcomes of smoking cessation support services • Support primary health care to provide systematic cessation support • Support community leadership for a tobacco free generation	• *Intersectoral engagement primarily through ARPHS. The CMH Living Smokefree team is the largest of any DHB, and provides leadership in this space at national meeting* • *CMH has strong culturally appropriate smoking cessation support services, always pushing to try new things* • *The DHB could be doing more to support evaluation of work of Smokefree team - new researcher position to support evaluation will help* • *Team have dedicated staff working with primary care, and with primary maternity providers. Cannot support all 113 practices* • *Tobacco free generation embedded in CMH Living Smokefree strategy, but more is required to engage community leadership.* *Summary* *Strong team in this space, leading unit in New Zealand. With 50,000+ smokers still to quit in Counties we are **not** on track to be Smokefree 2025. The Team is currently examining the most cost-effective interventions to undertake next, to propose for the 2020-2025 strategy period.*
Nutrition/ physical activity	• Sugar-sweetened beverage tax/levy • Develop and implement healthy environment policies to promote physical activity and healthy eating • Limit marketing and sponsorship of unhealthy food and drinks to children • Optimise urban design to support behaviour	• Support inter-sectoral stakeholders to further enhance healthy environments • Leadership by example in implementation of healthy food and drink policies • Encourage community settings to implement healthy food and drink policies	• *Engagement through Healthy Auckland Together (HAT). Progress appears very slow, particularly without support from the recommended government policies* • *We are implementing Healthy Food & Drink Policy, including having a clause in funder contracts expecting providers to have aligned policy* • *Contributed to funding for Wai Auckland project (being run out of ARPHS)* • *Programmes funded by CM Health include Te Rito Ora* (breastfeeding), *Mum's Kitchen Rules (0-2 year olds), Active Futures (2-4 year olds), Active Families (5-18 yrs), and green prescriptions.*

			• *There is a new MoH initiative:* Healthy Active Learning – *need to understand the opportunity for CM Health* • *CE has written to local school principals encouraging a water-only beverage policy* • *Chairs/CE's policy advocacy work – push for mandated policies in schools, not voluntary, then need to support schools to achieve – we don't have resource to provide that support?* • *Weight Management in Children HealthPathway is operational, including training for clinicians and Read coding in primary care* • *Have little resource to support community settings to implement policies.* Healthy Families *has a $3.3M per year budget in our area, but does not work directly with us* • *New internal* Healthy Weight Action Group*, looking at options for CM Health actions, with clear focus on equity.* *Summary* *Given the size of the problem, with the largest number of people of unhealthy weight in New Zealand, we have made only limited investments in this area. The Strategy Refresh may provide an opportunity to address this.*
Optimising health service investment mix	• Provide leadership and infrastructure with mandate to support wider prioritisation decisions of health services • Better use of local and national data	• Service planning to actively consider the entire person's journey and opportunity cost related to primary prevention, risk factor modifications, treatment, and end of life care	• *Primary care co-design for long-term conditions, regional pathways, regional service design. Good use of data for service planning and modelling* • *Gap in joining up the acute part of the system with the prevention part of the system – prioritisation in acute care usually doesn't take into account opportunity cost in primary, community, prevention part of system.* *Summary* *CM Health probably doing better than most DHBs in using data to support evidence-based service design. There is however a long way to go, and few examples of cross-service or cross-journey planning.*

Limiting alcohol and substance abuse	• Legislation and regulation in reducing availability that is temporal, spatial and age based • Reduced advertising and sponsorship, particularly youth exposure • Increase the price of alcohol through pricing policies such as increases in taxation and minimum unit pricing	• Enhancing linkage to rehab and support services • Further support system wide alcohol harm minimisation programme, including systematic implementation of alcohol harm reduction brief interventions • Consider further analyses on adverse trends in substance abuse • Better defining the roles of compulsory treatment	• *Significant difficulties in linkage to rehabilitation/support services – it is hoped that the restructuring in the mental health NGO space will assist in this* • *The Alcohol Harm Minimisation Team is developing a plan for the next 5 years to inform the Strategic Refresh, including assessing the most cost-effective interventions to consider next* • *There has been considerable success in introducing Alcohol ABC to primary care, to the extent that PHOs are adopting it as standard care in their strategies* • *Other drugs – given that alcohol has by far the largest impact of any drug, work has concentrated there.* *Summary* *Having an Alcohol Harm Minimisation Team is a step in advance of most DHBs. However we are only small steps into a long journey to reduce the harm alcohol is causing in Counties Manukau*
Clinical Guidelines	• Re-establish a clinical guidelines group • Implementation of guidelines supported by an electronic clinical pathway and information technology tools capturing relevant clinical information aligned with clinical workflow to inform clinical decision making • Increasing awareness and developing ways to prevent over-diagnosis and over-treatment, which represent opportunity cost for effective interventions as well as potential for harm	• Support clinical audits to inform quality improvement • Change management support to reduce unexplained service gaps • Participation in regional and national guideline development	• *This is a core Ko Awatea function – teaching quality improvement methodology and assisting the carrying out of audits, and doing audits of audits* • *Audit of guideline implementation – all the evidence says that we can have all the guidelines we like but unless robust implementation plan pretty much a waste of time* • *IT decision support is a real gap, with a larger level of change support needed.* *Summary* *Quality and process improvement functions and methodology are among the best in the country. Addressing service gaps and change management are less robustly addressed. Good guideline implementation requires integration into standard work processes – our IT solutions are well behind on our expectations in this area*

Active identification of service gaps of proven interventions	• National leadership in defining clinical actionable indicators • Health technology assessment and implementation	• Better use of routine data • Participation in regional and national implementation planning	• *Strong use of data in the population health and secondary care areas. Strained capacity and work urgency makes it difficult to get key clinical input at times* • *Still measurement gaps particularly in primary care, also scattered registries – eg in child health* • *Regional work transparency and effectiveness is improving* • *Need more systematic processes for driving pathway work, particularly linking data across different providers.* *Summary* *Capacity constraints, strikes, etc make it difficult to be proactive in planning – more work at the crisis intervention end of the spectrum as opposed to planning in advance of requirements. Cost restraint assists in getting active participation in rationing discussions. Not assisted with the tardiness of capital proposals running through the process.*
Reducing barriers to health services	• Review of primary care capitation weightings, co-payment amounts • Addressing health literacy demands across the system, and improving cultural competency resources	• Consider reduction of costs barriers for target populations with a focus to equity such as co-payment, transport. • Publicly accessible list of primary care, afterhours and pharmaceutical dispensing fees	• *Need to consider more than cost barriers – co-design – health literacy, ambulatory pathways work.* • *Implicit bias – could do more work here – build on conversations from Patient Safety Week, work with/support PHOs working on this* • *There is national review work looking at capitation weighting but locally the substantially reduced contract for LTC support which was contributing to reducing barriers is having an impact* • *Healthpoint and provider websites provides detail on health care providers and access times.* *Summary* *Difficult to reduce cost barriers outside national policy settings. Trying to maximise service utility through co-design.*

Counties Manukau District 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:

Mr Ken Whelan, Crown Monitor is allowed to remain for the Public Excluded section of this meeting.

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
Board Induction & Sub-Committees	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Public Interest** The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)(ii)]
Public Excluded Minutes of 31 October 2019 and Actions	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Public Excluded Minutes of the Audit Risk & Finance Committee & the Hospital Advisory Committee	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
FPIM Funding Confirmation	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Negotiations with B Braun Ativum	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Position** The disclosure of the information would be likely to prejudice the commercial position of the person who supplied or who is the subject of the information. [Official Information Act 1982 S9(2)(b)(ii)]
Baxter Healthcare Contract	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities & Negotiations** 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 and negotiations. [Official Information Act 1982 S9(2)(i)&(j)]
Gastroenterology Expansion	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
CM Health Blood Transfusion Contract Set Up	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry on, without prejudice, or disadvantage, negotiations. [Official Information Act 1982 S9(2)(j)]
Cabinet Fees Framework	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confidentiality of Advice by Officials** The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and Officials. [Official Information Act 1982 S9(2)(f)(iv)]

Chief Executive's Report & ED Deep Dive	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Public Interest** The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)(ii)]
Healthy Together Strategy Refresh	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
2020/21 Budget Assumptions & Trade Offs	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]