**CAPITAL & COAST DISTRICT HEALTH BOARD**

**Public Agenda**

31 MAY 2017

Board room, 11th Floor, Grace Neill Block, Wellington Regional Hospital, 1.00pm

<table>
<thead>
<tr>
<th>ITEM</th>
<th>ACTION</th>
<th>PRESENTER</th>
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<tbody>
<tr>
<td><strong>1 PROCEDURAL BUSINESS</strong></td>
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<td>1.00pm</td>
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<td>1.1</td>
<td>Karakia</td>
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<td>Apologies</td>
<td>Record</td>
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<td>1.3</td>
<td>Continuous disclosure</td>
<td>Confirm</td>
<td>A Blair</td>
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<td>Accept</td>
<td>A Blair</td>
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<tr>
<td>1.4</td>
<td>Confirmation of draft Minutes 26 April 2017</td>
<td>Approve</td>
<td>A Blair</td>
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<td>1.5</td>
<td>Matters arising</td>
<td>Note</td>
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<td>1.6</td>
<td>Action list</td>
<td>Note</td>
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<td>1.7</td>
<td>CCDHB Work plan 2017</td>
<td>Note</td>
<td>A Blair</td>
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<td>1.8</td>
<td>Chair’s report (verbal)</td>
<td>Note</td>
<td>A Blair</td>
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<tr>
<td>1.9</td>
<td>Chief Executive’s report</td>
<td>Note</td>
<td>D Chin</td>
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<td></td>
<td></td>
<td>1.9.1 Financial summary, March 2017</td>
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<td>18</td>
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| **2 PRESENTATIONS** | | | | | |
| 2.1 | Public Health Organisation | Note | R Haggerty | 30 |
| | | | | 1.30pm |
| 2.2 | Sub Regional Strategic Pacific Health Advisory Group | Note | T Pereira | 30 |
| | | | | 2.00pm |
| | | | | 44 |

| **3 DECISION** | | | | | |
| 3.1 | Risk management policy | Endorse | C Lowry | 48 |
| | 3.1.1 CCDHB Risk Management Policy – Hazard and reporting risk matrix | | | 50 |
| 3.2 | Protected disclosure policy | Endorse | R Palairet | 68 |
| | 3.2.1 Protected disclosure policy | | | 70 |
| 3.3 | CPHAC/DSAC committee membership | Endorse | R Haggerty | 77 |
| 3.4 | Cognitive Institute Partnership | Endorse | D Hickey | 78 |
| 3.5 | 3DHB Mental Health electronic client management system | Endorse | S Hunter | 81 |
| 3.6 | Conflict of management plan | Endorse | R Paliaret | 89 |

| **4 FOR DISCUSSION** | | | | | |
| 4.1 | Health and Safety Report April 2017 | Note | T Davis | 10 |
| | | | | 92 |
| 4.2 | Quality and safety update | Note | C Lowry | 10 |
| | | | | 108 |
### 4.3 3DHB (Provider /Funder) MHAIDS update

**Note** N Fairley  

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### 5 FOR INFORMATION

#### 5.1 CCDHB Primary Mental Health Services

**Note** A Gray  

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#### 5.2 Sub Regional Strategic Pacific Health – Quarter 3 Pacific Health Report

**Note** T Fagaloa  

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#### 5.3 Rheumatic Fever

**Note** T Fagaloa  

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### 6 OTHER

#### 6.1 General Business

**Note** A Blair  

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#### 6.2 Resolution to Exclude the Public

**Approve** A Blair  

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### ADJOURN

### APPENDICES

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| Conflict Management Plan  
| Ministry of Health Conflict Interest Guidelines | 184 |
| 4.2 | CCDHB April patient experience survey  
| CCDHB Health Matters (refer to 1.9 Appendix 3 above) | 216 |
| 4.3 | Te Haika data  
| MHAID 3DHB BSC  
| MHAID 3DHB - Wairarapa | 217 |
| 5.2 | Pacific balanced scorecard | 229 |
## CAPITAL & COAST DISTRICT HEALTH BOARD

**Interest Register**

31 MAY 2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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</thead>
</table>
| **Mr Andrew Blair**   | Chair, Southern Partnership Group (appointed jointly by Ministers of Finance and Health to provide governance for the redevelopment of Dunedin Hospital)  
| **Chairperson**       | Member of the Board of Trustees of the Gillies McIndoe Research Institute  
|                       | Chair, Hutt Valley District Health Board (from 5 December 2016)  
|                       | Former Member of the Hawkes Bay District Health Board (2013-2016)  
|                       | Former Chair, Cancer Control (2014-2015)  
|                       | Former CEO Acurity Health Group Limited  
|                       | Director, Breastscreen Auckland Limited  
|                       | Director, St Marks Women’s Health (Remuera) Ltd  
|                       | Director, Safer Sleep Ltd  
|                       | Director, Safer Sleep LLC Ltd  
|                       | Advisor to the Board, Forte Health Limited, Christchurch  
|                       | Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector |
| **Dame Fran Wilde**   | Deputy Chair, Capital & Coast District Health Board  
| **Deputy Chairperson**| Chair, Remuneration Authority  
|                       | Deputy Chair NZ Transport Agency  
|                       | Chair Wellington Lifelines Group  
|                       | Director Museum of NZ Te Papa Tongarewa  
|                       | Member Whakarewarewa Foundation  
|                       | Director Business Mentors NZ Ltd  
|                       | Director Frequency Projects Ltd  
|                       | Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims  
|                       | Chair Wellington Culinary Events Trust  
|                       | Chair National Military Heritage Trust |
| **Mr Roger Jarrold**  | Member, Capital & Coast District Health Board  
| **Member**            | Chair, Capital & Coast DHB FRAC committee  
|                       | Trustee, Auckland District Health Board Charitable Trust  
|                       | Employee CFO, Downer New Zealand Ltd  
|                       | Director, Downer New Zealand Ltd  
|                       | Director, Works Infrastructure Cortex Resources JV Ltd  
|                       | Director, Works Infrastructure Harker Underground Construction JV Ltd  
|                       | Director, Works Finance (NZ) Ltd  
|                       | Director, DGL Investments Ltd  
|                       | Director, TSE Wall Arlidge Ltd  
|                       | Director, Waste Solutions Ltd  
|                       | Employer (Downer NZ) subcontracts to Spotless  
<p>|                       | Director, Underground Locators Ltd |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
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</thead>
</table>
| Mr Darrin Sykes      | - Member, Capital & Coast District Health Board  
|                      | - Deputy Chair, Capital & Coast District Health Board, FRAC committee  
|                      | - Trustee, Wellington Regional; Sports Education Trust (trading as Sports Wellington)  
|                      | - Member, Sport and Recreation New Zealand (trading as Sport NZ)  
|                      | - Chief Executive, Crown Forestry Rental Trust  
| Ms Sue Kedgley       | - Member, Capital & Coast District Health Board  
|                      | - Member, CCDHB HAC committee  
|                      | - Member, Greater Wellington Regional Council  
|                      | - Member, Consumer New Zealand Board  
|                      | - Shareholder in Green Cross Health  
|                      | - Step son works in middle management of Fletcher Steel  
|                      | - Deputy Chair, Consumer New Zealand  
|                      | - Environment spokesperson and Chair of Environment committee, Wellington Regional Council  
| Dr Roger Blakeley    | - Member of Capital and Coast District Health Board  
|                      | - Deputy Chair, Wellington Regional Strategy Committee  
|                      | - Councillor, Greater Wellington Regional Council  
|                      | - Director, Port Investments Ltd  
|                      | - Director, Greater Wellington Rail Ltd  
|                      | - Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council  
|                      | - Member, Harkness Fellowships Trust Board  
|                      | - Member of the Wesley Community Action Board  
|                      | - Independent Consultant  
|                      | - Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland  
|                      | - Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington.  
| Ms Kim Ngarimu       | - Member of Capital and Coast District Health Board  
|                      | - Member, Medical Council of New Zealand (MCNZ)  
|                      | - Member, Māori Heritage Council  
|                      | - Board Member, Te Māngai Pāhō (Māori Broadcasting Agency)  
|                      | - Alternate Crown Trustee, Crown Forestry Rental Trust  
|                      | - Director, Taaua Ltd (Public policy and management consulting company)  
|                      | - Trustee, Judith and Taina Ngarimu Whānau Trust (has shareholdings in various health related companies – share acquisition and sale is independently managed)  

Capital & Coast District Health Board
<table>
<thead>
<tr>
<th>Name</th>
<th>Member</th>
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<tbody>
<tr>
<td>Ms ‘Ana Coffey</td>
<td>Member of Capital &amp; Coast District Health Board</td>
</tr>
<tr>
<td></td>
<td>Councillor, Porirua City Council</td>
</tr>
<tr>
<td></td>
<td>Director, Dunstan Lake District Limited</td>
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<tr>
<td></td>
<td>Trustee, Whitireia Foundation</td>
</tr>
<tr>
<td>Ms Eileen Brown</td>
<td>Member of Capital &amp; Coast District Health Board</td>
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<tr>
<td></td>
<td>Board member (until Feb. 2017), Newtown Union Health Service Board</td>
</tr>
<tr>
<td></td>
<td>Employee of New Zealand Council of Trade Unions</td>
</tr>
<tr>
<td></td>
<td>Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union.</td>
</tr>
<tr>
<td></td>
<td>God daughter/family friend employed as a solicitor at specialist health law firm, Claro.</td>
</tr>
<tr>
<td>Dr Kathryn Adams</td>
<td>Member, Capital &amp; Coast District Health Board</td>
</tr>
<tr>
<td></td>
<td>Fellow, College of Nurses Aotearoa (NZ)</td>
</tr>
<tr>
<td></td>
<td>Reviewer, Editorial Board, Nursing Praxis in New Zealand</td>
</tr>
<tr>
<td></td>
<td>School Nurse Vaccinator (casual) Regional Public Health, HVDHB</td>
</tr>
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<td>Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health</td>
</tr>
<tr>
<td></td>
<td>Secretary, National Party Ohariu Electorate</td>
</tr>
<tr>
<td></td>
<td>Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa</td>
</tr>
<tr>
<td>Ms Sue Driver</td>
<td>Community representative, Australian and NZ College of Anaesthetists</td>
</tr>
<tr>
<td></td>
<td>Board Member of Kaibosh</td>
</tr>
<tr>
<td></td>
<td>Daughter, Policy Advisor, College of Physicians</td>
</tr>
<tr>
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<td>Former Chair, Robinson Seismic (base isolators, Wgtn Hospital)</td>
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<td>Advisor to various NGOs</td>
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### EXECUTIVE LEADERSHIP TEAM

#### MAY 2017

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Experience and Positions</th>
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<tbody>
<tr>
<td>Debbie Chin</td>
<td>Chief Executive Officer</td>
<td>Member, Rotary&lt;br&gt;Member, HBL FPSC Procurement Steering Group (regional Chief Executive representative)&lt;br&gt;Member, HBL Shared Services Council (regional Chief Executive representative)&lt;br&gt;Trustee, Wellington Hospitals Foundation&lt;br&gt;DHB lead CE for sector performance frameworks</td>
</tr>
<tr>
<td>Chris Lowry</td>
<td>General Manager Hospital and Healthcare Services</td>
<td>Trustee on Life Flight Trust Board&lt;br&gt;Son works at HVDHB</td>
</tr>
<tr>
<td>Rachel Haggerty</td>
<td>General Manager, Strategy Innovation &amp; Performance</td>
<td>Chair, Takanini Care Ltd&lt;br&gt;Director, Haggety &amp; Associates</td>
</tr>
<tr>
<td>Donna Hickey</td>
<td>General Manager, People and Capability</td>
<td>Sister is a nurse, working for Plunket</td>
</tr>
<tr>
<td>Thomas Davis</td>
<td>General Manager, Corporate Services</td>
<td>None</td>
</tr>
<tr>
<td>Nigel Fairley</td>
<td>General Manager of 3DHB Mental Health, Addictions and Intellectual Disability Services</td>
<td>President, Australian and NZ Association of Psychiatry, Psychology and Law&lt;br&gt;Trustee, Porirua Hospital Museum&lt;br&gt;Fellow, NZ College of Clinical Psychologists&lt;br&gt;Director and shareholder, Gerney Limited</td>
</tr>
<tr>
<td>Mr John Tait</td>
<td>Chief Medical Officer</td>
<td>Member Fertility Associates&lt;br&gt;Member, National Maternity Monitoring Group&lt;br&gt;Member, ACC taskforce neonatal encephalopathy&lt;br&gt;Member, Waikato Women’s service taskforce&lt;br&gt;Board member, Wellington Hospitals Foundation</td>
</tr>
<tr>
<td>Catherine Epps</td>
<td>Executive Director of Allied Health, Technical &amp; Scientific</td>
<td>Deputy Chair, National DHB Directors Allied Health&lt;br&gt;Expert Advisor (Leadership) to New Zealand Speech-Language Therapists Association&lt;br&gt;Brother is employed at Waikato and Waitemata DHBs</td>
</tr>
<tr>
<td>Andrea McCance</td>
<td>Executive Director of Nursing &amp; Midwifery</td>
<td>Trustee, Mary Potter Hospice</td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>相关信息</td>
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<tr>
<td>Tony Hickmott</td>
<td>Chief Financial Officer</td>
<td>Director, Allied Laundry (CCDHB representative)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sister-in-law is medical director for Student Health Services at Victoria University</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Niece is employed by Deloitte Auckland as a senior marketing advisor</td>
</tr>
<tr>
<td>Roger Palairet</td>
<td>Chief Legal Counsel</td>
<td>Chair and Trustee of Carers NZ (non-profit organisation promoting the interests of family carers; funders include MoH, MSD and Waitemata DHB)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practices law as Palairet Law, specialising in public law</td>
</tr>
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<td>Sister-in-law is a paediatric nurse at CCDHB</td>
</tr>
<tr>
<td>Shayne Hunter</td>
<td>Chief Information Officer Technology, 3 DHB</td>
<td>Currently in transition from a role at the Ministry of Health and assisting Rillstone Wells on the RHIP/CRISP review</td>
</tr>
<tr>
<td>Dr Pauline Boyles</td>
<td>Director of Disability Strategy and Performance</td>
<td>Member on the Ministry of Health National Advisory Group for Review of Behaviour Support Services</td>
</tr>
<tr>
<td></td>
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<td>Past President/ Advisor to Board, Wellington Riding for the Disabled</td>
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<td></td>
<td>Managing Director, Dream Achievers Ltd</td>
</tr>
<tr>
<td>Arawhetu Grey</td>
<td>Director Māori Health Services/Manager Planning &amp; Funding Mental Health and Addiction Services</td>
<td>Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group</td>
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<td></td>
<td>Director, Gray Partners</td>
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<tr>
<td>Taima Fagaloa</td>
<td>Director of Pacific Peoples’ Health/Manager Planning &amp; Funding, Child &amp; Population</td>
<td>Cousin works as a community health worker for Ora Toa Health</td>
</tr>
<tr>
<td></td>
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<td>Director, TCF Consulting Limited</td>
</tr>
<tr>
<td>Jannel Fisher</td>
<td>Communications Manager</td>
<td>Mother-in-law and sister-in-law are a Bureau nurse and Healthcare assistant respectively</td>
</tr>
<tr>
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<td>Another sister-in-law is a nurse at CCDHB</td>
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<tr>
<td>Robyn Fitzgerald</td>
<td>Board Secretary</td>
<td>Daughter is a nurse at HVDHB</td>
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</table>
PRESENT: Mr A Blair (Chair)
Dame F Wilde (Deputy Chair)
Dr K Adams
Dr R Blakeley
Ms E Brown
Ms A Coffey
Ms S Kedgley
Mr R Jarrold
Mr D Sykes
Mrs S Driver
Ms K Ngarimu

IN ATTENDANCE: Mrs D Chin (Chief Executive)
Ms C Lowry (General Manager Hospital and Healthcare Services)
Ms A Gray (Director Māori Health Services)
Mr T Davis (General Manager Corporate Services)
Mr N Fairley (General Manager 3DHB Mental Health, Addictions and Intellectual Disability Services)
Mr J Tait (Chief Medical Officer)
Ms C Epps (Executive Director of Allied Health, Technical and Scientific)
Ms A McCance (Executive Director of Nursing and Midwifery)
Mr T Hickmott (Chief Financial Officer)
Ms J Fisher (Communications Manager)
Mrs R Fitzgerald (Board Secretary)

SPEAKERS Dr C Fawcett (Item 2.1)
Mr Hefford (Item 2.1)
Dr B Betty (Item 2.1)
Ms A Balram, ICC Programme Manager (Item 2.1)
Ms E Hickson, Director of Nursing (Item 2.2)
Dr P Boyes, Director Strategic Disability Services (Item 2.2)
Ms S Williams, Manager Wellness and Long Term Conditions (Item 2.1)
Ms F Ryan, Contractor (Item 2.1)

MEMBER OF PUBLIC: Reporter from the Dominion Post
Two members of the general public.
1 PROCEDURAL BUSINESS

Item 1.1 PROCEDURAL
Karakia was led by Darrin Sykes. Chair, Andrew Blair, welcomed Board members, Executive team members and the member of public.

Item 1.2 APOLOGIES
Apologies were RECEIVED from ‘Ana Coffey.

Item 1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS
An update of interests was provided by Roger Jarrold and Roger Blakeley.

Update
1. Roger Jarrold informed the committee that Downers have acquired the trading assets of Hawkins Ltd and 19% of Spotless shares in Australia.
2. Roger Blakeley has been confirmed as a Board member of the Wesley Community Action Board.

CONFLICTS RELATED TO ITEMS ON THE AGENDA
No other conflicts were foreshadowed in respect of items on the current agenda but there would be an additional opportunity at the beginning of each item for members to declare conflicts of interest.

Item 1.4 MINUTES OF PREVIOUS MEETING 22 March 2017

RESOLVED THAT:
The minutes of the CCDHB Board meeting held on 22 March 2017, taken with the public present are confirmed as a true and correct record.

Moved: Fran Wilde  Seconded: Roger Blakeley  CARRIED

Item 1.5 MATTERS ARISING UPDATE
Nil.

Item 1.6 ACTION LIST
The reporting timeframes on the other open action items were NOTED.

Item 1.7 CCDHB WORK PLAN 2017

Noted changes.

Actions:
1. Regional Services Plan to be presented to the Board in May
2. 3D Mental Health Group to report back to the Board in May.
2 PRESENTATIONS

Item 2.1 Healthcare Homes
Dr C Fawcett, Mr Hefford, Dr B Betty and Ms A Balram, presented to the Board on Healthcare Homes. Multiple channels into General Practices; managing incoming calls; special arrangements for high and complex care; Patient portal; emailing your GP; seeing personal notes on line; expanding roles into General Practices; bringing in pharmacies; virtual consults.

DNA rates have improved through triaging over the phone. Overflow to local A&M and GP paying difference. Building links with District Nurses and Allied Health teams. The development of parameters around patient care – this will identify who should be hospitalised and who can be cared for in the community. Dialogue between Hospital based specialists and community based health workers to keep focused on outcome of patients.

Horizontal referral around the community; building a skills and specialist network; costs of delivering afterhours; specialist care, nursing, and allied health have supported the growth of this initiative.

The Chair thanked the presenters for taking the time to present to the Board, and commended the efforts of all those involved in the Healthcare homes initiative.

Item 2.2 Sub Regional Disability Strategy 2017-22
Ms E Hickson and Dr P Boyes gave a presentation on the Sub regional Disability Strategy 2017-22 and presented a patient’s story on her experience with the health sector and the barriers she faced to get information and appropriate care.

3 DECISIONS

3.1 The updated Sub Regional Disability Strategy 2017-22

The Board:

(a) Noted that service planning in the sub-region with regard to disability integration has been driven by the previously endorsed Valued Lives Full Participation 2013–2018

(b) Noted the national and including international drivers for change, particularly the ‘New Zealand Disability Strategy 2016–2026’ and the ‘United Nations Convention on Rights of Persons with Disabilities’

(c) Noted that we are learning more about disabled communities as data gathering becomes more intuitive and complex. This drives the shift toward a more enabling health system for disabled people, in order to improve equity of health outcomes

(d) Noted the need for disability literacy in the health workforce, acknowledging that disabled people themselves are best placed to know what they need on a daily basis to achieve positive wellbeing

(e) Noted the significance of embedded co-design and joint ownership of planning with community

(f) Noted that the updated Strategy contains a detailed section 3 on the actions and outcomes that make up the framework. This provides direction for health sector leaders to work alongside disability communities in addressing inequities and ensuring better health outcomes, through to 2022 and beyond
(g) **Noted** the effort of the Sub-Regional Disability Advisory Group members and the Disability Strategy Team in producing this Strategy

(h) **Approved** the draft Sub-Regional Disability Strategy 2017–2022 in its entirety

(i) **Noted** and thanked the team that had developed the strategy.

**Moved:** Eileen Brown  **Seconded:** Fran Wilde  **CARRIED**

### 3.2 Consumer Engagement and Consumer Council

The paper was taken as **read**.

The Board:

(a) **Noted** the contents of this report

(b) **Endorsed** the establishment of a Consumer Council Working Group which will include representation from the Māori Partnership Board, Mental Health consumer groups, SRDAG, SRSHAG, Board representative (Sue Driver) and be able to co-opt others to participate

(c) **Approved** Sue Driver being a Board representative on this Working Group.

**Action:**

3. This group to provide a Terms of Reference, work programme, timeline and to report back to the Board in 3 months.

**Moved:** Fran Wilde  **Seconded:** Roger Jarrold  **CARRIED**

### 4. DISCUSSION

#### 4.1 CHAIR’S REPORT

The Chair’s verbal report included:

- Correspondence received from
  - Peter Anderson, Chair, NZHPL
  - Deputy State Services Commissioner regarding Board members standing for Parliament
  - Ministry of Health – update on Human Support and Pay Equity Agreement
- Meeting at the Regional DHB symposium, Wairarapa
- Regional Governance Group – TAS and letter of expectation from DHBs; Shared services; Reappointment of Murray Bain to NZHP Board; Working with the Institute of Directors on a questionnaire on an evaluation of the Board’s performance – Roger Jarrold to participate on preliminary evaluation of survey; discussion on NZHPL
- Visited Ratonga Ra o Porirua; Karori Medical Centre; Wellington Regional Hospital
- Pending meeting with Lester Levy, Chair of Auckland DHBs
- Pending meeting with the Mayor of Wellington
- Interview/media articles with Doctor; regular Chair’s column in CCDHB’s staff newsletter.

The report was **RECEIVED**.

**Item 4.2 CHIEF EXECUTIVE’S REPORT**

Items in the CEO’s report were discussed and further details provided by executive members.
The Board noted the contents of this report.

The report was RECEIVED.

**Item 4.3 CCDHB HEALTH AND SAFETY REPORT (for the month of March 2017)**

The report was taken as read.

The Board:
(a) Noted the health and safety report for the month of March 2017
(b) Noted the current health and safety risks
(c) Noted the number of staff and ‘Other’ H&S reported incidents.

**Item 4.4 HOSPITAL SERVICES REPORT**

The report was taken as read.

The Board:
(a) Noted the contents of the report
(b) Noted performance against the Electives health target, recovery plan and forecast position to meet target by the end of June
(c) Noted the improvement in performance against the Shorter Stays in ED target and that this is expected to continue to improve as the improvement initiatives are implemented
(d) Noted the balanced scorecard.

**Item 4.5 3D MENTAL HEALTH GROUP UPDATE**

The paper was taken as read.

The Board ENDORSED the conclusions and recommendations of this report.

The Chair thanked Board members, Fran Wilde and Eileen Brown and commended those others who participated on this working group.

Moved: Roger Blakeley Seconded: Fran Wilde CARRIED

5. INFORMATION PAPERS

**Item 5.1 CPHAC/DSAC UPDATE**

The report was taken as read.

Work programme was tabled.

**Item 5.2 POPULATION HEALTH UPDATE**

The report was taken as read.

The Board noted the contents of the report which outlines key recent public health activities from our regional services.

**Action:**
4. Next quarterly update to provide some traffic lights on issues such as rheumatic fever, dental work, and breast screening.
6 GENERAL BUSINESS

Nil

7 RESOLUTION TO EXCLUDE THE PUBLIC

Item 7.1 RECOMMENDATION

The Board NOTED and RESOLVED to:

(a) AGREE that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>REASON</th>
<th>REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Excluded Minutes</td>
<td>For the reasons set out in the respective public excluded papers</td>
<td></td>
</tr>
<tr>
<td>Public Excluded Matters Arising from previous Public Excluded meeting</td>
<td>For the reasons set out in respective public excluded papers</td>
<td></td>
</tr>
<tr>
<td>Chair’s report</td>
<td>Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations</td>
<td>9(2)(i)(j)</td>
</tr>
<tr>
<td>CEO’s report</td>
<td></td>
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<tr>
<td>FRAC report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Pharmacy Service Agreements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18 Annual Plan: Financial Commitments</td>
<td>Subject to Ministerial approval</td>
<td>9(2)(f)(v)</td>
</tr>
</tbody>
</table>

Moved: Andrew Blair   Seconded: Fran Wilde   CARRIED

The meeting closed at 3.34pm.

6 DATE OF NEXT MEETING

31 May 2017, 11th Floor Boardroom, Grace Neill Block, Wellington Regional Hospital.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting

DATED this ................................................day of...............................................2017

Andrew Blair
CCDHB BOARD CHAIR

CCDHB Minutes – 26 April 2017
## SCHEDULE OF ACTION POINTS – PUBLIC MEETING

<table>
<thead>
<tr>
<th>Action No</th>
<th>Date of meeting</th>
<th>Agenda item number</th>
<th>Topic</th>
<th>Action</th>
<th>Designated to</th>
<th>How dealt with</th>
<th>Delivery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>P0002</td>
<td>26 April 2017</td>
<td>1.7</td>
<td>CCDHB Work Plan 2017</td>
<td>Regional Services Plan to be presented to the Board in May</td>
<td>Dir Sip</td>
<td>Paper/Workshop</td>
<td>May 2017</td>
</tr>
<tr>
<td>P0004</td>
<td></td>
<td>3.2</td>
<td>Consumer Engagement and Consumer Council</td>
<td>Provide terms of reference, work programme and timeline to Board</td>
<td>Dir SIP</td>
<td>Paper</td>
<td>Jul 2017</td>
</tr>
<tr>
<td>P0005</td>
<td></td>
<td>5.2</td>
<td>Population Health Update</td>
<td>Provide traffic lights on issues such as rheumatic fever, dental work and breast screening.</td>
<td>Dir SIP</td>
<td>Paper</td>
<td>August quarterly report update</td>
</tr>
<tr>
<td></td>
<td>11 Nov 2016</td>
<td>2.2</td>
<td>Health and Safety Report</td>
<td>Management to request a one page summary from contractors to identify ratio per work hours; targets to be met; trends and overall performance.</td>
<td>GM CS</td>
<td>Report</td>
<td>When data available</td>
</tr>
<tr>
<td></td>
<td>28 Oct 2016</td>
<td>2.2</td>
<td>Health and Safety Report</td>
<td>Management to describe the work programme with primary care that includes an acute demand work stream and the health care home programme of work.</td>
<td></td>
<td></td>
<td>May 2017</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Targets for the total recordable injury rate, serious harm and lost time injuries are to be set for the New Year.</td>
<td></td>
<td>Report</td>
<td>June 2017</td>
</tr>
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</table>
### CLOSED since last meeting – 26 April 2017

<table>
<thead>
<tr>
<th>Action No</th>
<th>Date of meeting</th>
<th>Agenda item number</th>
<th>Topic Action</th>
<th>Action</th>
<th>Designated to</th>
<th>How dealt with</th>
<th>Delivery date</th>
</tr>
</thead>
<tbody>
<tr>
<td>P0003</td>
<td>26 Apr 2017</td>
<td>1.7</td>
<td>CCDHB Work Plan 2017</td>
<td>3D Mental Health Group to report back to the Board in May</td>
<td>Dir SIP</td>
<td>Paper</td>
<td>May 2017 Report tabled at April meeting</td>
</tr>
<tr>
<td>P0001</td>
<td>22 Mar 2017</td>
<td>2.2</td>
<td>Health and Safety Report</td>
<td>Management to separate Mental Health volume</td>
<td>GM CS</td>
<td>Report</td>
<td>April 2017</td>
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<td>January</td>
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<td>March</td>
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<td>May</td>
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<td>July</td>
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<tr>
<td><strong>CPAC-DSDAC membership and meeting timetable</strong></td>
<td></td>
<td>Health System Plan</td>
<td>Strategic Planning</td>
<td>Final Operating and Capital Budget 2017/18</td>
<td></td>
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<tr>
<td><strong>Quarter 1</strong></td>
<td></td>
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<tr>
<td><strong>Quarterly performance report</strong></td>
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<tr>
<td><strong>Report</strong></td>
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<tr>
<td><strong>Health Services update</strong></td>
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<tr>
<td>Month</td>
<td>Legal update</td>
<td>Legal update</td>
<td>SAS annual plan</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Integration work programme</td>
<td>Integration work programme</td>
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<td>March</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<tr>
<td>April</td>
<td>Dental work and Breastscreening</td>
<td>Rheumatic Fever</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<tr>
<td>May</td>
<td>Legal update</td>
<td>Legal update</td>
<td>SAS annual plan</td>
<td>Legal update</td>
<td>Legal update</td>
<td>Integration work programme</td>
<td>Integration work programme</td>
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<tr>
<td>June</td>
<td>Integration work programme</td>
<td>Integration work programme</td>
<td>Integration work programme</td>
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<td>Integration work programme</td>
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<td>July</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<td>August</td>
<td>Community Investment Update</td>
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<td>September</td>
<td>Community Investment Update</td>
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<td>October</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<tr>
<td>November</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<tr>
<td>December</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
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<td>Community Investment Update</td>
<td>Community Investment Update</td>
<td>Community Investment Update</td>
</tr>
</tbody>
</table>

**HEALTH AND SAFETY SITE VISITS**
- **6:30pm - 9:00pm**
- **Health and Safety**
- **Healthcare Homes**
- **Wellington Hospital Foundation (WHF) Update**
- **Antimicrobial resistance, infectious diseases within the hospital and community**
- **WHF**
- **WHL**

**PRESENTATION**
- Maori Partnership Board
- SRDAG
- SRPHAG
- TBA (Pharmac)
- TBA (HWNZ)
- **HEALTH AND SAFETY VISITS BOARD SITE VISITS**
- **11:45am - 12:30pm**
- **Emergency Preparedness**
- **Update (David Moore)**
- **Healthcare Homes**
- **Wellington Hospital Foundation (WHF) Update**
- **Antimicrobial resistance, infectious diseases within the hospital and community**

**TBA**: To Be Announced

**Comment [28301017]**: New item to align with HVDHB reporting

**Comment [28301018]**: Update requested by Board
PUBLIC
Capital & Coast District Health Board
BOARD PROCEDURAL
Date: 15 May 2017

Author Debbie Chin, Chief Executive Capital & Coast DHB

Subject CHIEF EXECUTIVE’S REPORT

RECOMMENDATION

It is recommended that the Board:

a. Note the contents of this report.

APPENDICES

1. Financial Summary
2. Health Matters
3. Clinical Governance Terms of Reference.

1 FINANCIAL UPDATE

1.1 Financial overview

The DHB result is favourable to budget by $1.12m for March 2017 and favourable to budget by $1.64m year to date.

The DHB has an actual deficit of ($4.04m) for the month and a year to date actual deficit of ($15.35m).

The year to date variance had been impacted by two industrial action periods, increased throughput volumes in the hospital, the November earthquake and copper pipe costs. The final Budget for 2016/17 has been revised to a deficit projection of ($28m) for the year.

Activity movement compared to last year

<table>
<thead>
<tr>
<th>As reported in MoH MIF report</th>
<th>Mar-17</th>
<th>Mar-16</th>
<th>Variances</th>
<th>Months % change</th>
<th>YTD 16/17</th>
<th>YTD 15/16</th>
<th>Variances</th>
<th>YTD % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>5,698</td>
<td>5,543</td>
<td>(155)</td>
<td>-2.8%</td>
<td>48,763</td>
<td>48,117</td>
<td>1,646</td>
<td>2.8%</td>
</tr>
<tr>
<td>Casewights (Excl MH)</td>
<td>6,127</td>
<td>5,983</td>
<td>(144)</td>
<td>-2.4%</td>
<td>51,406</td>
<td>51,263</td>
<td>(143)</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Bed Days (calculated from Hours)</td>
<td>13,611</td>
<td>12,553</td>
<td>(155)</td>
<td>-2.8%</td>
<td>113,100</td>
<td>111,651</td>
<td>(449)</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Length of Stay (excluding day patients)</td>
<td>3.85</td>
<td>3.76</td>
<td>(0.09)</td>
<td>-2.4%</td>
<td>3.89</td>
<td>3.81</td>
<td>(0.07)</td>
<td>-1.8%</td>
</tr>
<tr>
<td>ED Presentations</td>
<td>5,444</td>
<td>5,385</td>
<td>(59)</td>
<td>-3.0%</td>
<td>47,331</td>
<td>46,673</td>
<td>(658)</td>
<td>-1.4%</td>
</tr>
<tr>
<td>ED Admissions</td>
<td>1,546</td>
<td>1,343</td>
<td>(203)</td>
<td>-15.1%</td>
<td>11,124</td>
<td>11,509</td>
<td>385</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Financial Results

<table>
<thead>
<tr>
<th>Net Result</th>
<th>March 17</th>
<th>March 17</th>
<th>Month</th>
<th>YTD 16/17</th>
<th>YTD 15/16</th>
<th>YTD 16/17</th>
<th>YTD 15/16</th>
<th>YTD % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CCDHB</td>
<td>(4,044,603)</td>
<td>(5,160,377)</td>
<td>(1,115,774)</td>
<td>(15,345,716)</td>
<td>(16,989,881)</td>
<td>(1,644,165)</td>
<td></td>
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</tr>
</tbody>
</table>
2 TREASURY REPORT

Treasury Report on District Health Board Financial Performance to 2016 and 2017 Plans
We have been asked to report the Board on Treasury’s analysis for CCDHB. We will provide a presentation to the Board following our discussions with Treasury, which is occurring just before the Board meeting.

3 PRIVACY WEEK – ‘IT’S ABOUT PEOPLE’ – 8-12 MAY

Acknowledging Privacy Week was a good opportunity for all staff at CCDHB to remind themselves of their responsibilities about handling personal information appropriately. As part of the planned activities scheduled for Privacy Week staff were provided with information, posters, and a quiz on privacy.

Safeguarding personal information and the release of information is critical in maintaining the confidence of our clients and consumers.

To ensure we don’t become ‘front page’ headlines it is important to assess the privacy impact of any new project within the DHB which deals with personal information.

Our information privacy and security governance group is creating a clear process setting out when a privacy impact assessment is required; who is responsible for undertaking one; and what happens to the assessment once it has been completed. A draft policy is being developed and will be circulated for feedback within the organisation in the coming weeks.

4 WANNACRY “RANSOMWARE” CYBER ATTACKS

On Saturday 13th May New Zealand awoke to the news of a large scale ransomware cyber attack targeting organisations in Europe, the UK and other northern hemisphere countries. It was reported that there had infections in as many as 74 countries, including the UK, Australia, the US, China, Russia, Spain, Italy and Taiwan. The WannaCry “ransomware” attack, which affected hundreds of thousands of users, demands payments of as much as US$600 in electronic currency (Bitcoin) to free files from encryption.

The National Health Service (NHS) services across England and Scotland were hit severely. The NHS declared a “major incident” after cyber attacks hit dozens of hospitals. Some of the affected hospitals had to divert ambulances, scrap operations and shut down their computer systems or ask patients to avoid contacting their family doctors unless absolutely necessary.

This cyber attack was fast-moving and spread to hundreds of countries.

As soon as we became aware of the attack (around 8:30am on the 13th May NZ time) the ICT Major Incident Response (MIM) process was invoked. This included:

- Establishing a response team and identifying a MIM lead
- Contacting our lab service, the regional systems providers, selected vendors, the Ministry of Health and NZ National Cyber Security Centre
- Locking down our firewalls, regular checking for virus updates and applying these
- Forcing an update to all PC’s that we manage based on Microsoft’s recommendations
- Planning controlled updates to servers based on Microsoft’s recommendations
- Communications (regular) with CEs, communication staff and staff in general
- Taking the precaution of blocking all incoming emails that originated outside of NZ over the weekend
• Increasing the frequency of data back ups for our key systems
• Actively monitoring firewalls, Anti-Virus and major file stores for any unusual activity.

We also linked in with the DHBs nationally along with the Ministry of Health who coordinated a sector wide response. Representation included DHB, primary care, pharmacy, ambulance, vendors and the NZ National Cyber Security Centre and provided regular updates.

There have been no reported infections at any health organisation in NZ.

We remain vigilant. This virus is mutating so we are not out of the woods. We continue to actively monitoring for any unusual activity, and new alerts and advice from the NZ National Cyber Security Centre, the media and our DHB colleagues. Staff are being reminded on a regular basis to THINK BEFORE YOU CLICK and what to do if they think they may have been infected. Our staff are our last line of defence.

5 HEALTH TARGETS

5.1 Shorter Stays in Emergency Department (SSiED)

Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.

5.2 Current Performance

Summary of Key features for the last month

CCDHB SSIED performance for April 2017 was 91.3%. The overall SSIED performance improved from last month but is a 1% decline compared to the same month last year.

ED admitted patients’ compliance was 83% for April 2017 which is a reduction of 1.5% on the result for April 2016. 96% of ED patients were treated and discharged within the 6hr SSiED target.

The total ED volumes and subsequent admissions are contributing factors with ED averaging 171 patients a day for April 2017. This is an increase on average of 2 patients per day when compared to the volumes recorded in April 2016.

Bed occupancy continues to be a contributing factor to SSiED compliance. The occupancy percentage utilisation for April 2017 was 94.1% which is 9.1% above an estimated optimum occupancy of 85%.

Acute flow improvement projects are well underway with trials of new models of care continuing to be progressed.

SSIED and flow Results

<table>
<thead>
<tr>
<th>Month Year</th>
<th>Numerator: Patients with LOS less than Six Hours</th>
<th>Denominator: The total patients seen in the ED</th>
<th>Percentage within Target</th>
<th>Variance from 95% Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td></td>
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</tbody>
</table>
CCDHB performance for ED treated and discharged patients for April 2017 was 96%.

CCDHB performance for ED admitted patients for April 2017 was 83% which is a reduction of 1.5% on the result for April 2016.

5.3 Factors Impacting on Performance

The total ED volumes and subsequent admissions are contributing factors with ED averaging 171 patients a day for April 2017. This is in an increase on average of 2 patients per day when compared to the volumes recorded in April 2016.

5.3.1 Occupancy

The occupancy rate is based on core Adult Wards (Wellington and Kenepuru) but excludes 4 North and ICU.
Bed occupancy continues to be a contributing factor to SSiED compliance. The occupancy percentage utilisation for April 2017 was 94.1% which is 9.1% above an estimated optimum occupancy of 85%.

**CCDHB Occupancy and SSIED Rate**

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>SSIED</td>
<td>92%</td>
<td>92%</td>
<td>88%</td>
<td>85%</td>
<td>84%</td>
<td>86%</td>
<td>86%</td>
<td>89%</td>
<td>90%</td>
<td>93%</td>
<td>93%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>92%</td>
<td>92%</td>
<td>96%</td>
<td>97%</td>
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</table>

5.4 **Priority Work Streams – Acute flow**

Frances Health (FH) has continued to work with both ED and General Medicine over January and February.

5.4.1 **Emergency department**

ED Leadership team continues to meet every Thursday to progress the work programme. Improvements are being made with early SMO assessment.

5.4.2 **General medicine**

The focus in April has been continuing to revise, plan and trial Rapid cycle tests of change of 3 of the 4 projects identified as “Timely Care” work streams. The Key projects have been agreed, work groups commenced and initiatives include:

1. Improving the interface between ED and MAPU – to reduce the delay in identifying appropriate Gen Med patients and timely transfers from ED to MAPU, encouraging assessment in MAPU rather than ED. First achievable goal of better signage in ED and coming into the main hospital corridor directing GP referred patients to MAPU so they don’t get into the ED triage/assessment track is proving to be successful with patients being able to find their way to MAPU.

   Allied Health and Radiology have been involved in smoothing process for MAPU patients. There is an audit/process mapping of general medicine patients and their journey through ED to MAPU occurring in April, results not yet available.

2. Facilitating ambulatory care in MAPU – safely discharge greater number of patients on the day. This was trialled for 5 days the last week of March. Good feedback has been received from medical and nursing staff. Revisions to the process have been made and a second trial will be conducted the week of 8-12 May.

3. Timely on-the-day discharge – removing barriers to getting patients home earlier in the day. A rapid cycle test of change occurred over 3 days in 5 South and 6 East in
March. The results in 6 East were very positive and having a dedicated discharge nurse each morning has been embedded in the daily routine. The results in 5 south were good, with suggestions of how to improve the process in the three pods. The use of a discharge nurse has become business as usual in both areas.

4. Meeting the needs of potentially long stay patients in a timely fashion are still developing processes and are working on a trial for May.

5.4.3 Other specialties

The approach to improve specialty responsiveness to ED is being progressed with a focus on General Surgery, Paediatric Medicine and Orthopaedics.

Nurse led discharge which supports earlier time of discharge on the day therefore creating capacity, has been implemented and is now business as usual in the two acute medical wards. This is now being rolled out across the other in patient wards.

Ward rounding processes are being reviewed across the services with the aim of ensuring assertive ward rounding is in place in all areas with a focus on discharge planning and management.

Work is being progressed with mental health services. The number of patients presenting to ED have been showing an increase month by month over the last two years. There are delays for Consult Request to Attend for patients. This does include patients where a request is made prior to the patient being fit for assessment. The mental health and ED teams have met and completed process mapping of current process and issues to identify opportunities for improvement. This will be progressed over the next two months.

5.5 Elective Services

5.5.1 Elective Discharges Health Target

Improvement continues to be made against the health target. As at the end of April we have achieved 98% of the target and are now 274 discharges behind target. For the month of April we exceeded our in-house recovery plan of 461 discharges by 45, achieving 515 local elective discharges.

The original plan and budget for outsourcing provided for 974 discharges which have been reforecast to 1033, while staying within the original budget. We continue to outsource non cataract ophthalmology, general surgery and gynaecology procedures.

5.5.2 ESPI Compliance

<table>
<thead>
<tr>
<th></th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May*</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESPI 2</td>
<td>23</td>
<td>13</td>
<td>11</td>
<td>15</td>
<td>9</td>
<td>11</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>ESPI 5</td>
<td>6</td>
<td>13</td>
<td>15</td>
<td>19</td>
<td>19</td>
<td>12</td>
<td>18</td>
<td>2</td>
</tr>
</tbody>
</table>

April ESPI 2 and 5 results are not yet confirmed by MOH and the results above are as per our internal reporting.
We are forecasting 7 non-compliant ESPI 2 and 2 non-compliant in ESPI 5 at May* month end. This will be within accepted tolerance levels.

5.5.3 Cardiothoracic Waiting List

The cardiac waitlist is currently at 68 - 72 which is within the maximum number of 71 patients however it continues to be a challenge with the large number of cancellation due to no ICU beds. The casemix continues to be complex and we continue to outsource to Wakefield where possible. The wait list is being actively managed to ensure patients are being treated as close to the clinical treat by dates as possible.

5.6 Faster Cancer Treatment

5.6.1 62 day target

The target is that patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and the triaging clinician believes the patient needs to be seen within two weeks.

The 62-day wait is measured from receipt of the referral to the date of the patient’s first cancer treatment (or other management). The target is that by July 2016, 85 per cent of patients meeting the criteria should commence treatment within 62 days, increasing to 90 per cent by June 2017.

Approximately 25 per cent of newly-diagnosed cancer patients will be covered by the 62-day target. A large proportion of newly-diagnosed cancer patients will continue to access treatment through pathways not covered by the target.

CCDHB results for April were 93%. This is an improvement on previous months and has lifted the DHBs rolling quarterly performance to 81% as outlined in the table below.

<table>
<thead>
<tr>
<th>2016/17</th>
<th>Q2</th>
<th>Oct</th>
<th>26</th>
<th>5</th>
<th>31</th>
<th>84%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nov</td>
<td>35</td>
<td>7</td>
<td></td>
<td>42</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>Dec</td>
<td>16</td>
<td>5</td>
<td>21</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>Jan</td>
<td>19</td>
<td>3</td>
<td>22</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feb</td>
<td>17</td>
<td>10</td>
<td>27</td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mar</td>
<td>19</td>
<td>5</td>
<td>24</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td>Apr</td>
<td>13</td>
<td>1</td>
<td>14</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>225</td>
<td>52</td>
<td>277</td>
<td>81%</td>
<td></td>
</tr>
</tbody>
</table>

Numbers captured for this rolling quarter are lower than previous months. The number of patients not meeting the target remain comparable, but this coupled with low numbers entering the pathway is reflecting on the percentage compliance achieved.

5.6.2 31 Day Indicator

Patients with a confirmed diagnosis of cancer to receive their first cancer treatment within 31 days.

For the month of April 39 patients were included at time of reporting. 39 patients (100%) were within the indicator timeframe. This has improved our performance against this indicator to 88.2%.
The reason for the lower than expected number of patients identified within the reporting is being investigated. Some of this is related to surgeon vacancies and access to ICU creating delays. A key facet in achieving the target is the ability to “live track” patients as they progress through the system. Most DHBs who have achieved the target have this ability. How we might implement this at CCDHB is currently being explored.

6 COMMUNICATIONS

6.1 Media

6.1.1 Media enquiries and releases

There were 57 media enquiries in April. Around 27% related to patient condition updates. Key matters for the other media enquiries were:

- Temporary reduction in mental health beds
- Access to aged residential care services
- Support for families with Down syndrome babies.

Two media releases were issued, as well as numerous pitches to reporters:

- New space for kids at ED
- Talking now for peace of mind later
6.2 OIA Requests

<table>
<thead>
<tr>
<th>Requests received in April</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requests sent in April</td>
<td>21</td>
</tr>
<tr>
<td>Responses sent on time</td>
<td>81%</td>
</tr>
</tbody>
</table>

6.3 Website

In April, the website was visited 48,305 times by 22,646 people. This was a dip compared with recent months and is likely to be due to school holidays and a high number of public holidays.

The 5 most visited website pages in April were:

<table>
<thead>
<tr>
<th>Website page</th>
<th>Page views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homepage</td>
<td>32,991 (32%)</td>
</tr>
<tr>
<td>Staff login</td>
<td>31,549 (31%)</td>
</tr>
<tr>
<td>Careers (this has just been moved from a separate website to the main corporate site)</td>
<td>3,740 (4%)</td>
</tr>
<tr>
<td>Search</td>
<td>3,177 (3%)</td>
</tr>
<tr>
<td>Wellington Regional Hospital</td>
<td>2,193 (2%)</td>
</tr>
</tbody>
</table>

6.4 Social Media

The number of people following us on Facebook continues to increase. Our number of page likes rose by nearly 4% during April.
The post which reached the most people in April was about the paediatric oncology unit’s new end-of-treatment bell.

6.5 Internal Communications

6.5.1 Health Matters staff newsletter

The latest copy of the Health Matters staff newsletter is attached as Appendix 2.

The April edition includes articles about:
- starting the Care Capacity Demand Management Programme
- the importance of interpreters for deaf patients
- injury management course for managers
- savings from Follow Me printing
- preventing patient falls in hospital.
6.5.2 Internal campaigns
The main internal campaign in April was the Care Capacity Demand Management Programme survey.

6.6 Kapiti Community Meeting
We were invited by the Kapiti District Council Community Board Chairs to present at a public meeting. The meeting was attended by over 50 people.

Our presentation covered information about the health of people in Kapiti, local health services, and what the long term planning means for the community. Dr Chris Fawcett, a local GP, provided an update on the Health Care Home initiative.

There was a discussion session at the end of the presentation. Topics covered ranged from home support services and travelling to Wellington to the mobile surgical bus and maternal mental health services.

The meeting was positive, and the community feedback was invaluable. We have committed to regularly attend community meetings, and strengthen the relationship between the DHB, council and community.

7 CLINICAL

7.1 300 Health Pathways now live
The 3D Health Pathways, developed for general practice teams in the Wairarapa, Hutt Valley and Capital & Coast DHBs, has reached its 300 live pathways milestone.

Health Pathways is a “one stop shop” for best-practice, condition-specific guidelines and associated information. The online resource is designed for primary health care practitioners to use during consultation, helping them manage and refer their patients to the most appropriate specialist, hospital or community-based services. This not only helps patients get the right care, but greatly improves relationships between the people involved.

The pathways are developed by consensus and collaboration between hospital clinicians and general practice teams from the Wairarapa, Hutt Valley and Capital & Coast DHB areas. It is a well-used resource with 1400 page views on average a day. The website is https://3d.healthpathways.org.nz/

7.2 Clinical Council
The Clinical Council now has an established monthly meeting pattern to review clinical issues and papers coming to the Board. The members are keen to ensure that the addition of a new group to the Clinical Governance structure at CCDHB adds value to the way we work; and so have begun a conversation about prioritisation tools for items needing clinical council sign-off. The Terms of Reference are also attached for information – see Appendix 3.
7.3 **International Nurses and International Midwives Day**

Both International Midwives and International Nurses Day were celebrated at CCDHB. The latter on 12th May involved an awards ceremony to recognise our most successful nurses. The awards ceremony was well attended by nurses, leaders, unions, universities, primary health organisations, and a number of board members attended too.

7.4 **Safe Practice Effective Communication (SPEC)**

Restraint and seclusion minimisation across MHAIDS and recent reports from the Business Intelligence Analysis Unit within CCDHB and Te Pou have indicated a sustained reduction across all areas, in particular Te Whare Matairangi has had a 62% reduction in last 12 months. The target set for the national KPI Seclusion reduction work was 30%. A review group for the MHAIDS 3DHB seclusion minimisation policy review has been initiated. The introduction of Safe Practice effective Communication (SPEC) training is well underway, with three weeks in every month dedicated to training and approximately 120 staff now trained.

7.5 **Winter Planning**

Considerable work has been undertaken across the organisation to plan for the anticipated increased capacity needed during the winter months. As part of this plan, the flu vaccine programme has been actively promoted and rolled out across the organisation. The implementation has used both the Occupational Health and Safety staff plus roving champions from all of the key DHB sites. At the time of writing this report, just over 50% of staff have been vaccinated. Continued initiatives to reach night staff, community staff, and others mean that the numbers are expected to continue to rise.

8 **MENTAL HEALTH**

8.1 **Forensic Services – Linking our patients with the community**

The Forensics Services Inpatient facilities are based at Ratonga o Rua Porirua Campus.

There is regular planning, coordinating and facilitating the educational, social, cultural and daily life skill activities/events to empower, educate and enhance patient’s life skills, social skills and confidence whilst receiving treatment and care within the unit. The patients are always interested in meeting and listening to members of the community who are potentially influence and inspire positive changes to their lives.

Pasifika month is coming up in June and the Mayor of Porirua Mr Mike Tana will speak to our clients and staff about his community commitments as a mayor, rugby player, and how he helps to support and implement the positive changes to people of Porirua community. In April, Billy Graham, boxing personality came to the unit and shared some motivational thoughts with the clients. Other upcoming invited guests include Norm Hewitt, ex All Black and Keith Quinn, rugby commentator.
9 SUB REGIONAL PACIFIC STRATEGIC HEALTH ADVISORY GROUP

9.1 Porirua Social Sector Trial – Tumai Hauora Ki Porirua Alliance

The Porirua Social Sector Trial (PSST), initiated in 2013, is one of 16 Social Sector Trials around the country. The vision for the PSST was, through interagency collaboration, to improve the health of the Porirua community by keeping people well and by providing prompt local treatment when people are unwell. Porirua is the only SST with health outcome objectives: to reduce ambulatory sensitive hospitalisations (ASH) and emergency department attendances among Porirua residents aged 0-74 years.

Compass Health PHO managed the PSST, with the support of five central government agencies (MSD, Health, Education, Justice and the New Zealand Police) to work collaboratively.

A local Steering group and Clinical group were set up to investigate the drivers behind high ED attendance rate. Discussions with the community, government agencies and the health sector resulted in an action plan to address focus areas:
1. Improved self-management, resilience and wellbeing for communities in Porirua
2. A 'well start' to life for children in Porirua
3. Improved access to appropriate primary care in Porirua East and Titahi Bay
4. An aligned inter-agency response to targeted communities
5. Supportive environments.

9.2 CCCDHB Oral Health case study

CCDHB contract Regional Public Health to deliver the Bee Healthy Dental Service. The role of Bee Healthy is to enrol and assess the oral health of all children, including pre-schoolers aged 0-4 years. In 2010 reporting by Regional Public Health identified significant concerns in relation to the low enrolment rate of Pacific children (19%, population 2100) and Maori children (21%, population 3570) living in CCDHB. The CCDHB Board, Maori Health Partnership Group and the 3DHB Sub Regional Pacific Strategic Health group highlighted significant concerns and requested an immediate review of the service.

The Bee Healthy Service in collaboration with the CCDHB Maori and Pacific Directorates developed the Porirua East Oral Health Strategy. This reinforced a different approach to identifying where Maori and Pacific children were not enrolled through sharing information between GP clinics and the Bee Healthy service. Through this approach, Waitangirua Medical Centre identified 300 children who were not enrolled in the Bee Healthy Service. Parents and caregivers were sent letters by Bee Healthy advising that if they had not responded in two weeks, their child/ren would be automatically enrolled in the Service. By 2015 the enrolment had increased for Pacific children by 65% and Maori children by 55%.

As a result, almost 100% of GP clinics have adopted this approach to ensure all pre-schoolers have been enrolled in the Bee Healthy Service. In 2016, 87.4% of Pacific children, and 64% of Maori children were enrolled. The Porirua Social Sector trial have supported this approach.

The CCDHB Oral health case study became a catalyst to identifying a better way for pre-schoolers to be enrolled in oral health by amalgamating new born enrolments for Oral
health, Immunisation, Wellchild Tamariki Ora and BCG Tetanus) into one process thus making it easier for the parent and caregivers to sign up to these programmes through one process.

9.3 **Porirua Social Sector Trial contributions to improved health outcomes**

Implementation and monitoring began in November 2013, with the 3 year trial ending in 2016. Reporting was on a 3-monthly basis and included both quantitative and qualitative outcomes. Some key outcomes in the presentation to the Prime Minister during his visit included:

- A reduction in the number of admissions to hospital for cellulitis skin conditions with the biggest reduction being for our children and young people.

- Almost 2000 extra children in Porirua and 5000 extra children in the wider Wellington region enrolled and receiving free dental care for those 0-4 years old.
Key health messages promoted at more than 40 community events
- Distribution of over 4000 skin care packs and hundreds of toothbrushes, tissues and liquid soap to support wellness
- Greater social service cohesiveness within the district court such as Kaumatua supporting the family violence court
- Trial participation in many community development groups such as Safer Porirua, Porirua Warm Housing Group, Youth2Work, CCDHB Child Health and Respiratory Groups and the newly established Pathway to Engagement; intergenerational family violence prevention group.

PSST has won the ‘Not for Profit Community’ category at the 2015 Westpac Porirua Business Awards, and the Capital & Coast DHB, ‘Excellence in Community Health Wellbeing, Celebrating Our Success in 2015 Award.

9.4 Going forward

There is further potential for greater joined up, strategic thinking and delivery across a community-wide focus, such as children and youth.

Further collaboration and integration across social sector agencies and services requires: co-ordinated funding decisions or joint funding; joint or interdependent accountabilities; shared strategies; joint or complementary outcomes; and aligned planning processes and timeframes.

The role of CCDHB in this forward approach is being developed as part of the locality approach. This will include working with the community, other agencies and local council on the issues that impact on health such as social determinants. Meaningful engagement is essential to assist in reducing avoidable demand for healthcare.
9.5 Prime Minister’s Visit

The Right Honourable Prime Minister Bill English and Honourable Minister Amy Adams recently visited Compass Health, Porirua to share in the Porirua Social Sector Trials.

Pictured are: Euon Murrell, Porirua Leader, Taima Fagaloa, CCDHB Manager, Localities programme, CCDHB CEO Debbie Chin, Ranei Wineera-Parai, Manager, Tumai Hauora ki Porirua Alliance, Prime Minister English, Minister Amy Adams, CCDHB Chair Andrew Blair, D Larry Jordan, GP and Chair Compass Health, Sandra Williams, former Chair, Peter Gush and Ruth Richardson, Regional Public Health.

9.6 Evolve – Te Whanganui-a-Tara Youth Development

Evolve is a central city Youth One Stop Shop (YOSS) providing free wrap-around health and social services for 10 – 24 years olds in Wellington. Youth have been actively part of its development, decision making, presentation, and operation since its beginnings in 2004 and this has been a large contributor to its success.

Its enrolled population has grown to 1,200 plus 4,300 casuals over the past 13 years. Evolve employs 24 staff, including three part-time GPs, who last year took 13,000 visits between them. Currently Evolve has four contracts with CCDHB totalling $755,000, which constitutes its primary source of funding. All four contracts expire on 30 June 2017.

Last year, Evolve was forced to close its books to new patients, and has only been taking on priority (vulnerable) youth while referring over 370 youth elsewhere. This was due to significant increases in demand – largely for mental health services – while resources and staff capacity had reached their limit.

Following productive engagement with Evolve on the sustainability issues, and in keeping with its action plan to contribute to the Prime Minister’s Youth Mental Health Project (expires June 2017), CCDHB agreed to fund another 0.5 FTE GP for the next three years. A 1.0% increase in overall funding has also been approved to adjust for increased CPI (Evolve had no core DHB contract increase since 2010).
Additionally, CCDHB has provided a one-off boost of $35,000 for Evolve to acquire The Outcomes Measurement Model (TOMM) reporting system, an innovative quality improvement tool used by 9 of the 11 YOSS nationwide.

Also of note is that Evolve was part of the Well Health PHO, which recently amalgamated with Compass Health. It is CCDHB’s intention to use this change as an opportunity to engage with Compass Health about increasing its focus on Youth.

The following list highlights the range of services provided by Evolve Youth Health:

<table>
<thead>
<tr>
<th>Evolve Wellington Youth Service: Service Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Health Care</td>
</tr>
<tr>
<td>HEAADSSS and other assessments</td>
</tr>
<tr>
<td>Health information &amp; decision making</td>
</tr>
<tr>
<td>Immunisations</td>
</tr>
<tr>
<td>ACC</td>
</tr>
<tr>
<td>Smoking cessation</td>
</tr>
<tr>
<td>Diabetes clinic</td>
</tr>
<tr>
<td>Liaison with specialist services</td>
</tr>
<tr>
<td>Sexual &amp; Reproductive Health Care</td>
</tr>
<tr>
<td>STI testing &amp; treatment &amp; contact treatment</td>
</tr>
<tr>
<td>Contraceptive advice</td>
</tr>
<tr>
<td>Emergency contraceptives &amp; follow-up</td>
</tr>
<tr>
<td>Free condoms</td>
</tr>
<tr>
<td>Pregnancy testing &amp; follow-up</td>
</tr>
<tr>
<td>Pregnancy care</td>
</tr>
<tr>
<td>Cervical screening</td>
</tr>
<tr>
<td>Liaison with specialist services</td>
</tr>
<tr>
<td>Mental Health Care</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Care plans</td>
</tr>
<tr>
<td>Brief interventions e.g. stress management</td>
</tr>
<tr>
<td>Medication support &amp; maintenance</td>
</tr>
<tr>
<td>General counselling</td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>Art therapy</td>
</tr>
<tr>
<td>Anxiety group</td>
</tr>
<tr>
<td>Wellbeing group</td>
</tr>
<tr>
<td>Mindfulness sessions</td>
</tr>
<tr>
<td>Liaison with specialist services/shared care</td>
</tr>
<tr>
<td>AOD Specialist case review &amp; planning</td>
</tr>
<tr>
<td>Psychiatrist case review &amp; planning</td>
</tr>
<tr>
<td>Youth Justice Support</td>
</tr>
<tr>
<td>Youth justice assessments</td>
</tr>
<tr>
<td>Support for Court appearance</td>
</tr>
<tr>
<td>Support with bail conditions &amp; community service</td>
</tr>
<tr>
<td>Attending Family Group Conferences</td>
</tr>
<tr>
<td>Mentoring</td>
</tr>
<tr>
<td>Networking and liaison</td>
</tr>
<tr>
<td>Social Work Support</td>
</tr>
<tr>
<td>Housing &amp; accommodation support</td>
</tr>
<tr>
<td>Child, Youth &amp; Family liaison</td>
</tr>
<tr>
<td>Child protection</td>
</tr>
<tr>
<td>Homelessness outreach</td>
</tr>
<tr>
<td>Attending Family Group Conferences</td>
</tr>
<tr>
<td>Networking &amp; liaison</td>
</tr>
<tr>
<td>Income &amp; Employment Support</td>
</tr>
<tr>
<td>Benefit advice &amp; advocacy</td>
</tr>
<tr>
<td>Support to transition to employment/training</td>
</tr>
<tr>
<td>Support with CV writing &amp; interview preparation</td>
</tr>
<tr>
<td>Studylink support</td>
</tr>
<tr>
<td>Budgeting advice</td>
</tr>
<tr>
<td>Support to access food parcels</td>
</tr>
<tr>
<td>Young Parent Support</td>
</tr>
<tr>
<td>Antenatal clinical care</td>
</tr>
<tr>
<td>Antenatal classes in partnership with BirthEd</td>
</tr>
<tr>
<td>Weekly parents’ support group</td>
</tr>
<tr>
<td>Lactation consultant</td>
</tr>
<tr>
<td>Resource library</td>
</tr>
<tr>
<td>Equipment loan, clothes swaps, etc</td>
</tr>
<tr>
<td>Parenting programme</td>
</tr>
<tr>
<td>Gender &amp; Sexuality Support</td>
</tr>
<tr>
<td>Partnership with School’s Out queer youth</td>
</tr>
<tr>
<td>support</td>
</tr>
<tr>
<td>Partnership with Transm trans youth support</td>
</tr>
<tr>
<td>Clinical care for gender diverse young people</td>
</tr>
<tr>
<td>Social support for LGBTQ young people</td>
</tr>
<tr>
<td>Advocacy &amp; liaison</td>
</tr>
<tr>
<td>School Based Health Service/Outreach</td>
</tr>
<tr>
<td>Seven school clinics across Wellington &amp; Porirua</td>
</tr>
<tr>
<td>HEAADSSS assessments</td>
</tr>
<tr>
<td>General, sexual and mental health care</td>
</tr>
<tr>
<td>Liaison with school pastoral care team</td>
</tr>
<tr>
<td>Health promotion programmes</td>
</tr>
<tr>
<td>Youth development programs</td>
</tr>
<tr>
<td>Workforce Development</td>
</tr>
<tr>
<td>Youth Work interns</td>
</tr>
<tr>
<td>Nursing student placements</td>
</tr>
<tr>
<td>Counselling student placements</td>
</tr>
<tr>
<td>4th &amp; 5th year Medical student rotations</td>
</tr>
<tr>
<td>GP Registrar training</td>
</tr>
<tr>
<td>Youth health &amp; development training &amp; expertise</td>
</tr>
</tbody>
</table>

9.7 Kapiti Youth Support (KYS)

KYS is another YOSS that provides free wraparound services to approximately 5390 youth in the Kapiti region. In addition to contracts for School Based Health Services and Adolescent Primary Healthcare with CCDHB, KYS also receive funding from MidCentral DHB.

CCDHB is due to meet with KYS to discuss new contracting arrangements in the coming weeks – it is noted that KYS contract targets and funding for the adolescent health contract has not increased since 2008.

Similar to Evolve, KYS has seen an increase in demand for mental health services with Manager Rachel Osborne, noting, “KYS continues to work closely with the secondary mental health service but there is an alarming trend towards mental health service referring on to KYS for counselling...”
A particular highlight for KYS has been their involvement in the development of the aforementioned TOMM reporting tool which provides a holistic report on the youth’s wellbeing incorporating clinical measures, service usage, and self-ratings of wellbeing. There is considerable opportunity to utilise TOMM to produce more meaningful reporting on Youth wellbeing and this will be considered as part of the contract negotiation for both YOSS.

10 BIRTHING HUBS

Birth Hub is a group of dedicated individuals from the birthing community in Wellington (parents, midwives, childbirth educators plus others) who are working together to progress The Birth Centre for Wellington project creating a home-like, midwifery-led Birth Centre. Birth Hub wrote to the Board of CCDHB to seek to engage on the development of a Birthing Centre, outside of Wellington Regional Hospital.

On the advice of the Chair, this letter was addressed by Debbie Chin and Rachel Haggerty meeting with Birth Hub directly to discuss their concerns. This was a valuable discussion. CCDHB is doing some internal work to evaluate whether the development of such a birthing unit would be valuable. Birth Hub were interested in this work and further conversations will be held with them during the course of this work. They agreed that direct engagement with the Board was not required and should coincide with the findings of this work.
Capital & Coast DHB

Board Financial Overview

March 2017
FINANCIAL PERFORMANCE RESULT AND OVERVIEW

Result for period ended Mar 2017

<table>
<thead>
<tr>
<th>Account Type in $000s</th>
<th>March 2017</th>
<th>Year to Date</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>1000. Revenue</td>
<td>85,685</td>
<td>86,496</td>
<td>(811)</td>
</tr>
<tr>
<td>3000. Outsourced Services</td>
<td>3,012</td>
<td>2,431</td>
<td>(581)</td>
</tr>
<tr>
<td>4000. Clinical Supplies</td>
<td>10,957</td>
<td>9,865</td>
<td>(1,092)</td>
</tr>
<tr>
<td>5000. Infrastructure &amp; Non-Clinical Services</td>
<td>7,979</td>
<td>8,747</td>
<td>768</td>
</tr>
<tr>
<td>6000. Other Providers</td>
<td>29,204</td>
<td>30,137</td>
<td>932</td>
</tr>
<tr>
<td>Total</td>
<td>(4,045)</td>
<td>(3,970)</td>
<td>(75)</td>
</tr>
<tr>
<td>Add Revised Additional Budget</td>
<td>(1,191)</td>
<td>1,191</td>
<td>(5,005)</td>
</tr>
<tr>
<td>Total</td>
<td>(4,045)</td>
<td>(5,160)</td>
<td>1,116</td>
</tr>
</tbody>
</table>

The DHB result is favourable to budget by $1.12m for March 2017, and favourable to YTD budget by $1.64m. The DHB has an actual deficit of ($4.04m) for the month and a year to date actual deficit of ($15.35m).

The year to date variance had been impacted by two industrial action periods, increased throughput volumes in the hospital, the November earthquake and copper pipe costs. The final Budget for 2016/17 has been revised to a deficit projection of ($28m) for the year.

Revenue year to date is unfavourable due to reduced funding relating to debt to equity conversion and reduction in capital charge rate. This is offset by reduced interest and capital charge costs. In addition, there is deferral of the elective revenue due to lower volumes achieved in Hospital Services, which was partially impacted by the 2 RMO strikes. This is offset by additional revenue for ACC related work, research funds, and inter-district revenue flow from other DHBs.

Staff costs have been contained and there are a number of staff vacancies. Medical staff vacancies in critical areas are being backfilled with locums to make sure that the patient journey is not compromised.

Clinical supplies costs have been impacted by increased costs of patient appliances, higher pharmaceutical volumes and the release of new Pharmac drugs, as well as price increases and the mix of other treatment related disposables used, such as blood products and catheters. A high priority in the ongoing sustainability plan is consistent reviews of clinical supplies, consumables costs and volumes. The key focus in this area is to identify cost pressures as early as possible and seek to mitigate the financial risk through process and system changes or price and product changes.
External Providers Review

The external provider payments variance year to date is $1.4m favourable to budget. The main drivers for these variances are:

- **Pharmaceuticals** $582k favourable variance due to timing of claims.
- Capitation costs are ($358k) adverse mainly due to MOH unbudgeted programmes (mainly Care-Plus Services). These are all offset by MoH additional revenue for new contracts.
- ARC rest home and hospital services have a net favourable variance of $1.5m. Services are volume driven and subject to a review process. A trend of lower average volumes has been achieved with better NASC management.
- HoP (Health of Older People) is ($549k) adverse due to higher claims for In Between Travel (some of which has additional funding) as well as respite service volume increases.
- Mental Health expenses are ($584k) adverse due to some services under review.
- Other expenses are $1.2m favourable mainly due to the release of a favourable IDF wash-up for 2015-16.
- IDF outflows for the current year are ($385k) adverse mainly due to sleepover settlement paid to Hutt DHB as well as increased share of 3 DHB contracts for Labs and Home Community Support.

### External Provider Payments - $000s

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Last year</th>
<th>Actual vs Budget</th>
<th>Actual vs Last year</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital &amp; Coast DHB - Funder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YTD March 2017</td>
<td>Year to Date</td>
</tr>
<tr>
<td><strong>Pharmaceuticals</strong></td>
<td>51,368</td>
<td>51,950</td>
<td>49,269</td>
<td>582</td>
<td>(2,099)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory Transition</strong></td>
<td>44,159</td>
<td>43,801</td>
<td>43,038</td>
<td>(358)</td>
<td>(1,121)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ARC-Rest Home Level</strong></td>
<td>13,373</td>
<td>12,996</td>
<td>12,777</td>
<td>(377)</td>
<td>(596)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ARC-Hospital Level</strong></td>
<td>31,319</td>
<td>33,188</td>
<td>32,642</td>
<td>1,869</td>
<td>1,323</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>16,660</td>
<td>16,076</td>
<td>15,721</td>
<td>(584)</td>
<td>(938)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Palliative Care/Fertility/Comm Rad</strong></td>
<td>7,071</td>
<td>7,144</td>
<td>5,994</td>
<td>73</td>
<td>(1,077)</td>
<td></td>
<td></td>
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<tr>
<td><strong>Other</strong></td>
<td>17,954</td>
<td>19,124</td>
<td>18,471</td>
<td>1,170</td>
<td>517</td>
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<td></td>
</tr>
<tr>
<td><strong>IDF Outflows</strong></td>
<td>68,359</td>
<td>67,974</td>
<td>53,935</td>
<td>(385)</td>
<td>(14,424)</td>
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</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>266,156</td>
<td>267,596</td>
<td>252,905</td>
<td>1,440</td>
<td>(13,250)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Employee FTE Financial Reporting to Ministry of Health (MOH Accrued FTE)

For financial accounting purposes MOH require an accrued FTE measure (as shown in the table below). This measure includes all hours on an accrual basis including leave accruals, overtime and casual hours. As an FTE measure this is highly volatile for a 24/7 facility due to the divisor being set based on the number of working days in the month. The year to date total is an average for the year. The average dollars per FTE year on year is impacted by MECA increases.

<table>
<thead>
<tr>
<th>Month - March 2017</th>
<th>Capital &amp; Coast DHB</th>
<th>Year to Date</th>
<th>Annual</th>
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</thead>
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<tr>
<td></td>
<td>MOH Accrued FTE</td>
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<td></td>
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<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Last year</td>
</tr>
<tr>
<td></td>
<td>YTD March 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FTE</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Last year</td>
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<tr>
<td></td>
<td>880</td>
<td>866</td>
<td>900</td>
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<tr>
<td></td>
<td>2,114</td>
<td>2,162</td>
<td>2,216</td>
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<tr>
<td></td>
<td>709</td>
<td>688</td>
<td>715</td>
</tr>
<tr>
<td></td>
<td>141</td>
<td>139</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>838</td>
<td>871</td>
<td>854</td>
</tr>
<tr>
<td></td>
<td>4,682</td>
<td>4,726</td>
<td>4,817</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>871</td>
<td>853</td>
<td>860</td>
</tr>
<tr>
<td></td>
<td>2,213</td>
<td>2,226</td>
<td>2,168</td>
</tr>
<tr>
<td></td>
<td>700</td>
<td>681</td>
<td>718</td>
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<tr>
<td></td>
<td>140</td>
<td>142</td>
<td>174</td>
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<tr>
<td></td>
<td>837</td>
<td>871</td>
<td>845</td>
</tr>
<tr>
<td></td>
<td>4,761</td>
<td>4,781</td>
<td>4,764</td>
</tr>
<tr>
<td></td>
<td>Average FTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14,687</td>
<td>15,287</td>
<td>14,378</td>
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<td>7,057</td>
<td>7,076</td>
<td>6,708</td>
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<tr>
<td></td>
<td>6,766</td>
<td>6,797</td>
<td>6,647</td>
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<tr>
<td></td>
<td>4,366</td>
<td>4,473</td>
<td>4,467</td>
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<td>6,349</td>
<td>6,253</td>
<td>6,086</td>
</tr>
<tr>
<td></td>
<td>8,239</td>
<td>8,112</td>
<td>7,962</td>
</tr>
<tr>
<td></td>
<td>Average $ per FTE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>124,110</td>
<td>128,898</td>
<td>122,957</td>
</tr>
<tr>
<td></td>
<td>61,043</td>
<td>60,654</td>
<td>59,097</td>
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<td></td>
<td>35,222</td>
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<td>35,221</td>
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<td></td>
<td>39,211</td>
<td>38,072</td>
<td>36,614</td>
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<td></td>
<td>53,629</td>
<td>53,214</td>
<td>51,296</td>
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<td></td>
<td>70,121</td>
<td>70,395</td>
<td>68,142</td>
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<tr>
<td></td>
<td>Cost per FTE all Staff</td>
<td>70,121</td>
<td>70,395</td>
</tr>
<tr>
<td></td>
<td>92,251</td>
<td>93,556</td>
<td>92,209</td>
</tr>
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</table>

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CCDHB Financial Overview

Page 4

February 2017
### CCDHB STATEMENTS OF FINANCIAL POSITION

<table>
<thead>
<tr>
<th>Actual</th>
<th>Actual Budget</th>
<th>At March 2016</th>
<th>At June 2016</th>
<th>Actual vs Budget</th>
<th>Actual vs March 2016</th>
<th>Notes</th>
</tr>
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<tr>
<td>97</td>
<td>99</td>
<td>93</td>
<td>89</td>
<td>12,869</td>
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<td>7,451</td>
<td>7,233</td>
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<td>36,637</td>
<td>41,309</td>
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<td>44,284</td>
<td>4,673</td>
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<td>8,454</td>
<td>8,157</td>
<td>7,345</td>
<td>8,211</td>
<td>7,345</td>
<td>812</td>
<td>3 Inventory/Stock</td>
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<td>3,964</td>
<td>4,446</td>
<td>4,017</td>
<td>4,726</td>
<td>4,017</td>
<td>429</td>
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<td>78,825</td>
<td>73,504</td>
<td>61,432</td>
<td>79,611</td>
<td>75,746</td>
<td>12,072</td>
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</tr>
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<td>465,051</td>
<td>486,456</td>
<td>491,678</td>
<td>472,192</td>
<td>473,318</td>
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</tr>
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<td>9,201</td>
<td>9,201</td>
<td>8,360</td>
<td>8,360</td>
<td>8,462</td>
<td>841</td>
<td>2 Work in progress - CRISP</td>
</tr>
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<td>14,731</td>
<td>9,636</td>
<td>11,987</td>
<td>22,539</td>
<td>18,395</td>
<td>(2,351)</td>
<td>3 Work in progress</td>
</tr>
<tr>
<td>488,983</td>
<td>487,293</td>
<td>512,026</td>
<td>499,593</td>
<td>500,074</td>
<td>(24,730)</td>
<td>5 Total fixed assets</td>
</tr>
<tr>
<td>6,468</td>
<td>6,468</td>
<td>6,468</td>
<td>6,468</td>
<td>0</td>
<td>0</td>
<td>6 Investments in New Zealand Health Partnership</td>
</tr>
<tr>
<td>1,150</td>
<td>1,150</td>
<td>1,150</td>
<td>1,150</td>
<td>0</td>
<td>0</td>
<td>6 Investment in Allied Laundry</td>
</tr>
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<td>7,618</td>
<td>7,618</td>
<td>7,618</td>
<td>7,618</td>
<td>0</td>
<td>0</td>
<td>7 Total Investments</td>
</tr>
<tr>
<td>575,425</td>
<td>568,414</td>
<td>581,075</td>
<td>586,821</td>
<td>583,437</td>
<td>(12,663)</td>
<td>8 Total Assets</td>
</tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9 Bank overdraft HBL</td>
</tr>
<tr>
<td>58,741</td>
<td>58,691</td>
<td>67,249</td>
<td>62,832</td>
<td>64,504</td>
<td>8,557</td>
<td>10 Capital Charge payable</td>
</tr>
<tr>
<td>81</td>
<td>81</td>
<td>62,326</td>
<td>37,081</td>
<td>34,326</td>
<td>4,200</td>
<td>11 Loans - Current portion</td>
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<td>930</td>
<td>1,396</td>
<td>1,316</td>
<td>1,794</td>
<td>0</td>
<td>(80)</td>
<td>12 Capital Charge payable</td>
</tr>
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<td>20,160</td>
<td>23,520</td>
<td>18,728</td>
<td>18,382</td>
<td>16,816</td>
<td>(4,792)</td>
<td>13 Current Employee Provisions</td>
</tr>
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<td>42,225</td>
<td>41,992</td>
<td>42,642</td>
<td>39,615</td>
<td>42,642</td>
<td>650</td>
<td>14 Accrued Employee Leave</td>
</tr>
<tr>
<td>15,599</td>
<td>9,109</td>
<td>7,945</td>
<td>7,945</td>
<td>9,565</td>
<td>(1,646)</td>
<td>15 Accrued Employee salary &amp; Wages</td>
</tr>
<tr>
<td>137,737</td>
<td>134,790</td>
<td>200,205</td>
<td>167,829</td>
<td>168,144</td>
<td>65,415</td>
<td>16 Total current liabilities</td>
</tr>
<tr>
<td>628</td>
<td>628</td>
<td>277,628</td>
<td>302,954</td>
<td>305,628</td>
<td>277,000</td>
<td>17 Crown loans</td>
</tr>
<tr>
<td>8,223</td>
<td>8,249</td>
<td>7,607</td>
<td>7,619</td>
<td>7,407</td>
<td>(842)</td>
<td>18 Restricted special funds</td>
</tr>
<tr>
<td>229</td>
<td>229</td>
<td>230</td>
<td>229</td>
<td>229</td>
<td>0</td>
<td>19 Long-term employee provisions</td>
</tr>
<tr>
<td>5,765</td>
<td>5,765</td>
<td>6,236</td>
<td>5,765</td>
<td>5,765</td>
<td>0</td>
<td>20 Long-term employee provisions</td>
</tr>
<tr>
<td>14,845</td>
<td>14,871</td>
<td>291,029</td>
<td>317,101</td>
<td>319,029</td>
<td>276,158</td>
<td>21 Total non-current liabilities</td>
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<td>152,582</td>
<td>149,661</td>
<td>491,234</td>
<td>484,930</td>
<td>487,173</td>
<td>341,574</td>
<td>22 Total Liabilities</td>
</tr>
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<td>422,843</td>
<td>418,754</td>
<td>89,841</td>
<td>101,891</td>
<td>96,264</td>
<td>328,913</td>
<td>23 Net Assets</td>
</tr>
<tr>
<td>424,373</td>
<td>763,363</td>
<td>424,817</td>
<td>428,962</td>
<td>432,302</td>
<td>338,546</td>
<td>24 Crown Equity</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3 (3,484)</td>
<td>0</td>
<td>25 Capital authorities</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(10,000)</td>
<td>0</td>
<td>26 Deficit support</td>
</tr>
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<td>339,000</td>
<td>339,000</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>27 Capital Injection</td>
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<td>23,596</td>
<td>23,560</td>
<td>24,271</td>
<td>23,392</td>
<td>24,271</td>
<td>(713)</td>
<td>28 Reserve</td>
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<td>364,126</td>
<td>368,170</td>
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<td>352,825</td>
<td>1,077</td>
<td>(17,707)</td>
<td>29 Retained earnings</td>
</tr>
<tr>
<td>422,843</td>
<td>418,754</td>
<td>89,841</td>
<td>101,891</td>
<td>96,264</td>
<td>328,912</td>
<td>30 Total Equity</td>
</tr>
</tbody>
</table>

**Month:** Mar 17

**Variance:**
### Capital & Coast DHB

#### Statement of Cashflows

<table>
<thead>
<tr>
<th>Month: Mar 17</th>
<th>Variance</th>
<th>Year to Date</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
<td>Last year</td>
<td>YTD Mar 2017</td>
</tr>
<tr>
<td><strong>Actual</strong></td>
<td>88,989</td>
<td>87,236</td>
<td>88,148</td>
</tr>
</tbody>
</table>

**Operating Activities**

- **Receipts**
  - 811,002

- **Payments**
  - 781,171

**Investing Activities**

- **Receipts**
  - 1,086

- **Payments**
  - 11,568

**Financing Activities**

- **Receipts**
  - 0

- **Payments**
  - 4,592

**Opening cash**

- 28,857

**Net inflow/(outflow) of CCDHB funds**

- 2,580

**Closing cash**

- 24,265

#### Notes

- YTD Mar 2017
- Actual Budget
- Last year
- Actual vs Budget
- Actual vs Last year

### Capital Charge paid

- 3,269

### GST (net)

- 2,365

### Payments - total

- 781,171

### Net cash flow from operating Activities

- 29,831

### Net cash flow from investing Activities

- (14,098)

### Net cash flow from financing Activities

- (11,568)

### Net inflow/(outflow) of CCDHB funds

- 4,165

### Year to Date

- 24,265

**Variance**

- Month: Mar 17
- Year to Date

- 89,054
- 28,857
- 24,265

31 May 2017 - CCDHB Board PUBLIC papers - Chief Executive's Report
Notes to the Balance Sheet and Cashflows

A) Notes to Balance Sheet:
1. The DHB’s cash balance at the end of March is higher than budget mainly due to less than expected capital spend and other timing differences. All surplus funds are invested by New Zealand Health Partnerships in short term investments;
2. Accounts receivable is lower than budget due to timing differences. Some of the main customers include Ministry of Health $3.5m, Hutt Valley DHB $2.6m, Clinical Training Agency $0.8m;
3. Total non-current assets are lower than budget. This mainly due to lower than expected capital spend;
4. Accounts payable, accruals and provisions are lower than budget mainly due to timing differences. Some main suppliers include Healthcare Logistics $0.7m, Medtronic NZ Ltd $0.5m, University of Otago $0.4m, various Strategy, Innovation and Performance Directorate (SIPD) related accruals $23.6m;
5. Employee related accruals and provisions are significantly higher than budget. This is due to the increase in accrual for unpaid days and annual leave liability. It includes accrued annual leave $36.8m, accrued salary and wages $9.1m, CME $11.1m;
6. Capital charge payable is in line with budget;
7. Crown loans and equity are significantly different to budget. This is due to the conversion of all Crown loans to equity in February 2017. The Government has changed its policy on the capital financing of the DHB health sector. DHBs will no longer have access to Crown debt financing for funding of capital investment. Instead the Crowns contribution to DHB capital investment will now be solely funded via Crown equity injections. As a result of the new capital financing policy, in February 2017, CCDHB converted total loans of $339 million into equity.

B) Notes to Cash flow statement:
8. The net cash flow from operating activities is lower than budget. This is due to timing differences;
9. The net cash flow from investment activities is less than the budget. This is due to timing differences;
10. The net cash flow from financing activities is significantly lower than the budget. This is mainly due to the non receipt of deficit support of $10m from the Ministry. The Ministry expects to pay the deficit support to CCDHB in May17.

C) Ratios
1. Current Ratio – This ratio determines the DHB’s ability to pay back its short term liabilities. DHB’s current ratio is 0.55 (2015/16: 0.45);
2. Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base. DHB’s total liability to equity ratio is 26:74 (2015/16: 83:17). For a detailed explanation, refer note 5 on Crown loans and equity under ‘Notes to balance sheet’.
Cash Forecast
We have projected our cash position based on the proposed capital budget and a forecast deficit of $28m for 2016/17. However any deterioration in these forecasts may put the facility limit at risk and we continue to monitor this closely. The projected cash position includes deficit support of $10m which is expected to be received in May 2017. The working capital facility limit is approximately $50m.
It is **recommended** that the Board:

a) **Note** that this report represents the first Pacific peoples report to the new CCDHB Board

b) **Note** the purpose and priorities of the Sub Regional Pacific Strategic Health Group

c) **Note** the member profiles of the Sub Regional Pacific Strategic Health Group

d) **Note** the case study video presentation on Pacific consumer experiences of health in CCDHB.

### 1 BACKGROUND TO THE DEVELOPMENT OF THE SUB REGIONAL GROUP

In 2010, Capital and Coast, and Hutt Valley DHBs reviewed the way in which Pacific representation provided support to the DHBs in order to consider a joined up approach across the CCDHB, HVDHB and Wairarapa DHB. The results of the review highlighted:

- That the groups have a limited understanding in how their functions directly influence funding or contracting decisions regarding services that impact directly on Pacific people
- That membership on these groups have focussed heavily on ethnic representation rather than specific competencies, skills and knowledge
- That there has been an under-utilisation of Pacific community knowledge to assist and support DHBs to improve quality assessments of providers with suitable and successful track records in delivering effective services to Pacific people.

The review recommended that a joint sub regional Pacific group be established to provide high level strategic support to the DHBs. The new configuration would incorporate membership that would reflect a focus on primary care, disability, mental health, and that the skills sought would have experience in the governance sector, pacific leadership, health and social service areas.

### 2 CURRENT POSITION

The Joint SRPSHG currently has membership on the CPHAC and DSAC sub-committee. Over time changes have occurred to the group structure and membership which has allowed the group to continue to review its effectiveness. With this in mind, the SRPSHG are provided with quantitative and qualitative data to ensure the information provided supports robust and relevant feedback. This allows the SRPSHG to monitor Pacific health outcomes in relation to progress on key performance indicators.
The group meet quarterly. The administrative support of the group is provided by both Capital and Coast and Hutt Valley Pacific Directorates of which meetings alternate between the two DHBs. The SRPSHG has been utilised by the former 3DHB Service, Integration and Development Unit by policy leaders and portfolio managers and will continue to be utilised by the new Service, Integration and Performance Directorate. Both CEs are active members who attend regularly. The MOH Chief Advisor is also in attendance as ex-officio. The Primary Health Organisations attend the meeting on an annual basis to provide an update on their impact of their services on Pacific people.

For Capital and Coast DHB, the priorities of the SRPSHG have been:

- Child health:
- Long term conditions
- Do Not Attend rates
- Workforce development
- Ambulatory Sensitive Hospitalisations

The priorities have formed the basis of the CCDHB Pacific action plan Toe timata le upega 2017-2020 with the balance score card being presented to the SRPSHG quarterly.

3 PROGRESS

The SRPSHG continues to provide value to the DHBs within the sub-region. A range of initiatives have been supported by the SRPSHG:

- CCDHB Oral Health case study: Advocated for an improvement in enrolment rates for Pacific children aged 0-4 years. This led to the review of the Bee Healthy Service. In 2016 87.4% of Pacific children enrolled in the Bee Healthy Service, an improvement from 19% in 2011;
- Pacific Do Not Attend rates decreased from 27% in 2010 to 12% in 2014.
- The SRPSHG assisted Pharmac to develop their Pacific Responsiveness Strategy;
- Presentation on the submission to Pharmac on changes to the use of glucose strips for blood sugar testing;
- Submissions to CCDHB board on fluoridation
- Hosting of the first Health and Social Service Pacific Alliance Symposium (Michael Fowler) which has led to the establishment of key referral pathways across Pacific social and health services;
- Representation in the Disability advisory group and CPHAC;
- Co-led the Pacific Action Plan forums with the CCDHB Chief Executive and Pacific community in 2016;
- Launched the Pacific Actions plans for both Hutt Valley and Capital and Coast DHB;

The SRPSHG continues to provide high level support to the DHBs. Attached are the profile backgrounds for each member.
Mr Fa’amatuainu Tino Pereira MNZM (Chairperson)

Mr Pereira currently the managing director of his company Niu Vision Group. Mr Pereira continued to play leadership roles across Pacific Island communities. These roles touch on core dimensions of Pacific Island community life, social, economic, ecumenical and demographic. He has been involved in many forums raising and developing critical issues affecting Pacific and wider health sector. He has over 20 years of chairmanship and participation in many public sector and community organisations. Mr Pereira currently holds the chairmanship for the Pasefika Healthy Home Trust, Ministry of Social Development Pacific Advisory Forum, Pacific Business Trust, Council of Pacific Collectives, and Pacific Panel for Vulnerable Children and Central Pacific Trust.

Mr Apinelu Faapoi Mark Poutasi

Mr Poutasi has knowledge and experience of working in health and public health section as a Public Health Analyst. Mr Poutasi is interested in contributing to “fence building at the top of the cliff”. Mr Poutasi hopes to focus on outcomes for Pacific children and young people, his experience in the MOH Pacific Youth Project and project work focussed on at risk youth will contribute to the groups focus on outcomes for Pacific children. Mr Poutasi is currently on leave travelling overseas.

Reverend Tavita Filemoni

Mr Filemoni has strong links with Pacific communities in particular his links with the Wellington Region Samoa Council of ministers and community leaders and secretary of the Wellington Samoan Ministers Fraternal will be instrumental in linking in with Pacific people who attend Pacific churches.

Dr Sunia Foliaki

Dr Foliaki currently working as a Research officer with the Centre for Public Health Research at Massey University since 2002 and has been involved in health research and review of various aspects of New Zealand health topics and issues. Dr Foliaki’s PHD research is on the prevalence of asthma amongst Pacific people in Tonga, Fiji, Samoa, Cook Islands, Niue, and Tokelau. He is the Regional Coordinator for Oceania International study of asthma and allergies. Dr Foliaki’s links to the Pacific communities is through the chairperson of the Tongan Cancer Society, Tongan church and community, social activities.

Dr Tua Loto-Sua

Mrs Loto-Sua will have her PHD in Public Policy (Victoria University) conferred in May 2017. Currently works at Hutt Union Health service as a Primary Health Nurse and very keen in ensuring Pacific people can access Primary Health especially in the area of health
literacy. She has extensive nursing experience in the hospital, primary health in management and Pacific service development. Mrs Loto-Sua is involved with the community with lifestyle programmes to prevent risks of long term conditions and continue to pursue Pacific health research as a future aspiration.

Dr Margaret Southwick

Dr Margaret Southwick, of Porirua, received the Queen's Service Medal on 25 March 2009 for services to the Pacific Islands community. Dr Southwick has been involved with the health of the Pacific Islands community in Wellington for many years. She was instrumental in the establishment of the Pacific Health Research Centre and School of Pacific Health Education at the Whitireia Community Polytechnic. She is the lead researcher for Searching for Pacific Solutions: a Community-Based Joint Intervention Project of the Ministry of Health, the Health Research Council, the Alcohol Advisory Council and ACC. She is a member of the Pacific Research Advisory Committee and the Health Workforce Advisory Committee of the Ministry of Health. Dr Southwick is a councillor of the New Zealand Nursing Council, where she helped to develop the Making Waves Pacific Community Sexual Health Trainers Programme.

Dr Alvin Mitikulena

Dr Alvin Mitikulena is a Director of the Kilbirnie Medical Centre of which is run by the Mitikulena family. He is of Niuean and Samoan descent. Dr Mitikulena is an active member of the Pacific community. The Kilbirnie Medical Centre were recent winners of the Clinical Excellence Award based on patient initiative pilot based on Cardiovascular Risk Assessment for high needs patients.

Dr Zoe Irvine

Dr Zoe Irvine works as an Emergency Care Consultant for Kenepuru After Hours medical clinic in Porirua. Dr Irvine is of Samoan descent. Dr Irvine recently published her thesis on Pacific ethnic groups and frequent hospital presentation: which considered the use of ED and by controlling for proximity to the hospital and socioeconomic status, Dr Irvine is able to demonstrate greater variation between Pacific ethnic groups than between Pacific and Non-Māori/Non Pacific (nMnP), or between Maori and nMnP groups.
## BOARD DECISION

**Date:** 18 May 2017

**Author**
Caroline Tilah, Executive Director (Operations) Quality Improvement & Patient Safety Directorate, Hospital Services.

**Endorsed by**
Chris Lowry, General Manager Hospital & Healthcare Services

**Subject**
CCDHB RISK MANAGEMENT POLICY

## RECOMMENDATIONS

It is **recommended** that the CCDHB Board:

a) **Note** that the revised Risk Management Policy and Hazard and Reporting Risk Matrix was discussed at the April 2017 FRAC meeting

b) **Note the** CCDHB Finance Risk & Audit Committee agreed to the recommendation to endorse the policy and recommend to the Board for approval

c) **Approve** the Risk Management Policy and risk matrix.

## APPENDIX


### 1. PURPOSE

With changes following the introduction of the Health and Safety at Work Act 2015 and associated regulations in April 2016, and an external review of our health and safety governance systems, it was necessary to revise our previous risk management policy and procedure.

### 2. BACKGROUND

The CCDHB Risk Management Framework provides a generic framework, principles and process for guiding the delivery of risk management to ensure CCDHB is operating in accordance with the 2008 Health and Disability Service Standards and the AS/NZS ISO 31000:2009 standard for Risk Management. There is now also a requirement for boards to be aware of health and safety risks as they have accountability and liability under the health and safety legislation.

The revised CCDHB Risk Management Policy (see **Appendix 1**) has adopted a new risk matrix for hazards and risks that focusses on the risk of harm. The new risk matrix has a risk rating range from 1 – 25 (15 – 25 being extreme risk) and enables the risk owners greater visibility of the effect of the control measures on the residual risk rating.

Once finalised and approved the:

- The existing combined CCDHB risk register is to be updated within one week of the risk management policy being approved by the board
- The existing risk register will be modified to reflect the new risk matrix and terminology
- The Risk Management E Learning module will be developed and once completed wider dissemination/ownership of the risk register can be initiated
The new SQUARE Hazard/Risk module taxonomy can be finalised. Ideally this will be a 3DHB module but will require discussion and agreement regarding the hazard/risk matrix. The other 2 DHB’s use the existing risk matrix on SQUARE.
Risk Management Policy

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Document author: Executive Director Operations Quality Improvement & Patient Safety Directorate

Issued by: Finance Audit & Risk Committee (FRAC)

Version: Version 6 (CCDHB 1.8748/1.8772)

Applicable to: All CCDHB workers

Contact Person: Executive Director Operations Quality, Improvement & Patient Safety Directorate

**Risk Management Policy**

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**Contact Person:** Executive Director Operations Quality, Improvement & Patient Safety Directorate

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Risk Management Policy

1. Purpose
The purpose of this policy is to define the identification, reporting, management and reviewing of risk as a component of the CCDHB Risk Management Framework.

2. Background
Capital Coast District Health Board (CCDHB) is a crown agent and needs to comply with a range of acts and regulations including the Crown Entities Act, Public Finance Act, Charitable Trusts Act, and the NZ Public Health & Disabilities Act. Its vision is centred on better health and independence for people, families and communities through the three strategic objectives of shorter safer health journeys, growing our people and best value for money. It operates within the strategic context of a national, regional and local healthcare system with established DHB roles - planner, funder, provider, and owner of crown assets.

CCDHB has a well-established governance structure. The Finance, Risk & Audit Committee (FRAC) of the CCDHB board receives regular reports on key risks, has oversight of the adequacy of internal controls (including risk management) and is focused on matters of financial and contractual significance to CCDHB. CCDHB has always recognised the importance of risk management in delivering quality services and effective governance. Key risks are reported upwards from directorates to the Executive Leadership team (ELT) and FRAC on a monthly basis.

The DHB has also established Internal and External Audit functions which provide independent professional assessments as to key risks, the accuracy and integrity of CCDHB financial reports, and the adequacy of internal controls (i.e. ANZ Financial Management audit, Ministry of Health Certification Audit).

CCDHB recognises that effective risk management is an integral component of good governance and success in risk management is crucial if it is to realise potential opportunities, manage uncertainties, operate within its risk tolerance levels, receive early warnings, and meet its strategic and operational business objectives. The CCDHB Risk Management Framework provides a generic framework, principles and process for guiding the delivery of risk management to ensure CCDHB is operating in accordance with the 2008 Health and Disability Service Standards and the AS/NZS ISO 31000:2009 standard for Risk Management, the Health and Safety at Work Act 2015 and associated regulations.

3. Scope
The purpose of this policy and risk management framework is to provide direction and guidance on the governance and management of risk in order that CCDHB operates successfully. Ultimately the framework aims to ensure the safety of patients, workers and...
Risk Management Policy

the public and to deliver quality, patient centred services which are safe and effective and provide excellent health outcomes for our population and a positive patient experience.

Risk management includes all those coordinated activities which direct and control CCDHB with regard to risk. The risk management process is characterised by the systematic application of management policies, procedures and practices. Key activities include communicating, consulting, establishing the risk context, and identifying, analysing, evaluating, treating, monitoring and reviewing risk.

The system of risk management contributes to sustainable performance improvement and includes the culture, structure and processes within CCDHB that support risk management. The scope includes all workers within CCDHB, which includes anyone engaged in working to support the achievement of CCDHB objectives. This may include but is not limited to:

- Employees
- Agency workers
- Self-employed workers/contractors
- Volunteers
- Consultants
- Third party service providers, and any other individual or suppliers working for [organisation], including personnel affiliated with third parties, contractors, temporary workers and volunteers
- Students

4. Definitions

Risk Assessment This is a careful examination of what, in the workplace, could cause harm, loss or damage and assessing your current control measures, so that you can weigh up whether you have taken enough precautions or should do more to prevent them.

Hierarchy of Controls Where a risk cannot be eliminated a prescribed hierarchy of control measures must be implemented to control the risk. The measures are stated later in this document.

Risk Management Risk management in the health care sector has been defined as “designing and implementing a programme of activities to identify and avoid or minimise risks to patients, employees, visitors and the institution; to minimise financial losses (including legal liability) that might arise consequentially; and to transfer risk to others through payment of premiums (insurance)”. (Safety and Ethics in HealthCare: – A guide to getting it Right).

Document author: Executive Director Operations Quality Improvement & Patient Safety Directorate

Authorised by [Designation/Committee]: Finance Audit & Risk Committee (FRAC)/CCDHB Board

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### Risk Management Policy

**Hazard**
Any source of potential damage, harm or loss.

**Risk**
Effect of uncertainty on achieving CCDHB objectives, expressed in terms of a combination of the consequence (or impact) of an event (including changes in circumstances) and the associated likelihood (or probability) of occurrence. (AS/NZS ISO 31000: 2009 Risk Management Standard Principles and Guidelines)

**Risk Control**
The process to control and reduce risk to a tolerable (acceptable) level and is integral to quality improvement initiatives. A risk is deemed acceptable when there are adequate control mechanisms in place and the risk has been managed as far as is reasonably practicable.

**Risk Owner**
The relevant manager who takes responsibility and is accountable for overseeing the development and implementation of mitigation strategies.

**Risk Report**
The formal document that captures, represents and tracks risk movement on a monthly basis by CCDHB.

**PCBU**
This is a ‘person conducting a business or undertaking’. A PCBU may be an individual person or an organisation. CCDHB is a PCBU.

**Officer**
This is a person who occupies a specified position or who occupies a position that allows them to exercise significant influence over the management of the business or undertaking. This includes for example, but may not be limited to, company directors and chief executives.

### 5. Roles and Responsibilities

It is the ultimate accountability of the Board of CCDHB to ensure that risks to the organisation are appropriately governed and managed. The Chief Executive Officer (CEO) is tasked with the responsibility of ensuring that the framework for risk management clearly and appropriately allocates risk management responsibilities across the organisation at enterprise, strategic, project and operational levels.

CCDHB workers will comply with their designated roles and responsibilities for managing and reporting risk (as defined in Appendix 1). Confirmed strategic risks are validated by Executive Leadership Team/Finance Risk and Audit Committee (FRAC).
Risk Management Policy

6. Training
A generic eLearning Risk Management training tool is being developed and will be mandatory for all management positions that incorporate responsibility for risk management. In the interim the Health & Safety Service and the Directorate Quality Managers provide one to one training in hazard and risk management as required till the eLearning tool is completed.

7. Hazards
Hazards are defined as any source of potential damage, harm or loss. It is important that we are taking all reasonably practical steps to identify any hazard, assess the risk, manage the risk (application of the hierarchy of control measures) and monitor the control measures. We require all hazards that cannot be eliminated immediately to have a formal risk assessment and the effectiveness of the control measures monitored. WorkSafe promote a four step approach to the risk management process.

A positive, proactive and planned approach is required so that looking for hazards becomes part of the work culture, a natural, normal part of managing, supervising and undertaking your job. It is important to understand not only what is likely to go wrong but also how and why people or the organization could be harmed or suffer loss.

Hazards can be identified through:

- walking around and inspecting the working area with colleagues, Health and Safety Representatives (HSR’s), managers etc..
- discussions with workers and users;
- checking that policies, procedures and guidelines are in use;
- carrying out audits;
Risk Management Policy

- comparing previous incidents and ill health statistics that have occurred within the area, CCDHB or other District Health Boards;
- brainstorming ideas with groups of colleagues about practices and procedures;
- referring to manufacturer’s instructions.

It is important to consider any long-term hazards to health such as high levels of noise or exposure to harmful substances, as well as safety hazards. For each hazard you need to be clear about who might be harmed; it will help you identify the best way of managing this risk. That doesn’t mean listing every one by name, but rather identifying groups of people such as workers, visitors, bystanders, or someone else’s workers. This harm could be acute (occur immediately) or chronic (occur slowly over a long period of time).

The persons affected will range from those involved in the task including workers, patients, students etc. Also consider workers and whether any of them might be vulnerable (e.g. young people, pregnant women, casual workers, night shift workers, workers with reduced literacy levels).

Consider whether your workers’ general health could reduce their ability to work safely (e.g. reduced mobility, existing illnesses or injury). In each case identify how they might be harmed, i.e. what type of injury or ill health might occur e.g. the hazard could cause musculoskeletal injuries, breathing difficulties, burns etc.

8. The Risk Management Process

Risk is the correlation between the likelihood and consequence of a risk event, which may reflect a potential lost opportunity, threat or adverse impact. Decisions about risk need to be made within the context of the organisation’s internal and external environment. Consultation and communication are essential components of risk discussion and risk identification. Context is about setting the parameters to be taken into account.

These will include:
- Regional Services Plan
- CCDHB Annual Plan
- Legal obligations (Legal compliance provides the background context for controlling and moderating risk within CCDHB).
- Political and reputational drivers and trends having impact on DHB objectives
- Timeframes and strategic directions stipulated by Ministry of Health
- Funding availability and/or restrictions placed on use of funding
- Health and Safety legislative requirements
- Union requirements and those of the regulatory bodies
- Capabilities and resources available
Risks can be identified by any individual employee at any level, groups or committees. Appendix 2 has a list of possible sources for identifying risks. The aim is to ensure risks are immediately visible to the line manager.

8.1 Risk Categories
The line manager has to ensure there is sufficient analysis and evaluation of the risk to ensure there is comprehensive assessment of all the risks. CCDHB has seven agreed risk categories to ensure comprehensive risk assessment and to determine the main risk category for the DHB Risk Register:

- Patient Care
- Operational
- Health & Safety
- Financial
- Legal
- Governance
- Reputational

8.2 Describing Hazard
Consistency with the risk description is required. Workers should state the activity (nature of the hazard), the shortfall (nature of the injury) and the consequence (any injury or loss that might arise). For example:

- A Patient Care risk may be: *Following an increase in demand for MRI scans there is a significant waitlist that may result in delayed diagnosis and treatment*

- A Health and Safety risk may be: *The handling of heavy or overfilled linen bags may result in musculoskeletal injuries to workers*

Each risk has a risk number which is a unique identifier for each assessed risk. This will remain in place if the risk rating is increased or decreased.

8.3 Applying Risk Analysis
Managers need to analyse the current level of risk with their existing control measures in place. Taking into consideration these measures, determine the:

**Consequence**
Allocate a consequence score (Please refer to Appendix 3 for the risk matrix using table 1 definition of consequences by category table) taking into consideration the existing control measures in place.
Risk Management Policy

Likelihood
Then allocate a likelihood score (Please refer to Appendix 3 for the risk matrix using table 2 of the risk matrix) to assess the potential of the consequence occurring, taking into consideration the existing control measures in place.

Current Risk Score
Then calculate the current risk score by multiplying the consequence score by the likelihood score.

The outcome of assessing the residual risk score determines if the risk is adequately controlled or if additional controls are required.

8.4 Managing the Level of Risk
Having identified and determined the current level of risk, managers must determine if there is anything else can be done to eliminate or further reduce the level of risk. The law requires that everything ‘so far as is reasonably practicable’ to protect people from harm.

Compare the current controls with the hierarchy of controls below, good practice (nationally and internationally) and see if there is more that could be done to reduce the level of risk.

Putting controls in place need not be expensive. For example, placing a mirror on a dangerous blind corner to help prevent vehicle accidents is a low-cost precaution considering the risks.

To help in the assessment of risk it is important that there are appropriate policies, procedures, good practice standards and guidelines in place. They must be suitable and sufficient, up-to-date and used.

8.5 Hierarchy of Control Measures
If the risk cannot be eliminated, then you must:

- Substitute (wholly or partly) the hazard giving rise to the risk with something that gives rise to a lesser risk;
- Isolate the hazard giving rise to the risk to prevent any person coming into contact with it;
- Implement engineering controls;
- If a risk then remains, you must minimise the remaining risk, so far as is reasonably practicable, by implementing administrative controls;
- If a risk then remains, the PCBU must minimise the remaining risk by ensuring the provision and use of suitable personal protective equipment;

It must be ensured that any control measures implemented are monitored, reviewed and if necessary enforced.
8.6 Re-applying the Risk Analysis

Having identified any additional control measures required to further control the risk, it is important to reassess and identify the residual level of risk that will be left when they are implemented. Again identify the:

**Consequence**

Allocate a consequence score (Please refer to Appendix 3 for the risk matrix using table 1 definition of consequences by category table) **with the additional control measure(s) in place.**

**Likelihood**

Then allocate a likelihood score (Please refer to Appendix 3 for the risk matrix using table 2 of the risk matrix) to assess the likelihood of the consequence occurring, **with the additional control measure(s) in place.**

**Residual Risk Score**

Then calculate the residual risk score by multiplying the consequence score by the likelihood score.

8.7 Record the Findings

Having determined the current control measures, level of risk and any additional controls required it is important that the findings are recorded and implemented, so they can be monitored. When completing the risk assessment it must be suitable and sufficient, but also straightforward enough for everybody to understand. It must be shown that:

- a thorough check was made
- the obvious significant risks were dealt with, taking into account the number of people who could be involved
- the precautions are reasonable
- the solutions are realistic, sustainable and effective

It is essential that appropriate control measures are in place and maintained. It is therefore necessary to record all significant findings of a risk assessment. It is important that the risk assessment is:

- implemented within each unit, department, specialty, Directorate
- brought to the attention of workers who are affected by this
- updated when any change occurs

8.8 Implementation

All recommendations for additional controls that are identified during the assessment need to be implemented, monitored and reviewed for their effectiveness.
8.9 Monitoring and Review
All CCDHB risks are to be visible on the central risk register and are to be discussed and reviewed at the relevant Directorate monthly governance meetings and a monthly update provided by the risk owner. The risk owner is responsible for ensuring that all risk assessments are reviewed in line with the timescales identified on the individual assessment.

New and closed risks will be evaluated at the Directorate governance meetings and validated by the Executive Directors. They will then be tabled at the HHS for review and authorisation.

The electronic database Stash (SharePoint) is where the electronic risk register is currently used to collate and report monthly risk movement. A hazard and risk module will be developed within the adverse events and feedback system (SQUARE) and once complete the electronic database in stash will be disestablished.

The Directorate Quality Managers support their Executive Directors with risk education and administration oversight of the Combined Risk Register and ensure the risk owners update their risks monthly. The Executive Director (Operations), Quality Improvement & Patient Safety Directorate completes the combined risk register monthly risk report for HHS and FRAC.

9. Compliance Effectiveness of this Policy
This is completed via external audits completed by the MOH Certification Audit Process. ANZ Financial Management Audit, and ACC Accreditation Programme Audit, and DHB requested external audit agencies i.e. Price Waterhouse Cooper.

10. Related Documents:
- New Zealand Health & Disability Standards NZS 8134:2008
- New Zealand Health and Disability Sector, National Policy for the Management of Healthcare Incidents (2008), Version 1.0
- Health and Safety at Work Act 2015
- Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
- Health and Safety at Work (Asbestos) Regulations 2016
## Appendix 1: Roles and Responsibilities for Managing and Reporting Risk

### Capital Coast District Health Board (CCDHB) Board Members

The CCDHB Board members are defined as Officers under the Health and Safety at Work Act 2015. They therefore have a governance role over the work undertaken by the CCDHB. Officers must exercise due diligence to ensure the DHB meets its obligation to keep everyone safe.

They have the overall responsibility for risk management and authorising the CCDHB Risk Management Policy, including setting the level of tolerance for risk.

With the introduction of the Health and Safety at Work Act 2015 the Board must ensure that the risk process identifies critical health and safety risks, and ensures appropriate controls are applied and monitored to reduce the risk of serious injury or illness. While the Board delegates to the Finance, Risk and Audit Committee (FRAC) the oversight of the CCDHB Risk Management framework and processes, this does not change their due diligence obligations. The Board will review the organisation’s health and safety hazards and risks at least annually to satisfy that the risks are appropriately assessed and prioritised and the controls are appropriate and adequately resourced. The Board will require reports on the effectiveness of existing controls to inform the review.

The Board through the CEO will provide biannual risk management compliance statements to the Ministry of Health.

The Board through the CEO will inform the Ministry as soon as possible of any risk that the Minister should be made aware of, together with the DHB’s mitigation strategy for managing the risk.

### Chief Executive Officer (CEO)

The CEO is an OFFICER under the Health and Safety at Work Act 2015. An officer is defined as a person in a health governance role or anyone else who has significant influence over the work undertaken by the CCDHB. Officers must exercise due diligence to ensure the DHB meets obligation to keep everyone safe. They do this by:

- Ensuring they understand the DHB’s business, its hazards and risks
- Making available resources and processes, and ensure they are being used to eliminate or minimise the risks
- Ensuring there are processes and a culture in place to support reporting of hazards, incidents and accidents
- Ensuring the CCDHB is compliant with its obligations to protect its workers and others affected by the activities of the DHB.
## Risk Management Policy

The CEO does this through ensuring:
- The provision of a monthly report to the Board through FRAC on key strategic and emerging risks that have been identified through the risk management reporting processes, and their impact on the DHB’s strategic objectives as identified in the DHB Annual Plan and the Regional Services Plan. This must identify the critical health and safety risks, and apply and monitor appropriate controls to reduce the risk of serious injury or illness.
- Risk ownership and responsibility for the oversight of mitigation strategies for those risks identified as extreme and very high or that have been accepted as having strategic impact.
- Assurance is provided to the Board through FRAC, on the effectiveness of the risk management process, and the overall system of internal control. In particular, appropriate controls to reduce the risk of serious injury or illness.

### Chief Financial Officer

The Chief Financial Officer is responsible for ensuring:
- The provision of a monthly financial commentary to the FRAC Committee.
- The CEO is informed of any severe or major financial risk that they should be made aware of and mitigation activities undertaken.
- Reporting on the monitoring and investigation into potential fraud.

### General Manager Hospital & Healthcare Services

The General Manager Hospital & Healthcare Services is responsible for ensuring:
- The provision of a monthly risk report to the CEO of the top risks from across the DHB, identifying key risks against delivery planned in the DHB Annual Plan and the Regional Services Plan, and ensuring the CCDHB is compliant with its obligations to protect its workers and others affected by the activities of the DHB.
- Those risks identified at DHB level that cannot be effectively mitigated, are appropriately escalated to the CEO and Board via ELT and FRAC.

### Executive Leadership Team (ELT)

ELT as a group is responsible for ensuring:
- The development of the risk management policy which establishes risk tolerance levels and reporting parameters, for recommendation to the Board through FRAC.
- Agreement on those risks that should be appropriately addressed at an organisation-wide level.
- Effective monitoring, management and reporting of all identified and emerging risks within the DHB.
**Risk Management Policy**

<table>
<thead>
<tr>
<th><strong>CCDHB HHS / MHAID Management Team</strong></th>
<th>Will provide oversight of CCDHB HHS risk by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Reviewing the monthly risk report that contains the significant current (RAC 1 &amp; 2) risks, emerging risks, new risks, closed risks and all health and safety risks regardless of RAC rating.</td>
</tr>
<tr>
<td></td>
<td>• The risk report is amended as agreed, and then presented to ELT and FRAC.</td>
</tr>
</tbody>
</table>

| **Individual ELT members & Professional Heads** | Individual members of ELT and Professional Heads of departments have authority to identify risks from their professional perspective to be added to the DHB risk register and if required, be a risk owner. They also need to ensure that they comply with CCDHB obligations to protect its workers and others affected by the activities of the DHB. |

<table>
<thead>
<tr>
<th><strong>Executive Directors Operations</strong></th>
<th>Are individually responsible for ensuring:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Appropriate, timely communication to the General Manager Hospital Healthcare Services and CEO of serious emerging risk, and to the Executive Director Quality, Improvement &amp; Patent Safety for monthly reporting purposes</td>
</tr>
<tr>
<td></td>
<td>• A process for identifying, validating and authorising new risks in their area, together with an appropriate risk owner</td>
</tr>
<tr>
<td></td>
<td>• Effective monitoring and management of risks within the Departments under their responsibility and ensuring monthly written updates completed within set timeframes.</td>
</tr>
<tr>
<td></td>
<td>• Notification of any emerging risks that may not have been through the risk assessment process.</td>
</tr>
<tr>
<td></td>
<td>• Where risks eventuate, these have been managed to minimise adverse impact on the patient and the DHB, and ensuring that risk management processes continue to reduce the chances of a recurrence.</td>
</tr>
<tr>
<td></td>
<td>• Ensuring that employees within their span of control are appropriately trained in the policy and processes of risk identification, management, reporting and monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Executive</strong></th>
<th>Responsible for ensuring:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Document author:** Executive Director Operations Quality Improvement & Patient Safety Directorate

**Authorised by [Designation/Committee]:** Finance Audit & Risk Committee (FRAC)/CCDHB Board

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### Risk Management Policy

| Director (Operations) Quality, Improvement and Patient Safety | • Communicating directly to the General Manager Hospital Healthcare Services or ELT member of serious emerging risk as elevated by the Executive Directors of the Directorate’s via the combined risk register.  
| | • The collation of a monthly risk report to the General Manager Hospital Healthcare Services, for review at ELT and validation, prior to presentation to FRAC on significant current, emerging risks, new risks, closed risks and all health and safety risks regardless of RAC rating.  
| | • Assist with the identification and documenting of emerging organisational risk from all available sources both internal and external on the DHB Risk Register and to the organisation incorporated into the CCDHB monthly Risk Report.  
| | • Assist with the development and implementation of the CCDHB Risk Management Framework, including methodology and tools required for ensuring the effective implementation of the risk management policy.  
| | • The development, provision, implementation and evaluation of a Risk Management eLearning package for workers to ensure the continuing embedding of the risk management process within the organisation.  
| | • That information and support is provided to all senior management with regard to the management of risk through the Directorate Quality Managers. |

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**Document author:** Executive Director Operations Quality Improvement & Patient Safety Directorate  
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## Risk Management Policy

<table>
<thead>
<tr>
<th>Line Managers</th>
<th>Line Managers are responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>∑ Reviewing all hazards reported to them and taking all reasonably practicable steps to ensure that all risks within their areas of control are identified, validated, assessed, reported and monitored (including ensuring that each risk has an owner) in accordance with this policy for both business and clinical risks.</td>
</tr>
<tr>
<td></td>
<td>∑ Ensuring that where risks are identified, they are managed to minimise adverse impact (as defined by this policy) on the DHB, and that risk management processes are activated to ensure that the chances of a recurrence of the event are reduced.</td>
</tr>
<tr>
<td></td>
<td>∑ Ensuring that employees within their span of control are appropriately trained in the policy and processes of risk identification, management, reporting and monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Managers</th>
<th>Are responsible for ensuring:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>∑ The facilitation of the risk management framework within their directorate through manager support, education and their respective governance structures.</td>
</tr>
<tr>
<td></td>
<td>∑ Assisting managers with the development/assessment of new risk</td>
</tr>
<tr>
<td></td>
<td>∑ Liaison and feedback with their Directorate Quality Facilitators on risk mitigation</td>
</tr>
<tr>
<td></td>
<td>∑ Administration oversight of their Directorate’s risks on the combined DHB risk register ensuring the risk owners have updated their risks monthly.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health and Safety Service</th>
<th>The Health and Safety Service will be responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>∑ The facilitation of the risk management framework through manager support, education and governance structures as it relates to health and safety risks</td>
</tr>
<tr>
<td></td>
<td>∑ Assisting managers with the development/assessment of new health and safety risks</td>
</tr>
<tr>
<td></td>
<td>Providing advice and guidance in relation to:</td>
</tr>
<tr>
<td></td>
<td>∑ Occupational Health - where there may be an impact on the health and well-being of workers.</td>
</tr>
<tr>
<td></td>
<td>∑ Health and Safety - where a risk is related to health and safety.</td>
</tr>
</tbody>
</table>

| Workers | All workers will have the ability to identify hazards and are responsible for actively reporting them to their managers for risk assessment. |
# Risk Management Policy

## Appendix 2: Sources for Identifying Risk

<table>
<thead>
<tr>
<th>Sources for Identifying Risks</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance meetings&lt;br&gt;Workers meetings&lt;br&gt;Unions</td>
<td></td>
</tr>
<tr>
<td>Complaints, Consumer focus groups, Reports from Health and Disability Commissioner, ministerial or OIA request data.</td>
<td></td>
</tr>
<tr>
<td>Medico-legal data</td>
<td></td>
</tr>
<tr>
<td>Reviewing the strength of controls, policies, guidelines and statutory requirements</td>
<td></td>
</tr>
<tr>
<td>Media interest, Fraud Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction surveys, workers’ questionnaires</td>
<td></td>
</tr>
<tr>
<td>Audits &amp; reviews (internal)</td>
<td></td>
</tr>
<tr>
<td>Audits &amp; reviews (external)</td>
<td></td>
</tr>
<tr>
<td>Examination of local, national or international experience from media</td>
<td></td>
</tr>
<tr>
<td>Risk management reviews/training</td>
<td></td>
</tr>
<tr>
<td>Anticipated projects</td>
<td></td>
</tr>
<tr>
<td>Clinical and non-clinical performance indicators</td>
<td></td>
</tr>
<tr>
<td>Annual strategic &amp; business planning process (AP/Service/Regional plans)</td>
<td></td>
</tr>
<tr>
<td>Occupational Health reports</td>
<td></td>
</tr>
<tr>
<td>Financial reports</td>
<td></td>
</tr>
<tr>
<td>Health &amp; Safety reports</td>
<td></td>
</tr>
<tr>
<td>Inspecting the working area with colleagues, Health and Safety Representatives (HSR’s), managers etc.</td>
<td></td>
</tr>
<tr>
<td>Discussions with workers and users</td>
<td></td>
</tr>
<tr>
<td>Checking that policies, procedures and guidelines are in use.</td>
<td></td>
</tr>
<tr>
<td>Comparing previous incidents and ill health statistics that have occurred within the area, CCDHB or other District Health Boards.</td>
<td></td>
</tr>
<tr>
<td>Health &amp; Safety reports</td>
<td></td>
</tr>
<tr>
<td>Interview/focus group discussion, Mortality &amp; Morbidity Operational Review findings</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3: Risk Matrix

Document author: Executive Director Operations Quality Improvement & Patient Safety Directorate
Authorised by [Designation/Committee]: Finance Audit & Risk Committee (FRAC)/CCDHB Board
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Risk Management Policy

Table 1: Consequence Score (Severity Levels) and Examples of Consequence

<table>
<thead>
<tr>
<th>Risk Domain</th>
<th>Consequence Score</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proprietary</td>
<td>Mild</td>
<td>Use that publicity as a result of poor performance (e.g. targets or release of National 135 report)</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>Use of public confidence at service level to influence service delivery.</td>
</tr>
<tr>
<td></td>
<td>Major</td>
<td>Use of public confidence at national level to influence service delivery.</td>
</tr>
<tr>
<td></td>
<td>Catastrophic</td>
<td>Use of public confidence at international level to influence service delivery.</td>
</tr>
</tbody>
</table>

Table 2: Likelihood Score (Probability Levels) and Examples of Likelihood

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Probability Level</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Almost Certain</td>
<td>Weekly</td>
<td>75%</td>
</tr>
<tr>
<td>2 - Likely</td>
<td>Monthly</td>
<td>50%</td>
</tr>
<tr>
<td>3 - Possible</td>
<td>Bi-monthly</td>
<td>25%</td>
</tr>
<tr>
<td>4 - Rare</td>
<td>Yearly</td>
<td>5%</td>
</tr>
</tbody>
</table>

Table 3: Likelihood and Likelihood Score (Consequence Score) and Examples of Likelihood Score

<table>
<thead>
<tr>
<th>Likelihood Score</th>
<th>Consequence Score</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Almost Certain</td>
<td>5</td>
<td>Risk management action inadequate.</td>
</tr>
<tr>
<td>2 - Likely</td>
<td>3</td>
<td>Risk management action ineffective.</td>
</tr>
<tr>
<td>3 - Possible</td>
<td>2</td>
<td>Risk management action limited.</td>
</tr>
<tr>
<td>4 - Rare</td>
<td>1</td>
<td>Risk management action ineffective.</td>
</tr>
</tbody>
</table>

Table 4: Risk Rating Summary

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Grade</th>
<th>Timescales for Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Low Risk</td>
<td>Quick, easy and effective</td>
<td>Immediate action.</td>
</tr>
<tr>
<td>2 - Medium Risk</td>
<td>Quick, easy and effective</td>
<td>Immediate action.</td>
</tr>
<tr>
<td>3 - High Risk</td>
<td>Quick, easy and effective</td>
<td>Immediate action.</td>
</tr>
<tr>
<td>4 - Extreme Risk</td>
<td>Quick, easy and effective</td>
<td>Immediate action.</td>
</tr>
</tbody>
</table>

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RECOMMENDATIONS
It is recommended that the Board:

a) **Notes** that the draft revised Protected Disclosures Policy will be circulated for consultation with employees and unions before it is approved by ELT in its final form

b) **Agrees** to the Protected disclosures Policy being amended to specifically refer to Board members possibly making protected disclosures

c) **Agrees** to the revised Protected Disclosures Policy being finalised by management following consultation with employees and unions.

APPENDIX

1. **Draft Protected disclosure policy.**

1. **PURPOSE**

1.1 The CCDHB Protected Disclosures Policy is overdue for review. A draft revised Policy has been prepared, and it is subject to consultation with employees and unions and final approval by ELT.

1.2 The revised Policy is relevant to Board members making or receiving protected disclosures, so we are putting the draft Policy to the Board before carrying out wider consultation.

2. **BACKGROUND**

2.1 The Protected Disclosures Act 2000 (the Act) protects employees who disclose serious wrongdoing in or by their public sector organisation (including DHBs). Provided the employee follows the process set out in the Act (and the Policy), they are protected from legal retaliation, discrimination or liability resulting from the disclosure.

2.2 The Protected Disclosures Policy is relevant to the Board because the “employees” protected by the Act include members of boards or governing bodies. Board members may therefore make protected disclosures. They may also receive protected disclosures.

2.3 CCDHB is required to have a Protected Disclosures Policy under the Act, and the Ombudsman monitors compliance.
3. DETAILS IN THE REVISED POLICY

3.1 The revised Policy has been amended to specify that “employees” who may make protected disclosures include Board members. This is provided for in the Act, but this detail was not included in the existing Policy.¹

3.2 The existing Policy is a “3D” document, and the references to Hutt Valley and Wairarapa DHBs have been removed from the revised draft.

3.3 The descriptions of how the protected disclosures system works have been improved, including the processes for employees making protected disclosures. The process involves escalation through the CCDHB management hierarchy. Some of the titles of CCDHB managers have changed following the restructuring last year.

3.4 Board members are expected to make any protected disclosures to the Chair, or to an external authority (defined as an “Appropriate Authority” in the Act). The Act lists the Appropriate Authorities relevant to the whole public sector, and they include (among others) the Commissioner of Police, Auditor-General, Ombudsman, Health and Disability Commissioner and Director-General of Health. The complete list of Appropriate Authorities from the Act is included in the revised Policy.

3.5 Board members may make a protected disclosure to the Minister, but only if they are dissatisfied with the outcome of an earlier disclosure to an Appropriate Authority.

3.6 Disclosures to a Board member or the Chair must either be referred to the Chief Executive for investigation, or to an Appropriate Authority if the Chief Executive may be involved in the matter, or if an initial disclosure has not been acted on quickly enough.

3.7 If employees (including Board members) make disclosures that do not comply with the processes in the Act (and as articulated in the Policy) they will potentially be breaching their confidentiality obligations, and they will not have the protection against legal retaliation, discrimination or liability provided by the Act.

¹ The Board Governance Manual refers to the Protected Disclosures Act and says Board members may make protected disclosures.
Type: Policy

Name: Protected Disclosure

Purpose
This policy provides a Capital & Coast DHB (CCDHB) internal procedure for receiving and dealing with information about serious wrongdoing. It also outlines other steps made available to employees by the Protected Disclosures Act 2000 (the Act).

The objectives of the Act and this policy are to promote the public interest by:
- facilitating the disclosure and investigation of matters of serious wrongdoing in or by CCDHB; and
- by protecting CCDHB employees who make disclosures on information about serious wrongdoing in or by CCDHB in accordance with the Act.

Scope
This policy applies to:
- all employees of the CCDHB
- those volunteers, contractors, individuals covered by special staff status, and others where a DHB has advised them this policy will apply.

For ease of reference, this policy refers only to employees but applies equally to the other people referred to.

Definitions

Employees:
The term employee, for the purposes of this policy, includes:
- a staff member or present employee
- a former employee
- a person seconded to CCDHB
- a person under a contract for services to CCDHB
- a person concerned in the management of CCDHB (including a person who is a member of the board or governing body of the organisation)
- an employee or former employee of an organisation providing services to CCDHB and who is or was based on CCDHB premises.
Disclosures which are protected under the Act:

A disclosure of information will be a protected disclosure if:

- the information is about serious wrongdoing in or by CCDHB; and
- the employee believes on reasonable grounds that the information is true or likely to be true; and
- the employee wishes to disclose the information so the serious wrongdoing can be investigated; and
- the employee wishes the disclosure to be protected.

A disclosure of information is not protected if it is known to the employee to be false or is made in bad faith (e.g. malicious).

If an employee believes on reasonable grounds that the information he or she discloses is about serious wrongdoing, in or by CCDHB, but the belief is mistaken, the disclosure is still a protected disclosure.

The disclosure of information protected by legal professional privilege is not protected by the Act.

Serious wrongdoing:

Serious wrongdoing includes:

- unlawful, corrupt or irregular use of public funds or public resources;
- an act, omission or conduct that poses a serious risk to public health, public safety or the environment;
- conduct that poses a serious risk to the maintenance of the law, including the prevention, investigation, and detection of offences, and the right to a fair trial;
- an offence;
- conduct by a public official that is oppressive, improperly discriminatory or grossly negligent, or that constitutes gross mismanagement.

Policy content and guidelines

Protection

The protections for employees making protected disclosures are:

- Employers are not allowed to take retaliatory action against employees who make protected disclosures; an employee has a personal grievance under employment law if an employer does take retaliatory action;
- No person who makes a protected disclosure is liable to any civil, criminal or disciplinary proceedings; and
- Protected disclosures are confidential (with the limited exceptions referred to below).
Confidentiality

Every person who receives a protected disclosure must use his or her best endeavours not to disclose any information that might identify the person who made the disclosure, unless:

- the employee consents in writing to disclosure of his/her identity; or
- the person who has acquired knowledge of the protected disclosure reasonably believes that disclosure of identifying information is essential:
  - to the effective investigation of the allegations in the protected disclosure; or
  - to prevent serious risk to public safety or public health or the environment; or
  - to comply with the principles of natural justice.

Note:

This means that every endeavour will be made to keep the identity of the employee confidential, but it might be necessary to disclose it for the reasons stated in the Act. In that case the other protections in the Act still apply.

The Act also provides that a request for information under the Official Information Act 1982 (other than one made by the Police for the purpose of investigating an offence) may be refused if it might identify a person who has made a protected disclosure.

Principles of Natural Justice

Any investigation or inquiry will be conducted in accordance with the principles of natural justice including:

- advising all parties who may be affected by the outcome of the inquiry, of the process; and
- providing sufficient particulars of all information and evidence; and
- allowing all parties who may be interested in the outcome of the inquiry to have an opportunity to forward submissions to the inquiry team.

Process

Disclosure process

If you have an instance of serious wrongdoing that you wish to disclose in accordance with this policy, follow the following steps:

Step one

Consider whether the matter that you are concerned about fits the definition of serious wrongdoing (set out above). If it does, then disclosing the serious wrongdoing will be a protected disclosure, as long as the disclosure process set out in this policy is followed.

Step two

Consider whether the serious wrongdoing you are concerned about would be better dealt with in some other way. For example:

- if it is a systems or process issue, it may be appropriate to complete a Reportable Events form via SQUARE; or
by discussion with your professional peers or workmates.

**Step three**
Raise the matter with your service leader, business manager, executive director operations, manager or clinical leader.

This disclosure **must** be made or confirmed in writing and **must** make it clear that you are making a protected disclosure in terms of this policy. This removes misunderstandings as to what was disclosed and when the disclosure was made and so that that person receiving the disclosure knows to follow the procedures laid down.

**Step four**
If you are not satisfied with the response of the person with whom you raised the matter in step three, or not satisfied with the results of any investigation, raise the matter again with your executive level manager or executive clinical leader (e.g. Executive Director of Nursing and Midwifery, CMO, General Manager Corporate, General Manager Hospital and Healthcare Services, General Manager People & Capability etc.)

Again, it is essential to make or confirm the disclosure in writing and make it clear that you are making a protected disclosure in terms of this policy.

**Step five**
If you are not satisfied with the response of the person with whom you raised the matter in step four, or not satisfied with the results of any investigation, raise the matter directly in writing with the Chief Executive.

If the Chief Executive is not available, direct your disclosure to the person acting in the Chief Executive’s place (usually the General Manager Hospital and Healthcare Services).

**Step six**
If you are not satisfied with the response of the Chief Executive, or not satisfied with the results of any investigation, raise the matter in writing with the Chair of the Board.

**Note:**
Attention is drawn to the sections on pages 5 and 6 (**Disclosure to the Chief Executive, Disclosure to an Appropriate Authority, Disclosure to the Ombudsman or Minister**) which detail further procedures made available by the Act in certain circumstances.

A former employee should apply the above steps, or the alternative procedures that follow, as appropriate to their circumstances.

Board members should make any protected disclosures to the Chair of the Board or a relevant Appropriate Authority.
Investigation process

Any employee to whom a protected disclosure is made must arrange to carry out the following steps:

- record the nature of the disclosure and pertinent details about the disclosure (e.g. how this was made, and by whom) in writing;
- form a preliminary assessment of the merits of the claim;
- advise the Chief Executive and the Chief Legal Counsel as soon as practicable, together with any intervening level of management, and recommend an appropriate investigation process;
- arrange for whatever investigation is supported by the Chief Executive, to be carried out with the results to be communicated to the Chief Executive.
- Note: any investigation must be conducted in accordance with the principles of natural justice – refer above.
- advise the person making the protected disclosure of the outcome of the investigation and any action to be taken as a result.

Responsibility for carrying out any of the above steps may be transferred by the Chief Executive to another person.

Where the disclosure is made to the Chair of the Board, the matter must be referred to the Chief Executive for investigation except where the Chair of the Board decides to conduct an alternative form of investigation.

Advice to the Board

The Chief Executive must advise the Board of:

- the results of every preliminary investigation; and
- the final outcome of every protected disclosure investigation

Alternative procedures made available by the Act

Disclosure directly to the Chief Executive (or deputy)

Section 8 of the Act allows an employee to make a disclosure directly to the Chief Executive or a deputy where the employee believes on reasonable grounds that:

- the organisation does not have any internal procedures for receiving and dealing with information about serious wrongdoing; or
- the person they are required to report the serious wrongdoing to, in accordance with internal procedures, is or may be, involved in the serious wrongdoing; or
- it is not appropriate to report the serious wrongdoing to that person because of their relationship or association with the alleged wrongdoer.

The Chief Executive or deputy shall then arrange for the investigation procedures described above to be carried out. The Chief Executive’s deputy is the person acting in the Chief Executive’s place from time to time (usually the General Manager Hospital and Healthcare Services).
Disclosure to an Appropriate Authority

Section 9 of the Act allows an employee to make a disclosure to an Appropriate Authority where:

- the Chief Executive is or may be involved in the serious wrongdoing; or
- the matter requires urgent action; or
- there has been no action or recommended action in regards to a protected disclosure within 20 working days of the disclosure having been made, in accordance with the procedure set out above.

An Appropriate Authority includes:

- the Commissioner of Police
- the Controller and Auditor-General
- the Director of the Serious Fraud Office
- the Inspector-General of Intelligence and Security
- the Ombudsman
- the Parliamentary Commissioner for the Environment
- the Independent Police Conduct Authority
- the Solicitor-General
- the State Services Commissioner
- the Health and Disability Commissioner
- the head of every public sector organisation
- the heads of some private sector professional organisations who have disciplinary powers over members.

The Ministry of Health (MOH) has also set up a 0800 number which is known as the ‘health integrity line’, to provide an independent reporting mechanism if required. The phone number is 0800 424 888.

Disclosure to the Ombudsman or Minister

Section 10 of the Act allows an employee to make disclosure directly to the Ombudsman or a Minister of the Crown where the employee has followed the above procedure and believes, on reasonable grounds, that the person/appropriate authority to which the disclosure was made:

- has not investigated the matter; or
- has decided to investigate the matter but has not made progress with the investigation within a reasonable time; or
- has investigated the matter but not taken or recommended any action.

References

Protected Disclosures Act 2000
Protected Disclosures Amendment Act 2009
State Sector Act 1988
Official Information Act 1982
Privacy Act 1993
Health Information Privacy Code 1994
Related Documents

Making Protected Disclosures Guide
CCDHB Fraud Policy
2DHB Confidentiality Policy

Disclaimer: This document has been developed by Capital & Coast District Health Board (CCDHB) specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at their own risk and CCDHB assumes no responsibility whatsoever.
RECOMMENDATION

It is recommended that the Board:

a) Approve the appointment of two additional CCDHB Board members to the Community and Public Health Advisory Committee (CPHAC) and Disability Services Advisory Committee (DSAC).

1. PURPOSE

The purpose of this paper is to obtain approval for the appointment of two additional CCDHB Board members to the Community and Public Health Advisory and Disability Services Advisory Committees.

2. BACKGROUND

In January 2017 the CCDHB Board approved the memberships of the Board Committees. The appointment of members to the 3D CPHAC/DSAC was discussed with the new Wairarapa DHB Board Chair, including our proposed members for such a Committee. These were:

Eileen Brown
‘Ana Coffey
Sue Driver
Sue Kedgley
Kim Ngarimu
Fran Wilde
Andrew Blair (Board Chair).

The final number of members from the three DHBs, ratification of the Committee Chair, and the frequency of meetings, was to be agreed in consultation with the Chair of the Wairarapa DHB for endorsement at the CCDHB January 2017 meeting.

However, when the Board minutes were confirmed for the January Board meeting not all those board members listed in the original paper for the CPHAC/DSAC committees were confirmed. This was an oversight. Interest in CPHAC/DSDAC membership has been registered from Ms Driver and Ms Coffey.

3. NEXT STEPS

It is recommended that the appointment of Ms Sue Driver and Ms ‘Ana Coffey as CCDHB Board representatives to the Community and Public Health Advisory and Disability Services Advisory Committees be approved by the Board.
BOARD DECISION
Date: 9 May 2017

Author: Donna Hickey, General Manager People and Capability
Endorsed by: Debbie Chin, Chief Executive

Subject: COGNITIVE INSTITUTE PARTNERSHIP

RECOMMENDATIONS

It is recommended that the Board:

a) **Agree** that CCDHB needs to achieve transformational change to improve its performance and achieve financial sustainability.

b) **Note** the work of the Cognitive Institute, which includes:
   i. Creating solutions that respond to critical challenges faced by organisations and health care professionals

c) **Note** recent discussions with the Ministry, Council of Trade Unions (CTU) and other unions including New Zealand Nurses Organisation (NZNO), Resident Doctors Association (RDA), Public Service Association (PSA), Association of Professional and Executive Employees (APEX) and the Association of Salaried Medical Specialists (ASMS) align with us working with the Cognitive Institute now and overlaying that work with the High Performance High Engagement framework and model for the Health sector, once it has been developed.

d) **Endorse** subscribing to, and partnering with, the Cognitive Institute to support us in bring about sustainable transformational change together with our staff and unions.

APPENDIX


1. EXECUTIVE SUMMARY

1.1 Background

The DHB is facing significant financial pressures and has been challenged over a long period of time to achieve better financial outcomes. We need to work to transform the system in the DHB and our community.

There is a considerable body of research that shows that even if organisations do find savings through cost-cutting or technology, there are other, more effective ways to realize savings over time.

The Board has previously discussed the pressures in the system at a Board workshop. As part of that the World Economic Forum Case for Change regarding the Financial Sustainability of Health Systems was discussed.

This paper identified the top seven most promising areas for potential productivity improvement as:
   i. Measure value and invest for the greatest returns
   ii. Foster skill and will to create value-conscious consumers
iii. Pay for value, not volume
iv. Proactively reach out to predict and prevent ill health and manage disease
v. Reinvent the delivery system with new models of care
vi. Promote technology innovations that lower cost and leverage talent to raise quality
vii. Implement modern management practices and focus on performance.

These require transformational change.

Transformational change, strategic HR and cultural change support organisations to select and retain the right employees and help them be productive and find solutions. They involve high employee engagement and participation to find solutions and savings and to work more effectively and productively. These are the areas where the real gains to the bottom line are likely to be found.

Successful transformational change focuses on changing how people think and behave. Transforming how work gets done in the flow of daily activities requires a real knowledge of the system and work undertaken.

Organisations that successfully implement and sustain transformational change need to understand how work gets done in the flow of daily activities and design change to create an environment that encourages adoption of new ways of doing things.

1.2 Proposed Approach

If we are to make changes we need external support for a sustained programme and we need to do it with urgency. We need it to involve partners who know our business and who are able to work with credibility in it. Not to do this, increases the risk of failure and also increases the length of time it takes for external providers to get up to speed.

The Cognitive Institute has a faculty of clinicians with extensive clinical and leadership experience. It is interested in working with us to undertake transformational change and it is able to begin to do that as soon as we agree. It works with the whole organisation but having such credibility with the clinicians, means that it is more likely to be successful in a health environment than other organisations.

The Cognitive Institute is a credible organisation internally and externally. It also has demonstrable achievements in different health care settings in different countries and cultures.

The Cognitive Institute would provide research, training and partner with us to address the influence and impact of organisational climate, leadership commitment, reliability science and high-performance work practices on quality and safety outcomes.

Their work recognises existing effective systems and programmes, builds an improvement culture and the capability to understand value and deliver safe and reliable care.

They will develop a bespoke programme, focussed on the areas of most need for us in terms of improvement and savings to achieve measurable results that will also drive safer and more reliable patient care.

To have an organisation that can drive these areas will not support us in finding savings and managing risk including management of the not insignificant financial and other costs associated with the consequences of waste and duplication of effort.

The DHB also supports the concept and approach around High Performance High Engagement that the Ministry and CTU are actively considering for the Health Sector.
Recent discussions with the Ministry and CTU have emphasised that if we were to partner with the Cognitive Institute now, we can overlay any work with the High Performance High Engagement approach that has yet to be determined for the Health sector. The two programmes are not mutually exclusive and could work well in tandem. Both have been supported by the unions at various times.

2. COSTS

Phases 1-4: Needs analysis, education, training and support:
- Dependent on organisation size and complexity and is premised on single site organisations, as well as organisation’s safety culture and readiness
- It is anticipated the needs analysis phase could take up to six months and this phase will design a plan around training delivery requirements for individual partners
- Education training and support depends on organisation size and complexity and is premised on single site organisations, as well as organisation’s safety culture and readiness
- Some activities require an additional fee for licensed content depending on organisation size e.g. Speaking Up for Safety Train the Trainer Programme. Approximately AUD $150,000 per annum, includes partnership.
<table>
<thead>
<tr>
<th>Subject</th>
<th>3DHB MENTAL HEALTH ELECTRONIC CLIENT MANAGEMENT SYSTEM</th>
</tr>
</thead>
</table>

**RECOMMENDATIONS**

It is **recommended** that the Board:

a) **Note** that this paper is part of the response to the reviews initiated by the Mental Health, Addictions and Intellectual Disability Service 3DHB (MHAIDS 3DHB) as a result of suicides and homicides relating to mental health clients in the care of, or who had contact with, the service between February 2015 and April 2016.

b) **Note** that 3DHB ICT was identified in the reports as a critical enabler of service improvement with recommendations addressing technical issues with the current electronic systems and establishing one standardised, integrated, accessible mental health record for mental health clients.

c) **Note** that a two phased approach to improved electronic systems is proposed:

   i. Phase one – an interim package of high priority improvements to core DHB systems (Concerto and WebPAS) and the implementation of a single ‘Care/Partnership/Treatment’ Plan system, to be integrated with the current DHB systems.

   ii. Phase two – a fully integrated electronic client management system across MHAIDS 3DHB, to be accessible by Secondary Care, Primary Care and NGOs as well as clients and their support people, family and whānau; this would be integrated into the wider health information ‘ecosystem’, with appropriate security and privacy controls.

d) **Note** that Phase one will be delivered over the next six months, while phase two will take at least 18 months and most likely between three and five years to complete.

e) **Note** that the phased approach enables a number of the review recommendations to be addressed quickly and reduces current risks, and supports further enhancements that may be needed until the completion of Phase two (should it extend to between three and five years).

f) **Note** that Phase one options considered for the single “Care/Partnership/Treatment” Plan included:

   i. building a solution (rejected on the basis of cost, timeframe and risk).

   ii. buying an existing solution.

g) **Note** that the Connected Care system from Whānau Tahi is recommended as the interim solution as it is proven and already used by a number of DHBs and other organisations in New Zealand and overseas, including for the care planning of patients with long term conditions and by the Mental Health Services at Hawke’s Bay and Northland DHBs.

h) **Note** that phase two will determine the future requirements and identify the most appropriate fully integrated electronic client management solution.

i) **Note** that the number of devices available to 3DHB MHAIDS staff (desktop and laptop PCs, terminals,
tablets) will need to increase to support the effective use of the new system, as well as upgrading the data communications network infrastructure for accessing the systems.

j) **Note** that the estimated one-off cost for Phase one is $589,300 with annual operating costs of $205,500; costs for each DHB are estimated at:

<table>
<thead>
<tr>
<th></th>
<th>Capital &amp; Coast DHB</th>
<th>Hutt Valley DHB</th>
<th>Wairarapa DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>One off</td>
<td>343,933</td>
<td>139,073</td>
<td>106,294</td>
</tr>
<tr>
<td>Annual Charge</td>
<td>146,250</td>
<td>24,375</td>
<td>4,875</td>
</tr>
</tbody>
</table>

k) **Note** that costs have been included in the 2017/18 budgets for each DHB.

l) **Note** that the ICT and business workstreams in Phase one will be overseen by a Steering Group.

m) **Approve** the phased approach and implementing the Whānau Tahi’s Connected Care system in Phase one.

n) **Approve** the funding being allocated from the DHB’s capital and operational budgets to support Phase one.

### APPENDICES

1. **Detail for Phase one of the ICT changes**
2. **High level MHAIDS 3DHB work plan.**

### 1. PURPOSE

The purpose of this paper is to provide an update and make recommendations on ICT improvements for the Mental Health, Addictions and Intellectual Disability Service 3DHB (MHAIDS 3DHB) to support Client Pathway Improvements. The recommendations in this paper align to those of the MHAIDS 3DHB Boards’ Working Group that was established to consider the findings of the MHAIDS 3DHB reviews.

### 2. BACKGROUND

#### 2.1 Reviews and Recommendations

A number of reviews were initiated by MHAIDS 3DHB as a result of ten suicides and five homicides in relation to mental health clients in the care of, or who had contact with, the MHAID 3DHB service between February 2015 and April 2016. The reviews were commissioned to determine if or where any service improvements could be made.

Suicides reviewed were those where there had been a ‘one off’ contact with either the Capital & Coast DHB Mental Health Crisis Team (six) or the Hutt Valley DHB Mental Health Crisis Team (four) between September 2015 and April 2016. The homicides reviewed (five) involved five community mental health clients between February 2015 and March 2016 and the findings were released publicly on 26 January 2017.

The review process included case file reviews carried out by external mental health professionals and an Expert Panel that considered the case file reviews as a whole to identify any systemic matters. The reviews identified both the existing electronic health record used by MHAIDS 3DHB and the use of a combined electronic-paper record as significant risks to good client care.

The review team made a number of recommendations related to electronic systems including:

a. Establish one standardised, integrated, accessible mental health record for mental health clients

b. Every assessment or other intervention by a medical person should be in the electronic record and signed off by them
c. Address the technical issues with ‘dating’ of versions of the electronic record entries and to address the capacity to provide progress notes within the electronic record (additional to the electronic record documents)
d. Review the use of data to inform and support systems of reporting to improve clinical review and practice improvement
e. Have greater clarity around the purpose and use of client recovery plans.

2.2 The current MHAIDS 3DHB ICT environment

The current MHAIDS 3DHB ICT environment is as follows:
- Hutt Valley DHB MHAIDS staff use Concerto for clinical activity and through this access the DHBs webPAS (Patient Administration System) for demographic information
- Capital & Coast DHB MHAIDS staff mainly use MAP (Concerto) for clinical work, with a mix of clinical and administration staff accessing the DHBs webPAS for demographics and diagnosis collection
- Wairarapa DHB MHAIDS staff use primarily a paper-based system.

Although both Hutt Valley and Capital & Coast DHBs use Orion’s Concerto solution, they use two different versions of it. Terminology confusion also arises, with Capital & Coast DHB staff referring to “MAP” and Hutt Valley DHB staff to “Concerto”, although they are essentially the same type of system.

The current ICT systems are considered not fit for purpose as:
- they are hospital focused yet MHAIDS 3DHB sees clients frequently over a long period of time in community care
- there is an absence of a ‘continuous clinical notes’ capability to adequately document multiple and regular contacts with clients. The MHAIDS environment is dynamic and, while assessments of clients are relevant at a specific point in time, there is a requirement to capture additional information (e.g. a contact in between formal appointments) that may be pertinent to a reassessment or review at a later point.

There are inconsistencies in how the system is used within each of those DHBs, and considerable variation in whether it is clinicians or administrators who are expected to update system documents with demographic details, or write up clinical notes.

These issues, combined with flexibility in existing functionality (e.g. MHAIDS staff being able to amend records with no documented visibility of changes made), contribute to inconsistent business processes as well as a resistance to and misuse.

Another factor is the low number of devices available to staff so they can access the current systems. There are approximately 1240 MHAIDS 3DHB staff – Capital & Coast DHB: 1,200, Hutt Valley DHB: 200, and Wairarapa DHB: 40. At some sites, the ratio of staff to PC/Terminal devices is between 3:1 and 4:1. Further, there is limited support mobility as most devices are non-portable and physically based at the MHAIDS sites. This impacts on the quality of patient care and staff productivity, amongst other things.

2.3 Electronic Health Records

The Ministry of Health has been undertaking sector-wide consultation on a national electronic health record. The indicative business case recommends implementing a national platform that enables a unified view of patient health information that is distributed in various systems (electronic health records) across the sector, rather than a single record.

The proposed future state for MHAIDS 3DHB, as outlined in the next section of this paper, is an electronic client management system. This system would be accessible by Secondary Care, Primary Care and NGOs as well as clients and their supporters, family and whānau. It would be integrated into the wider health information ecosystem including with the national platform when it is available, with appropriate security and privacy controls.
3. PROPOSED WAY FORWARD

3.1 Phased approach

The review has identified ICT as a critical enabler for service improvement. A two phased approach is proposed.

3.1.1 Phase one (six months to complete)

- Focuses on delivering an interim package of priority ICT solutions for 3DHB MHAIDS over the next six months; the details of the proposed work to be undertaken can be found in appendix one.
- Significantly increase the number of devices used by 3DHB MHAIDS staff (desktop and laptop PCs, terminals, tablets and mobile phones).

3.1.2 Phase two (at least 18 months but likely between three to five years to complete)

- Implement a fully integrated electronic client management system across MHAIDS 3DHB, to be accessible by Secondary Care, Primary Care and NGOs as well as clients and their supporters, family and whānau.

This approach aligns to the MHAIDS 3DHB work plan outlined in appendix two. It enables a number of the review recommendations to be addressed quickly and reduces current risks. It also reflects the reality that it will take considerable time to implement (buy or build) a system to meet the needs of all stakeholders, which in itself introduces the risk of delay for phase one. A critical dependency is clarity with regards to the operating/care model that the electronic client management system needs to underpin. The proposed approach enables a step progression that can survive should completion of phase two extend to between three and five years.

A further consideration is that there may be a requirement to implement a regional or national mental health client management system.

We believe that there is no viable or cost effective alternative to the proposed two-phase approach in order to progress the resolution of high priority systems issues raised in the review with the urgency the reflects the findings/recommendations of the review. All efforts will be made to maximise reinvestment opportunities from phase one in the subsequent phase.

3.2 Proposed phase one ICT solution

The proposed phase one ICT solution will comprise:

- Changes to the MAP/Concerto applications used at the DHBs, and associated clinical process/forms changes
- Implementation of a Single “Care/Partnership/Treatment” Plan solution that is integrated with MAP/Concerto.

A Single “Care/Partnership/Treatment” Plan solution that is able to meet the immediate requirements of MHAIDS 3DHB has been identified. It is available in the market today and is the Connected Care platform provided by an Auckland based organisation called Whānau Tahi.

The core components Whānau Tahi Connected Care include:

- Care planning
- Secure communication and collaboration
- Clinician/care provider interaction, including a portal for patients and whānau to view their information
The benefits of the Whānau Tahi Connected Care solution are:

- It is a proven and open solution that is used by a number of DHBs and other organisations in New Zealand and overseas. In New Zealand it is predominately used for the care planning of patients with long term conditions and it is currently used by the Mental Health Services at Hawke’s Bay and Northland DHBs.
- It is available installed or ‘as-a-service’. It is proposed to adopt the ‘as-a-service’ model. This reduces the setup timeframe and requires a modest level of investment to implement the system and the service can be discontinued with three months’ notice.

Other systems have been considered and while these look promising they:

- Lack the maturity of the Whānau Tahi solution and/or are not yet proven.
- Are primary care focussed and would require time and investment to modify to create what would be a bespoke solution for MHAIDS 3DHB.
- Introduce delay and risk.

The option of building a solution was rejected on the basis of cost, timeframe and risk.

It should be noted that the Whānau Tahi solution is considered interim at this stage. Phase two will determine the future requirements and identify the most appropriate fully integrated electronic health record solution. The Whānau Tahi solution or a currently excluded option may or not be a preferred solution to meet those needs.

3.3 Governance

The ICT and business streams of work in phase one will be overseen by a Steering Group, either established from scratch or by expanding an existing group.

4. COSTS AND ASSUMPTIONS – PHASE ONE

The costs for Phase one are broken into three key areas:

- Internal DHB systems
  - Internal and external ICT resources to undertake the design, development and implementation work for the MAP/Concerto changes listed above.
  - Internal and external ICT resources to support the implementation of a Single “Care/Partnership/Treatment” Plan solution which includes integration to MAP/Concerto.
  - Data communications network infrastructure.
- Externally provided systems
  - The costs to implement a Single “Care/Partnership/Treatment Plan solution including integration with 3DHB systems and the on-going costs to run and support the system.
- Project management
  - An ICT Project Manager to develop and manage the ICT stream of work.
  - A MHAIDS 3DHB Project Manager (PM) to develop and manage the MHAIDS stream of work, including the process of gathering requirements and sign off, and business changes. This person will work very closely with the ICT PM to ensure this is a coordinated plan and activity.
A summary of the estimated costs follows:

<table>
<thead>
<tr>
<th>Cost area</th>
<th>$ (One off)</th>
<th>$ (Monthly)</th>
<th>$ (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal ICT costs (including 20% contingency)</td>
<td>99,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External costs (Project Management, Whānau Tahi)</td>
<td>187,800</td>
<td>14,000</td>
<td>168,000</td>
</tr>
<tr>
<td>Staff devices (Desktop and laptop PCs, Terminals, Tablets and mobile devices) – see assumptions</td>
<td>120,000</td>
<td>625</td>
<td>7,500</td>
</tr>
<tr>
<td>Data communications network infrastructure</td>
<td>175,000</td>
<td>2500</td>
<td>30,000</td>
</tr>
<tr>
<td>Training – see assumptions</td>
<td>7,500</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total costs</td>
<td>589,300</td>
<td>17,125</td>
<td>205,500</td>
</tr>
</tbody>
</table>

It is proposed to split the costs across the DHBs as follows:

<table>
<thead>
<tr>
<th>Cost area</th>
<th>Split</th>
<th>One off / Annual Charge</th>
<th>$ CCDHB</th>
<th>$ HVDHB</th>
<th>$ WRDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Core’ activities – MAP/Concerto changes, Project Management, Whānau Tahi set up costs, training</td>
<td>Equal share</td>
<td>One off</td>
<td>98,100</td>
<td>98,100</td>
<td>98,100</td>
</tr>
<tr>
<td>Whānau Tahi support and maintenance</td>
<td>Based on share of registered users (*)</td>
<td>Annual Charge</td>
<td>140,000</td>
<td>23,333</td>
<td>4,667</td>
</tr>
<tr>
<td>Staff devices</td>
<td>Based on actual purchases (**)</td>
<td>One off</td>
<td>100,000</td>
<td>16,667</td>
<td>3,333</td>
</tr>
<tr>
<td>Data communications network infrastructure</td>
<td>Based on ratio of MHAIDS staff</td>
<td>One off</td>
<td>145,833</td>
<td>24,306</td>
<td>4,861</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>One off</td>
<td>343,933</td>
<td>139,073</td>
<td>106,294</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Charge</td>
<td>146,250</td>
<td>24,375</td>
<td>4,875</td>
</tr>
</tbody>
</table>

Notes:

- Given the interim nature of aspects of the Phase one, a full financial analysis has not been completed; a full financial analysis will be completed for Phase two.
- The cost estimates are conservative and allow for some contingency. Costs will be reviewed and confirmed during the setup phase of the project and all attempts will be reduce them. Some high level requirements will need to be gathered and provided to Whānau Tahi in order to align the product functionality and formalise the quote.
- The costs for core development and implementation activities are split equally as each DHB would need to undertake this individually if ‘going alone’ – in this case all three DHBs are making a saving by funding collectively; this is the approach taken in other projects e.g. ePharmacy.
- (*) For the purposes of this paper the split of costs above for “Whānau Tahi support and maintenance” is the ratio of staff – Capital & Coast DHB (1200 = 83 percent), Hutt Valley DHB (200 = 14 percent) and Wairarapa DHB (40 = 3 percent). The actual costs may vary as not all staff will at each DHB be registered users of the Whānau Tahi system, primary Capital & Coast DHB staff as a number of them support service provided under national and regional contracts.
- (**) For the purposes of this paper the split of costs above for “staff devices” is based on the ratio of staff as noted above. The actual costs will vary as they will be based on actual devices purchased by each DHB.
• Internal ICT costs are based on the currently agreed internal recovery rates for ICT resources. Internal resources required are a Business Analyst for the duration, and an Architect, Analyst Programmer and Test Analyst for Whānau Tahi integration, plus an Analyst Programmer for changes to Concerto.

• The estimate for external costs includes:
  - Provision for a contract ICT Project Manager at a cost of $86,400 (based on 30 hours a week for 6 months at $120 per hour)
  - Provision for a contract MHAIDS 3DHB Project Manager at a cost of $86,400 (based on 30 hours a week for 6 months at $120 per hour)
  - Whānau Tahi has provided a preliminary quote of $15,000 for implementation and $14,000 per month to provide the Connected Care platform for use across MHAIDS across 3DHB. The current quote is based on utilising specific functionality with the Connected Care platform, and an estimated percentage of each DHBs population having a plan on the system. A six month pilot period is available with an approximate discount of 50 percent.

• Training costs are for developing the training material. Staff training will be provided within currently available MHAIDS/ICT Desktop Support resources, and by Whānau Tahi (as part of their quote for implementation)

• Funding of $120,000 is to provide 75 additional devices (desktop and laptop PCs, terminals and tablets) to 3DHB MHAIDS staff with annual costs of $7,500 for software maintenance and support

• Provision is being made for upgrading the data communications network infrastructure for a number of MHAIDS 3DHB sites as the current network infrastructure is at capacity. The investment required is a $176,000 (one off cost) and $30,000 (annual cost), comprising:
  - Network switches = $76,000
  - Extra wireless coverage (access points) = $20,000
  - Tory St cable management and rack upgrade (required for extra capacity) = $40,000
  - Extra cabling (contingency for extra outlets etc) = $40,000
  - Extra $30,000 per annum for additional WAN capacity at the remote sites

Key assumptions are:
• MHAIDS 3DHB can make internal resource available to support the project
• Training can be covered by current staff, i.e., no external resources will be required
• There are no significant changes required to the webPAS Patient Administration System, however if work is required this can be undertaken using internal resources
• Access to devices (desktop and laptop PCs, Terminals, Tablets and mobile devices) is not prerequisite to proceeding with phase one and can be rolled out to staff over the balance the 2016/17 financial year and through 2017/18
• Funding of approximately $195,000 is available from the 2016/17 and 2017/18 financial year budgets to provide 150 additional devices to 3DHB MHAIDS staff.

5. SECURITY AND PRIVACY

All the activity in phase one aligns with our current processes so there are no additional security risks or client privacy risks associated with the Concerto/MAP systems. The Whānau Tahi Connected Care solution will undergo a security and privacy assessment, with the risk expected to be low. The solution is used by other DHBs, resides on Connected Health (the NZ Health System’s secure network), and has previously undergone an independent security assessment for the former National Health IT Board. The system enables access to be controlled by role, which means there can be control of what individuals are able to view.

As part of the phase two project, a full Privacy Impact Assessment will be completed.
6. RISKS

The key risks are:

<table>
<thead>
<tr>
<th>Description</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended changes to clinical documents may result in changes to processes</td>
<td>A Process Analyst has been engaged from an external consulting firm by MHAIDS 3DHB to manage changes to the administrative pathway.</td>
</tr>
<tr>
<td>(administrative and clinical) supported by the Capital &amp; Coast DHB/Hutt</td>
<td></td>
</tr>
<tr>
<td>Valley DHB WebPAS and MAP/Concerto platforms.</td>
<td></td>
</tr>
<tr>
<td>If changes are not implemented across all DHBs at the same time (or very</td>
<td>Mitigation details are currently being identified and will be confirmed during the project setup phase.</td>
</tr>
<tr>
<td>close to it) this may impact on service delivery.</td>
<td></td>
</tr>
<tr>
<td>There is a risk that Wairarapa may not be ready to move from a mostly paper</td>
<td>Ensure appropriate clinical leadership, training and supervision is put in place.</td>
</tr>
<tr>
<td>based system to an electronic system.</td>
<td></td>
</tr>
<tr>
<td>The estimated costs exceed the budget.</td>
<td>Ensure good practice disciplines are applied for project management and governance.</td>
</tr>
</tbody>
</table>

7. NEXT STEPS

<table>
<thead>
<tr>
<th>What</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish project - plan, resources, budget, steering group.</td>
<td>June 2017</td>
</tr>
<tr>
<td>Implement the MAP/Concerto changes.</td>
<td>30 June 2017</td>
</tr>
<tr>
<td>• Implement the electronic prescription function. This is already</td>
<td></td>
</tr>
<tr>
<td>planned for implementation at Capital &amp; Coast DHB.</td>
<td></td>
</tr>
<tr>
<td>• Continuing workshops to design a common Intake Form and an Initial</td>
<td></td>
</tr>
<tr>
<td>Assessment document.</td>
<td></td>
</tr>
<tr>
<td>• ICT to provide MHAIDS staff with access to a development Concerto/:bold</td>
<td></td>
</tr>
<tr>
<td>MAP environment so they can view and test the new forms.</td>
<td></td>
</tr>
<tr>
<td>• Continuing workshops to align the Concerto/MAP electronic folder</td>
<td></td>
</tr>
<tr>
<td>structure across the three DHBs, aligning with the regional</td>
<td></td>
</tr>
<tr>
<td>Clinical Portal structure where possible.</td>
<td></td>
</tr>
<tr>
<td>• Implement ‘in-house’ developed Continuous Notes solution, based on</td>
<td></td>
</tr>
<tr>
<td>what is being piloted by the Capital &amp; Coast DHB Health Care Homes</td>
<td></td>
</tr>
<tr>
<td>project (with a Go-Live date of 18 May 2017).</td>
<td></td>
</tr>
<tr>
<td>Single “Care/Partnership/Treatment” Plan solution</td>
<td>30 September 2017</td>
</tr>
<tr>
<td>• Workshop with Whānau Tahi booked for middle/late May to further</td>
<td></td>
</tr>
<tr>
<td>explore available functionality and workflow.</td>
<td></td>
</tr>
<tr>
<td>• Workshop with John Conneely from Hawke’s Bay DHB (HBDHB) Mental</td>
<td></td>
</tr>
<tr>
<td>Health Service. He has worked closely Whānau Tahi on the HBDHB</td>
<td></td>
</tr>
<tr>
<td>implementation and would be able to provide advice and feedback to</td>
<td></td>
</tr>
<tr>
<td>MHAIDS 3DHB.</td>
<td></td>
</tr>
<tr>
<td>Setup, rollout and training.</td>
<td></td>
</tr>
</tbody>
</table>
Author: Roger Palairet, Chief Legal Counsel, Capital & Coast DHB
Endorsed by: Debbie Chin, Chief Executive, Capital & Coast DHB
Subject: Conflict Management Plan – Roger Jarrold

RECOMMENDATIONS

It is recommended that the Board:

a) **Note** Roger Jarrold has recently disclosed two new interests related to his role as an employee of Downer:

b) **Note** the interests recently disclosed by Roger Jarrold are relevant to current or potential transactions by CCDHB and the situation in regard to possible conflicts is potentially complex.

c) **Note** the Chair and CCDHB have received advice from Robert Buchanan, Public Law and Governance specialist.

d) **Note** the advice says it is incumbent on the Board to respond to disclosures of interest by Board members and that a Conflict Management Plan would be helpful for the Board.

e) **Agree** to adopt the Conflict Management Plan that deals with those interests that has been prepared for the Board.

APPENDICES

1. Legal advice from Robert Buchanan
2. Conflict Management Plan

1. PURPOSE

1.1 Roger Jarrold has recently disclosed two new interests related to his role as an employee of Downer:

   (1) Downer is acquiring Hawkins Limited; and

   (2) Downer is bidding to acquire shares in Spotless Australasia.

1.2 The Chair and CCDHB have taken advice, and the attached Conflict Management Plan has been prepared to assist the Board.

2. LEGAL ADVICE

2.1 Robert Buchanan is a Public Law and Governance specialist. He has provided advice (Appendix 1). In summary he is saying:

   - Roger Jarrold clearly has an “interest” because he is a director of Downer and various other companies that could benefit (directly or indirectly) from transactions entered into by CCDHB.
Roger Jarrold recognising and declaring the interests is an appropriate first step.

Responding to conflicts of interest is the collective responsibility of the Board as a whole – led by the Chair.

Once a member’s conflict of interest arises, the options under the New Zealand Public Health and Disability Act are limited. The member must not participate in any deliberations or decision of the Board relating to an affected transaction.

There is a process for the Board to effectively waive a conflict of interest for the purposes of deliberation (but not decision-making), but there are transparency procedures that discourage this process (including reporting in the Annual Report).

Sometimes it will be a matter of judgement as to whether a conflict of interest in fact exists. The link between an interest and a transaction may be so "remote" or “nebulous” that an ostensible conflict of interest may be disregarded. Information may also be anticipated to become generally available through a CCDHB accountability or procurement process, so there is no commercial advantage in an interested member having access to the information.

These judgements will be easier for the Board to make if a Conflict Management Plan is in place.

3. CONFLICT MANAGEMENT PLAN

3.1 Managing the interests disclosed by Roger Jarrold is potentially complex because of the breadth of the interests and the fact that they are obviously relevant to current or potential transactions of CCDHB. Most other interests disclosed by Board members tend to be narrower, and are less likely to touch on such significant transactions entered into by CCDHB as the Spotless and Allied Laundry Services Limited transactions, construction contracts and the litigation against Fletchers.

3.2 The advice from Robert Buchanan is that it is best practice for the Board to put in place a Conflict Management Plan for this kind of complex situation. We have prepared a Conflict Management Plan which incorporates the advice from Robert Buchanan, and steps through Roger Jarrold’s interests and the most likely potential conflicts. A copy of the Conflict Management Plan is attached (see Appendix 2).

3.3 The Conflict Management Plan is intended to be a standalone document that the Board can refer to without necessarily needing to consider separate legal advice. This does not mean that it will not be appropriate to obtain separate legal advice if unexpected or difficult issues arise.

3.4 The primary point under the Conflict Management Plan is that Roger Jarrold will withdraw from any discussion or decision by the Board in relation to actual or potential transactions between CCDHB and Downer, Hawkins, Spotless, and any of their competitors. The Conflict Management Plan includes guidance for the Board in recognising a conflict of interest (paragraph 12).

3.5 There may be circumstances where the Board decides there is no conflict of interest, or that Roger Jarrold should participate in discussion despite a conflict of interest. The Conflict Management Plan provides guidance on those circumstances (paragraph 13).
4. MINISTRY OF HEALTH CONFLICT OF INTEREST GUIDELINES

4.1 The Conflict of Interest Guidelines published by the Ministry of Health in 2016 (Appendix 3) is a useful summary of the principles and rules that apply to DHB Board members in relation to conflicts of interest. A copy has been posted on Board Books for members’ reference – now and into the future.

4.2 The Conflict Management Plan is consistent with the Ministry of Health Guidelines. In particular the Guidelines emphasise that it is the responsibility of the Board as a whole to consider how to respond to disclosures of interest and potential conflicts.
RECOMMENDATIONS

It is recommended that the Board:

a) Note the number of reported Health & Safety incidents has declined this month
b) Note that there were no reported Notifiable Events this month, continuing a five month trend
c) Note the number of physical assaults on MHAIDS staff has declined this month
d) Note the number of incidents resulting in lost time injuries has declined to 3 from 11 the previous month
e) Note 46% of employees have currently received the annual influenza vaccination.

All information accurate at time of report production – 06/04/2017

APPENDICES

1. Health & Safety Risk Register
2. Health & Safety Incident Statistics
3. Wellness and Injury Management.

EXECUTIVE SUMMARY

The report format has been slightly updated for this month and will continue to be developed over the coming months as further data becomes available.

1. RISK REGISTER – Appendix 1.

There are currently 10 active health and safety risks identified on the risk register.

2. INCIDENTS – Appendix 2

H&S incident reporting is encouraged from all workers. Each incident reported is required to be investigated by the relevant manager and appropriate actions are put into place to prevent a re-occurrence. As part of the investigation managers are required to state what actions are required to prevent a recurrence and how they intend to implement them.

Higher reporting indicates a stronger health and safety culture and provides a more realistic picture of the exposure to hazards experienced by our workers. It is the actual work injury claims that accurately reflect the level of harm that is occurring.

Full details are provided in the performance summary.

2.2 Performance Summary

Definitions

- Incidents - Total number of incidents that were reported
- Injury Claims - Any injury resulting in an ACC45 claim
• **Medical Fee Only Claims** - Any incident which results in an ACC45 claim for treatment but with no lost time
• **Lost Time Injury** - Any incident which results in an ACC45 lost time injury
• **Lost Time Injury Frequency Rate** - The number of lost-time injuries (per million hours worked) within a given accounting period relative to the total number of hours worked in the same accounting period (number of LTIs x 1,000,000 / number of hours worked for month)

**Key:** In comparison to previous month - ▲ - Increased ▼ - Decreased ◼ - Maintained
### H&S Incidents

<table>
<thead>
<tr>
<th>Category of Incident</th>
<th>Directorate</th>
<th>Service</th>
<th>Days Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other – overstretched, injured back</td>
<td>MHAIDS</td>
<td>Hikitia Te Wairua (Youth Intellectual Disabilities Secure Unit)</td>
<td>7</td>
</tr>
</tbody>
</table>

### Performance Indicator

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Target</th>
<th>Status</th>
<th>Trend (Past 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Reported Incidents</td>
<td>109</td>
<td>162</td>
<td></td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td>- Number of Reported Incidents - Non MHAIDS</td>
<td>51</td>
<td>63</td>
<td></td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td>- Number of Reported Incidents - MHAIDS</td>
<td>58</td>
<td>99</td>
<td></td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td>Number of Notifiable Events</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Incidents involving visitors</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Incidents involving contractors</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Staff & Others Incident Lag Indicators

<table>
<thead>
<tr>
<th>Category of Incident</th>
<th>Current Month</th>
<th>Previous Month</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood or Body Fluid Exposure</td>
<td>14</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Slips, Trips, Falls</td>
<td>5</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Physical Assault of Workers - Excluding MHAIDS</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Physical Assault of Workers - MHAIDS</td>
<td>12</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Patient Handling</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Object Handling</td>
<td>3</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Hit by or Ran into Object</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

### Leading Indicators

<table>
<thead>
<tr>
<th>Leading Indicators</th>
<th>Current</th>
<th>Previous</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Pre-Employment Health Screening completed prior to start</td>
<td>83</td>
<td>70%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% of H&amp;S Fundamentals Managers completed</td>
<td>77%</td>
<td>76%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of H&amp;S Incidents investigated within 14 days*</td>
<td>44%</td>
<td>61%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

*Pre-employment health Declarations being returned with less than the required 2 weeks’ notice is the cause of this
*A two month lag in reporting is required to allow for accurate reporting

### Claims & Injury Statistics

<table>
<thead>
<tr>
<th>Category of Incident</th>
<th>Current</th>
<th>Previous</th>
<th>Target (Past 12 months)</th>
<th>Trend - MHAIDS (Past 12 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Injury Claims</td>
<td>8</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Medical Fees Only Claims</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Lost Time Injuries</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Lost Days</td>
<td>10</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lost Time Injury Frequency Rate</td>
<td>4.5</td>
<td>8.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Previous Month

<table>
<thead>
<tr>
<th>Category of Incident</th>
<th>Directorate</th>
<th>Department</th>
<th>Days Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slip, Trip, Fall</td>
<td>Medicine, Cancer &amp; Community</td>
<td>Ward 6 South</td>
<td>4</td>
</tr>
<tr>
<td>Physically Assaulted</td>
<td>MHAIDS</td>
<td>Te Whare Ra Uta (Psychogeriatric Unit)</td>
<td>2</td>
</tr>
<tr>
<td>Other – Falling patient grabbed employee</td>
<td>Medicine, Cancer &amp; Community</td>
<td>ORA – Ward 4 Kenepuru</td>
<td>3</td>
</tr>
<tr>
<td>Slip, Trip, Fall</td>
<td>MHAIDS</td>
<td>Needs Assessment &amp; Service Coordination</td>
<td>6</td>
</tr>
<tr>
<td>Slip, Trip, Fall</td>
<td>MHAIDS</td>
<td>Psychogeriatric Community Service</td>
<td>6</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>Surgery, Women &amp; Children’s</td>
<td>Ward 2</td>
<td>7</td>
</tr>
<tr>
<td>Physically Assaulted</td>
<td>MHAIDS</td>
<td>Haumitiketike (Adult Intellectual Disabilities Secure Unit)</td>
<td>10</td>
</tr>
<tr>
<td>Patient Handling</td>
<td>Medicine, Cancer &amp; Community</td>
<td>Medical Assessment Planning Unit</td>
<td>14</td>
</tr>
<tr>
<td>Physically Assaulted</td>
<td>MHAIDS</td>
<td>Tawhirimatea (Extended Rehabilitation Unit)</td>
<td>18</td>
</tr>
<tr>
<td>Physically Assaulted</td>
<td>MHAIDS</td>
<td>Haumitiketike (Adult Intellectual Disabilities Secure Unit)</td>
<td>28</td>
</tr>
<tr>
<td>Hit by object causing a Slip, Trip, Fall</td>
<td>MHAIDS</td>
<td>Te Whare o Matairangi (Adult Acute Psychiatric Unit)</td>
<td>45</td>
</tr>
</tbody>
</table>

### Past 12 months

![Graph](graph.png)

- General LTI's
- MHAIDS LTI's
2.4 Notifiable Events

No notifiable events were reported in March 2017. There have been 2 Notifiable Events reported in the past 12 months.

2.5 Serious Injury Reduction

The Government has set a target of reducing serious injuries and fatalities in the workplace by at least 25% by 2020. As can be seen from 2.3 above, CCDHB has a very low incidence of Notifiable Events which are serious injuries and fatalities.

3. WELLNESS AND INJURY MANAGEMENT – Appendix 3

3.1 EAP

After a slight rise, the number of employees referring to EAP continues to decline. Information is now provided in appendix 3 to show the number of referrals by Directorate as well as the reasons stated for referral.

3.2 Workplace Injury Management – Wellnz

A Government syndicated contract commenced on the 1st January 2017. We have started to see a reduction in the monthly management costs form the end of January 2017 onwards.

Lumbar sprain injuries remain the most frequent type of injury reported with moving and handling being the largest reported causes of claims.

4. EMPLOYEE PARTICIPATION AND ENGAGEMENT

4.1 Health & Safety Representative (HSR) Elections

Information was been sent Directorate General Managers and Executive leads to disseminate to managers. The election process commenced in February 2017 and elections took place in March. New H&S Committee structures will be confirmed in June.

5. OTHER BUSINESS

5.1 New H&S Advisor

The H&S Service has now employed a Health & Safety Advisor (1fte). They commenced their post on the 3rd April 2017. This now takes the total count of H&S Advisors to 1.
5.2 Policies and Procedures

The updated Management of Workplace and Aggression procedure, Lone and Community Worker Procedure and new First Aid at Work Procedure have been out for consultation. We are in the process of consolidating all replies form the consultation.

5.2 DAA group Health and Safety Governance Review - April 2016

The DAA Group are due to return on the 23rd May 2017, to undertake a review into the implementation of the recommendations form their previous audit in April 2016. A full report should be available for the next Board meeting.

5.3 Annual Influenza Campaign

The annual vaccination campaign commenced on the 27th March.

A series of fixed and clinics mobile vaccination clinics have been held throughout the DHB and community bases. This was followed by drop-in clinics from the 24th April.

The campaign is supported by in-house ‘champions’ who will be offering vaccinations within their own areas.

The graphs below show the number of employees vaccinated as at the end of business on the 5th May 2017 and also displays Directorate and employee group totals. We currently have 46% of all employees vaccinated. Last year we achieved 58% which was the lowest of a DHB’s. Our target this year is 80%.

This information is available to all managers via payroll Kiosk and will enable them to monitor their own areas, and to drive the campaign in their areas.
<table>
<thead>
<tr>
<th>Risk Number</th>
<th>Risk Description</th>
<th>Risk Owner</th>
<th>Pre Mitigation</th>
<th>Post Mitigation</th>
<th>Risk Category</th>
<th>Mitigation</th>
<th>Pre Mitigation</th>
<th>Post Mitigation</th>
<th>RAC rating</th>
<th>Risk Profile</th>
<th>Change in Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>118</td>
<td>Asbestos Management</td>
<td>EDO CSS</td>
<td>Unlikely</td>
<td>Very High</td>
<td>Health &amp; Safety</td>
<td>Removal of asbestos containing material (ACM) will only be undertaken as required. Asbestos removal or investigation activities are currently occurring around campuses using certified asbestos management contractors. Register in place Trades staff have been provided specific PPE and training when there is a need to manage asbestos</td>
<td>Unlikely</td>
<td>High</td>
<td>Isolation, management and removal process are in place for identified asbestos containing material</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Overfilled Linen Bags</td>
<td>EDO CSS</td>
<td>Likely</td>
<td>High</td>
<td>Health &amp; Safety</td>
<td>Allied Laundry continue to dispose bags. To date at least 2000+ bags have been disposed</td>
<td>Unlikely</td>
<td>High</td>
<td>Risk Owner changed</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Inadequate Physical Space</td>
<td>OM CHS</td>
<td>Likely</td>
<td>High</td>
<td>Health &amp; Safety</td>
<td>Feasibility for additional adjacent space being explored.</td>
<td>Unlikely</td>
<td>High</td>
<td>No change</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Risk Number</td>
<td>Risk Description</td>
<td>Risk Owner</td>
<td>Pre Mitigation Likelihood</td>
<td>Pre Mitigation Consequence</td>
<td>Risk Category</td>
<td>Mitigation</td>
<td>Post Mitigation Likelihood</td>
<td>Post Mitigation Consequence</td>
<td>Post Mitigation RAC rating</td>
<td>Change in Reporting Period</td>
<td></td>
</tr>
<tr>
<td>------------</td>
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<td>-----------------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>67 (QIPS1 9/15)</td>
<td>Physical Assaults on Staff On-going high rate of physical assaults on Emergency Department and MHAID DHB staff by patients.</td>
<td>GM CS</td>
<td>Almost Certain</td>
<td>High</td>
<td>2</td>
<td>Health &amp; Safety</td>
<td>Draft Management of Workplace Violence &amp; Aggression Procedure to go for consultation next month. Meeting held with MHAIDS &amp; Capability Development on how better to promote personal safety &amp; de-escalation courses.</td>
<td>Almost Certain</td>
<td>High</td>
<td>2</td>
<td>Likelihood amended to certain reflecting current incidents and lack of progress to mitigate.</td>
</tr>
<tr>
<td>130</td>
<td>Staff Risk of Exposure to Blood and Body Fluids Staff caring for patients are at risk of exposure to blood and body fluids that has the potential to cause them long term harm.</td>
<td>GM CS</td>
<td>Likely</td>
<td>High</td>
<td>2</td>
<td>Health &amp; Safety</td>
<td>Staff training in required blood, body fluid safety process and action required if exposed. Regular monitoring of BBFE reportable events. Hazard Register 7 South/Ward 2 as a residual hazard risk rating of a 2.</td>
<td>Unlikely</td>
<td>High</td>
<td>3</td>
<td>This risk is monitored on a continual basis with any identified incidents managed as and when they occur</td>
</tr>
<tr>
<td>129</td>
<td>Slips, Trips &amp; Falls Staff through work duties at risk of slips, trips and falls which has the potential for harm.</td>
<td>GM CS</td>
<td>Likely</td>
<td>High</td>
<td>2</td>
<td>Health &amp; Safety</td>
<td>Prompt reporting of contributing factors for repair, staff awareness and education, regular monitoring of reportable events. Hazard Register Kenepuru Theatres a residual hazard risk rating of a 2</td>
<td>Unlikely</td>
<td>High</td>
<td>3</td>
<td>This risk is monitored on a continual basis with any identified incidents managed as and when they occur by the relevant manager. Dedicated incident investigation for is available for managers to utilise to aid in their investigations</td>
</tr>
<tr>
<td>Risk Number</td>
<td>Risk Description</td>
<td>Risk Owner</td>
<td>Pre Mitigation Likelihood</td>
<td>Pre Mitigation Consequence</td>
<td>Risk Category</td>
<td>Mitigation</td>
<td>Post Mitigation Likelihood</td>
<td>Post Mitigation Consequence</td>
<td>RAC Rating</td>
<td>Risk Profile</td>
<td>Change in Reporting Period</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
<td>------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
<td>---------------</td>
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<td>---------------------------</td>
<td>-----------------------------</td>
<td>------------</td>
<td>----------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| 155         | Management of Aged Residential Care Contracts  
The management of contracts for services such as aged residential care need to include consideration of the requirement of the health and safety at work act 2015 to ensure the DHBs obligations under the act are met. | GM SIP | Likely | High | 2 | Health & Safety | All providers have been reminded of their responsibilities under the ACT. Portfolio Managers will meet with all providers over the course of the year to ensure that provider Boards have considered their responsibilities and identified their high risks and have mitigations in place. Contract clauses have been reviewed and are considered sufficient to discharge the DHB Boards responsibilities. Audits cover H&S and ARC in particular to ensure policies are followed. Note DAA auditors of ARC facilities are required to meet international standards. The DHB Contractors policy (control of contractors) has been reviewed and is due to be disseminated for consultation. Contracts for services will be reviewed to ensure are consistent with the policy requirements. | Likely | Moderate | 2 |
| 164 (was 127 & 128) | Manual Handling – Patient & Object  
While moving patients’ and equipment staff at risk of a manual handling injury. | GM CS | Almost Certain | High | 2 | Health & Safety | Manual handling training, regular monitoring of reportable events. Hazard Register Kenepuru Theatres a residual hazard risk rating of a 2. Discussions are still taking place regarding the redevelopment of the current method of training delivery to meet the requirements of the NZ Moving & Handling Guidelines All reported incidents involving patient or object handling are reviewed by the Safe Handling Advisor. | Almost Certain | High | 2 | Specific investigation forms have now been developed to aid managers in their investigations. |
<table>
<thead>
<tr>
<th>Risk Number</th>
<th>Risk Description</th>
<th>Risk Owner</th>
<th>Pre Mitigation Possibility</th>
<th>Pre Mitigation Consequence</th>
<th>Pre Mitigation Risk Rating</th>
<th>Pre Mitigation Risk Category</th>
<th>Mitigation Possibility</th>
<th>Mitigation Consequence</th>
<th>Mitigation Risk Rating</th>
<th>Mitigation Risk Category</th>
<th>Post Mitigation Possibility</th>
<th>Post Mitigation Consequence</th>
<th>Post Mitigation RAC rating</th>
<th>Risk Profile</th>
<th>Change in Reporting Period</th>
<th>Risk Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>116</td>
<td>Temperature at Ward Block Kenepuru Hospital</td>
<td>EDO</td>
<td>Likely</td>
<td>High</td>
<td>2</td>
<td>Health &amp; Safety</td>
<td>Likely</td>
<td>Low</td>
<td>Moderate</td>
<td>3</td>
<td>Updated</td>
<td>No change</td>
<td>Updated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluctuating environmental temperatures in clinical areas within the ward block throughout the year. The temperature variance is unpredictable as can change dependant on weather conditions. These impacts on delivery of patient care, staff and general business.</td>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EDO</td>
<td>Likely</td>
<td>High</td>
<td>2</td>
<td>Health &amp; Safety</td>
<td>Monitoring the temperature routinely. When entering reportable event informing staff to record the actual temperature at the time. Encourage staff with regular hydration to prevent dehydration when temp exceeds acceptable levels. Portable dyson fans in place combined with other portable fans. Portable air conditioning units in medication rooms. Open windows within the limits of safety dependant on patients group.</td>
<td>Likely</td>
<td>Low</td>
<td>Moderate</td>
<td>3</td>
<td>Updated</td>
<td>No change</td>
<td>Updated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>162</td>
<td>Potential risk of failure /movement of unsecured heavy plaster ceiling during a design level seismic event which may lead to serious harm.</td>
<td>EDO</td>
<td>Likely</td>
<td>High</td>
<td>2</td>
<td>Health &amp; Safety</td>
<td>Trial completed . Identified issues with managing infrastructure above ceiling tiles and will need to be considered in costing and scope of any replacement programme. Further assessment of cost is underway. Replacement soft fibre tiles will be trialled in a small area before the end of April. The trial is designed to determine the logistics of replacement.</td>
<td>Highly</td>
<td>Unlikely</td>
<td>Very</td>
<td>high</td>
<td>Updated</td>
<td></td>
<td>Updated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2 – MONTHLY H&S INCIDENT STATISTICS

2.1 Total Reported Incidents

2.2 Reported Physical Assaults and Abusive/Threatening Behaviour Incidents

2.3 Reported Incidents by Directorate
2.4 Injury Claims

There were 13 incidents which resulted in injury claims this period

YEARLY STATISTICS (past 12 months)

2.5 Total Reported Incidents

2.6 Reported Incidents by Directorate
3.1 EAP SERVICES STATISTICS (last 12 months)

3.1.1 Costs – Total = $85,201.34

NOTE: No invoice was received for May-16. All costs incurred were added to the following month’s invoice

3.1.2 Monthly Referrals to EAP:

by Directorate

- Not Stated, 5
- Clinical & Support Services, 5
- Corporate Services, 3
- Medicine, Cancer & Community, 4
- Surgery, Womens & Children, 8
- SIP, 1
- MHAIDS, 5

Reasons for Referrals (as stated by worker)

- Workload, 35
- Bullying, 48
- Trauma, 7
- Safety, 20
- Restructuring, 11
- Relationship with Manager, 48
- Relationship with Co-Worker, 32
- Redundancy, 7
- Performance, 18
- Harassment, 12
- Conditions, 22
- Discipline, 15
- Discrimination, 4
- Environment, 46
- Career, 46
- Relationship with Co-Worker, 1
- Relationship with Manager, 5
- Work Hours, 1
- Workload, 1
- Bullying, 2
- Career, 2
- Conditions, 1
- Safety, 2
- Redundancy, 1
- Environment, 2

3.1.3 Reasons for Referrals (as stated by worker) last 12 months
3.2 Injury Management Costs

3.2.1 Monthly costs (last 12 months)

<table>
<thead>
<tr>
<th>Month</th>
<th>Case &amp; Claims Management</th>
<th>Medical Fees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-16</td>
<td>$12,471.00</td>
<td>$18,138.57</td>
<td>$30,609.57</td>
</tr>
<tr>
<td>Jun-16</td>
<td>$17,095.00</td>
<td>$22,050.86</td>
<td>$39,145.86</td>
</tr>
<tr>
<td>Jul-16</td>
<td>$22,541.00</td>
<td>$29,087.77</td>
<td>$51,628.77</td>
</tr>
<tr>
<td>Aug-16</td>
<td>$24,386.90</td>
<td>$14,381.36</td>
<td>$38,768.26</td>
</tr>
<tr>
<td>Sep-16</td>
<td>$29,942.55</td>
<td>$62,962.20</td>
<td>$92,904.75</td>
</tr>
<tr>
<td>Oct-16</td>
<td>$26,483.35</td>
<td>$32,905.90</td>
<td>$59,389.25</td>
</tr>
<tr>
<td>Nov-16</td>
<td>$26,478.75</td>
<td>$35,524.90</td>
<td>$62,003.65</td>
</tr>
<tr>
<td>Dec-16</td>
<td>$30,065.60</td>
<td>$29,368.29</td>
<td>$59,433.89</td>
</tr>
<tr>
<td>Jan-17</td>
<td>$27,908.20</td>
<td>$14,309.65</td>
<td>$42,217.85</td>
</tr>
<tr>
<td>Feb-17</td>
<td>$37,079.71</td>
<td>$32,719.80</td>
<td>$69,799.51</td>
</tr>
<tr>
<td>Mar-17</td>
<td>$29,979.35</td>
<td>$56,855.82</td>
<td>$86,835.17</td>
</tr>
<tr>
<td>Apr-17</td>
<td>$14,245.28</td>
<td>$31,356.69</td>
<td>$45,601.97</td>
</tr>
<tr>
<td>Total</td>
<td>$298,676.69</td>
<td>$379,661.81</td>
<td>$678,338.50</td>
</tr>
</tbody>
</table>

Notes:
- **Sept-16** - has shown a spike in costs mainly due to $30,514.65 being paid out in surgery fees
- **Feb-17** - has shown a spike in medical fees due to $7,759.29 in surgery fees, $2,720 in dental fees and $10,185.32 in specialist consultation fees
- **Mar-17** - included a fee for surgery of $32,612.08
3.2.2 Medical Fees Breakdown by Directorate
April 2017

Past 12 Months

3.2.3 Injury Claims by Category (past 12 months)
### 3.2.5 Claims Summary by Accident Date

<table>
<thead>
<tr>
<th>Month</th>
<th>No. of Claims</th>
<th>Medical Fees Only Claims</th>
<th>No. of Lost Time Injuries</th>
<th>Days Lost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>May-16</td>
<td>30</td>
<td>21</td>
<td>9</td>
<td>162</td>
</tr>
<tr>
<td>Jun-16</td>
<td>23</td>
<td>17</td>
<td>6</td>
<td>44</td>
</tr>
<tr>
<td>Jul-16</td>
<td>31</td>
<td>18</td>
<td>13</td>
<td>212</td>
</tr>
<tr>
<td>Aug-16</td>
<td>25</td>
<td>15</td>
<td>11</td>
<td>134</td>
</tr>
<tr>
<td>Sep-16</td>
<td>19</td>
<td>12</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>Oct-16</td>
<td>23</td>
<td>14</td>
<td>9</td>
<td>106</td>
</tr>
<tr>
<td>Nov-16</td>
<td>19</td>
<td>15</td>
<td>5</td>
<td>134</td>
</tr>
<tr>
<td>Dec-16</td>
<td>25</td>
<td>18</td>
<td>8</td>
<td>161</td>
</tr>
<tr>
<td>Jan-17</td>
<td>25</td>
<td>17</td>
<td>7</td>
<td>134</td>
</tr>
<tr>
<td>Feb-17</td>
<td>32</td>
<td>27</td>
<td>5</td>
<td>75</td>
</tr>
<tr>
<td>Mar-17</td>
<td>28</td>
<td>16</td>
<td>12</td>
<td>143</td>
</tr>
<tr>
<td>Apr-17</td>
<td>13</td>
<td>10</td>
<td>3</td>
<td>17</td>
</tr>
</tbody>
</table>

*The number of days lost are attributed to the month in which the lost time injury occurred i.e the 212 days lost in July 16 is the cumulative days lost relating to the 13 LTIs since then, not the days lost in the month.
BOARD DISCUSSION
Date: 24 May 2017

Author
Caroline Tilah, Executive Director Quality Improvement and Patient Safety Directorate CCDHB
Shawn Sturland, Executive Director Quality Improvement & Patient Safety Directorate CCDHB

Endorsed By
Chris Lowry, General Manager Hospital and Healthcare Services

Subject
QUALITY AND SAFETY REPORT

RECOMMENDATION
It is recommended that the Board:

a) Note the report for March to April 2017.

APPENDICIES
1. CCDHB April patient experience survey
2. CCDHB Health Matters.

1 EXECUTIVE SUMMARY
The Health and Disability Commissions report for the period July – December 2016 has been received. We have completed an evaluation of the report and HDC complaints for 2016. This has identified that no complaints logged in 2016 from HDC were because of an inappropriate or poor response from CCDHB to a complaint (a good indicator that our standard complaint process is effective). The four top HDC complaint issues relate to standard of clinical care, access/funding, consent/information and communication.

The CCDHB monthly Patient Experience survey for in patients shows that out of all the dimensions we measure, our patients give us the highest ratings for compassion, dignity and respect, with nearly nine out of 10 (87%) rating our performance as ‘very good’.

We are currently reviewing and developing the Patient Safety Strategy for the next three years with a focus on continuing to strengthen our patient safety culture. As an immediate action as part of this work the Quality Directors and professional leads are reviewing the serious and sentinel event review process.

The Improvement Movement continues to be progressed. This initiative is aimed at building on our improvement culture and developing capability within the organisation to support the identification and implementation of improvement initiatives. This will continue to contribute to our overall performance and experience for patients and staff. The first 12 week improvement training finishes on 24 May with an improvement showcase to be held. The second 12 week improvement training will commence on 29 May 2017.

The HQSC have produced a “Governing for quality: A quality and safety guide for district health boards”, to help district health boards (DHBs) put quality and safety at the centre of governance and drive improvement in their organisations. The HQSC are available to meet with the Board to discuss this and there is a link to this publication on the HQSC intranet page.
SHORTER SAFER PATIENT JOURNEYS

Our purpose is to provide high quality health care and educate people on how to stay healthy. We want people to get the health care they need, in a way that suits them. To do this we need to be innovative and work with our community. Quality is a fundamental part of the patient experience, and enabled through our Quality Framework (Consumer Value, Effectiveness, Risk, Workforce) which provides the infrastructure for quality reporting and clinical governance direction throughout the organisation.

2 CONSUMER VALUE (PATIENT EXPERIENCE)

Focussing on consumer value encourages our DHB to involve our communities in improving equity for our populations. We receive consumer information through our complaints and compliments feedback, the National and CCDHB patient satisfaction surveys and through consumer engagement. This information is analysed and reflected in continuous improvements.

2.1 Compliments & Complaints

In March we had more complaints than compliments which is the first time this has occurred (for April they are equal). Standard of clinical care remains our major complaint category followed by communication.

<table>
<thead>
<tr>
<th>CCDHB - Complaint themes</th>
<th>Oct to Dec 15</th>
<th>Jan to Mar 16</th>
<th>Apr to Jun 16</th>
<th>Jul to Sep 16</th>
<th>Oct to Dec 16</th>
<th>Jan to Mar 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard of Clinical Care</td>
<td>35%</td>
<td>39%</td>
<td>35%</td>
<td>31%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>Communication</td>
<td>25%</td>
<td>28%</td>
<td>21%</td>
<td>27%</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>
2.2 Health & Disability Commission (HDC)

The number of HDC complaints for CCDHB remains within normal variation. During April we received three new complaints from HDC and 6 HDC complaints were closed. Five HDC complaints are under investigation (2 MHAID, 2 SWC & 1 SWC/CCS). We are awaiting the outcome of 34 HDC complaints.

In summary:
- No complaints logged in 2016 from HDC were because of an inappropriate or poor response from CCDHB to a complaint (a good indicator that our standard complaint process is effective).
- The four top HDC complaint issues relate to Standard of Clinical Care, Access/Funding, Consent/Information and Communication. This is consistent with the national position.
- An analysis of HDC complaints based on the 2016 HDC reports has been completed by our Consumer Experience Officer and is being presented at The Clinical Governance meeting on 25 May 2017 to discuss actions.

<table>
<thead>
<tr>
<th>Main complaint issue</th>
<th>Jan-Jun</th>
<th>Jul-Dec</th>
<th>Total 2016</th>
<th>CCDHB % Total 2016</th>
<th>National % total 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard of Clinical Care</td>
<td>17</td>
<td>18</td>
<td>35</td>
<td>57%</td>
<td>56%</td>
</tr>
<tr>
<td>Access/funding</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Consent/Information</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Facilities issues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Documentation</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1.5%</td>
<td>1%</td>
</tr>
<tr>
<td>Boundary Issues</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1.5%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Professional conduct</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1.5%</td>
<td>2%</td>
</tr>
</tbody>
</table>
2.3 **CCDHB Monthly Patient Experience Survey**

Our April inpatient experience survey was focussed on compassion, dignity & respect. Four in 10 in-patients (43%) say that being treated with compassion, dignity and respect is one of the three things that make the most difference to their care and treatment. Out of all the dimensions we measure, our patients give us the highest ratings for compassion, dignity and respect, with nearly nine out of 10 (87%) rating our performance as ‘very good’. The April Patient Survey report is attached – Appendix 1.

3 **EFFECTIVENESS**

Effectiveness focuses on monitoring and evaluation of patient care and performance in relation to our peers to ensure focussed quality improvement.

3.1 **Improvement**

CCDHB is focussed on supporting innovation and the method of achieving sustainable change through improvement. We use the Institute for Healthcare Improvement (IHI) - Model of Improvement. Our staff receive training on this through the Service Improvement Section of the Front Line Leadership Programme and also within the focussed “CCDHB Improvement Movement Training” that is aimed at building capability and capacity within our work force. A summary of the organisation wide improvement projects currently underway are outlined below:

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Aim</th>
<th>Related Strategic Objective/s</th>
<th>Status</th>
</tr>
</thead>
</table>
| **Electronic Results Sign Off**                        | To understand the issues leading to high numbers of electronic results remaining unsigned and identify areas of improvement. | Shorter, Safer, healthcare journeys                | Serial tests to GP go live 3 April 2017  
Autosign rules protocol and first new rule to test the process awaiting sign off by the HHS leadership team.  
Implementation of new ordering doctor windowlet planned for April |
| **Sweet As**                                           | To reduce preventable hypoglycaemic events on Ward 5 South by 25% by 01/06/2017. | Shorter, Safer, healthcare journeys                | Currently trialling the new prescription form in General Medicine and General Surgery. The time frame has been extended following additional requirements identified by the Medicine Review Committee |
| **Management Operating System - Phase 2**             | To implement the management operating system in ICU by July 2017      | Shorter, Safer, healthcare journeys Growing our People Better Value for Money | ICU team finalising strategy. Once finalised will identify KPIs to monitor progress against strategy |
| **Improving Dental & Oral Health Reception Processes** | This project aims to standardise the Dental & Oral Health services reception processes across the Wellington and Kenepuru sites to reduce unutilised | Growing our People Better Value for Money          | Running PDSA cycles for change ideas. Have seen an improvement in DNAs, especially in the Wellington campus |
Tu Pounamu

To increase the cumulative composition of Māori staff from 5.3% to 7% by December 2017. To increase the cumulative composition of Pacific staff from 6% to 8% by December 2017.

Growing our People

Initial work on updating our HR data information system data capture has gone to the vendor AMS for assistance with making the changes in Leader. This has also been discussed at a national meeting run by AMS to seek support from other DHBs. Planning next steps with workstreams.

Alerts

To implement a policy for electronic patient alerts and have a clear process and across CCDHB by June 2017.

Shorter, Safer, Healthcare journeys

Draft alerts process confirmed. Presented to HHS Leadership meeting April 27th meeting and agreed with changes to date.

In the data capture/problem defining phase to focus improvement activity

Improving acute Flow – General Surgery, Orthopaedic and Mental Health services

Francis Group are leading this piece of work. QIPS Improvement Advisors (IA’s) currently working on Mental health work stream, General surgical work stream & Orthopaedic work stream. Currently identifying problem areas and providing detailed analysis

Outpatients paper vs electronic medical records

ELT appointed professional leads as sponsor. Meeting planned in early June to discuss a way forward.

Management Operating System Phase 1 – Data Visualisation procurement

11 companies requested the data for analysis and their video submission.

Ward 7 South

Working with Ward 7 South Performance Improvement team. Staff engagement survey completed. Results are to be shared with the staff to validate findings. Next steps focus groups to identify areas for improvement.

3.2 HQSC Open Campaign - Quality Safety Markers

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand’s health care through the national patient safety campaign Open for better care. The quality and safety markers (QSMs) help evaluate the success of the campaign nationally and determine whether the desired changes in practice and reductions in harm and cost have occurred. CCDHB July to September 2016 QS Markers were published 19/12/2016.

<table>
<thead>
<tr>
<th>Marker Definition</th>
<th>NZ Goal</th>
<th>NZ Avg</th>
<th>Q1 Jan – Mar 15</th>
<th>Q2 Apr – Jun 15</th>
<th>Q3 Jul – Sep 15</th>
<th>Q4 Oct – Dec 15</th>
<th>Q1 Jan to Mar 2016</th>
<th>Q2 Apr to June 16</th>
<th>Q3 July to Sept 16</th>
<th>Q4 Oct to Dec 16 (NA = Not achieved)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FALLS: Percentage of patients aged 75 and over (Maori and Pacific Islanders 55)</td>
<td>90%</td>
<td>93%</td>
<td>87%</td>
<td>92%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>91%</td>
<td>91%</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

Capital & Coast District Health Board

112
and over) that are given a falls risk assessment.

FALLS: Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk.

<table>
<thead>
<tr>
<th></th>
<th>90%</th>
<th>90%</th>
<th>91%</th>
<th>95%</th>
<th>99%</th>
<th>99%</th>
<th>99 %</th>
<th>96%</th>
<th>93% Achieved</th>
</tr>
</thead>
</table>

New Safe Surgery QS Marker as of 01/07/2016

<table>
<thead>
<tr>
<th>Observations – number of observational audits carried out for each part of the surgical checklist (Minimum 50)</th>
<th>Sign in</th>
<th>41 NA</th>
<th>56 Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time out</td>
<td>51 A</td>
<td>95 Achieved</td>
</tr>
<tr>
<td></td>
<td>Sign out</td>
<td>36 NA</td>
<td>59 Achieved</td>
</tr>
</tbody>
</table>

Uptake, percentage of audits where all components of the checklist were reviewed (target 100%)

<table>
<thead>
<tr>
<th>Sign in</th>
<th>0 NA</th>
<th>91 NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time out</td>
<td>88 NA</td>
<td>93 NA</td>
</tr>
<tr>
<td>Sign out</td>
<td>0 NA</td>
<td>93 NA</td>
</tr>
</tbody>
</table>

Engagement, percentage of audits with engagement scores of 5 or higher (target 95%)

<table>
<thead>
<tr>
<th>Sign in</th>
<th>0 NA</th>
<th>73 NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time out</td>
<td>69 NA</td>
<td>90 NA</td>
</tr>
<tr>
<td>Sign out</td>
<td>0 NA</td>
<td>89 NA</td>
</tr>
</tbody>
</table>

HAND HYGIENE: Percentage of opportunities for hand hygiene

| 80% | 80% | 72% | 79% | 81% | 80% | 78% | 82% | HQSC advised national reporting is now 3 times a year so no update for Q4 |

SURGICAL SITE INFECTIONS: Percentage of hip and knee arthroplasty primary procedures were given an antibiotic in the right time.

| 99% | 95% | 98% | 100% | 100 % | 100% | 100% | 100% | 100% |

SURGICAL SITE INFECTIONS: Percentage of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose

| 99% | 98% | 98% | 98% | 100 % | 99% | 99% | 99% | 98% |

SURGICAL SITE INFECTIONS: Percentage of hip and knee arthroplasty primary procedures were given appropriate skin prep

| 99% | 100 % | 100% | 100% | 100 % | 100% | 100% | 99% | HQSC advised this process marker has been discontinued as consistently at 99% nationally since Jan 2015 |

Process marker for Cardiac Surgical Site Infection

<table>
<thead>
<tr>
<th>Introduced Q.3 at the 5 DHBs performing cardiac surgery</th>
<th>Timing</th>
<th>100</th>
<th>Results are a quarter in arrears</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dosing</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skin prep</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

### 3.3 Safe Surgery Quality Safety marker (QSM)

While this quarter is reported as not achieved significant progress has been made. Previous quarters have indicated the number of trained auditors was insufficient to capture the information required to demonstrate achievement of the marker. This has been addressed by increasing the number of staff trained in auditing as per the HQSC method. The additional training has enabled the minimum number of required cases to be audited for this quarter. We expect this will continue to improve and that the marker will be achieved in the next quarter.
3.4 Certification

A progress report on the low actions is due to the MOH by the 25 05 2017.

3.5 Controlled Documents (Policies/Procedures/Protocols/Guidelines)

As a DHB we are actively engaging in policy development and the development of sub-regional and regional controlled documents. Each Executive Director now receives a monthly update on policies for their services to ensure that there is oversight, and if out of date an action plan in place. Overall policy compliance rate is 68% which is a reduction in compliance. The organisational clinical policies are being distributed to the relevant directorate where the speciality exists for follow up HR and finance have action plans in place currently.

4 RISK (SAFETY)

CCDHB is committed to providing a safe environment for all patients/clients who use our services and recognise that despite the best intentions of the staff, incidents and errors will occur. The DHB is committed to ensuring that the risk management and patient safety systems enable early identification, review and system changes to improve safety.

4.1 Risk Framework

The CCDHB revised Risk Policy was endorsed by the Finance Risk and Audit Committee and is being presented to the Board meeting in May for approval. The new risk matrix will be effective as of 1 July 2017. This allows time for implementation and training to occur. All current risks will also be updated against the new risk matrix. A hazard/risk module for SQUARE is currently being explored. Agreement on this will require a 3DHB discussion.

4.2 Patient Safety Agenda

Increasing demand for health services, and the increasing intensity and complexity of those services (people are living longer, with more complex co-morbidities and expecting high levels of advanced care) imply that the number of patients harmed while receiving care will only increase (Hollnagel, 2015).

As identified at the Hospital Health Services (HHS) Leadership meeting in February 2017, there is an opportunity to reduce patient harm and improve patient experience by implementing a more proactive approach to patient safety. We want our approach to patient safety to change from ensuring that ‘as few things as possible go wrong’ to ‘as many things as possible go right’. Our current Safety 1 approach does not consider that every day clinical work is variable and flexible.

CCDHB staff have been involved in further investigation into other approaches. The Professional Leads and Executive Directors of Quality are progressing this with a discussion paper being presented to the Clinical Governance meeting at the end of May 2017.

To improve communication of key messages learnt through our serious and sentinel event reviews the Patient Quality Safety Indicator Committee is producing a monthly article in Health Matters (also visible on the communication boards). For April this was focussed on falls with the focus – attached Appendix 2. For May the focus is on hand hygiene “PREVENTING INFECTION IS IN YOUR HANDS”.

Appendix 2.
4.3 Clinical & Quality Safety Measures

CCDHB has monthly clinical measures reporting in place that contains control charts for an agreed set of clinical and quality measures (data from our reportable events and other relevant data sources). All measures show no special cause variation.

GROWING OUR PEOPLE

We want to be a highly regarded organisation and a preferred place to work. A place where our staff feel valued, have development opportunities, are involved in improving the way we do things, and have a safe workplace. Workforce is focused on how we are facilitating collaboration and thereby ensuring CCDHB is getting the best value for public health system resources.

5 WORKFORCE (INCLUDES SUB-REGIONAL/REGIONAL COLLABORATION)

Workforce is focused on how we are facilitating regional and sub-regional collaboration and thereby ensuring CCDHB is getting the best value for public health system resources.

5.1 Improvement Movement - Improvement Training

The QIPS improvement team started the CCDHB Improvement Movement in November 2016. The purpose of the improvement movement is to build a culture of continuous improvement and improvement capability at CCDHB. The first 12 week improvement training finishes on 24 May with an improvement showcase. The 2nd 12 week improvement training will commence on 29 May 2017. A total of 223 staff have attended the 1 hour taster session, and 15 have completed the 12 week training module.

5.2 CCDHB Child Youth Mortality Review Committee (CYMRC) Update

Current HQSC guidelines for CYMRC require that at minimum, 70% of child / youth deaths need to be reviewed per year – this equates to approximately 21 cases for CCDHB.

The CYMRC 12th Data Report (2011 – 15) was released by HQSC on 13 April 2017. There has been an increase in child and youth deaths nationwide. The suicide rate for CCDHB is the
leading cause of death for youth in the age category 20 – 24. It is the second leading cause of death for youth in the age category 15 – 19. The rate has been trending up over the last 3 years.

There have been increases in both “sudden unexpected death in infancy (SUDI)” and suicide rates nationwide. CCDHB has a relatively low SUDI rate compared to the rest of the country, but there are still ethnic disparities across this group which requires our focus.

Nationwide there are ethnic inequalities. Māori and Pacific groups display multiple disadvantages resulting in higher morbidity and mortality across almost all causes of death. The CYMRC aim is to eliminate this gap and reduce the health gradient for these ethnicities. As a result, CCDHB CYMRC will be focusing on cases involving intentional injuries, SIDS / SUDI cases, and prioritizing cases which pertain to people with multiple disadvantages and those of ethnic minority groups, due to the vulnerability across those groups. This is a protected quality assurance activity and as such the operational learning’s will be shared with the DHB through the six month report. This is tabled at our HHS Clinical Governance where actions can be identified and linkages made with other services such as Māori and pacific and mental health services as required.
**RECOMMENDATIONS**

It is **recommended** that the Boards:

a) **Note** that the implementation of the combined CCDHB-HVDHB Crisis Resolution Service (CRS) is progressing, with outstanding vacancies being the key remaining challenge – these are being actively recruited to

b) **Note** that there has been a 65 percent decrease in the number of people assessed by the 3DHB Mental Health, Addictions and Intellectual Disability Service (MHAID) in police cells since 2015

c) **Note** that the Crisis Resolution Service will soon have all permanent full time Senior Medical Officer (SMO) positions filled

d) **Note** that Clinicians from Hutt Valley and Capital & Coast DHBs now have access to electronic health records in Concerto & WebPAS

e) **Note** that the Ministry of Health has recently released the new draft suicide prevention strategy for public consultation and we are developing our feedback to this

f) **Note** that the Human Rights Commission commissioned a report that reviewed seclusion and restraint practices in NZ. Within the report, a number of good practices examples from within the 3DHB MHAIDS

g) **Note** that the South Community Mental Health team, the Alcohol & Drug Service and the Wellington Community Mental Health teams will soon be moving to a purpose-renovated facility in Adelaide Road, Wellington

h) **Note** that the Child and Adolescent Mental Health Service (CAMHS) team in the Wairarapa has one of the lowest wait times in New Zealand

i) **Note** that a letter has gone to the Ministry of Health from five of the National Forensic General Managers regarding resource issues in the ID Forensic Services nationally.

**APPENDICES**

1. [Te Haika referral and response data April 2017](#)

2. [MHAIDS 3DHB Balanced score card – March 2017](#)

3. [Wairarapa DHB data](#)
1. PURPOSE

This paper provides the Boards of Wairarapa, Hutt Valley, and Capital & Coast DHBs with an update on the three key projects that the Mental Health, Addictions and Intellectual Disability Service (MHAIDS) 3DHB is currently working on and to provide an overview of the draft suicide prevention strategy that has been release by the Ministry of Health for consultation.

2. CRISIS RESOLUTION SERVICE (CRS)

Police data shows that there has been a 65 percent decrease across our region of the number of 3DHB MHAIDS clients in police cells since 2015. This is reflected in a proportionate increase in people coming through emergency departments.

There has been much progress in all areas with some delays due to the service still needing to recruit sufficient staff to achieve the full model fidelity. There have also been some on-going and long-standing challenges regarding the implementation of the new model from staff and their union representation. Following formal consultation, there have been numerous meetings and discussions with individuals and teams along with their representatives. CCDHB staff on employment and agreements prior to the formation of 3D service are still being resolved. A proposal to reach agreement has been sent to the national organizer of the PSA. Hutt Valley staffing issues whereby the mediated agreement which has resolved. There are new employment agreements to the two relevant staff in which they agree to work across DHB boundaries to provide services. New staff are coming on-board signing onto the 3DHB service.

2.1 Workstream one – Rosters

The key focus of this workstream is to employ and allocate sufficient numbers of staff to cover crisis response 24 hours a day, seven days a week for both the Hutt Valley and Capital & Coast geographical boundaries. This workstream is dependent upon successful recruitment and the full agreement of staff to work across the two DHBs.

2.1.1 Milestones

- Appointment of a single team leader
- Appointment of a lead clinician (psychiatrist) and the imminent filling of a longstanding psychiatrist vacancy in the Hutt. This will mean for the first time in a number of years the combined DHBs will have all permanent full time Senior Medical Officer (SMO) positions filled
- Appointment of a single clinical nurse specialist
- Appointment of a single day coordinator
- Overall increase in clinicians to the joint service
- Acute resource coordinator (ARC) now facilitating admissions to acute inpatient units and respite across the 3DHB
- Increased presence in the Wellington ED from 7.30 am – 11.30 pm every day.

2.1.2 Key outstanding issues

While agreement has been reached with new staff and staff who were in the previous Hutt crisis assessment team (CAT) to work across the DHBs, there are still some unresolved issues with the previously employed Wellington CAT to fully accept the new model. This is subject to current and ongoing mediation between the DHBs and the PSA. While this has been an ongoing concern for the past year, a resolution is anticipated over the next two to three months;
There has been positive recruitment to key positions over this period of time; however there have also been resignations. There are still a number of vacancies that need to be filled before the new model can be fully implemented. In particular there needs to be higher staff coverage to increase the night response to the emergency departments.

2.2 Workstream two – Information & Technology

The key focus of this workstream is improving the information and technology systems and their availability for staff by ensuring that there are consistent processes as well as up-to-date technology. Electronic Whiteboards have been purchased. They have specifically designed for Mental Health & Addictions Services; they give a live real time view of caseload and pending workloads.

2.2.1 Milestones

- Clinicians from the 2DHBs (Hutt Valley and Capital & Coast DHBs), have access to both electronic health records (Concerto & WebPAS) – this is still being ironed out but we are confident this will be finalised with ICT soon
- The Crisis resolution plan is now able to be uploaded to Medical Application Portal (MAP) and visible within the specialist assessment folder
- Large monitors, additional PCs, and laptops have been purchased in preparation for use of the electronic whiteboards and the interim CRS report
- The CRS now have access to Emergency Department Information Services (EDIS) at Wellington ED from the Kenepuru base
- Single email address for CRS has been developed
- Installation of a Capital & Coast DHB computer at the police hub
- A shared G: drive for the CRS across Capital & Coast and Hutt Valley DHBs.

2.2.2 Key outstanding issues

There has been training using the Medical Application Portal but there some outstanding training issues as follows:

- The interim solution for the electronic whiteboard, the CRS Workload Report, has been developed and staff are awaiting training
- The Hutt Valley Electronic Whiteboards have arrived; the connections are currently occurring by ICT. CCDHB are still waiting for Electronic Whiteboards to be in installed.

2.3 Workstream three – Documentation

The key focus of this workstream is for there to be one documentation pathway for CRS across the DHBs.

2.3.1 Milestones

- An agreement has been reached on the required documentation for CRS across both DHBs
- Significant progress with the operations manual (draft attached) and the desk file has been made.

2.4 Workstream four – Model

The key focus of this workstream is to develop an agreed model of care for the CRS and its interface with other key stakeholders.

2.4.1 Milestones

- Key components of the model have been developed and shared with other operational areas
3. DRAFT SUICIDE PREVENTION STRATEGY

The Ministry of Health have recently released the new Suicide prevention strategy in draft for consultation.

Every year over 500 people die by suicide in New Zealand. This has a devastating impact on the lives of the people involved and impacts all of us in some way. The current New Zealand Suicide Prevention Strategy 2006–2016 that has guided suicide prevention activity in New Zealand since 2006, has come to an end.

‘A Strategy to Prevent Suicide in New Zealand: Draft for public consultation’ outlines a framework for how the Ministry of Health (the Ministry) and other Government agencies, including DHBs, can work together to reduce suicidal behaviour in New Zealand. It also identifies a set of priority areas for action.

This draft strategy is a public consultation document. It offers an opportunity to change how we think and talk about suicidal behaviour.

The five sections of the draft strategy cover:

- The impact of suicidal behaviour in New Zealand, its causes and how we can prevent it
- The proposed approach and vision for preventing suicidal behaviour
- How the vision will become reality
- How we will know whether we are making progress
- Feedback process.

The draft strategy explains that because suicidal behaviour has no one cause, there is no single solution for preventing it. What works for one person may not work for another person.

To prevent suicidal behaviour across the country, it is stated that we need to do a broad range of activities over a long period. These different types of activities need to focus on giving people the best opportunity to have a healthy future and providing them with appropriate support when they need it.

The range of activities involves three different types of approaches:

- Universal – for all people
- Targeted – for some people, in particular those who belong to groups at higher risk of suicidal behaviour
- Indicated – for the small proportion of people who are at high risk of suicidal behaviour.
The Strategy explains why we need to do this, but does not clearly define actions. There is no literature review that includes what other countries are doing to successfully reduce suicide rates. It appears that the action plans need to be developed by DHBs and other government and non-Government agencies.

The current 3DHB Suicide Prevention Plan is for the period 2015 to 2017. The Ministry has recently asked for this plan to be refreshed and extended for one year in order to coincide with the implementation of the new national strategy once it is finalised. This refresh will be co-ordinated across the 3DHBs and completed in partnership with internal and external stakeholders.

The graphs on the following page show data of suspected suicides by Region (red), Client contact and age range for 2016 (provisional data pending coronial findings), and by District Health Board (blue) that were identified as clients of MHAID Service.

Please note: This data is provisional pending coronial findings:
The nine suicides in Wairarapa region represent the highest per region in New Zealand.

4. **TE WHARE AHURU, PUREHUREHU RENOVATIONS AND HAUMETIKETIKE INDIVIDUAL SERVICE UNITS (ISU)**

Te Whare Ahuru is the adult acute mental health unit at Hutt Valley Hospital. There are a number of working groups around the development of this service. It is proposed that the unit undergoes a renovation and a draft project plan is being developed.

Purehurehu - one of our regional forensic units is undergoing an upgrade this is out to tender currently.

An extension is planned for Haumietiketike, one of the national forensic intellectual disability services. This will be a new national service based on individual service units, funded by the Ministry of Health. The strategic plan for ISU has been presented to the national investment committee in May and a full business case with a single stage business case is currently being prepared.

5. **HUMAN RIGHTS COMMISSION (HRC) REVIEW OF RESTRAINT & SECLUSION IN NZ**

There has been a recent media release of a report commissioned by the New Zealand Human Rights Commission titled “Thinking Outside the Box: A review of seclusion and restraint practices in New Zealand” by Dr Sharon Shalev.

During October and November 2016, Dr Sharon Shalev, an international expert in the field of solitary confinement and seclusion and members of the Human Rights Commission and Ombudsman’s Office completed an independent review of seclusion and restraint practices in a number of New Zealand detention settings.
Dr Shalev’s report is focused on facilities that are subject to monitoring under the Optional Protocol to the Convention Against Torture (“OPCAT”), The Crimes of Torture Act 1989. These facilities included prisons, health and disability units, police cells, Child, Youth and Family care and protection units, and youth justice residences.

Prior to the site visits, a substantial amount of information was requested by the Human Rights Commission, including Restraint and seclusion policies and five years’ worth of seclusion and restraint data.

The 3DHB MHAIDS Inpatient units were the first such facilities to be reviewed and included:

- Tawhirimatea Regional Rehabilitation Unit at Ratonga Rua hospital;
- Haumietiketike Adult Forensic Intellectual Disability Unit Ratonga Rua hospital;
- Te Whare Ahuru acute adult inpatient unit at Hutt Hospital and Te Whare o Matairangi acute adult inpatient unit at Wellington Hospital.

Toni Dal Din, 3DHB MHAIDS Director of Nursing, facilitated the site visits and accompanied the reviewers during the visits.

The visits were between three to four hours long and the agenda included:

- A brief introductory meeting with the unit/institution manager;
- A walkthrough the initial process for new arrivals at the unit;
- A tour of the unit (rooms, showers, exercise yards, communal areas, holding rooms and special rooms);
- Background on current occupants and reasons for their placement;
- Time to observe routines and interactions in the unit;
- An opportunity to informally speak to staff and service users;
- Time to scrutinise unit policies, registers (seclusion & restraint) and documentation (including daily observation logs, incident reports);
- Staff handover;
- Quick debrief.

They also reviewed complaints procedures and data on complaints dating back six months where possible.

The key findings that related to Health facilities included:

- Overall, the data revealed a high use of seclusion and restraint in New Zealand, and an over representation of ethnic minority groups, in particular Māori, in seclusion;
- Stark physical environments and impoverished regimes in seclusion, secure care and segregation units, and in a number of cases no access to basic fixtures such as a call-bell to alert staff, a toilet or fresh running drinking water;
- A small but persistent number of people in health and disability facilities were subjected to long-term restrictive measures, and discussion of future plans for these individuals appeared to be focused on variants of seclusion and restraint. For the individuals concerned, prolonged seclusion and/or restraint (and often both) had thus become a chronic state rather than an emergency short term response to an acute situation;
- Review processes were not always robust.
Key recommendations related to Health facilities included:

- The use of seclusion, segregation and all forms of restraints should be significantly reduced, reserved for the most extreme of cases and then used only for a very short time;
- Decisions to use seclusion or restraint should be based on an individualised and proportionate risk-needs based approach and be regularly and substantively reviewed;
- Minimum standards for the provision of decent living conditions and essential provisions as set out in human rights instruments must always be met. Specifically, cells and rooms must be of a reasonable size, clean, safe, well ventilated, well lit and temperature controlled. Basic requirements regarding access to fresh air and exercise, food and drinking water must always be adhered to across all detention contexts;
- All cells/rooms must be equipped with a means of attracting the attention of staff and these must be regularly checked to ensure that they are in good working order;
- Data on the use of seclusion/segregation/secure care units and the application of restraints should be recorded more fully and analysed for trends and protected characteristics such as age, gender and ethnic origin. The apparent overrepresentation of ethnic minorities, in particular Māori, in seclusion and segregation units in prisons and in health and disability units.
- Oversight mechanisms need to be strengthened, in particular with regard to placement in, and ways out of, seclusion and segregation units. These should be made proportionally more exacting as time in seclusion/segregation progresses.

Good practice examples were identified in our units such as:

- In Te Whare o Matairangi it was noted that newly arrived patients arriving to the de-escalation unit received a welcome pack with toiletries, a pen, a notebook, information on daily routines and activities available in the unit. An information booklet on the complaints system, peer support and other relevant information is also supplied;
- Newly arrived residents at Haumietiketike Intellectual Disability Secure Inpatient unit were also provided with ‘housekeeping guidelines’ setting out expectations and the unit’s daily routines, as well as illustrated guidance on making complaints;
- In a number of units (though not all), where patients were secluded, the bedroom they were originally allocated in the general units was kept for them (Te Whare o Matairangi);
- Secluded patients at Te Whare o Matairangi mental health unit could operate their own window blinds, and the Tawhirimatea Rehabilitation unit was spotlessly clean. One of the long term residents in Haumietiketike unit had a bedroom, an activities room, and a vegetable patch;
- In one Health and Disability Unit (Haumietiketike), family members were invited to participate in six monthly reviews that also included the patient’s care team, occupational therapist, psychology and psychiatry. This, and in particular the involvement of the patient’s family, was excellent practice.

6. **TE HAIKA**

Te Haika is the telephone call centre which triages crisis and acute calls 24 hours per day, seven days per week. Clients phone in on a specific phone number – 0800 745 477. The call centre is staffed by registered health professionals who manage referrals to MHAID Services for Wairarapa, Hutt Valley and Capital & Coast DHBs. Prior to July 2015, this service only covered Capital & Coast DHB. In July 2015, the service was expanded to Wairarapa and Hutt Valley during normal work hours, and from 1 July 2016 the service has covered the region 24 hours per day, seven days per week.

Te Haika’s referral and response data for April 2017 is attached as Appendix 1.
7. RELOCATION OF COMMUNITY MENTAL HEALTH TEAMS

The South Community Mental Health team, Alcohol & Drug Service and Wellington Community Mental Health team are moving to a purpose-renovated facility on Adelaide Road. We are awaiting for the Seismic assessment before proceeding with renovation. The owner is to fund the renovation which has a timeframe of approximately four months for completion.

8. ICAFS (INFANT, CHILD AND ADOLESCENT FAMILY SERVICE)

An independent review of the ICAFS has started. Waiting times is a key issue for the 3DHB MHAIDS, although it should be acknowledged that access has increased significantly across the all of the Child and Adolescent Mental Health Service (CAMHS) teams. The CAMHS team based in the Wairarapa has one of the lowest wait times in the country.

9. CAMHS (CHILD & ADOLESCENT MENTAL HEALTH SERVICE) WAIRARAPA

A blessing has been scheduled for the 23 May 2017, with the relocation to follow later on in the week.

10. CLIENT PATHWAY

In response to Serious Adverse Events (including service user harm, and in some cases harm to others), and the resulting recommendations from formal reviews undertaken SAEs have increased from less than 1 per month to 3 per month.

Analysis of those recommendations indicates that reviewing the Client Pathway across the 3 DHBs and addressing inconsistencies in practice would cover off many of the identified recommendations.

Steady progress is being made with the Client Pathway since the contracting of a Project Manager. Various workshops have been held during 2017 engaging key staff across the 3 DHBs. Two process improvement workshops were held in April 2017, covering the later stages of the Client Pathway from “Entry” through to “Service Exit”.

A high level design document has been prepared that presents a summary of the key documents and applications that will provide improvements to the Client Pathway and comprise the interim Electronic Health Record (EHR) for the 3DHB MHAID Service. The process and application changes described will also profoundly change how clinicians interact with clinical documentation and will establish a mode of practice for the future.

The ICT 3D Continuous Notes application has been demonstrated to three groups of 3DHB MHAIDS staff, including senior clinicians and is meeting with positive feedback.

Regular monthly meetings have been established with ICT representatives, providing an opportunity to ensure requirements and development timeframes are understood.

Meeting with different sector/team representatives to ensure the commonly determined systems, processes and documentation as outlined in the high level design will work to subsume those teams’ requirements; e.g. Early Intervention Service (EIS), Central Region Eating Disorder Service (CREDS). Engage professional leaders.

A draft implementation plan (with a Communications plan) is being prepared. This is a significant change in approach from a paper-based system to an electronic system.
11. CONSUMER REVIEW

There are nine consumer roles across Hutt Valley and Capital & Coast DHBs. In Wairarapa DHB there is no specific consumer role but on-going discussions are being held as to how consumer input into the service can be achieved.

The consumer review for MHAID Service 3DHB was commenced in mid-2015. A consultation paper was released in January 2017. The decision document has now been finalised and is available on the intranets and advertisement for our Director of Consumer Participation is underway.

The consultation paper proposed a Director of Consumer Participation and a hybrid model (combination of contracted consumer organisations and employed roles).

12. BALANCED SCORECARD

The balanced scorecard (BSC) for March 2017 is attached as appendix two. The 3DHB MHAIDS continues to invest in the BSC as a single portal for its performance indicators.

There are a number of audits underway and data fixes are applied. Some measurements are still in draft until we can be confident about the data. As an interim measure Wairarapa DHB data is being collated manually and reported as an appendix to the BSC.

The Balanced scorecard is both a Management and Governance tool. It is recommended that the Boards focus on the following eight key indicators:

1. 7 day Discharge from Acute Units
2. 28 day readmission rate
3. Seclusion
4. Sick Leave
5. Annual Leave
6. Turnover of Staff
7. Finances
8. Overtime.

There will be a demonstration to the Board on these eight indicators and what plans there are to improve results from MHAID Service.

13. PERFORMANCE APPRAISALS

The Directors of Operations and Human Resources are working to ensure that appropriate templates are in use and that all managers complete and document staff appraisals in a timely manner. The 3DHB MHAIDS is focusing on this key indicator as historically the Service has not performed as well on it.

14. INPATIENT SERVICE ACTIVITY

The following IP activity is for April 2017:

<table>
<thead>
<tr>
<th>TWOM</th>
<th>Rangatahi</th>
<th>Ra Uta</th>
<th>Purehurehu</th>
<th>Rangipapa</th>
<th>Hikitia</th>
<th>Haumie</th>
<th>Tane M</th>
<th>Tawhiri</th>
<th>Nga T</th>
<th>TWA</th>
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<tbody>
<tr>
<td>Admissions</td>
<td>44</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
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## 15. 3DHB MHAIDS Financial Overview Year-To-Date (YTD) April 2017

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<th>(000$)</th>
<th>YTD Actuals</th>
<th>YTD Budgets</th>
<th>YTD Variance</th>
<th>YTD Actuals</th>
<th>YTD Budgets</th>
<th>YTD Variance</th>
<th>YTD Actuals</th>
<th>YTD Budgets</th>
<th>YTD Variance</th>
<th>YTD Actuals</th>
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</thead>
<tbody>
<tr>
<td>1000: Revenue</td>
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<td>94,598</td>
<td>(307)</td>
<td>20,135</td>
<td>19,640</td>
<td>495</td>
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<td>2,812</td>
<td>876</td>
<td>(1,936)</td>
<td>1,317</td>
<td>776</td>
<td>(551)</td>
<td>7,753</td>
<td>4,688</td>
<td>(3,065)</td>
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<td>4000: Clinical Supplies</td>
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<td>968</td>
<td>158</td>
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<td>388</td>
<td>(612)</td>
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<td>(476)</td>
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</table>

### Key:
- TWOM – Acute unit Wellington Hospital
- TWA – Acute unit Hutt Hospital
- Rangatahi – Regional Acute Adolescent unit, Kenepuru Hospital
- Ra Uta – Psychogeriatric unit, Kenepuru Hospital
- Hikitia – National Intellectual Disability Secure Youth unit
- Haumietiketike – National Intellectual Disability Secure Adult unit
- Manawatu and Whakaruru – Intellectual Disability Step Down Cottages
- Purehurehu and Rangipapa – Regional Forensic Secure units
- Puakeo and Saunders House – Forensic Service Step Down Cottages
- Tane Mahuta, Tawhirimatea and 7 Cottages – Regional Inpatient Rehabilitation and Extended Care.
At Hutt Valley DHB for MHAID Service, there is a surplus to budget of $333K for the month and $254K YTD. This is due mainly from increased revenue for the Wairarapa DHB Inpatients and some cost savings from outsourced medical costs.

At Hutt Valley DHB for MHAID Service continues to be impacted by the increased number of inpatient admissions. A small variation in this has a significant impact.

For MHAID Service in Capital & Coast DHB funding for rehabilitation 3 beds was ceased in December 2015. This adverse variance was offset by favourable variances in specialist assessments and forensic courts’ revenue. Costs associated with these revenue increases were reflected in the personnel and outsourced expenses.

Personnel costs had a favourable variance to budget year to date of ($875K). Some costs were reflected in outsourced medical that was higher than budget due to vacancies being replaced by locums and included the stretch and savings targets of $4.7M and additional revenue associated cost as above. YTD, Outsourced staff costs were adverse to budget by ($578K) due to backfilling of medical and allied staff vacancies. Savings reflected in personnel cost.

The overall service continues to actively manage overtime that is trending downwards towards 2.5 percent of total personnel hours over the last 12 months. Both overtime and sick leave are trending downwards in costs. Sick leave is currently averaging at 3 percent, well within the range between 3 percent–4 percent amongst the participating DHBs at the national KPI forum.

Overall operational performance was $5.4M favourable before the savings target. After the savings target of $5.6M for YTD, the Service was $118K adverse to budget. With constant occupancy and vacancy management challenges, the 3DHB MHAIDS has still successfully achieved 92 percent YTD.

Over the remainder of the financial year, the operational team is focusing on high annual leave balances, with a targeted approach towards people with higher than two-year entitlements across the 3DHB MHAIDS with careful leave planning over the next few months.

16. NATIONAL RESOURCE ISSUE IN ID FORENSIC SERVICES

On 5 May a letter from a collective of the five national forensic services GM’s was sent to Jill Lane (Director Services Commissioning, MoH) attention to other relevant senior officials.

This letter was a collective escalation of the significant resource issues in the ID Forensic Services nationally. CCDHB are aware of this issue due to holding two national contracts (NIDCA and National Youth Unit) and the impact this is having from a national perspective. Our services, particularly the NIDCA are facing the escalation of this issue by external agencies such as the Courts, Corrections and wider forensic mental health services due to the inability to admit clients appropriately or in some cases at all. This bed crisis is across both hospital and community secure facilities and is reflective of the wider capacity and capability issues being experienced by disability services nationally. This has reached critical levels. This matter has been raised over the last 18 months by these services (including our own) however no action resulting in increased purchasing has ensued.

DHB CE’s of the five regions were either involved in the original discussions and drafting or have been notified since.