**MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD**

**Tuesday, 9 April 2019**

**Venue:** Room 202, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

<table>
<thead>
<tr>
<th>CMDHB BOARD MEMBERS</th>
<th>CMDHB MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Gosche – Chairman</td>
<td>Margie Apa – Chief Executive Officer</td>
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<tr>
<td>Dr Lyn Murphy</td>
<td>Margaret White – Chief Financial Officer</td>
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<td>Apulu Reece Autagavaia</td>
<td>Dr Gloria Johnson – Chief Medical Officer</td>
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<tr>
<td>Dr Ashraf Choudhary</td>
<td>Dr Jenny Parr – Chief Nurse &amp; Director of Patient &amp; Whaanau Experience</td>
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<td>Catherine Abel-Pattinson</td>
<td>Dinah Nicholas – Board Secretary</td>
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<td>Colleen Brown</td>
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<td>Dianne Glenn</td>
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<td>George Ngatai</td>
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<td>Katrina Bungard</td>
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<td>Pat Snedden</td>
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<td>Kylie Clegg</td>
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**PART 1 – Items to be considered in public meeting**

**AGENDA**

<table>
<thead>
<tr>
<th>BOARD ONLY SESSION (8.00 – 9.00am)</th>
<th>Page No.</th>
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</thead>
<tbody>
<tr>
<td>1. <strong>GOVERNANCE</strong></td>
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<tr>
<td>9.10 – 9.15am</td>
<td>2</td>
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<tr>
<td>1.1 Apologies</td>
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<tr>
<td>1.2 Disclosures of Interest</td>
<td>3-5</td>
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<tr>
<td>1.3 Specific Interests</td>
<td>6</td>
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<tr>
<td>2. <strong>BOARD MINUTES</strong></td>
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<tr>
<td>9.15 – 9.20am</td>
<td>7-17</td>
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<td>9.20 – 9.25am</td>
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<tr>
<td>2.1 Confirmation of Minutes of the Meeting of the Board – 20 February 2019</td>
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<tr>
<td>9.25 – 9.27am</td>
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<td>2.2 Action Items Register</td>
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<td>9.27 – 9.30am</td>
<td>26-31</td>
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<td>2.3 Draft Minutes Hospital Advisory Committee – 13 March 2019 (Lyn Murphy)</td>
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<td>2.4 Draft Minutes Community &amp; Public Health Advisory Committee – 27 February 2019 (Colleen Brown)</td>
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<tr>
<td>3. <strong>EXECUTIVE REPORTS</strong></td>
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<tr>
<td>9.30 – 9.45am</td>
<td>32-41</td>
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<td>9.45 – 9.50am</td>
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<td>9.50 – 10.00am</td>
<td>58-73</td>
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<td>10.00 – 10.05am</td>
<td>74-82</td>
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<tr>
<td>3.1 Chief Executive Officer’s Report (including Patient Story) (Margie Apa)</td>
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<td>3.2 Corporate Affairs and Communications Report (Donna Baker)</td>
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<td>3.3 Health and Safety Performance Report (Elizabeth Jeffs)</td>
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<td>3.4 Finance and Corporate Business Report (Margaret White)</td>
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**Morning Tea Break (10.05– 10.20am)**

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<thead>
<tr>
<th>4. <strong>DECISION PAPERS</strong></th>
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<tbody>
<tr>
<td>10.20 – 10.35am</td>
<td>83-92</td>
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<td>10.35 – 10.45am</td>
<td>93-101</td>
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<tr>
<td>4.1 2019 Triennial Election Report (Karli Menary)</td>
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<td>4.2 Community Water Fluoridation Position Statement (Margie Apa/Doone Winnard)</td>
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<th>5. <strong>RESOLUTION TO EXCLUDE THE PUBLIC</strong></th>
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<tr>
<td>102-105</td>
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</table>
## Board Member Attendance Schedule 2019

<table>
<thead>
<tr>
<th>Name</th>
<th>Jan</th>
<th>20 Feb</th>
<th>Mar</th>
<th>9 Apr</th>
<th>15 May</th>
<th>26 Jun</th>
<th>July</th>
<th>7 Aug</th>
<th>18 Sep</th>
<th>31 Oct</th>
<th>Nov</th>
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<td>Mark Gosche (Chair)</td>
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<td>Dr Lyn Murphy</td>
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<td>Reece Autagavaia</td>
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<td>Catherine Abel-Pattinson</td>
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<td>Dr Ashraf Choudhary</td>
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<td>Kylie Clegg</td>
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# BOARD MEMBERS’ DISCLOSURE OF INTERESTS
9 April 2019

*New items in red italics*

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
</tr>
</thead>
</table>
| Mark Gosche, Chair       | • Trustee, Mt Wellington Licensing Trust  
• Director, Mt Wellington Trust Hotels Ltd.  
• Director, Keri Corporation Ltd  
• Trustee, Mt Wellington Charitable Trust  
• Chief Executive, Vaka Tautua  
• Trustee, Pacific Information Advocacy & Support Services Trust  
• Life Member, Labour Party  
• Life Member, ETU Union  
• Deputy Chair & Board Member, Housing NZ |
| Dr Ashraf Choudhary     | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Catherine Abel-Pattinson | • Board Member, Health Promotion Agency  
• National Party Policy Committee Northern Region  
• Member, NZNO  
• Member, Directors Institute  
• Husband (John Abel-Pattinson), Director, Blackstone Group Ltd  
• Husband, Director, Blackstone Partners Ltd  
• Husband, Director, Bspoke Ltd  
• Husband, Director, 540 Great South Ltd  
• Husband, Director, Barclay Suites  
• Husband, Director, various single purpose property owning companies  
• Co-Chair, National Party Health Policy Committee |
| Colleen Brown            | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• Member, Auckland Council Disability Advisory Panel  
• Member, NZ Disability Strategy Reference Group  
• District Representative, Neighbourhood Support NZ Board  
• Chair, Rawiri Residents Association  
• Director and Shareholder, Travers Brown Trustee Limited |
<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliations</th>
</tr>
</thead>
</table>
| Dianne Glenn  | • Member, NZ Institute of Directors  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Member, National Council of Women of New Zealand  
• Justice of the Peace  
• Member, Pacific Women’s Watch (NZ)  
• Member, Auckland Disabled Women’s Group  
• Life Member of Business and Professional Women NZ  
| George Ngatai | • Director, Transitioning Out Aotearoa  
• Director, The Whanau Ora Community Clinic  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Huakina Development Trust (Partnership Clinic)  
• Lotteries Community (Auckland)  
• Board Member, Counties Manukau Rugby League Zone  
• Member, NZ Maori Council  
• Director & Shareholder, BDO Marketing & Business Solutions Limited (TBC)  
• Director & Shareholder, Ngatai Bhana Limited  
• Director & Shareholder, Family Care Limited |
| Katrina Bungard | • Chairperson MECOSS – Manukau East Council of Social Services.  
• Deputy Chair Howick Local Board  
• Member of Amputee Society  
• Member of Parafed disability sports  
• Member of NZ National Party |
| Kylie Clegg   | • Deputy Chair, Waitemata District Health Board  
• Trustee (ex officio) - Well Foundation (charity supporting Waitemata District Health Board)  
• Director, Auckland Transport  
• Director, Sport New Zealand  
• Director, High Performance Sport New Zealand Limited  
• Trustee & Beneficiary, Mickyla Trust  
• Trustee & Beneficiary, M&K Investments Limited (*includes a share of less than 1% in Orion Health Group*). Orion Health Group has commercial contracts with Counties Manukau District Health Board and healthAlliance. |
| Dr Lyn Murphy                                      | • Director and Shareholder, Bizness Synergy Training Ltd  
|                                                | • Director and Shareholder, Synergex Holdings Ltd  
|                                                | • Trustee, Synergex Trust  
|                                                | • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
|                                                | • Member, New Zealand Association of Clinical Research (NZACRes)  
|                                                | • Senior Lecturer, AUT University School of Inter professional Health Studies  
|                                                | • Member, Public Health Association of New Zealand  |
| Pat Snedden                                     | • Chair, Auckland District Health Board  
|                                                | • Chair, The Big Idea Charitable Trust  
|                                                | • Director, Te Urungi o Ngati Kuri Ltd  
|                                                | • Chair, National Science Challenge – E Tipu E Rea  
|                                                | • Chair, Manaiakalani Education Trust  
|                                                | • Director, Ports of Auckland (and subsidiaries)  
|                                                | • Trustee, Emerge Aotearoa Trust (and subsidiaries)  
|                                                | • Director & Shareholder, Snedden Publishing & Management Consultants Ltd  
|                                                | • Director & Shareholder, Ayers Contracting Services Ltd  
|                                                | • Director & Shareholder, Data Publishing Ltd  
|                                                | • Director, Ngati Kuri tourism Ltd*  
|                                                | • Director, Te Paki Ltd*  
|                                                | • Director, Waimarama Orchards Ltd*  
|                                                | • Director, Wharekapua Ltd*  
|                                                | • subsidiaries of Te Urungi o Ngati Kuri Limited  |
| Reece Autagavaia                                | • Member, Pacific Lawyers’ Association  
|                                                | • Member, Labour Party  
|                                                | • Trustee, Epiphany Pacific Trust  
|                                                | • Trustee, The Good The Bad Trust  
|                                                | • Member, Otara-Papatoetoe Local Board  
|                                                | • Member, District Licensing Committee of Auckland Council  
|                                                | • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation  
|                                                | • Member, Workforce Development Early Childhood Education Advisory Committee  |
| Ken Whelan, Crown Monitor                       | • Board Member, Royal District Nursing Service NZ  
|                                                | • Contracts with Francis Health & GE Healthcare (mainly Australia & Asia)  
|                                                | • Crown Monitor, Waikato District Health Board  |
### Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 9 April 2019

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Gosche</td>
<td>Social Wellbeing Board</td>
<td>Vaka Tautua has a contract with the Social Wellbeing Board.</td>
<td>20 February 2019</td>
<td>That Mark Gosche’s specific interest be noted and that he may remain in the room and participate in any discussion but be excluded from any voting, if applicable.</td>
</tr>
<tr>
<td>Margie Apa</td>
<td>Middlemore Foundation</td>
<td>Holds an ex officio role on the Middlemore Foundation.</td>
<td>20 February 2019</td>
<td>That Margie Apa’s specific interest be noted and that she may remain in the room and participate in any discussion but be excluded from any voting, if applicable.</td>
</tr>
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</table>
Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 20 February 2019

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

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT
Mark Gosche (Board Chair)
Catherine Abel-Pattinson
Colleen Brown
Dianne Glenn
Katrina Bungard
Kylie Clegg
Lyn Murphy
Pat Snedden
George Ngatai
Apulu Reece Autagavaia

ALSO PRESENT
Margie Apa (Chief Executive)
Margaret White (Chief Financial Officer)
Jenny Parr (Chief Nurse and Director Patient & Whaanau Experience)
Dinah Nicholas (Board Secretary)
Ken Whelan (Crown Monitor)
Donna Baker (GM Communications & Engagement)
Michelle Arrowsmith (Deputy Director-General, DHB Performance, Support & Infrastructure, Ministry of Health)

APOLOGIES
Apologies were received and accepted from Ashraf Choudhary (Board Member) and Dr Gloria Johnson (Chief Medical Officer).

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
There were no media present at this meeting.

WELCOME
George Ngatai opened the meeting with a karakia.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
The Disclosures of Interest were noted with the following deletion for George Ngatai – Community Organisation Grants Scheme (Auckland).

Ms Apa declared a specific interest in relation to Item 3.1 on the Public agenda today.
Mr Gosche declared a specific interest in relation to Item 5.1 on the Public Excluded agenda today.
AGENDA ORDER AND TIMING
Items were taken in the same order as listed on the Agenda.

2. BOARD MINUTES
   2.1 Minutes of the Meeting of the Board 12 December 2018

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

   That the Minutes of the Board Meeting held on the 12 December 2018 be approved.
   Carried

   2.2 Action Item Register
   Noted.

   2.3 Draft Minutes Hospital Advisory Committee – 29 January 2019
   The minutes were taken as read.

   Tamaki Oranga Services – it was noted that a review of the Tamaki Oranga Services is underway by independent reviewers. The outcome of the review is to be made available to HAC and the Board.

3 PRESENTATION
   3.1 Middlemore Foundation (Sandra Geange, Chief Executive, Middlemore Foundation)

   • The Foundation was founded towards the end of 1999 and, to date, has raised $36m of funding for the DHB and the Counties Manukau community.
   • Ms Geange took over as Chief Executive six-month’s ago and has a background in marketing, general management and executive leadership having lived and worked in South Auckland for 20-years.
   • The purpose of the Foundation is to help transform the health of the Counties Manukau community and help to improve lifelong outcomes for the people in our community.
   • The Foundation raises funds and connects that funding with DHB and community initiatives.
   • Traditionally the Foundation has been quite a traditional charitable fundraiser but with a change in strategy three years ago, the Foundation is now looking at a more innovative methodology for funding and partnering (ie) doing more partnering with corporates, engaging with the community more, representing Maaori & Pacific communities better, engaging with NGOs, building relationships within CM Health.
   • The Foundation is currently holding $4m worth of equity for certain divisions within CM Health – many are made up of historical donations, bequests or from fundraising efforts:
     o $1m – specifically tagged for the new spinal rehabilitation unit
     o $800k – Kidz First clinical equipment (should be spent within the next 12-month’s)
     o $800k – Kidz First ED upgrade
     o $400k – Burns unit
   The remainder is spread around Stroke, Respiratory, Surgery, Adult & Women’s Health.
   • The strategic direction of the Foundation for the next few years will continue to focus on:
     o Capital equipment requirements. Still working on this year’s list with a focus on Ophthalmology with a real opportunity to raise some significant funds to increase the
capacity of the Galbraith Ophthalmology suite which is stretched currently. Planning for the next financial year will commence shortly.

- Continuation of current campaigns (ie) Wool programme, Eye Glasses for children in the community, Books for Kids, Jammies in June, Mana Ariki programme.
- Looking into a Grateful Patient Programme.

The Chair commented that from the Board’s perspective, the hardest thing the DHB finds to fund are things in the community and would send that remit to the Foundation through Ms Apa and Ms White as representatives on the Middlemore Foundation Board.

The Chair thanked Ms Geange for her comprehensive briefing and invited her to return in six-month’s time to provide a further update to the Board.

The Chair asked that a letter of thanks from the Board be sent to the Middlemore Foundation in appreciation of what they do.

4 EXECUTIVE REPORTS

4.1 Chief Executive’s Report (Margie Apa)
The report was taken as read.

The Board were played a video on Call 4 Concern.

Growing Medical Leaders – Dr Peter Watson is the latest in a series of senior doctors who have completed their FRACMA training while working at the DHB and his addition to the group now brings to six the number of FRACMA-qualified clinical leaders employed at CM Health. This means the DHB now employ almost 20% of the total number of FRACMA-qualified doctors in New Zealand. Growing clinical leadership is very important and we are fortunate to have Dr Clive Benseman, Dr Gloria Johnson, Dr David Hughes, Dr Mary Seddon and Dr Vanessa Thornton working at CM Health.

Ward 21 - plans are underway for the new maternity ward on Ward 21 which should be ready in April 2019. Ward 21 will operate in addition to the 45-bed existing maternity ward and will primarily be used for antenatal care while the existing ward will focus on postnatal care with dedicated transitional care capacity for babies and their mothers.

Mr Whelan suggested that the opex impact of Ward 21 for 19/20 should be looked into and it would be useful to know what Plan B is for winter if maternity is in Ward 21.

Health Targets
ED 6-hour target – this target has been challenged by high hospital occupancy for the year. There are multiple initiatives are underway to improve patient flow and work towards achieving 90%+ of the target by the end of the year.

Faster Cancer Treatment target – four tumour streams contribute to this target. No one problem seems to contribute to them all but deep dives are underway into the pathways to work out what they might be, for example, understanding why the learnings from the successful pathways have not been translated into the others. It is important to understand this as quickly as possible as the reality is that Cancer is a life-threatening disease, in many respects.
Resolution (Moved: Dianne Glenn/Seconded: Catherine Abel-Pattinson)

That the Board:

Receive the Chief Executive’s Report.

Carried

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

Resolution (Moved: Colleen Brown/Seconded: Lyn Murphy)

That the Board:

Receive the Corporate Affairs and Communication Report for the period 28 November – 28 December 2018.

Carried

4.3 Health and Safety Performance Report (Elizabeth Jeffs and Maree Weston)
The report was taken as read.

Health & Safety Rep Training – training has recommenced, starting today.

Welcome Day – Welcome Day has been redesigned and out of that there will be different ways of undertaking orientation for health & safety and contractor management.

Aggression & Violence – reporting over the last six-month’s has increased particularly in Mental Health. Ms Abel-Pattinson noted that the new Tiaho Mai facility was designed to reduce aggression and be much safer for staff. Ms Jeffs was asked to provide a report in six-month’s time on the incident rates in Mental Health because if we do have a facility that has a measurable drop in aggression and violence incidents, then that would be something to share with other facilities.

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

That the Board:

Receive the Health and Safety Report for the period ending 31 December 2018.

Carried

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

The January result closed at $1.3m favourable, YTD $3.4m which are in alignment with our commitment pre-Christmas to move from a $53.5m deficit as in the annual plan, back to an improved
$45m. We need to move to financial independence and will get there by way of collective contribution.

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

That the Board:

Receive the Finance & Corporate Business Report for the period ending 31 December 2018.

Carried

5 INFORMATION PAPERS

5.1 Hospital in the Home (Penny Magud, GM Locality Services)
The paper was taken as read.

Since receiving dedicated SMO input for the pathway, referrals have increased by 50%. 82 patients are now following the pathway and we are seeing patients being stable out in the community where they would otherwise have been in the hospital. This leadership and commitment support has had a roll-on effect to other General Medical SMOs who have also now trialled the pathway and provided positive feedback. Community Central have also had staff attend ward handovers throughout December which has led to an increased awareness of the range of clinical care that can, and is, currently delivered outside of the hospital.

Resolution (Moved: Dianne Glenn/Seconded: Katrina Bungard)

That the Board:

Receive the update on the status of Hospital in the Home

Carried

5.2 External Signage Review (Parekawhia McLean, Director Strategy & Infrastructure)
The paper was taken as read.

An external review of wayfinding and signage on the Middlemore Hospital campus has been undertaken. All recommendations in the report are underway and will be completed by the end of this financial year, along with some additional recommendations made by the Executive Leadership Team on 5 February. All report recommendations are to be followed up through the Hospital Advisory Committee.

Ms Glenn advised that the parking machine in the Esme Green building does not provide parking receipts. Ms Apa confirmed that she would have this item added to the next Parking meeting agenda.

Resolution (Moved: Catherine Abel-Pattinson/Seconded: Lyn Murphy)

That the Board:
Receive the updated Report on the Middlemore Campus External Wayfinding and Signage review for Middlemore Hospital campus.

Note that the review is in response to an action item from the Board meeting of 6 December 2017, where a review of the Middlemore campus signage was requested to be undertaken by a traffic/transport management expert.

Note that the work detailed in this report is underway and will be completed within budget this fiscal year.

Carried

5.3 **Quarterly Workforce Report** (Aroha Haggie, GM Maaori Health)

The paper was taken as read.

*New Starts & Leavers* – for the quarter ended 30 September 2018, overall for Maaori we had an overall net growth of 21 people and for Pacific, 28. We are on track to reach our targets by 2025.

We do need to remember however, that in our recruitment processes we need to get better and more sophisticated in the way we are attracting people to work here (ie) we need to be seen as the best employer.

It was noted that the NRA reports are marked Private and Confidential. Ms Haggie advised that she believed there was nothing in the reports that would make them confidential and will notify the NRA that we are making these reports public.

 Resolution (Moved: Reece Autagavaia/Seconded: George Ngatai)

That the Board:

Receive the Maaori and Pasifika quarterly workforce reports July to September 2018.

Carried

5.4 **2019/20 Annual Planning Overview & Timeline** (Alanna Soupen)

The paper was taken as read.

The 2019/20 initial Annual Planning guidance was provided to DHBs on 20 December 2018 with a first draft Annual Plan due to the Ministry of Health by 5 April 2019 and a final version by 21 June 2019.

*Letter of Expectations for 21019/20* - The Minister’s Letter of Expectations identifies a number of areas of focus for the DHB, particularly around achieving equity for Maaori and Pacific across their life course and meeting our Treaty of Waitangi obligations. The Chair asked that the LoE be made available on Paanui and the CM Health website.

* Disability Paragraph (LoE page 3) - Ms Brown advised that there will need to be a regional plan put together through DISAC on how we can first, identify, and second, implement, the
kinds of issues the Minister might be requiring in his Letter and tease out what his letter really means.

- **Rural Health (LoE page 3)** – the Letter sets out an expectation that DHBs with rural communities consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services. Ms Glenn commented that CM Health is the only DHB that does not get the additional funding for rural communities. Ms White to look into why the DHB might not be considered to have a ‘rural community’ and what criteria you need to meet for a ‘rural community’.

Ms Apa to bring back to the next Board meeting (9 April) a simplified version of the Letter of Expectations showing, by way of traffic light system (red, amber, green), what the DHB is doing well, and what it is not.

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

That the Board:

Receive the overview of the 2019/20 planning guidance, key planning messages and proposed approach and timeline for the development of the 2019/20 Annual Plan.

Note the focus of the 2019/20 planning guidance on achieving measurable progress toward health equity, responding to unmet need, cross-sector collaboration and fiscal responsibility.

**Carried**

5.5 **Addressing the Equity Gap in Māori Childhood Immunisation** (Aroha Maggie & Mataroria Lyndon)

The paper was taken as read.

This paper outlined a range of new initiatives including:

1) Piloting an incentive scheme to engage with Outreach Immunisation Service.
2) Implementing a brief screening and referral tool for immunisations within current CM Health programmes.
3) Increasing collaboration between the OIS and Māori Health providers to enable better engagement with Māori whaanau.

The aim of the initiatives proposed is to address the disparities in immunisation coverage for Māori pepi/tamariki.

**Resolution** (Moved: George Ngatai/Seconded: Kylie Clegg)

That the Board

Receive this report on addressing inequity in Māori Childhood immunisation coverage.

Note the progress made on the initiatives to address the disparities in Māori immunisation coverage.
Note the design process and plan for these initiatives and the next steps for piloting.

**Carried**

7. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution** (Moved: Lyn Murphy/Seconded: ApuluReece Autagavaia)

That the Crown Monitor, Mr Ken Whelan, be permitted to remain in the Public Excluded section of this meeting.

That the Deputy Director-General, DHB Performance, Support & Infrastructure, Ms Michelle Arrowsmith, be permitted to remain in the Public Excluded section of this meeting.

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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<tr>
<td>Public Excluded Minutes of 12 December 2018 and Actions</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
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<td>Confidentiality of Advice by Officials Withholding the information is necessary to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by officials. [Official Information Act 1982 S9(2)(f)(iv)]</td>
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<td>Specialised Rehabilitation Indicative Business Case</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>Philips Master Maintenance Services Agreement</td>
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<td>Commercial Negotiations</td>
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<tr>
<td>Relocation &amp; Expansion of Radiology Services</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</td>
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<td>Contract for Supply of Taxi &amp; Patient Transport Services</td>
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<td><strong>IAAS Business Case</strong></td>
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<th><strong>Primary Acute Care Services Update</strong></th>
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<th><strong>AMHU Stage 2 Procurement &amp; Funding – Ratification of Circular Resolution</strong></th>
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<th><strong>Social Wellbeing Board Update</strong></th>
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<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<th><strong>LTC Model of Care Update – Transition Plan</strong></th>
<th>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.</th>
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CEO Update

That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982.

[NZPH&D Act 2000 Schedule 3, S32(a)]

Public Interest

The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest.

[Official Information Act 1982 S9(2)(ba)(ii)]

Carried

The public meeting closed at 12.10pm.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 20 FEBRUARY 2019.

______________________________  9 April 2019

BOARD CHAIR
<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 February 2019</td>
<td><strong>2019/20 Annual Planning Overview &amp; Timeline</strong></td>
<td>Look into why the DHB might not be considered to have a ‘rural community’ and what criteria you need to meet the guidelines for a ‘rural community’.</td>
<td>9 April</td>
<td>Margaret White</td>
<td>Refer slide attached from 13/3/19 ARF meeting.</td>
<td>✓</td>
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<tr>
<td></td>
<td></td>
<td>Bring back a simplified version of the Government’s Letter of Expectations showing, by way of traffic light, what the DHB is doing well, and what it is not.</td>
<td>9 April/15 May</td>
<td>Alanna Soupen</td>
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<tr>
<td>20 February 2019</td>
<td><strong>Health &amp; Safety Performance Report</strong></td>
<td>Aggression &amp; Violence – reporting over the last six-month’s has increased particularly in Mental Health. Ms Abel-Pattinson noted that the new Tiaho Mai facility was designed to reduce aggression and be much safer for staff. Provide a report in six-month’s time on the incident rates in Mental Health because if we do have a facility that has a measurable drop in aggression and violence incidents, then that would be something to share with other facilities.</td>
<td>7 August</td>
<td>Elizabeth Jeffs</td>
<td></td>
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<tr>
<td>20 February 2019</td>
<td><strong>Presentation</strong></td>
<td>Middlemore Foundation CEO – update to the Board</td>
<td>7 August</td>
<td>Sandra Geange</td>
<td></td>
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<tr>
<td>20 February 2019</td>
<td><strong>HAC Minutes 29.1.19</strong></td>
<td>Tamaki Oranga Service – an independent review is underway. Review to be made available to the Board &amp; HAC when completed.</td>
<td>26 June</td>
<td>Tess Ahern</td>
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<tr>
<td>12 December 2018</td>
<td><strong>CPHAC Minutes 26.9.2018</strong></td>
<td>Before School Checks – the Board asked that either Dr Tuohy, or a representative from the MoH, and Amanda Malu, Plunket be invited to attend the 3 April Board meeting to follow up the discussion on B4SC as that should coincide with the release of the scope of the Well Child review.</td>
<td>9 April</td>
<td>Margie Apa/ Carmel Ellis</td>
<td>Refer Item 4.1 on today’s Confidential agenda.</td>
<td></td>
</tr>
</tbody>
</table>
PBFF - Rural Adjuster

- Approximately 1.5% of the 2019/20 $13.9B funding or $200M
- The allocation is based on a capitation formula with 3 inputs
  - Weighted rural population
  - Weighted travel time away from a base hospital
  - Weighted travel to tertiary hospital

<table>
<thead>
<tr>
<th>DHB</th>
<th>Percentage share of rural adjuster</th>
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<tbody>
<tr>
<td>Southern</td>
<td>18.00%</td>
</tr>
<tr>
<td>West Coast</td>
<td>11.90%</td>
</tr>
<tr>
<td>Northland</td>
<td>10.80%</td>
</tr>
<tr>
<td>Waikato</td>
<td>8.80%</td>
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<tr>
<td>Canterbury</td>
<td>8.70%</td>
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<tr>
<td>Tairāwhiti</td>
<td>5.90%</td>
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<tr>
<td>Bay of Plenty</td>
<td>5.60%</td>
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<tr>
<td>Nelson Marlborough</td>
<td>5.30%</td>
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<tr>
<td>Hawkes Bay</td>
<td>4.40%</td>
</tr>
<tr>
<td>Lakes</td>
<td>4.30%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>100.00%</strong></td>
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<th>DHB</th>
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<tr>
<td>Taranaki</td>
<td>3.50%</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>3.30%</td>
</tr>
<tr>
<td>Whanganui</td>
<td>3.10%</td>
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<tr>
<td>Wairarapa</td>
<td>2.60%</td>
</tr>
<tr>
<td>MidCentral</td>
<td>2.40%</td>
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<tr>
<td>Auckland (incl Gulf Islands)</td>
<td>0.60%</td>
</tr>
<tr>
<td>Waitemata</td>
<td>0.50%</td>
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<tr>
<td>Counties Manukau</td>
<td>0.30%</td>
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<tr>
<td>Capital &amp; Coast</td>
<td>0.00%</td>
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<td>Hutt Valley</td>
<td>0.00%</td>
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<td><strong>Total</strong></td>
<td><strong>100.00%</strong></td>
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Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on Tuesday, 13 March 2019 at 1.00pm
Manukau SuperClinic (MSC), Conference Room 1, 901 Great South Road, Manukau, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

ALSO PRESENT

Margie Apa (Chief Executive)
Dr Gloria Johnson (Chief Medical Officer)
Avinesh Anand (Deputy CFO, Provider)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Dr Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Kate Yang (Business Manager, Service Leadership Team)
Christine Lockhart (Acting Secretariat)
Teresa Opai (Observer Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Members of ACC were present for the Public section of this meeting.

WELCOME

Tour of Manukau SuperClinic commenced at 1.30pm with Mary Burr, General Manager Surgery, Anaesthesia and Perioperative Services and Mark Moores, Clinical Director Surgery, Anaesthesia and Perioperative Services.

The meeting commenced at 2.30pm. Dr Murphy welcomed the Committee and introductions were made.
APOLOGIES
There were no apologies for this meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted. Kylie Clegg provided an update at the Audit Risk and Finance Committee.

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

1. **AGENDA ORDER AND TIMING**
   Items were taken in the same order as listed on the agenda.

2. **CONFIRMATION OF MINUTES**

   2.1 Confirmation of the Public Minutes of the Hospital Advisory Committee meeting held on 29 January 2019.

   **Resolution:** (Moved: Dianne Glenn / Seconded: Kylie Clegg)

   That the minutes of the Hospital Advisory Committee meeting held on 29 January 2019 be approved.

   **Carried.**

2.2 **Action Items Register – Public**

   Refer Action Items Register for actions of the Public meeting held on 29 January 2019.

   It was noted that all actions are either on task or have been rescheduled.

   **Action:** *The Committee requested a letter of appreciation to Manukau SuperClinic staff which was a very informative and impressive tour.*

3. **PROVIDER ARM PERFORMANCE REPORT**

   3.1 **Executive Summary (Margie Apa)**

   The report was taken as read.

   Ms Apa provided key highlights:
   - Financials tracking well ahead of budget including savings, however; mindful that the hospital is experiencing high occupancy rates over the last 10 days.
   - The RDA strikes will have an impact on elective and ESPI delivery targets. The services are planning to schedule additional clinics and outsource some of the elective procedures.
   - The Every Dollar Counts YTD unrealised savings have been offset by vacancies across the system.
• Advised that the Hospital in the Home utilisation to be evaluated. There is a step change over the coming year with additional SMOs. Noted definition of Hospital in the Home in CM Health is narrower than it is in other Health Systems. Noted it is important to be aware of what we are benchmarking against when comparing numbers of uptake.
• Regionally sharing Clinicians around the region for the extra Ophthalmology clinics.

3.2 Balanced Scorecard (Margie Apa)
The report was taken as read.

3.3 Hospital Services Project Portfolio Overview (Margie Apa)
The report was taken as read.

3.4 Finance Report – Provider Arm (Avinesh Anand)
The report was taken as read.

December 18/January 19 had high annual leave uptake, due to school holidays and summer break, which leaves underspend as the result.

3.5 Patient Experience & Safety Report (David Hughes)
Safety Experience Compliance Measurement Dashboard
The report was taken as read.

Dr Hughes advised Dashboard looking well into the green, with the exception of the category for “Patients whose dietary needs were always met”. Small sample sizes are an issue and team is continuously looking to improve this.

National Patient Experience Survey Results – November 2018
The report was taken as read.

Dr Hughes advised looking at doing an internal survey for “If you needed help from the staff getting to the toilet or using a bedpan, did you get it”, as there are opportunities to make this data collection more robust.

QSM Local Report – September 2018
The report was taken as read.

Dr Hughes advised QSM reviewing the pressure injury, work in progress.

3.6 Fundamentals of Care – July 2018 Peer Review (Dr Jenny Parr)
The report was taken as read.

Dr Jenny Parr presented a short video from Professor Alison Kitson and the voice of the International Learning Collaborative (ILC) united by a vision for improving the fundamentals of Care for patients.
Dr Jenny Parr provided key highlights:

- The collective is the collaboration and expectations that work in teams, practice leaders, research, and education.
- The 2nd review was adapted to the CM Health context and implemented with changed questions that are easy to understand and read. Put the measurement tools into the iPads and help with better data quality.
- Ko Awatea instrumental in the development, very sophisticated, looking at relationships of the components, which can highlight any issues.
- Currently running through a 3rd review.
- Noting that MidCentral and Southern DHB are shadowing with Dr Jenny Parr.

3.7 Q2 2018-19 Non Financial Summary Report (Alanna Soupen)
The report was taken as read.

Key Messages:
- The Child Health Team through the Raising Healthy Kids looking at an evaluation of the Child Healthy Weight Programme. They will investigate the decline in the uptake.

**Action:** The Child Health Team are to provide the Committee with the outcomes of the evaluation of the Child Healthy Weight Programme when complete and publicly available.

- The Drug Alcohol Service low performance is in part due to national staff shortages with significant amount of staff vacancies.
- The Committee discussed the Measles outbreak and the Immunisation with engaging 18-24 year olds who are not immunised.

4. CORPORATE REPORTS (FOR NOTING ONLY)

4.1 Facilities Service Report (Anton Ventor)
The report was taken as read.

4.2 Emergency Department, Medicine and Integrated Care (Brad Healey)
The report was taken as read.

4.3 Surgery, Anaesthesia & Perioperative Services (Mary Burr)
The report was taken as read.

4.4 Central Clinical Services (Ian Dodson)
The report was taken as read.

4.5 Kidz First & Women’s Health Clinical Services (Nettie Knetsch)
The report was taken as read.
4.6 Adult Rehabilitation & Health of Older People (Dana Ralph-Smith)
The report was taken as read.

4.7 Mental Health & Addictions (Tess Ahern)
The report was taken as read.

4.8 Middlemore Central (Ian Dodson / David Hughes)
The report was taken as read.

Resolution: (Moved: Dr Lyn Murphy / Seconded: Kylie Clegg)
That the Hospital Advisory Committee
Note and receive the reports.
Carried.
6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution: (Moved: Dr Lyn Murphy / Seconded: Kylie Clegg)

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

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

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<td>Confirmation of Minutes For the reasons given in the previous meeting. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<td>3.1 Patient Experience and Safety Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S9(2)(a)]</td>
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</table>

Carried

The open session of the meeting concluded at 4.00pm

Next meeting to be held on 2 May 2019

Signed as a true and correct record of the Counties Manukau District Health Board Hospital Advisory Committee meeting held on 13 March 2019.

Dr Lyn Murphy
Chair
Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 27 February 2019 at 9.00am – 12.30pm
Ko Awatea, Room 101, Middlemore Hospital, 100 Hospital Road, Otahuhu, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

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

ALSO PRESENT

Margie Apa (Chief Executive)
Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)
Dr Gary Jackson (Director, Population Health)
Dr Kate Yang (Business Manager, Primary Care)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

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

APOLOGIES

Apologies were received from Ashraf Choudhary, and George Ngatai.

WELCOME

The meeting commenced at 9.00am with a welcome from the Chair, Ms Brown.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

There amendments to the Disclosures of Interest were noted by Ms Tafau.
There were no amendments to the Disclosure of Specific Interests.
1. **AGENDA ORDER AND TIMING**

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

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 5 December 2018.**

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

Minutes: piece of work pg 8

That the minutes of the Community and Public Health Advisory Committee meeting held on 5 December 2018 be approved.

**Carried**

2.2 **Action Items Register/Response to Action Items**

Action Items were noted as being on track.

Women in Prisons: an update paper was provided by Ms Glenn in the Information Paper section of this agenda.

During the work plan discussion, later in the session, the items on the current Action Item register will be discussed for their relevance.

Add to the Action Item Register that Julia Burgess-Shaw is to present on what Youth activities CM Health are assisting in the community.

3. **BUSINESS CASE**

3.1 **Owning My Gout (Trevor Lloyd)**

Mr Lloyd gave an overview of the Business Case. The aim is to encourage Gout sufferers to go to the Pharmacy rather than the GP. Regular testing allows GPs to see when adherence to taking medication isn’t happening. The programme is assisting people as young as 19 to be able to manage their medication ongoing for the rest of their lives.

Business case has yet to be presented to ELT.

This programme is tailored to work easily for GPs and Nurses, but also for Pharmacists.

Capitation funding isn’t set up to cover a monthly GP visit. Also, many gout sufferers don’t only suffer from gout. A GP will focus on more serious issues before they get to gout and gout may be missed off the list.

Funding is available for funding new services. This is a good place for OMG to get funding.

The Stop Gout booklet is an easy to understand guide on how to manage symptoms. There is a gene that makes certain families susceptible to gout. The same gene also makes you more resistant to malaria.
Action
A copy of the Stop Gout booklet will be provided for the Committee.

Mr Lloyd is currently speaking with the MoH in regard to removing the co-payment for those on a Community Services card. The committee raised the difficulty of applying for a community services card as an issue.

Capital Coast DHB is undertaking a study where they are making the co-payment. It is showing that adherence to taking medication improves when the medication is fully funded.

The pharmacy model is one that the DHB will look to explore further. Smaller pharmacies are struggling to cope as people are travelling to bigger pharmacies to get free prescriptions.

The business case is still being updated and will go through ELT for endorsement.

4. Briefing Paper

4.1 Quarter 1 2018/19 Non-Financial Summary Report Alanna Soupen, Planning & Reporting Advisor)

Performance against mental health targets: transition planning and employment measure has improved in Q2. AOD 0-18 yr olds: waiting lists are long across the country. Staff retention is a problem in this area.

The discharge plan target was low. The committee was advised that this is a new target and there is high expectation that these figures will continue to increase.

Raising Healthy Kids Target: identification is good, but where is the data to show treatment? Programme is currently be evaluated and is due to be completed at the end of April 2019.

In regard to Immunisations, we do need to refresh our promotional messaging in regard to imms as the issues change for each generation.

Report on Q2 – will provide more insight from Health Kids team and more narrative on Mental Health, in particular AOD. Reiterate the focus on Maaori Immunisations.

Resolution

The Community & Public Health Advisory Committee:

Noted that this Quarter 1 2018/19 Summary Report was approved for forwarding to the Community and Public Health Advisory Committee by ELT on 11 December 2018.

Noted the results for Quarter 1 progress against draft planned 2018/19 actions and performance expectations, including commentary on challenges and resolution plans for those measures where performance was low.

Noted that due to Ministry of Health quarterly reporting delays, ELT received the Quarter 1 2018/19 Summary Report toward the end of Quarter 2. As Quarter 2 has now concluded, indicative Quarter 2 updates have been added to this Quarter 1 2018/19 Summary Report. Quarter 2 data has been added with additional commentary provided for those measures where performance continued to be low or dropped in Quarter 2, where this information is currently available. Information for some measures is not yet available and full Quarter 2
performance information will be provided in the Quarter 2 2018/19 Summary Report, after the completion of the Quarter 2 reporting cycle in February.

Noted that as the 2018/19 Annual Plan has yet to be approved by the Ministry of Health, for Quarter 1 the Ministry did not rate DHBs’ achievement against Annual Plan targets. For Quarter 1 descriptive assessments have instead been assigned by the Ministry, of either Satisfactory (S) or Not enough information/performance concerns (N). Performance against targets has therefore been provided by the Planning team for reference only and do not represent Ministry ratings of performance.

Reviewed the identified issues and associated actions for Quarter 1 2018/19.

Noted the appended Northern Region Health Plan Quarter 1 2018/19 summary report provided by the Northern Regional Alliance (Appendix 2).

Moved: Ms Colleen Brown/Seconded: Ms Dianne Glenn/Passed: Unanimously

5. UPDATE

5.1 Community Hubs – Current State (Alan Greenslade, Service Development Manager, Mangere/Otara Locality)

A broader piece of work is currently being undertaken – Primary and Community Care in a broader context, looking at what have we learnt in regard to place-based care that has been implemented over the last two years. What does it mean in terms of where we want to go? Looking at our priorities and also looking to eliminate inequities. Mr Hannant will return to CPHAC in the next few months to provider a further update.

Ms Tafau to include presentation with minutes.

Original vision slide
Strengths/Opportunities
Risks/Issues – not always about need, but opportunity
Place-based structures in tension with PHOs – more than one PHO operating in communities

Disability Services are not available in communities. CPHAC felt this was an opportunity for the DHB. There is the potential for finding space within the Community Hubs to set these types of support up.

The Northern Regional Long Term Investment Plan talks to the role of Community Hubs playing a part as we move forward.

Community Hubs graphic: Mr Greenslade will look to update to include disability services.

We have a lot of co-location but not enough integration. This is part of the next phase.

Opportunities & Issues
CPHAC raised Clendon/Rata Vine/Randwick Park as places with very few or no GP services. However Community Houses in those areas could be used to provide GP and other health services.

DNA rate is 18 to 20% lower at the Mangere Community Hub. One of the things the hub is investigating is an extension of hours of operation.
Otara Community Hub is a smaller property so does not have the same range of services as Mangere.

Botany Hub provides multiple services in a co-location. The DHB only owns a third of the title and has a good working relationship with East Health and integration is a work in progress.

New Hub opportunities slide

Next steps
CMDHB working with Waikato DHB and will set up a team to work together around planning for a new hospital, if this is agreed upon by the Government.

Resolution

The CPHAC Committee recommended an investigation into the disability services we currently have and how we could utilise community hub to expand these services.

Moved: Ms Colleen Brown/Seconded: Ms Katrina Bungard/Passed: Unanimously

Mr Greenslade advised that thought has been put into using community hubs to partner with education organisations. Work is currently be undertaken with ADHB stroke research in Otara/Botany, speech & language therapy students have been included. There is work with Botany hub to have a shared workforce. Additional investigation has been undertaken looking at Primary Care facilities being able to provide services in hard to reach communities.

Advertising of services in the community hubs is still a work in progress. There are forums in place where we have providers meet and share.

The committee thanked Mr Greenslade for his update.

6. DISCUSSION

6.1 2019 CPHAC Workplan (Kate Yang/Colleen Brown)

A strategic deep dive should marry up with HAC’s focus.
Operational Deep Dive – a look at business cases that will be going up to the Board.
Site Visits

Equity is to be at the forefront/ Maaori Health/Pacific Health/Service Risks (Oral Health) – collate information from teams as a regular update to CPHAC.

Deep Dives: focus on Equity
Youth – inequities for Maaori & Pacific. The difficulty in capturing data for immigrants was noted.
Disabled youth.
Need to focus on what lies within the DHB’s remit.

Older people: include information on how the DHB can disseminate information to the Asian community who are not aware of how to navigate our Health System.

The committee thanked Kate Yang for the work she has put in to forming this work plan.

Add Pacific Health to the December meeting.
The committee was advised that in other Committees (outside the DHB) Maaori Impact statements are part of every report/paper. Kate Yang will liaise with Aroha Haggie, GM Maaori Health, as to how the DHB could look to implement this initiative.

7. INFORMATION PAPERS

7.1 Long Term Conditions Model of Care Update

The paper was taken as read and noted.

7.2 Screening Female Prisoners
7.2.1 Women in Prison: Provision of Alternatives to Detention

The papers were taken as read and noted.

7.3 CPHAC Committee Visit to Papatoetoe High School 31.1.2019: Brief

The paper was taken as read and noted.

The meeting concluded at 11.30am.


Colleen Brown
Committee Chair
Information Paper
Counties Manukau District Health Board
Chief Executive’s Report

Recommendation

It is recommended that the Board:


Prepared and submitted by: Margie Apa, Chief Executive Officer

News and Events

Christchurch Tragedy

The recent traumatic events in Christchurch were devastating, not only for those affected personally but for the country as a whole.

As events unfolded, Counties Manukau Health’s (CM Health) primary role was to respond as required by the national incident control centre, led by the Ministry of Health and Canterbury DHB. We activated our own well-functioning national incident response system and increased extra security around our own sites.

On the Friday following the mass tragedy terror attack, teams were encouraged to observe a minute’s silence to acknowledge the tragic loss of life and impact not only on the families who lost members but those who were injured and the wider Muslim and Christchurch communities. Several services were held at the Spiritual Centre including Muslim Jumma Prayers.

It was a privilege to witness the out-pouring of support and aroha that staff provided to colleagues, friends and whaanau of Muslim faith. We provided support for any staff that needed it, and encouraged them to acknowledge and share their feelings. One of the wonderful things about being at Counties Manukau Health is treasuring the diversity our faiths, ethnicities and cultures bring. This sentiment was echoed by our staff and patients.

Security Incident on Orakau Road

On the morning of Saturday 23rd of March, two staff members were attacked on Orakau Road on the perimeter of the Western Campus car park. They had just finished their nightshift and were making their way to be picked up to go home. Our cameras did not clearly identify the assailants because of fog that morning and the attack happened just off our perimeter and was obscured. This is the first time we have had an incident reported of this severity, at this time in the morning and on the weekend.

This incident is devastating as staff safety is of utmost priority. We have acted swiftly where we have jurisdiction – extending the cover of additional car park security from 4.30pm – 8am and adding all day cover on weekends at the S-bend and Western Campus. In addition, we have:

1. Convened a joint agency review with Auckland Transport, Police, Secure Parking and Auckland Council to see how we can work together to make the public spaces surrounding Middlemore Campus safe for everyone; and
2. Expedited a business case that we have been working on since January 2019 to add more security features in the long run. NZ Police will also provide us with a peer review to check we do not miss anything.
We have been steadily increasing security over the past year, especially in light of concerns raised to us by staff. We increased the level of security in May 2018 and again in December 2018. Up to December 2018, we had our best 6 months for reduced incidents being reported.

You will appreciate some of these actions may take a bit longer to implement but we are committed to prioritising resources out of this financial year as we take advantage of some areas of underspend in our capital budgets. While Middlemore site will be the priority for the next few months, the Security and Facilities team are looking at all our sites including Manukau. Staff have been encouraged to make use of the visitor car park for night shifts or if they are called in, as well as Security escorts available.

**Car Parking Increases**

Secure Parking, which manages the parking facility on behalf of the owners, Accident Compensation Corporation (ACC), advised CM Health that car parking rates at Middlemore Hospital were set to increase from midnight 14/15 January.

Visitors to Middlemore Hospital are still able to park without charge for up to 30 minutes during visiting hours (2pm to 8pm) and for 15 minutes without charge outside of these times. The rate for 15 minutes to an hour’s parking is now $4.50, up from $4 and other increases have also been put in place.

CM Health and ACC have procedures in place to identify patients and close family members who may be eligible for subsidised car parking use on compassionate grounds.

**Industrial Action**

Contingency planning to address the NZRDA industrial action in January and February was coordinated through Middlemore Central.

Our priority was the provision of urgent and acute care to those who needed it, and our Emergency Department was fully staffed during the strikes. Senior Medical Officers worked additional hours to ensure we were able to continue to support our community.

Unfortunately, we had to reschedule some of our non-urgent patient appointments and elective surgery. Patients whose appointments were affected were contacted directly by letter, phone or text message and advised that we would reschedule all appointments to the next available date.

DHBs have continued to negotiate in good faith to reach an agreement with the NZRDA but we are preparing for ongoing industrial action from NZRDA.

**Measles Outbreak**

The outbreak of measles throughout the country has been concerning and CM Health has done its bit to support public health messages about vaccination.
Dr Pip Anderson was interviewed on PMN 531 and we shared the interview with our wider community through our Facebook channels. We also posted information on our website, through Medinz and on our social media pages about immunisation and vigilance regarding measles.

Internally, we put updates in Daily Dose, on Paanui and have put up posters to inform patients coming into ED. ARPHS also provided us with collateral which we have shared.

**Staff Forums**

We have held two staff forums this year, at Middlemore Hospital and Manukau Superclinic. It is the first time we have taken the forums out to a community site and more forums are planned for Botany Superclinic and Pukekohe Hospital.

Our March forum included an introduction to the new members to the Executive Leadership Team, information about upcoming changes to Ward 21, an update on Every Hour Counts, and an update about the Scott building project.

**Michelle Arrowsmith visit**

The Ministry of Health has appointed Michelle Arrowsmith to the role of Deputy Director-General DHB Performance, Support and Infrastructure. In late February, Michelle spent two days at CM Health touring our facilities and meeting with key leaders as well as attending Board and Executive Leadership Team meetings to better understand CM Health’s population, priorities and upcoming challenges.

**Our People**

**Welcome to new Kaumaatua**

We recently welcomed our new Kaumaatua, Te Teira Rawiri, with a powhiri at Te Manukanuka O Haturoa Marae where whaanau and colleagues came together in celebration. Matua Rawiri was previously the Kaumaatua for 9 years at Manukau Institute of Technology.

Matua Rawiri has a passion for working with all people and identifies ‘Manaakitanga to care’ as his number one value. He says he is excited about his new role and looks forward to working with the amazing people at CM Health and contributing to an organisation that cares about achieving health equity for our community, our people, whaanau.
Facilities

Scott Building

Auckland Council has now finally granted consent for us to begin work on the Scott Building recladding project. This is a significant three-year project consisting of 7 stages.

Remedial work will begin within the next few weeks to remove existing cladding from the exterior of the Scott Building and replacing it with a well tried and tested product which has been selected for both durability and fire safety. The uniqueness of this project is that patients will remain on the wards whilst the work is carried out.

The Facilities team are visiting each of the wards in the Scott Building to explain the process and have given an assurance that there will be minimal disruption to patients, staff and visitors. Drop-in sessions are also being arranged for all staff to understand how the work is being carried out.

*Below - an example of the hoarding that will be used viewed from the inside*
Performance and Outcomes Priorities

The Health Target Results for Quarter 3 will be available in the next report to the Board. Meanwhile, I have asked for Deep Dives into areas where CM Health did not achieve target in Q2: Faster Cancer Treatment, Emergency Department 6 hour waiting targets, Tobacco Cessation in the Primary Setting, and Immunisation for Maaori babies.

Faster Cancer Treatment

Target: 90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Overall, CM Health performance against the Faster Cancer Treatment (FCT) Health Target has declined since June 2018 with a steep drop off in January and February 2019. For the 6 month period between 1st September 2018 and the 28th of February 2019, CM Health performance was 75% of patients received their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

This is equivalent to 45 target breaches out of 183 referred patients. Of these breaches, 23 occurred in 2019. The breaches were largely due to four types of cancers: gynaecology, head & neck, lower gastrointestinal (bowel) and lung. Together, these types accounted for around half of all Faster Cancer Treatment patient volume and 80% of the capacity breaches.

Several issues contribute to this, the biggest of which are capacity constraints. Capacity factors include lack of diagnostic procedural capacity, oncology provider FTE, theatre capacity and regional radiation oncology capacity. Other reasons for the breaches include patient factors e.g., patient choosing to reschedule or delay appointments, clinical factors e.g., priority of other health matters over cancer, and system factors e.g., community referral prioritisation.

The table below illustrates our 62-day performance trends over time.

Actions taken to remedy this include:

- Meeting with cancer nurse coordinators & cancer trackers held to review & discuss hotspots.
- Meetings held with Gynaecology, Head & Neck, Lower Gastrointestinal (Bowel) & Lung cancer teams to take a more detailed look at hot spots and stream-specific issues.
- Following the tumour stream meetings, each of the 4 streams are developing service-led action plans.
Furthermore, a paper outlining key hotspots and resources required to sustainably achieve the target is being produced.

**Emergency Department**

**Target:** 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours

In December 2018, CM Health achieved the target for 87% total population (86% for Maaori, and 87% for Pacific).

Currently, ED has a challenging environment. Presentations have been increasing at a faster rate than the increase in resources and level of staffing over the last 4 years. The patients are increasing in complexity and this makes the diagnosing and treatment of the cases more difficult. Furthermore, the lack of inpatient capacity results in overcrowding of the Emergency Department. This makes the work for the nurses much harder as the ward patients are boarding in ED until a bed becomes available. These patients are usually sick and require in-patient care and ongoing management.

It is important to take into consideration that triage is placing patients in an order of urgency based on time sensitive treatment. For example, a dislocated shoulder is a triage 2, even if the patient is a fit and well patient, while a patient disabled with multiple chronic conditions could be classified as triage 4 but with a lot of complexity. Because of this, the Emergency Department also uses other quality measures to understand whether care given is appropriate and timely. An example of this is time for a patient to receive Percutaneous Coronary Intervention (PCI), which the clinicians feel is an important measure and perhaps a more accurate reflection of performance than the 6 hour target.

In the current resource constrained environment, the Emergency Department is working as efficiently as possible to provide the best care for the patients of Counties Manukau.

**Tobacco Cessation**

**Target:** 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

In December 2018, 89% of PHO enrolled patients who smoke had been offered help to quit smoking by a health care practitioner in the last 15 months. This included 88% of Maaori, 89% of Pacific, and 92% of Asian patients.

Smoking kills an estimated 5,000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector. Most smokers want to quit and there are simple effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt providers to routinely ask about smoking status as a clinical ‘vital sign’ and then to provide brief advice and offer quit support to current smokers.

There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. The quit rate is improved further by the provision of effective cessation therapies – both pharmaceuticals, in particular nicotine replacement therapy (NRT) and telephone or face-to-face support.

**Smoking Cessation ABC’s are:**

- Ask about and document every person’s smoking status.
- Give Brief advice to stop to every person who smokes.
- Strongly encourage every person who smokes to use Cessation support.

This has historically been a challenging target to meet. Although we usually meet the end of year target, performance varies throughout the year and PHOs often have to provide resource support to practices in high needs areas (for example, to call patients in the evening). Last year, we met the target for each ethnicity group which was a significant achievement.
Key initiatives to meet the target include:

a) **Active Clinical Leadership/Clinical Champions**
   The Smokefree Advisor – primary care have been working with Primary Health Organisations (PHOs) to discuss strategies such as appointment scanning, improved coding systems, ensuring opportunities are not missed if the patient attends the practice with a family member, etc.

b) **Active, Dedicated Management To Support ABC Activities In General Practice**
   All PHOs have committed staff to be responsible for ensuring this health target is achieved. The Smokefree Advisor – primary care provides a significant amount of support to both PHOs and practices in relation to ABC activities.

21 pharmacies in the district (evenly distributed across localities) are now providing brief advice and cessation support services. This activity counts towards achievement of the target and promotes alternative routes into cessation support (and primary care) for some of our harder-to-reach patients.

c) **Reminder, Prompting And Audit Tools**
   All of our PHOs support their practices to use audit tools and dashboards to indicate if patient smoking status is recorded, and whether brief advice has been given.

d) **Systems And Processes That Make Life Easier For Health Professionals**
   All our PHOs have systems and processes in place now which makes this activity ‘business-as-usual’ for their practices.

e) **Training**
   The CM Health Smokefree Advisor – primary care has provided a large number of training sessions to practice staff recently, particularly around referral for cessation support and then need for both pharmacotherapy and behavioural support.

f) **Staff Support**
   Most PHOs have provided extra resource (FTE) to practices to offer evening/weekend (moonlight) calling for brief advice.

g) **PHO Activities to Increase Delivery of ABC in General Practice**
   As part of the focus on cessation referral under the Amenable Mortality SLM, we have recently held a 2 hour workshop with PHOs to stocktake all regional existing activity in this area (of which there is a considerable amount) and identify gaps/areas of innovation for sharing.

   All of our PHOs working very closely with their practices and focus on practices with low performance.

Other activities include:
- Quitline data collected and sent to practices
- Employing PHO and practice Smokefree champion
- Systems prompts and reminders
- Provision of motivational interviewing/support groups
- Call centre support/funding, including to enter the data into the PMS
- Funded texting for practices for smoking brief advice
- Practice benchmarking reports and wall reporting
- Participation in quality improvement forums
- Development of an annual Smokefree plan
- Health promotion support and resources
- Promoting ABC Quit Card training;
- Running Group Based Therapy groups or training
- One to one additional training for staff to deliver a smoke free call centre service within their own practice
- Education (Continuing Medical Education / Continuing Nursing Education) sessions
- Innovation funding to help provide some additional resource for practices
- Encouraging high performing practices which are meeting the 90% target to aim for 100%
h) **Identifying and sharing the examples of best practice**  
PHOs continue to share practice success stories/learning and receive support from each other. In particular, the use of benchmarking, discussing any barriers to reaching the target, and asking for other strategies to try are useful.

**Immunisation**

**Target:** 95% of eight month olds will have had their primary course of immunisation on time (and significant progress has been made towards the target for the Maori and Pacific population groups).

In December 2018, 93% of eight month olds had their primary course of immunisation on time but only 83% of Maori babies met the target compared with 94% of Pacific babies.

A well-executed, universal immunisation programme is a cornerstone of public health and a highly effective way to prevent infectious disease (1). A national target for immunisation was first introduced in New Zealand (NZ) in 1993/1994 to reduce vaccine preventable diseases and to support engagement with primary care (2).

Since the introduction of the target, coverage rates have increased in NZ for all ethnic groups. Currently, despite overall coverage in Counties Manukau being above the national average, an equity gap continues with rates of immunisation lower among Maori compared with non-Maori across all childhood age groups.

Data for the 8-month-old target is presented below in Figure 1 which shows Maori immunisation coverage is currently 10% below our target and is also lower than other ethnic groups. Lower rates of immunisation place Maori children at greater risk of contracting vaccine-preventable diseases such as pneumococcal meningitis or pertussis (1, 3).

**Figure 1 - CM Health 8 month immunisation coverage, by ethnicity, 12 months to February 2019**

If we break these percentages into actual numbers (refer Table 1), an average of 53 Maori children each quarter are not immunised on time (12% of the eligible population) – this excludes those that have declined - which contributes to the equity gap in coverage.
### Table 1 - Māori immunisation coverage in Counties Manukau (Quarter Q1 to Q2 18/19)

<table>
<thead>
<tr>
<th>Quarter (2017-2018)</th>
<th>1</th>
<th>2</th>
<th>Total</th>
<th>Coverage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible</td>
<td>429</td>
<td>481</td>
<td>910</td>
<td></td>
</tr>
<tr>
<td>Fully Immunised by target age</td>
<td>357</td>
<td>395</td>
<td>752</td>
<td>82%</td>
</tr>
<tr>
<td>Declined Immunisations</td>
<td>24</td>
<td>29</td>
<td>53</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Cohort which we have the ability to influence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Immunised but after target age</td>
<td>18</td>
<td>25</td>
<td>43</td>
<td>5%</td>
</tr>
<tr>
<td>*Not Fully Immunised target age-passed (catching up on earlier missed immunisations)</td>
<td>30</td>
<td>32</td>
<td>62</td>
<td>7%</td>
</tr>
<tr>
<td>Total missed by target age</td>
<td>48</td>
<td>57</td>
<td>105</td>
<td>12%</td>
</tr>
</tbody>
</table>

**What are we doing?**

We have developed a range of initiatives to improve our immunisation coverage and address the disparity for Māori. These initiatives include:

- a) Piloting an incentive program for Māori to increase engagement with our immunisation services. This program is focused on Māori pepe in the six weeks to eight months age group.
- b) Increase collaboration between our Outreach Immunisation services (OIS) and Māori well child providers to support access and timely immunisation where families are not easily located.
- c) Our Outreach Immunisation service will increase their Saturday home visiting service prioritising Māori and Pacific families that have not being contactable.
- d) The Saturday ‘B4 School’ clinics continues to be a point of access for families with a targeted incentive offered for travel to those for children aged 4 years and 10 months.
- e) Our Immunisation Nurse Leader will work with all general practices with low Māori coverage rates to improve their performance.
- f) Our Immunisation Nurse Leader is working with the Smokefree Team Lead to design a screening and referral tool for immunisations that will be integrated into the Smokefree Team assessment forms. We envisage this work will contribute to increasing timely immunisation for children of whanau enrolled in the programme.
- g) We are working with the SUDI team to identify those babies at high risk of SUDI and who are also less likely to be immunised on time. Therefore, we aim to provide an opportunity to immunise before babies are late for their immunisations.

(Picture used with the permission from whaanau)
References


Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that the Board:

Receive the Corporate Affairs and Communications Report for the period 28 December 2018 – 28 February 2019.
Prepared and submitted by Donna Baker, General Manager Communications and Engagement and Parekawhia Mclean, Director Strategy and Infrastructure.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 28 December 2018 – 28 February 2019.

External Communications

Proactive Media

The Communications team proactively promoted a number of positive stories over this period, through national and local media and on the CM Health website. These included media releases on Crochet ‘Octopals’ for premature babies picked up by TVNZ’s One News; Tai chi classes; a free shuttle service trial for Middlemore patients; Smokefree service success picked up by Maori TV; mobile surgical bus in Counties Manukau; and Feet for Life clinic helping diabetic patients to avoid amputation which will be part of a NZ Herald feature series. Communications also assisted the producers of a new programme following local community Maori midwives.

Baby with Fracture

Communications supported and managed an issue relating to a baby with a suspected broken arm who was brought into hospital. The family posted a grievance on a social media website, and Communications worked with CEO, CMO to provide responses to media who requested information. The baby was later discharged to the care of Oranga Tamariki.

Resident Medical Officer Strike

Communications provided support to the contingency group and prepared information for the external website, including media release to inform the public about preparations for the strike.

Carparking

Communications facilitated general response to queries on carpark price increases at Middlemore with key messages including what is available for eligible family and clarifying that carpark decisions are made by the owner, ACC.
Proactive Releases and Website Stories

- Partners on a journey to a smoke-free life
- Visitor car park rates increase at Middlemore Hospital
- Free shuttle service trialled for Middlemore patients and staff
- Crochet ‘Octopals’ provide comfort for premature babies
- State of the art mobile theatre helps to meet demand
- Maternity Ward raises the bar on patient experience feedback
- Papakura birthing unit experience (video)
- Feet for Life clinic helps diabetic patients avoid amputation
- Strength and Balance classes – Frank’s story
- Kete Hauora Wellness Programme Directory now available to health professionals and social services
- New hepatitis C treatment to benefit patients

OIA - Official Information Act (1982)

Agencies have 20 working days to advise a decision on release of information requested under the OIA. This means that there is a rolling response from receipt in one month to response in next month. Requests will vary in their complexity, scope and considerations.

The State Services Commission

The State Services Commission (SSC) has recently (13 March) released the OIA performance report for all agencies for July –December 2018. CMDHB achieved 94.2% (113/120 responses) completed within 20 working days, and no complaints were upheld by the Ombudsman.

OIA-12227 Report Commissioned by Waitangi Tribunal on Disabled Māori

One of the largest Official Information Act requests to DHBs in December/January related to Waitangi Tribunal commissioned research on Health Care for Disabled Māori, informing a Waitangi Tribunal Claim and also to be used in submission to the current government Health and Disability Sector Review.

Health Select Committee

The Official Information Act Specialist was also involved in coordinating the DHB response to the Annual Review by the Health Select Committee, which occurred on 13 February. The response document covered 352 questions, half of which were new for this review round. After the hearing, a further 32 supplementary questions were received on Wednesday 14 March and submitted on Tuesday 19 March. Communications facilitated queries relating to the DHB’s appearance and in particular the DHB’s projected deficit. A short response was drafted to address queries from TVNZ, Radio NZ and Newstalk ZB.

More information on the OIA process and a form to submit requests is available: https://countiesmanukau.health.nz/about-us/official-information-act-requests/
Copies of recent OIA releases on common topics are also now on the website. https://countiesmanukau.health.nz/about-us/official-information-act-requests/publicly-released-oias/
Internal Communications

Midwifery Employee Representation and Advisory Service (MERAS) and NZ Resident Doctors’ Association (RDA) Strike Action

Internal communications continued to provide support to the contingency planning group and represented Counties in daily communications teleconference calls with National office.

Organisational Development (OD) Plans for 2019

Advice and support was given in developing the Employee Value Proposition survey which was circulated to a cross section of the organisation and an all employee Values Survey, designed to measure Values awareness across the organisation. In addition, internal communications provided advice and support to:
• The People and Professional Development Team, developing a communications plan to support the **People Leader Essentials programme**. Notices promoting the course have been scheduled in the Daily Dose. Emails have been issued to all GMs, SMs and CNDs, as well as through appropriate meetings where key staff come together.

• A Paanui page has also been developed which will house all the relevant information such as course dates, as well as blogs to further promote the courses. The key focus of these blogs is to highlight how they have helped staff who have already completed the courses.

• **Raahiri | Welcome to CM Health Day**
  Promotion of the first **Raahiri | Welcome to CM Health Day** (formerly Welcome Day). Interviews have been arranged with a number of new starters focusing on their role, location, what attracted them to CM Health, our values and what they hope to achieve during their time at Counties. These staff stories will be shared across internal communications channels.

**Care Capacity Demand Management (CCDM) and Trendcare**

In support of the CCDM programme, the team has developed a communication plan designed to effectively communicate timely information to key stakeholders, and to enable the successful adoption and implementation of CCDM and TrendCare. This will be presented at the next CCDM Council meeting, scheduled for 28 March 2019.

**Staff Forum**

Staff Forums for 2019 are underway. Internal communications has worked on improving the Staff Forum experience. This year, instead of four Staff Forums at Middlemore Hospital, the team has also scheduled forums at locality sites: Botany SuperClinic, Manukau SuperClinic, and Pukekohe Hospital. The sessions will also be videoed for those staff unable to attend. Where possible, we will look to include an engagement activity related to upcoming/current campaigns (e.g. the flu campaign).

**Team Counties Blogs**

No Team Counties blogs were published during this period. A blog schedule has been developed including the following segments:

• **Meet the Team blogs**: to showcase our people and the great work they do within their respective areas. This will help raise the profile of various teams, help familiarise new (and old) staff with teams they may not know exist within the CM Health group; and celebrate team successes and achievements.

• **Blogs from ELT members**.

**Changes to CM Health Shuttle Service**

Internal communications was asked to communicate the new trial shuttle service available to both staff and patients. Posters, an outpatient letter, content for Paanui, CM Health website, social media and, an advert for the Manukau Courier, were developed. Following feedback on the trialled service in late February, changes were made to the collateral to support changes to the service.
**Stakeholders & Communities**

**Hepatitis C**
We are working with the Northern Regional Alliance (NRA) and our Hepatitis C specialists to promote the Pharmac funding of Maviret, a drug that cures hepatitis C and can be prescribed by a GP. Our promotion started at the same time as the Health Promotion Agency’s (HPA) national campaign and the NRA’s regional advertising. In addition to using the national resources, we have also:
- Released a proactive story ‘New Hepatitis C Treatment to Benefit Patients’.
- Produced two videos with clinical nurse specialist Lucy Mills, explaining who should get tested and addressing the stigma. Another video in Mandarin (English subtitles) with GP Jing Dong, to target the significant portion of the Asian population who get hepatitis C in their countries of birth and are unaware they could be carrying the virus.

The resources were promoted on our internal and external channels and we are also working with our community partners and Asian Health teams to spread the message.

**Bowel Screening Programme – Otara Community Event**
We supported the Bowel Screening team in their second community event to promote the bowel screening test – the first event was in November last in Mangere.

**Smokefree**
We released a proactive story describing a couple’s journey to a smokefree life. The story was released on our external website, the CM Health, Healthy Together and Hang Tuff Don’t Puff social media channels, and shared by organisations such as Kia Ora Hauora and Drive Consumer Direction and on the Hapai Te Hauora newsletter.

**Advanced Care Planning (ACP)**
We’re supporting the ACP team to help promote programme out in the community. We’re currently looking into local champions to help push out the key messages and use for promotion, as well as connecting with aged care services and whaanau services in the community.

**Every Hour Counts**
Supporting the project team with design and templates to implement the Every Hour Counts communication plan

**‘The Right Care for you’ Campaign (Winter Comms)**
We’re currently finalising the comms plan for winter. The campaign will have the same look and feel as last year, but with a focus on influenza immunisation, particularly for children and elderly with an equity lens. We are currently working with the Asian, Fanau Ola, and Whaanau Ora teams to address how we can best support their community activity to promote our key messages.

We are concentrating our strategy on radio/digital/print advertising, particular with ethnic media outlets. Pharmacy will also be added as an access option.
Immunisation

Supporting the Immunisation team to promote whaanau to immunise against influenza. We are currently looking into leads for proactive stories in the local newspapers, as well as a video of a mother and baby on the process of getting baby’s immunisations.

Community Health Services

We are producing a video with the team, highlighting how the service works, who can be referred and can benefit from it.

Community/ Mental Health

We released a proactive story about the launch of Kete Hauora, a directory of wellness programmes available in the Counties Manukau district that can be accessed by health professionals, social service organisations and community house managers.

Pre Testie Bestie

We continue to support the South Auckland localisation strategy for the HPA’s Pre Testie Bestie campaign encouraging women to stop drinking alcohol if there is any chance they could be pregnant. The first activity was a stand at Waitangi ki Manukau on February 6 and had the support of CAYAD.

The stand had a photo booth which printed campaign branded photos. There were also giveaways such as cardholders for phones. Participants could also go in the draw to win a prize (UE Boom) if they shared their photos with the Pre-testie Bestie hashtag on their social media accounts.

Papakura Birthing Unit Video

We are supporting the Maternity Birthing Unit project group’s around raising the number of women and whaanau who use the birthing units. We have worked with the team to create a series of videos of the units which focus on the staff and the quality care they provide. The first video completed is on Papakura Birthing Unit.

Women’s Health

- Mangere Contraception Clinic: designed a paper and online survey to capture women’s experience who have attended the Clinic.
- Women’s Health Update Day: designed the collateral to promote the event on 1 May ‘Focus on Obesity –The growing Problem and Impact on Women’s Health.
- Our Maternity Monthly (OMM): The February 2019 edition of OMM was published on 5 March.
Falls Prevention Programme – Frank Toru’s Story
We are assisting to promote the strength and balance classes in the community. We have recently completed a video with South Auckland local Frank Toru who had a major fall last year. Frank is now doing tai chi classes at Clayton Park School hall. Tai Chi helps to prevent falls and improves health.

Lunar New Year
We worked closely with the Asian Health team to develop collateral (poster, screensaver, Paanui banner), promote a quiz and introduced a decoration competition for Lunar New Year. The quiz had 198 entries and the competition had five – the first winner received a prize of 88 fortune cookies, and all teams received a certificate.  
1st Winner: Te Rawhiti Community Mental Health Centre  
2nd Equal Winners: Health Intelligence & Informatics and Kidz First Neonatal Care  
3rd Equal Winners: BreastScreen and Mental Health Management Team  
Quiz Winner: Angelia Ong won the $20 Pak’n Save voucher

Research
We are supporting the Research team to develop collateral and promote the call for abstracts for the upcoming Research Week 1 - 5 July.

Promoting Allied Health (Maaori Workforce Development)
We are supporting the Maaori Workforce Development to promote Allied Health careers, with a focus on raising the number of tertiary students doing placement at CM Health. We have produced a video of Acute Spinal Physiotherapist, Jessica Penney on her experience working at Counties and how her cultural values enhance her ability to connect with patients. The video will be used as a recruitment tool for Allied Health, Maaori Workforce Development, Recruitment, as well as raise the profile of our Maaori staff. The video is in the editing stages and will be live in late March/early April.

Medinz communications with Primary Care
Seven routine and four urgent communications were posted during the reporting period with a focus on the junior doctors and MERAS (midwives) strikes.

Digital Channels

Website (www.countiesmanukau.health.nz)
We saw a small drop in traffic this period, which can be attributed to staff going on holiday as some traffic to the external website originates from staff. This is supported by the more expansive distribution of “time of day” metrics, which typically is closely matched with normal business hours.
Audience Growth Metrics

Social Media

Our social media period was a bit flat following a very strong end-of-year run. We saw our audience grow across all channels; however we observed fewer impressions and engagements per post. These lower numbers can be considered as a return to ‘normal’ after a December high.

<table>
<thead>
<tr>
<th></th>
<th>Total Followers</th>
<th>Follower increase</th>
<th>Messages Sent</th>
<th>Impressions</th>
<th>Impressions per Post</th>
<th>Engagements (incl. post clicks)</th>
<th>Engagements per Post</th>
<th>Post Clicks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health Facebook</td>
<td>8,460</td>
<td>+0.80%</td>
<td>26</td>
<td>88,377</td>
<td>3,399</td>
<td>11,812</td>
<td>454</td>
<td>8,219</td>
</tr>
<tr>
<td>Healthy Together Facebook</td>
<td>9,005</td>
<td>+1.57%</td>
<td>27</td>
<td>81,141</td>
<td>3,005</td>
<td>11,222</td>
<td>415</td>
<td>8,288</td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,656</td>
<td>+0.53%</td>
<td>41</td>
<td>35,883</td>
<td>877</td>
<td>107</td>
<td>2.6</td>
<td>52</td>
</tr>
<tr>
<td>CM Health LinkedIn</td>
<td>6,688</td>
<td>+2.69%</td>
<td>15</td>
<td>31,657</td>
<td>2,110</td>
<td>1,315</td>
<td>87</td>
<td>898</td>
</tr>
</tbody>
</table>

Figure 1 Web Site Data Metrics from Google Analytics

CM Health Facebook

The CM Health Facebook Page was once again our best performing channel, with reach over 88,000. The story of our nursing graduates was our most popular post, achieving an engagement rate of over 30%. Dr Andrew Connolly receiving acknowledgement in the New Zealand Order of Merit New Year Honours list was also quite popular; receiving more than 30 comments.
Top 4 Posts by Reactions

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last week we had the pleasure of welcoming 93 graduates who have chosen to begin their careers within the Counties Manukau region. This group includes registered nurses, enrolled nurses...</td>
<td>2,064</td>
<td>27</td>
<td>31.70%</td>
<td>6,511</td>
</tr>
<tr>
<td></td>
<td>Congratulations to Dr Andrew Connolly, Head of Department of General and Vascular Surgery who has been acknowledged in the New Zealand Order of Merit New Year Honours list.</td>
<td>1,102</td>
<td>33</td>
<td>25.82%</td>
<td>4,267</td>
</tr>
<tr>
<td></td>
<td>There is a train and bus station right outside Middlemore Hospital so why not opt for public transport to and from work? The new shuttle service for staff and patients is another great option...</td>
<td>1,061</td>
<td>13</td>
<td>17.17%</td>
<td>6,179</td>
</tr>
<tr>
<td></td>
<td>Are you (or anyone you know) looking for a new, meaningful role where you can make a real difference in your community and work with those as passionate as you are?</td>
<td>918</td>
<td>--</td>
<td>16.03%</td>
<td>5,727</td>
</tr>
</tbody>
</table>

Figure 8 Top 4 CM Health Facebook Posts by reactions

Healthy Together Facebook

Following a strong reporting period, we’re pleased to report further growth. Posts regarding health services available to the public continue to be very popular on this channel. Our post promoting the Papakura Birthing Unit reached nearly 30,000 people. Frank’s Tai Chi classes was also a popular piece this period.

Top 3 Posts by Reactions

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There’s nothing like being looked after by aunties when you’re with pepi, and the team at Papakura Birthing Unit are exactly that. If you’re a pregnant mama in South Auckland or know of someone who is, then Papakura Birthing Unit is a great place to have baby.</td>
<td>6,213</td>
<td>61</td>
<td>20.77%</td>
<td>29,912</td>
</tr>
<tr>
<td></td>
<td>After a fall last year, South Auckland local Frank Toru started tai chi classes to build his strength and balance. Check out his story below. There’s some awesome Community Group Strength and Balance classes whaanau to reduce falls and fractures, and support older people to ‘Live Stronger for Longer’.</td>
<td>1,083</td>
<td>23</td>
<td>15.41%</td>
<td>7,030</td>
</tr>
<tr>
<td></td>
<td>Measles is a serious illness whaanau. For more information or advice, please call Healthline on 0800 611 116. It’s important whaanau to get vaccinated, so if you haven’t been immunised...</td>
<td>805</td>
<td>5</td>
<td>19.97%</td>
<td>4,032</td>
</tr>
</tbody>
</table>

Figure 9 Top 4 Healthy Together Posts by reactions

CM Health LinkedIn

There was a notable drop in engagement metrics this reporting period on our LinkedIn channel, perhaps due to lack of celebratory content shared. Moving forward we should continue to share very positive content on this channel as it tends to be what resonates with our audience the most.
Top Posts by Engagement

<table>
<thead>
<tr>
<th>Image / Video</th>
<th>Post Content                                                                                                                                                                                                                                                                                                                                 #</th>
<th>Reactions</th>
<th>Comments</th>
<th>Engagement</th>
<th>Reach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Last week we had the pleasure of welcoming 93 graduates who have chosen to begin their careers within the Counties Manukau region. This group includes registered nurses, enrolled nurses and occupational therapists who will be working across a wide range of services in the DHB and out in our community at GP...</td>
<td>261</td>
<td>1</td>
<td>6.66%</td>
<td>3,934</td>
</tr>
<tr>
<td></td>
<td>Are you a Team Manager and ready for your next challenge? Do you want to work in an environment where you can make a difference to the community you live or work in? This might just be the role for you! Click on the link for more information...</td>
<td>134</td>
<td>0</td>
<td>5.75%</td>
<td>2,332</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau Health is trialling a new comforter for premature babies. Crochet ‘octopals’ are made using 100 per cent cotton and to a very specific size for safety reasons. Read more about this great initiative</td>
<td>80</td>
<td>1</td>
<td>5.39%</td>
<td>1,502</td>
</tr>
</tbody>
</table>

Figure 11 LinkedIn Top Posts by engagement

CM Health Twitter

We did not observe much change in Twitter metrics compared to the last period. However, our #SustainableTravel tweet was very popular with 16 engagements and reaching more than 6000 people.

<table>
<thead>
<tr>
<th>Tweets</th>
<th>Top Tweets</th>
<th>Tweets and replies</th>
<th>Promoted</th>
<th>Impressions</th>
<th>Engagements</th>
<th>Engagement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Health</td>
<td>@gconde . Jan 21</td>
<td>Opt for public transport this year! Train and bus stations right outside Middlemore Hospital. The shuttle service runs every 15 minutes including trips to Manukau train station and Papatoetoe train station. More information: bit.ly/2PAIOZ #SustainableTravel pic.twitter.com/CY7IAFT3tn</td>
<td>6,453</td>
<td>16</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@gconde . Jan 22</td>
<td>Counties Manukau Health is trialling a new comforter for premature babies. Crochet ‘octopals’ are made using 100 per cent cotton and to a very specific size for safety reasons. Read more about this great initiative: bit.ly/2QmPMnW #HaPai... bit.ly/2O2nPgW</td>
<td>1,108</td>
<td>4</td>
<td>0.4%</td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@gconde . Jan 7</td>
<td>Summer is here, and the chances of getting sunburnt are high! Check out these tips bit.ly/2QmQ69s, and make sure you and your whanau are #SunSmart, especially between the hours of 11am-4pm. #HealthyTogether #SunSmart facebook.com/countiesmanukau</td>
<td>947</td>
<td>2</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@gconde . Feb 7</td>
<td>Many thanks to everyone who attended the Pre-testicole bestie stand yesterday at Watangai to support women to have an alcohol-free pregnancy. It was a great turnout! It was amazing to see friends and whanau supporting this important kaupapa. pretesticolebestie pic.twitter.com/TJopYXwa58</td>
<td>811</td>
<td>11</td>
<td>1.4%</td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@gconde . Jan 9</td>
<td>Really the way to treat gool is to get on the Allopurinol which slows down the production of uric acid... redoranz.co.nz/International</td>
<td>805</td>
<td>14</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>CM Health</td>
<td>@gconde . Jan 22</td>
<td>Thinking about learning the reo whaiao? Manukau Institute of Technology are offering free reo Maori courses. Check out the link below #teaoohokowhara manukau.ac.nz/łożyudy /areas-of</td>
<td>754</td>
<td>8</td>
<td>1.1%</td>
<td></td>
</tr>
</tbody>
</table>
Social Listening

Peaks:
- Jan 30: Car chase with shooting and baby's broken arm.

Figure 12 Social volume, sentiment and sources
Figure 13 Social reach and hours
Figure 14 social influence, topics and weekdays
News/Media Listening

Peaks

- **December 30**: Otara shooting and “water incident”

![Figure 15 social volume, sentiment and sources](image-url)
Figure 16 hours and reach
Figure 17: Influence, topics, and weekdays.
Counties Manukau District Health Board
Occupational Health and Safety Performance Report

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period from 1 January 2019 ending 28 February 2019.

Note this report was endorsed by the Executive Leadership Team on 2 April to go forward to the Board.


Glossary for Monthly Performance Scorecard and Report

<table>
<thead>
<tr>
<th>Lost time incidents</th>
<th>Any injury claim resulting in lost time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost time injury Frequency Rate</td>
<td>No of lost time Injuries per million hours worked.</td>
</tr>
<tr>
<td></td>
<td>LTIFR (Lost Time Injury Frequency Rate) = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td>Injury Severity Rate</td>
<td>Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked.</td>
</tr>
<tr>
<td></td>
<td>LTISR (Lost Time Injury Severity Rate) = (Number of Lost Hours / Hours Worked) x 1,000,000.</td>
</tr>
<tr>
<td>Notifiable Injury/illness</td>
<td>(a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations.</td>
</tr>
<tr>
<td></td>
<td>(b) any admission to hospital for immediate treatment</td>
</tr>
<tr>
<td></td>
<td>(c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance</td>
</tr>
<tr>
<td></td>
<td>(d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals.</td>
</tr>
<tr>
<td></td>
<td>(e) any other injury/illness declared by regulations to be notifiable.</td>
</tr>
<tr>
<td>Notifiable Incident</td>
<td>An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person’s health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident.</td>
</tr>
<tr>
<td>Notifiable Event</td>
<td>Death of a person, notifiable injury or illness or a notifiable incident.</td>
</tr>
<tr>
<td>Pre-Employment</td>
<td>Health screening for new employees.</td>
</tr>
<tr>
<td>Worker</td>
<td>An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer.</td>
</tr>
<tr>
<td>Reasonably Practicable</td>
<td>Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and the cost associated with elimination of the hazard/risk.</td>
</tr>
</tbody>
</table>
Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
</tr>
<tr>
<td>ARF</td>
<td>Audit, Risk and Finance</td>
</tr>
<tr>
<td>ASRU</td>
<td>Auckland Spinal Rehabilitation Unit</td>
</tr>
<tr>
<td>BBFE</td>
<td>Blood and/or Body Fluid Exposure</td>
</tr>
<tr>
<td>CCS</td>
<td>Central Clinical Services</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee Assistance Programme (Counselling)</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>EMIC</td>
<td>Emergency Medicine &amp; Integrated Care</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>HSNO</td>
<td>Hazardous Substance New Organisms Act</td>
</tr>
<tr>
<td>HSWA</td>
<td>Health and Safety at Work Act 2015</td>
</tr>
<tr>
<td>IRS</td>
<td>Incident Reporting System</td>
</tr>
<tr>
<td>JCC</td>
<td>Joint Consultative Committee</td>
</tr>
<tr>
<td>LTI</td>
<td>Lost Time Injury</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MMC</td>
<td>Middlemore Central</td>
</tr>
<tr>
<td>OHSS</td>
<td>Occupational Health and Safety Service</td>
</tr>
<tr>
<td>PHCS</td>
<td>Primary Health &amp; Community Services</td>
</tr>
<tr>
<td>PEHS</td>
<td>Pre-Employment Health Screening</td>
</tr>
<tr>
<td>SAP</td>
<td>Surgical, Anaesthesia &amp; Perioperative</td>
</tr>
<tr>
<td>SPEC</td>
<td>Safe Practice and Effective Communication</td>
</tr>
<tr>
<td>WellNZ</td>
<td>Injury Management Third Party Administrator</td>
</tr>
</tbody>
</table>

Purpose

The purpose of the Health and Safety report is to provide monthly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Counties Manukau District Health Board.

Executive Summary

- **Notifiable event and WorkSafe notification:**
  There were no notifiable events in January/February 2019.

- **Incident Reporting in January/February:**
  Incident reporting for January saw a two year peak of 151 incidents being reported which included 43 in the ‘other category’. The ‘other category’ includes incidents related to injury from stationary objects, flea bites, cars broken into and the temperature of facilities. In addition 38 incidents related to violence and aggression incidents. The violence and aggression figure for January is consistent with the January 2018.

  February incidents returned to the typical level of 111. There were slightly more BBFE incidents than usual partly due to increase in awareness of reporting and an issue with incorrect disposal of used sharps which saw an increase in injuries for the cleaning staff.
Current Issues Update

- **Violence and Aggression key initiatives:**
  An investigation into the rise in reporting of incidents involving violence and aggression within the Acute Mental Health Services (Tiaho Mai and Kuaka) has taken place. As a result the MH team has installed personal lockers for service users in Tiaho Mai for secure storage of service users’ cigarettes and lighters to reduce tension when the service stores the personal items.

- **Actions following ACC AEP Audit (November 2018):**
  a. Contractor Management: new policy and process have been sent to the services for feedback/
  b. Worker Participation – Worker Engagement Participation and Representation (WEPR) policy, process and pathway framework has been sent to the Unions and meetings for feedback and negotiation have been organised.
  c. Injury Management action points reviewed with WellNZ and plan for closeout within the next quarter to ensure compliance for annual ACC Injury Management audit in November 2019.

- **OHSS Team Resource:**
  1 x H&S Business Partner vacancy to be recruited in March.

- **Code Orange pilot:**
  Code Orange/ED Violence & Aggression monitoring project continues with ED staff reporting high risk incidents through RiskPro and the majority of the incidents captured through the intranet. The below is a sample of the data from June 2018.
Key findings from Pilot during the Jul-Jan pilot are:

- Highest number of incidents happened in the waiting room/triage representing double the number of other areas.
- The period September-November had the highest number of incidents and with the presence of alcohol noted as a contributory factor. The presence of drugs was noted as highest in November with no notation if patients were presenting with both alcohol and drug.
- Recommendations from the pilot study include an increase in security presence during the peak periods and to extend the period of the data capture to capture a full year of data.
# Health and Safety Performance Scorecard

## Lagging Indicators

### Number of Reported Incidents

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>111</td>
<td>-</td>
</tr>
<tr>
<td>Contractors</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Students</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Visitor</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### Number of Injury claims

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 month rolling average</td>
<td>&gt;14</td>
<td>10</td>
</tr>
<tr>
<td>January figure</td>
<td>14.60</td>
<td>-</td>
</tr>
</tbody>
</table>

### Predominant Incident Profile

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBFE</td>
<td>21</td>
<td>-</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Aggression and Violence</td>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>Slips/ Trips/ Falls</td>
<td>4</td>
<td>-</td>
</tr>
</tbody>
</table>

## Leading Indicators

### Attendance at H&S Orientation

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Rating</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target or better</td>
<td>Achieved</td>
<td>✔️</td>
</tr>
<tr>
<td>95-99.9%</td>
<td>Substantially achieved</td>
<td>✔️</td>
</tr>
<tr>
<td>90-94.9%</td>
<td>Not achieved, but progress made</td>
<td>✔️</td>
</tr>
<tr>
<td>&lt;90%</td>
<td>&gt;10% away from target</td>
<td>✔️</td>
</tr>
</tbody>
</table>

### H&S Representative training completed

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Rating</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target or better</td>
<td>Achieved</td>
<td>✔️</td>
</tr>
<tr>
<td>95-99.9%</td>
<td>Substantially achieved</td>
<td>✔️</td>
</tr>
<tr>
<td>90-94.9%</td>
<td>Not achieved, but progress made</td>
<td>✔️</td>
</tr>
<tr>
<td>&lt;90%</td>
<td>&gt;10% away from target</td>
<td>✔️</td>
</tr>
</tbody>
</table>

### Pre-employment health screening completed

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Rating</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target or better</td>
<td>Achieved</td>
<td>✔️</td>
</tr>
<tr>
<td>95-99.9%</td>
<td>Substantially achieved</td>
<td>✔️</td>
</tr>
<tr>
<td>90-94.9%</td>
<td>Not achieved, but progress made</td>
<td>✔️</td>
</tr>
<tr>
<td>&lt;90%</td>
<td>&gt;10% away from target</td>
<td>✔️</td>
</tr>
</tbody>
</table>

### Indicators in Red

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTIFR</td>
<td>• 12 month rolling average figure remains above the target at 14 (vs target of 10) and lower than January figure of 14.60.</td>
</tr>
<tr>
<td>H&amp;S Representative training completed</td>
<td>• 7 candidates attended the H&amp;S Representative training session in February 2019.</td>
</tr>
</tbody>
</table>

### Indicators in Orange

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance at H&amp;S Orientation</td>
<td>• 33 out of the 36 participants eligible to attend the orientation attended.</td>
</tr>
<tr>
<td></td>
<td>• It is noted that the Orientation for staff will change from 26 February with a new format for the Welcome Day, H&amp;S requirements being delivered through manager training and an online course (similar to WDHB format).</td>
</tr>
</tbody>
</table>

### Indicators in Blue

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-employment health screening</td>
<td>• 35 of the 36 new starters received full clearance prior to their start date.</td>
</tr>
</tbody>
</table>
completed

- The remaining candidate has yet to complete additional health screening as requested by the OHN team. The manager has been informed and they are on restricted duties until full clearance obtained.

LTIFR

The LTIFR rolling average figure of 14 is lower than the previous rolling average of 14.6 and while still above the target of 10 has remained reasonable stable. The peak that appeared in October 2018 was the result of new claims that have been loaded in that time and not backdated to the injury date.

CMH will discuss the impact of the reporting process with WellNZ and report on how we can backdate the LTI total figure to appropriate months, rather than create peaks due to input of approved claims. This will not impact the 12 month rolling figure as discussed above, but will potentially even out the peaks.

Severity remains consistent coming off the high of March 2018 and consistent with the Australian benchmarking figure.
Injury Claim Data

<table>
<thead>
<tr>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total $ cost for month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lost days for month</td>
<td>$ total for month</td>
<td>$ total for month</td>
<td>$ total cover cost for month</td>
<td>Total $ cost for month</td>
</tr>
<tr>
<td>155.30</td>
<td>19,964.65</td>
<td>6,538.85</td>
<td>21,262.05</td>
<td>47,765.55</td>
</tr>
</tbody>
</table>

Key Health and Safety Risks

CM Health key H&S risks with update/status of management of the risk, including key initiatives to reduce risk.

### Key

- **Risk is well managed – all significant actions complete**
- **Risk is well managed - some minor actions to be completed**
- **Risk is being managed and has some significant actions underway**
- **Risk is being managed and has some significant actions yet to progress**

### Risk: Occupational Health & Safety - Aggression and Violence

(Emergency Department, Mental Health, Community Mental Health)

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Code Orange pilot running in ED and will review at end of Feb/Mar on effectiveness and programme rollout.</td>
<td>• Code Orange pilot statistics reviewed and recommendation the full year data be collected to identify key periods of increased verbal and physical abuse towards staff. Current data indicated peak September to November.</td>
</tr>
<tr>
<td>• Security team working with ED on Code Orange initiative and reviewing MAPA training to establish if an effective module for CMH.</td>
<td>• In response to staff concerns re safety in the car parking CCTV cameras upgraded at MSC to provide wider coverage of external areas.</td>
</tr>
<tr>
<td>• Investigation into Violence and Aggression within Acute Mental health unit. Review of controls and implementing/reviewing existing patient and staff safety protocols to ensure they are followed and effectiveness.</td>
<td>• Auckland Spinal Rehabilitation Unit (ASRU) located in Otara reviewed security controls with outcome of improving lighting, installing swipe access and other security enhancements to improve staff safety.</td>
</tr>
<tr>
<td>• New Tiaho Mai facility reviewed processes to align with new facility with some initial issues relating to software systems etc. This has been completed.</td>
<td>• Violence and aggression incidents at Tiaho Mai – Acute Mental Health Unit, Tiaho Mai staff and Managers working to improve current processes/controls to address concerns raised relating to staff risks.</td>
</tr>
<tr>
<td>• Letter received from WorkSafe (Jan 20) regarding staff safety in Acute mental health facility. Investigation into all issues raised with MH team and improved communication, review of controls and processes has taken place.</td>
<td>• Investigation following a MH near miss incident relating to staff wearing lanyards by patient, recommendation to replace lanyards with wristbands in high risk services.</td>
</tr>
<tr>
<td>• Tiaho Mai implementing digital lockers for service users to store their belongings in response to behaviour towards staff who confiscate service users tobacco and lighters.</td>
<td>• Tiaho Mai completed a Business Case to increase security to cover 24/7 have dedicated security cover overnight.</td>
</tr>
</tbody>
</table>
### Risk: Hazardous Substances and New Organisms (HSNO)/Contractor Management

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• H&amp;S external contractor provided recommendations on utilising WDHB Hazardous Goods Register.</td>
<td>• F&amp;E preparing Hazardous Goods Register for review as action point from previous Gavin Johnston Audit in 2017.</td>
</tr>
</tbody>
</table>

### Risk: Contractor Management

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Response received from identified contractors and compiled by H&amp;S Contractor.</td>
<td>• New GM Engineering and Facilities commenced and reviewing Contractor Management rollout and compliance.</td>
</tr>
<tr>
<td>• List represents a small number of current contractors and F&amp;E ensuring all current contractor information is captured.</td>
<td>• Contractor Management policy, procedure and audit framework under development by H&amp;S in consultation with stakeholders.</td>
</tr>
<tr>
<td>• Audit action points for Contractor Management reviewed with F&amp;E teams.</td>
<td>• HealthAlliance are leading process for the region to procure a Contractor Management system.</td>
</tr>
</tbody>
</table>

### Risk: Occupational Health and Safety - Safe Moving and Manual Handling

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Frequency of training programme will increase to 2 days a week from 31/01/2019 to increase number of patient facing staff trained.</td>
<td>• Programme being sourced for managing non-clinical manual handling for orderly and cleaning services.</td>
</tr>
<tr>
<td>• Increase in qualified educators with ongoing programme to increase number of educators.</td>
<td>• SPHM has moved from a project to being under control of permanent resource.</td>
</tr>
<tr>
<td>• Specific project in Orthopaedic ward to address management of safe handling of bariatric patients under review. In response to staff injury rates and specific needs within Orthopaedic wards.</td>
<td>• SPHM training programme continuing with review/feasibility of increasing frequency of training to improve timeframe for full training.</td>
</tr>
</tbody>
</table>

### Risk: Blood and Body Fluid Exposure (BBFE)

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• BBFE increase correlates to increase in demand with Xmas period noting a spike in cases. Senior staff working with colleagues under pressure main cause.</td>
<td>• BBFE incidents remain high although lower than December total.</td>
</tr>
<tr>
<td>• New intake of new nurse graduates during induction OHN specifically addressing risks/safety measures relating to BBFE. Last intake saw reduction in incidents following induction briefing.</td>
<td>• SAPS has the highest number of incidents. OHN working with service and report change in procedures contributed to some incidents.</td>
</tr>
<tr>
<td></td>
<td>• Inattention/distraction is still main cause.</td>
</tr>
<tr>
<td></td>
<td>• A review of whether fatigue is a root cause as increase correlates to December increase in acute ED surgeries at night.</td>
</tr>
<tr>
<td></td>
<td>• A literature search is being conducted to determine if there programmes in other organisation to address this risk.</td>
</tr>
</tbody>
</table>
## Risk: Occupational Health and Safety - Slips, Trips and Falls

### Previous Report Action
- A number of slips, trips and falls relate to walking/running in common area corridors.
- Review taking place with F&E on the non-slip lino in the ‘rainbow’ corridor.

### Current Action
- Reminder to be sent to all staff by Daily Dose to put out Wet Floor signs and call for cleaning assistance when spill is noticed.
- ED and MH increase in incidents which correlates to busy periods in both services and will include in fatigue review above.

## Risk: Compliance - Health & Safety Training Framework

### Previous Action Point
- H&S Rep training to recommence in Feb 2019.
- Review refresher training for existing H&S Reps with training provider.
- Review of MH First Aid training programme and number of CMH team to attend pilot of MH101 in Feb 2019.
- Fundamentals of Management H&S module under review and first cohort in Apr to deliver new programme.
- H&S Induction delivery changing from current one day format to combination of e-Learning and utilisation of similar format to WDHB with review currently underway. Change will be effective March 2019.

### Current Action
- H&S Rep training completed in Feb with slight decrease in numbers. Will continue in Mar/Apr.
- MH101 programme completed and funding requested to run 3 sessions up to June 2020.
- Fundamentals of Management H&S module under review.
- H&S Induction being customised from WDHB module and scoping use of H&S specific videos to cover specific topics and allow further accessibility for staff.
- H&S Training framework draft completed and being reviewed by ELT H&S Committee in Mar.

## Risk: Wellness – Employee Health and Wellbeing Programme (stress, fatigue, depression)

### Previous Action Point
- Mental health first aid (MHFA) training to address and identify stress, fatigue and depression planned in 2019, review on training course and delivery underway.
- Flu campaign national update in Feb with full rollout of campaign planned from 01 Apr 2019.
- Noted in review of ACC report on staff claims, an under representation of Maori/Pacific Island staff. Review of initiatives to improve and enable all staff to access injury support.

### Current Action
- Wellbeing booklet on sleep and a booklet of managing fatigue are under development.
- The Safer Nursing 24/7 Project has released a Draft National Code of Practice for Managing Fatigue and Shift Work in Hospital-Based Nursing for a 3-month period of public consultation from 10 December 2018. The Safer Nursing 24/7 project is funded by the Health Research Council and includes researchers from Massey University and the New Zealand Nurses Organisation, with an Advisory Group with broad representation from across the sector. The draft Code has been informed by a 2016-2017 national survey of nurses’ work patterns. The aim of the consultation process is to ensure that the final Code of Practice is understandable, effective and practical for implementation in New Zealand public hospitals.
### Risk: Physical environment (ventilation, lighting, noise, equipment)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Seasonal flea incidents with flea bites reported within theatres and ED.</td>
<td>• The weather has caused fleas to be prevalent. Cleaning services addressing when reported.</td>
</tr>
<tr>
<td>• Follow up with cleaning staff to reduce incidents and management of patient isolation if appropriate to reduce cross-contamination.</td>
<td>• Asbestos identified in Esme Green area during review of Fire and Smoke remediation work contracted through F&amp;E. Notification/remedial work underway.</td>
</tr>
<tr>
<td>• Asbestos removal continues at Galbraith with closed off area with lobby of Galbraith.</td>
<td>• Temperature issues due to high external temperatures and offices without air-conditioning reported in Esme Green. Recommendation for staff to take breaks, keep hydrated and use fans.</td>
</tr>
</tbody>
</table>

### Risk: Compliance - Worker Participation

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Draft WP framework to be presented to ELT in Feb for review.</td>
<td>• Worker Engagement Participation and Representation (WEPR) Policy and Pathway/Committees structure draft developed.</td>
</tr>
<tr>
<td>• Agreed with PSA/MH service that following agreement on WP framework, MH service will be pilot for rollout of framework.</td>
<td></td>
</tr>
<tr>
<td>• ELT H&amp;S committee meeting in Dec reviewed membership of committee; action points to finalise terms of reference and ensuring Union delegate representation at committee meetings.</td>
<td></td>
</tr>
</tbody>
</table>
Reported Incidents

Rolling year-on-year monthly comparison:
Previous 13 months – 113.5
Current 13 months – 125

Incidents have decreased against the previous 12 and 24 month results for same period with the year on year average rolling figure being higher and January standing out as the peak for the last two years – result of increase in reporting of key risk areas of aggression and violence, BBFE and M&H incidents.

Key Observations:

- **Other (33):** Highest reported incident category. The causes were ‘action/behaviour of employee/affiliate’ and ‘awkward position/posture’ was high. Safe moving of objects/equipment contributory factor.

- **Aggression and Violence (24):** Significant decrease from January figure of 38. EMIC higher in the category with a number of staff. Investigation/improvements to controls and processes in place. ED continuing with Code Orange initiative and the swipe card pilot study all working to reduce the A&V incidents, at this stage still encouraging capture of all incidents.

- **BBFE (21):** Slight decrease from Jan figure of 26. OHN follow up with services and individuals. 8 of the 21 BBFE incidents occurred in SAP and as well as 8 in EMIC reviewing if fatigue a contributory factor.

- **Moving & Handling (20):** Slight decrease from Jan figure of 22.

Worksafe Notification

No reported incidents for the period up to 28 February 2019.
**Aggression and Violence**

**Rolling year-on-year monthly comparison:**

- Previous 13 months – 27
- Current 13 months – 29
  - Incidents slightly less compared to previous February figure with reduction from January peak.
  - ED tracking ‘Code Orange’ trial working with Security Services to better control elevated behaviour.
  - EMIC is the highest area for reported incidents—result of consistent increase in reporting of aggression and violence incidents in ED. MH is the second highest area.
  - Causation profile:
    - Behaviour – Aggressive/Violent: 18;
    - Assistance unavailable/job factors/human factors: 5
    - Confused/disorientated: 1

**BBFE (Blood or Body Fluid Exposure)**

**Rolling year-on-year monthly comparison:**

- Previous 13 months – 23.2
- Current 13 months – 27
  - BBFE incidents slightly less than previous 12/24 month figures.
  - SAP and EMIC services have the highest incidents.
  - OHSS tracking trends and following up with services to reduce reoccurrence.
  - Causation profile:
    - Inattention/ distraction: 6
    - Patient condition/ acts of others: 4
    - Improper work techniques: 3
    - Job factor: 3
    - Other: 3
    - Defective tools/ equipment: 1
    - PPE not used: 1
Moving and Handling

Rolling year-on-year monthly comparison:
Previous 13 months – 22
Current 13 months – 24
• Decrease on February 2018 figures (20 versus 26) and rolling average shows a slight increase.
• M&H training programme with increase from 1 to 2 sessions per week and continue to train more facilitators through the train the trainer programme/reviews from WDHB team.
• SAP services have the highest reported M&H incidents with ARHOP second highest.
• Lack of appropriate lifting equipment being addressed and noted as a key causation of injury.
• H&S team working with non-clinical teams to review M&H training requirements.
• Causation profile:
  Lifting/carrying/load size: 9
  Awkward posture/equipment malfunction/job factors/action/behaviour of employee or patient/affiliate/human factors: 8
  Repetitive handling/movement: 2
  Staff – availability/skill mix: 1

Slips, Trips and Falls

Rolling year-on-year monthly comparison:
Previous 13 months – 14
Current 13 months – 13.2
• Slips, Trips and Falls incidents have dramatically decreased when compared with previous months total and slightly less on rolling average.
• Review to understand if January figures related to fatigue as well as high demand.
• Review in March to see if figures return to normal levels.
• SAP services have the highest incidents at 2.
• Causation profile:
  Slipped/tripped/stumbled; Surface – slippery/wet: 2
  Faulty equipment; human factors: 2
Reported Incidents Summarised by Workforce and Division

Occupational Health Service Update

Case and Claims Management:

Injury Management claims managed as high risk through WellNZ or low risk through Injury Case Manager at CMH.

Pending Claims requiring initial assessments and further investigation before a cover decision is made.

Complex claims may remain as pending up to 21 days, when a decision/or extension (awaiting further evidence with assessed by an OHP) pending decision to accept/decline claim.

ACC Audit reviewed Case Management and CMH retain tertiary accreditation for injury case management.

Vaccinations:

Vaccination programmes as part of the pre-employment screening programme have increased with clinics being full and concentration of activity related to intake of Graduate nurses and other staff commencing Jan/Feb 2019.
**Clinic Appointments:**

Decrease in clinic appointments with clinic appointments being dependent on numbers of pre-employment screening applicants requiring vaccinations.

Staff not attending booked clinic appointments have increased slightly. Follow up phone calls to identify key reasons for missing appointments are being conducted, although illness has contributed to this figure.

The Occupational Health Clinics have been full, due to the increase in referrals and the complexity of cases resulting in longer close out periods.
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Receive this paper noting that it presents an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 13 March 2019.

Submitted by: Margaret White – Chief Financial Officer

Glossary

ACC  Accident Compensation Corporation
AH  Allied Health
AMHU  Acute Mental Health Unit
CFO  Chief Financial Officer
CIIO  Chief Information Officer
hA  healthAlliance
HWNZ  Health Workforce New Zealand
IDF  Inter District Flows

Executive Summary

Purpose

The purpose of this paper is to provide the Board members with an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 13 March 2019.

1.0 Financial Report for the period ended 31 January 2019

The 31 January 2019 month consolidated result is $1.328m favourable (YTD $3.476m favourable) to budget. Performance by operating arm is presented in table 1 below.

| Table 1: Statement of Performance by Operating Arm for the period ended 31 January 2019 |
|---------------------------------|-------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| Net Result                      | Month Act $000   | Month Bud $000   | YTD Act $000      | YTD Bud $000      | YTD Var $000      | Full Year Bud $000 |
| Provider                        |                  |                  |                   |                   |                   |                   |
| Hospital Provider (348)         | (2,702)          | 2,354            | (1,549)           | (8,006)           | 2,354            | (11,457)          |
| Integrated Care (2,667)         | (2,748)          | 82               | (19,311)          | (19,048)          | 263              | (32,590)          |
| Provider                        |                  |                  |                   |                   |                   |                   |
| Funder (3,014)                  | (5,450)          | 2,436            | (17,762)          | (27,054)          | 9,292            | (44,047)          |
| Governance (1,695)              | (770)            | (926)            | (11,752)          | (5,508)           | 6,244            | (16,487)          |
| Surplus / (deficit) (4,910)     | (6,238)          | 1,328            | (29,155)          | (32,631)          | 3,476            | (53,495)          |
Hospital Provider Position is $1.550m favourable (YTD $6.096m favourable) to budget. Consistent with YTD trends the key drivers are reduced volumes and costs associated with a milder winter, the impact of vacancies, plus additional revenue from ACC Tahitian burns.

The unfavourable YTD result for integrated care primarily reflects the additional costs associated with increases in provision of community care.

**Funder**
The Funder Arm is $166k favourable (YTD $4.702m unfavourable) to budget, primarily reflecting additional IDF outflows together with delay to secure revenue initiatives.

**Governance**
Governance Arm is $182k unfavourable (YTD $428k favourable) to budget driven by a combination of vacancies and gains on sale of assets offset by unbudgeted consulting costs of $155k, Crown Monitor costs of $21k and Board approved legal fees $174k.

Consistent with YTD performance, the DHB forecast result remains at $45m deficit, which is an $8.5m improvement on $53.5m deficit as included in the 18/19 Annual Plan.

*The full Financial Variance Report for the period ended 31 January 2019 is presented in Appendix 1.*
Appendix 1 – Financial Report for the period ended 31 January 2019

YTD 31 January 2019 the consolidated result is $3.476m favourable to budget.

Table 2: Statement of Revenue and Expenditure for the period ended 31 January 2019

<table>
<thead>
<tr>
<th>Net Result</th>
<th>January 2019</th>
<th></th>
<th></th>
<th>Full Year Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Year to Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
<td>Bud</td>
</tr>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>139,354</td>
<td>140,838 (1,484)</td>
<td>987,995</td>
<td>986,235</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>2,969</td>
<td>2,957</td>
<td>12</td>
<td>26,193</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>142,323</td>
<td>143,794 (1,472)</td>
<td>1,014,187</td>
<td>1,007,011</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>54,884</td>
<td>59,790 (4,906)</td>
<td>386,878</td>
<td>400,752</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,941</td>
<td>990 (951)</td>
<td>12,821</td>
<td>6,938 (5,883)</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>5,550</td>
<td>5,733 (183)</td>
<td>43,703</td>
<td>40,668 (3,035)</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>62,017</td>
<td>61,076 (941)</td>
<td>435,344</td>
<td>427,650 (7,694)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>9,554</td>
<td>9,629 (74)</td>
<td>72,568</td>
<td>72,059 (509)</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>7,248</td>
<td>6,544 (704)</td>
<td>48,903</td>
<td>47,681 (1,222)</td>
</tr>
<tr>
<td>Operating Expenditure</td>
<td>141,195</td>
<td>143,762 (2,566)</td>
<td>1,000,217</td>
<td>995,749 (4,469)</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>1,127</td>
<td>33 (1,094)</td>
<td>13,970</td>
<td>11,263</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,946</td>
<td>3,163 (217)</td>
<td>21,489</td>
<td>22,140</td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>3,091</td>
<td>3,108 (17)</td>
<td>21,636</td>
<td>21,754</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(4,910)</td>
<td>(6,238) (1,328)</td>
<td>(29,155)</td>
<td>(32,631)</td>
</tr>
</tbody>
</table>

Commentary on Major Variances:

**Crown Revenue**

January 2019 month was $1.484m unfavourable to budget (YTD $1.759m favourable), reflecting the following:

- Delay to secure revenue initiatives $445k unfavourable (YTD $3.1m unfavourable);
- Mental Health and Health of Older People unbudgeted pay equity $463k favourable (YTD $3.1m favourable) with matching additional costs in provider payments;
- IDF inflows adjustment to contract YTD $1.4m favourable;
- Additional ACC arrears revenue $463k unfavourable (YTD $1.3m favourable);
- HWNZ training costs, invoiced ahead of plan $38k favourable (YTD $354k favourable);
- Bowel screening volumes variance to contract $68k unfavourable (YTD $554k unfavourable); and
- The elective programme is tracking 2.3% (346.76 WIES) behind contract, reflecting an adverse position of $1.2m unfavourable for the month (YTD $1.7m unfavourable).

**Other Revenue**
January 2019 month was $12k favourable to budget (YTD $5.417m favourable), reflecting the following:

- Favourable timing of Pacific contract revenue (offset by cost) $102k unfavourable (YTD $1.5m favourable).
- Retail pharmacy sales $52k favourable (YTD $699k favourable); reflecting growth in sales (offset by COGs).
- Tahitian burns additional billing $25k unfavourable (YTD $1.4m favourable); reflecting higher demand in 2019.
- Interest received $79k favourable (YTD $623k favourable) due to better than Budget cash position; and
- Closeout of the Ko Awatea Joint Venture asset.

**Personnel and Outsourced Personnel**
Net personnel costs for January are $3.955m favourable (YTD $7.991m favourable). Continued vacancies across the services (combination of lower acute demand and holding non clinical vacancies where appropriate) and the impact of the nursing strike has resulted in FTE and dollar costs under budget. Partial offsets YTD due to unrealised TAP savings and outsourced personnel. The January result also includes the following adjustments:

- SMO costs for cover for the first RDA strike 15-17 Jan 2019, $473k.
- Adjustment to provisions for MECA settled during the month (PSA AH, PSA Nursing and ETU), $1.3m; and
- Release of ACC Levy provision following confirmation of ACC employer status $2m.

**Outsourced services**
Outsourced Clinical Services were $183k favourable (YTD $3.035m unfavourable) driven by the following:

- Pacific contract costs higher than budget, offset by revenue, $109k favourable (YTD $1.4m unfavourable);
- An agreed overspend in Surgical services to meet the MOH Elective contract, $65k favourable (YTD $830k unfavourable); and
- Increased YTD MRI outsourcing due to staff shortages and delayed implementation of new machines, $59k unfavourable (YTD $782k unfavourable).

**Provider Payments**
January was $941k unfavourable to budget (YTD $7.694m unfavourable), reflecting the following:

- IDF wash up provisioning greater than budget, primarily ADHB $1.7m unfavourable (YTD $7.2m unfavourable);
- Mental Health unbudgeted pay equity $463k (YTD $3.1m unfavourable), offset by revenue; and
- Maori Health savings target shortfall $69k unfavourable (YTD $389k unfavourable), and the remaining balance being partly offset by additional revenue.

**Clinical supplies**
January was $74k favourable to budget (YTD $509k unfavourable), reflecting the following:

- Unrealised savings in Provider of $291k month (YTD $2.0m). Budgeted savings relate to procurement savings for Orthopaedic implants, value for money initiatives, wound care dressings and clinical supply cost savings as a result of bed closure; and
- Unbudgeted costs associated with additional Tahitian Burns patients; and
- Lower clinical equipment leasing costs $35k favourable (YTD $747k favourable).

**Infrastructure costs**
January was $704k unfavourable to budget (YTD $1.222m unfavourable), reflecting the following:
Cost of goods sold increase due to higher pharmacy sales (offset by revenue) $53k (YTD $718k); and

Unrealised Provider Arm savings $319k unfavourable (YTD $840k), related to Lambie Drive property leases, infrastructure costs attributed to bed closures and environmental sustainability, part offset by; and

Gain on sale of land in August (YTD $377k) that was not accounted for in 2017/18
Table 3: Statement of Financial Position as at 31 January 2019

<table>
<thead>
<tr>
<th></th>
<th>Act $000</th>
<th>Budget $000</th>
<th>Var $000</th>
<th>Dec-18 $000</th>
<th>Movement $000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty Cash</td>
<td>8</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Bank</td>
<td>24,236</td>
<td>(16,532)</td>
<td>40,768</td>
<td>26,491</td>
<td>(2,255)</td>
</tr>
<tr>
<td>Trust</td>
<td>2,834</td>
<td>833</td>
<td>2,001</td>
<td>2,830</td>
<td>4</td>
</tr>
<tr>
<td>Prepayments</td>
<td>2,525</td>
<td>637</td>
<td>1,888</td>
<td>2,493</td>
<td>32</td>
</tr>
<tr>
<td>Debtors</td>
<td>48,448</td>
<td>55,698</td>
<td>(7,250)</td>
<td>47,193</td>
<td>1,255</td>
</tr>
<tr>
<td>Inventory</td>
<td>8,017</td>
<td>8,740</td>
<td>(723)</td>
<td>8,181</td>
<td>(164)</td>
</tr>
<tr>
<td>Assets Held for Sale</td>
<td>5,320</td>
<td>5,320</td>
<td>-</td>
<td>5,320</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current Assets</strong></td>
<td>91,388</td>
<td>54,704</td>
<td>36,684</td>
<td>92,516</td>
<td>(1,128)</td>
</tr>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>212,420</td>
<td>212,420</td>
<td>-</td>
<td>212,420</td>
<td>-</td>
</tr>
<tr>
<td>Buildings, Plant &amp; Equip</td>
<td>638,077</td>
<td>682,876</td>
<td>(44,799)</td>
<td>640,007</td>
<td>(1,930)</td>
</tr>
<tr>
<td>Investment Property</td>
<td>1,824</td>
<td>1,824</td>
<td>-</td>
<td>1,824</td>
<td>-</td>
</tr>
<tr>
<td>Information Technology</td>
<td>4,162</td>
<td>4,178</td>
<td>(16)</td>
<td>4,162</td>
<td>-</td>
</tr>
<tr>
<td>Information Software</td>
<td>662</td>
<td>693</td>
<td>(31)</td>
<td>662</td>
<td>-</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>3,163</td>
<td>4,850</td>
<td>(1,687)</td>
<td>4,209</td>
<td>(1,046)</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>860,308</td>
<td>906,841</td>
<td>(46,533)</td>
<td>863,284</td>
<td>(2,976)</td>
</tr>
<tr>
<td>Accum. Depreciation</td>
<td>(199,148)</td>
<td>(203,524)</td>
<td>4,376</td>
<td>(199,178)</td>
<td>30</td>
</tr>
<tr>
<td>Net Cost</td>
<td>661,160</td>
<td>703,317</td>
<td>(42,157)</td>
<td>664,106</td>
<td>(2,946)</td>
</tr>
<tr>
<td>Work In-progress</td>
<td>80,461</td>
<td>45,115</td>
<td>35,346</td>
<td>79,344</td>
<td>1,117</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>741,621</td>
<td>748,432</td>
<td>(6,111)</td>
<td>743,450</td>
<td>(1,829)</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>46,445</td>
<td>55,439</td>
<td>(8,994)</td>
<td>46,445</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>879,454</td>
<td>858,575</td>
<td>20,879</td>
<td>882,411</td>
<td>(2,957)</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors</td>
<td>97,540</td>
<td>85,517</td>
<td>12,023</td>
<td>94,758</td>
<td>2,782</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>8,307</td>
<td>6,429</td>
<td>1,878</td>
<td>9,117</td>
<td>(810)</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>16,533</td>
<td>14,741</td>
<td>1,792</td>
<td>18,068</td>
<td>(1,535)</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>17,092</td>
<td>14,275</td>
<td>2,817</td>
<td>23,276</td>
<td>(6,184)</td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>116,783</td>
<td>109,199</td>
<td>7,584</td>
<td>109,085</td>
<td>7,698</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>256,255</td>
<td>230,161</td>
<td>26,094</td>
<td>254,304</td>
<td>1,951</td>
</tr>
<tr>
<td><strong>Working Capital</strong></td>
<td>(164,867)</td>
<td>(175,457)</td>
<td>10,590</td>
<td>(161,788)</td>
<td>(3,079)</td>
</tr>
<tr>
<td>Net Funds Employed</td>
<td>623,199</td>
<td>628,414</td>
<td>(5,215)</td>
<td>628,107</td>
<td>(4,908)</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Provisions</td>
<td>22,948</td>
<td>22,948</td>
<td>-</td>
<td>22,948</td>
<td>-</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>2,832</td>
<td>832</td>
<td>2,000</td>
<td>2,830</td>
<td>2</td>
</tr>
<tr>
<td>ACC Partnership Programme</td>
<td>1,155</td>
<td>1,155</td>
<td>-</td>
<td>1,155</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>26,935</td>
<td>24,935</td>
<td>2,000</td>
<td>26,933</td>
<td>2</td>
</tr>
<tr>
<td><strong>Crown Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Equity</td>
<td>408,990</td>
<td>419,675</td>
<td>(10,685)</td>
<td>408,990</td>
<td>-</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>291,395</td>
<td>291,401</td>
<td>(6)</td>
<td>291,395</td>
<td>-</td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>(104,121)</td>
<td>(107,597)</td>
<td>3,476</td>
<td>(99,211)</td>
<td>(4,910)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>596,264</td>
<td>603,479</td>
<td>(7,215)</td>
<td>601,174</td>
<td>(4,910)</td>
</tr>
<tr>
<td>Net Funds Employed</td>
<td>623,199</td>
<td>628,414</td>
<td>(5,215)</td>
<td>628,107</td>
<td>(4,908)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances:

- Closing bank was $40.768m favourable to budget. Net cash flows from operations (revenue, expenses and payroll) was $9.066m favourable to budget (refer cash flow variance explanation for further details).

- Debtors were $7.25m lower than Budget as a result of improved collections and timing differences.

- Net Fixed Assets and Investment in Associates are $20.879m lower than budget reflecting timing of major capital projects spend.

- Creditors are $12.023m favourable to Budget due to timing differences in Accounts Payable.

- Income In Advance was higher than Budget by $1.878m largely due to recovery of a bond for the AMHU Project now transferred from Accrued Creditors.

- Employee entitlements were $7.584m greater than budget mainly reflecting provisions for expired MECA settlements.

- The favourable working capital variance to Budget of $10.590m is mostly attributable to the timing matters detailed above.

- Crown equity variance of $10.685m reflects the delay in commencing Stage 2 of AMHU, resulting in less than forecast drawdown in our equity injection funding.
Table 4: Statement of Cash flow for the period ended 31 January 2019

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act $000</td>
<td>Budget $000</td>
</tr>
<tr>
<td>Cash flows from Operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>137,285</td>
<td>139,540</td>
</tr>
<tr>
<td>Other</td>
<td>2,837</td>
<td>2,840</td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(88,026)</td>
<td>(92,920)</td>
</tr>
<tr>
<td>Employees</td>
<td>(53,370)</td>
<td>(59,794)</td>
</tr>
<tr>
<td>Capital charge</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net cash from Operations</td>
<td>(1,274)</td>
<td>(10,334)</td>
</tr>
<tr>
<td>Cash flows from Investing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(1,453)</td>
<td>(5,046)</td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>(100)</td>
</tr>
<tr>
<td>Interest rec.</td>
<td>137</td>
<td>58</td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Net cash from Investing</td>
<td>(1,314)</td>
<td>(5,088)</td>
</tr>
<tr>
<td>Cash flows from Financing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>336</td>
<td>-</td>
</tr>
<tr>
<td>Crown Equity funding</td>
<td>1</td>
<td>4,743</td>
</tr>
<tr>
<td>Net cash from Financing</td>
<td>337</td>
<td>4,743</td>
</tr>
<tr>
<td>Net increase / (decrease)</td>
<td>(2,251)</td>
<td>(10,679)</td>
</tr>
<tr>
<td>Opening cash</td>
<td>29,329</td>
<td>(5,845)</td>
</tr>
<tr>
<td>Closing cash</td>
<td>27,078</td>
<td>(16,524)</td>
</tr>
<tr>
<td>Reconciliation Summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(4,910)</td>
<td>(6,237)</td>
</tr>
<tr>
<td>Add/(Less) non-cash items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depn</td>
<td>2,947</td>
<td>3,163</td>
</tr>
<tr>
<td>(1,963)</td>
<td>(3,074)</td>
<td>1,111</td>
</tr>
<tr>
<td>Add/(Less) items Classified as Investing or Financing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on Disposal</td>
<td>(336)</td>
<td>-</td>
</tr>
<tr>
<td>Add/(Less) Movements in Financial Position items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtor and Other Receivables</td>
<td>1,287</td>
<td>(1,356)</td>
</tr>
<tr>
<td>Inventories</td>
<td>(164)</td>
<td>100</td>
</tr>
<tr>
<td>Creditors</td>
<td>297</td>
<td>(6,004)</td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>(395)</td>
<td>-</td>
</tr>
<tr>
<td>1,025</td>
<td>(7,260)</td>
<td>8,285</td>
</tr>
<tr>
<td>Net Cash flow from Operations</td>
<td>(1,274)</td>
<td>(10,334)</td>
</tr>
</tbody>
</table>
Commentary on Major Variances for the month:

- Cash-flow from Crown Revenue is $2,255m unfavourable to budget, reflecting variances relevant to above and timing.

- Payments to suppliers were $4,894m higher than budget mainly as a result of variations to the planned timing of supplier payments versus the budget.

- Employee Payments were $6,424m favourable to budget representing net favourable personnel costs for the month and the timing of payroll payments.

- Fixed Assets $3,593m unfavourable to budget representing the timing of capital spend for major capital projects.
Decision Paper  
Counties Manukau District Health Board  
2019 Triennial Elections

Recommendation

It is recommended that the Board:

Receive the report regarding the 2019 Triennial Elections.

Agree that for the 2019 Counties Manukau District Health Board triennial election, to adopt either:

- The alphabetical order of candidate names; or
- The pseudo-random order of candidate names;
- The random order of candidate names

as permitted under regulation 13 of the Local Electoral Regulations 2001.

Prepared by Dinah Nicholas, Board Secretary.

Background

The 2019 Triennial local elections will be held on Saturday 12 October 2019.

The Local Electoral Regulations 2001 provide for the Board to resolve the order of candidate names to appear on the voting documents (alphabetical, pseudo-random or random order). If no decision is made, the order of names defaults to alphabetical.

For further information, please refer to the attached document.

Appendix

Report to the
Counties Manukau District Health Board
regarding the

2019 Triennial Elections

From the
Electoral Officer

22 February 2019
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Outline
The 2019 triennial local elections will be held on Saturday 12 October 2019. An update on preliminary matters relating to the elections is provided to the Board, including consideration of the order of candidate names to appear on the voting documents.

Background
Local elections are required to be undertaken according to the New Zealand Public Health & Disability Act 2000, the Local Electoral Act 2001 and the Local Electoral Regulations 2001.

Certain pre-election information and tasks are outlined in this report for the Board’s information and attention.

The Local Electoral Regulations 2001 provide for the Board to resolve the order of candidate names to appear on the voting documents (alphabetical, pseudo-random or random order). If no decision is made, the order of names defaults to alphabetical.

Narrative
2019 Elections
An election will be required for seven Counties Manukau District Health Board members, elected ‘at large’ from the Board area which comprises the southern part of the Auckland Council area and small northern parts of the Hauraki District Council and Waikato District Council areas.

The election will be undertaken on behalf of the Board by Auckland Council, Hauraki District Council and Waikato District Council, the constituent territorial authorities.

The Counties Manukau District Health Board electoral officer is Dale Ofsoske, the electoral officer for the three constituent territorial authorities.

Following the election, the Minister of Health will appoint a further four members, making a total of 11 Board members.

2019 Election Timetable
With an election date of Saturday 12 October 2019, the following key functions and dates will apply:

<table>
<thead>
<tr>
<th>Function</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominations open/roll open</td>
<td>Friday 19 July 2019</td>
</tr>
<tr>
<td>Nominations close/roll closes</td>
<td>(noon) Friday 16 August 2019</td>
</tr>
<tr>
<td>Delivery of voting mailers</td>
<td>from Friday 20 September 2019</td>
</tr>
<tr>
<td>Close of voting</td>
<td>noon Saturday 12 October 2019</td>
</tr>
</tbody>
</table>

A more detailed timetable is attached Appendix 1.

2019 Election Fact Sheet
A 2019 Election Fact Sheet summarising the key functions of the election (Appendix 2) is also attached.
Order of Candidate Names

Regulation 31 of the Local Electoral Regulations 2001 provides the opportunity for the Board to choose the order of candidate names appearing on the voting documents from three options – alphabetical, pseudo-random (names drawn out of a hat in random order with all voting documents printed in this order) or random order (names randomly drawn by computer with each voting document different).

The Board may determine which order the names of candidates are to appear on the voting documents, but if no decision is made, the order of names defaults to alphabetical.

The Board resolved to adopt the random order for the 2016 triennial elections.

Auckland Council considered this issue at their Governing Body meeting on 13 December 2018 and resolved to retain the alphabetical order of candidate names. This follows an analysis undertaken by the Auckland Council’s Research and Evaluation Unit which showed there was no compelling evidence that candidates being listed first were more likely to be elected.

Alphabetical Order

Alphabetical order is simply listing candidate surnames alphabetically and is the order traditionally used in local and Parliamentary elections.

Comments regarding alphabetical order are:

- voters are easily able to find names of candidates for whom they wish to vote. Some candidates and voters over the years have argued that alphabetical order may tend to favour candidates with names in the first part of the alphabet, but in practice this is generally not the case – most voters tend to look for name recognition, regardless of where in the alphabet the surname lies;

- the order of candidate names on the voting document matches the order listed in the candidate directory (candidate profile statements).

Pseudo-Random Order

Pseudo-random order is where candidate surnames are randomly selected, and the same order is used on all voting documents for that position. The names are randomly selected by a method such as drawing names out of a hat.

Comments regarding pseudo-random order are:

- the candidate names appear in mixed order (not alphabetical) on the voting document;

- possible voter criticism/confusion as specific candidate names are not easily found, particularly where there are many candidates;
- the order of candidate names on the voting document does not match the order in the candidate directory (candidate profile statements).

**Random Order**

Random order is where all candidate surnames are randomly selected and are listed in a different order on every voting document. The names are randomly selected by computer so that the order is different.

Random order enables names to be listed in a completely unique order on each voting document.

Comments regarding random order are:

- the candidate names appear in mixed order (not alphabetical) on the voting document;
- possible voter criticism/confusion as specific candidate names are not easily found, particularly where there are many candidates;
- the order of candidate names on the voting document does not match the order listed in the candidate directory (candidate profile statements).

There is no longer any price differential in printing costs between the three orders of candidate names.

**Number of Electors**

The number of electors for the 2019 triennial elections in the Counties Manukau District Health Board area is expected to be 360,000 (as at 31 January 2019 this was 359,031). This compares to 347,035 for the 2016 triennial election (+3.7%).

**Estimated Cost**

The cost to undertake the 2019 Counties Manukau District Health Board election is expected to be in the order of $500,000 + GST, this dependent on a number of variables such as actual costs, number of candidates, voter turnout etc. This estimated cost reflects a significant increase of postage costs from 2016 (+56.1% outgoing and +58.9% return).

This compares to the 2016 actual cost share of $458,651 + GST.

**Online Voting Trials**

Following a strong push by a number of local authorities (led by Auckland Council) in 2018 to trial online voting alongside postal voting for the 2019 local elections, the proposed trial was unfortunately halted due to costs. All security and delivery requirements for the online voting provider were met, but the cost involved forced the decision.

Work on a collaborative approach with relevant government sectors is continuing so as to deliver online voting for the 2022 local elections.
**Recommendation**

It is recommended that:

The Board resolves for the 2019 Counties Manukau District Health Board triennial election, to adopt *either:*

(i) the alphabetical order of candidate names; *or*

(ii) the pseudo-random order of candidate names; *or*

(iii) the random order of candidate names

as permitted under regulation 31 of the Local Electoral Regulations 2001.

**Author:**

Dale Ofsoske
Electoral Officer // Counties Manukau District Health Board
Election Services
### SATURDAY 12 OCTOBER 2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday 1 July 2019</td>
<td>Electoral Commission’s enrolment update campaign commences</td>
</tr>
<tr>
<td>Wednesday 17 July 2019</td>
<td>Public notice of election, calling for nominations, rolls open for inspection [Sec 42, 52, 53, LEA]</td>
</tr>
<tr>
<td>Friday 19 July 2019</td>
<td>Nominations open / roll open for inspection [Sec 42, LEA]</td>
</tr>
<tr>
<td>Friday 16 August 2019</td>
<td>Nominations close (12 noon) / roll closes [Sec 5, 42, 55 LEA, Reg 21, LER]</td>
</tr>
<tr>
<td>Wednesday 21 August 2019</td>
<td>Public notice of day of election, candidates’ names [Sec 65, LEA]</td>
</tr>
<tr>
<td>by Monday 16 September 2019</td>
<td>Electoral officer certifies final electoral roll [Sec 51, LEA, Reg 22, LER]</td>
</tr>
<tr>
<td>Friday 20 September - Wednesday 25 September 2019</td>
<td>Delivery of voting documents [Reg 51, LER]</td>
</tr>
</tbody>
</table>
| Friday 20 September - Saturday 12 October 2019 | Progressive roll scrutiny [Sec 83, LEA]  
Special voting period [Sec 5 LEA, Reg 35, LER]  
Early processing period [Sec 80, LEA] |
| by Friday 11 October 2019   | Appointment of scrutineers (12 noon) [Sec 68, LEA]                    |
| Saturday 12 October 2019    | **Election day** [Sec 10, LEA]                                        |
|                            | Close of voting (12 noon) [Sec 84, LEA]                                |
|                            | Preliminary results available Sunday morning 13 October 2019 [Sec 85, LEA] |
| Saturday 12 October (pm) - Thursday 17 October 2019 | Official count [Sec 84, LEA] |
| Thursday 17 October - Wednesday 23 October 2019 | Declaration of result/public notice of declaration [Sec 86, LEA] |
| Monday 9 December 2019      | Members come into office [Clause 14, Schedule 2, NZPHDA]              |
| mid-December 2019           | Return of electoral donations & expenses form [Sec 112A, LEA]          |

LEA = Local Electoral Act 2001  
LER = Local Electoral Regulations 2001  
NZPHDA = New Zealand Public Health & Disability Act 2000
Appendix 2:

FACT SHEET
Triennial election
Counts Manukau District Health Board
12 OCTOBER 2019

GENERAL
Triennial elections for elected members of most local authorities throughout New Zealand are to be conducted, by postal vote, on Saturday 12 October 2019.
The elections will be conducted under the provisions of the Local Electoral Act 2001, the Local Electoral Regulations 2001 and the New Zealand Public Health and Disability Act 2000.
City/district councils are legally required to conduct the district health board elections on behalf of the district health board.

POSITIONS
Elections for the Counties Manukau District Health Board will be required for seven positions, elected 'at large' from the Board area which comprises the southern and eastern part of the Auckland Council area, as well as small parts of the Hauraki District Council and Waitakere District Council areas.
In addition, following the election, the Minister of Health appoints a further four members, making a total of 11 members per board.

NOMINATIONS
Nominations open on Friday 19 July 2019 and close at noon on Friday 16 August 2019.
Nomination papers will be available during this period from:
• the electoral office (Electoral Services, Level 2, 198 Federal Street, Auckland);
• Counties Manukau District Health Board (Board Secretary, Ground Floor, 19 Lambie Drive, Manukau);
• by telephoning 09 973 5212;
• by accessing www.voteauckland.co.nz
To be eligible to stand for election, a candidate must be:
• a New Zealand citizen (by birth or naturalisation ceremony); and
• enrolled as a Parliamentary elector (anywhere in New Zealand); and
• nominated by two electors whose names appear on the electoral roll within the respective area that a candidate is standing for.

In addition, under the New Zealand Public Health and Disability Act 2000, as amended by the Crown Entities Act 2004, a candidate cannot be:
• a candidate for more than one district health board;
• a person who is an undischarged bankrupt;
• a person who is prohibited from being a director or promoter of, or being concerned or taking part in the management of, an incorporated or unincorporated body under the Companies Act 1993, or the Securities Act 1978, or the Securities Markets Act 1988, or the Takeovers Act 1993;
• a person who is subject to a property order under the Protection of Personal and Property Rights Act 1988;
• a person in respect of whom a personal order has been made under that Act that reflects adversely on the person's:
  • competence to manage his or her own affairs in relation to his or her property, or
  • capacity to make or communicate decisions relating to any particular aspect or aspects of his or her personal care and welfare;
• a person who has been removed as a DHB board member since the last DHB election, under clause 9(c) or 9(e) of Schedule 3 to the NZ Public Health and Disability Act 2000;
• a person who has failed to declare a material conflict of interest before accepting nomination as candidate at the last DHB election.
Detailed candidate information handbooks will be available from the electoral office from May 2019.

ELECTORAL ROLL
Those eligible to vote in this election are all resident electors whose names appear on the electoral rolls when they close on Friday 16 August 2019. The preliminary electoral roll will be compiled by each constituent territorial authority and will be available for public inspection at constituent territorial authority offices and libraries from Friday 19 July 2019 to Friday 16 August 2019.
All parliamentary electors, including those on the Māori Electoral Roll, are automatically enrolled on the local government resident electoral roll, at the address where they live.
Any alterations to the resident roll (e.g. change of address details, including new postal addresses) should be made by:
• completing the appropriate form at any post shop;
• phoning 0800 ENROLNOW (0800 367 656)
• accessing the Electoral Commission website on www.elections.org.nz

ELECTORAL SYSTEM
The single transferable voting (STV) electoral system will be used for the Counties Manukau District Health Board election.

VOTING PERIOD
Voting documents will be sent to all eligible electors, by post, from Friday 20 September 2019.

The voting period is three weeks (Friday 20 September 2019 to noon Saturday 12 October 2019). Electors may post their completed voting documents back to the constituent territorial authority electoral officer using the orange pre-paid envelope sent with their voting document. Polling places for the issuing of special voting documents and for the receiving of completed voting documents will be available from each constituent territorial authority office from Friday 20 September 2019 to noon Saturday 12 October 2019.

To be counted, all completed voting documents must be in the hands of the constituent territorial authority electoral officer or an electoral official by noon Saturday 12 October 2019.

Preliminary results for this STV election will be known as soon as all votes have been received and counted following the close of voting. A preliminary result is expected early on Sunday morning, 13 October 2019. These will be accessible on the Counties Manukau District Health Board’s website: www.countiesmanukau.health.nz.

CONTACT US
For further information regarding this election, please contact the electoral office:

Dale Ofoske, Electoral Officer
Counties Manukau District Health Board
C/o PO Box 5135, Wellesley Street, Auckland 1141
Email: info@electionservices.co.nz
Phone: 0800 922 822
Decision Paper
Counties Manukau District Health Board
Community Water Fluoridation Position Statement

Recommendation

It is recommended that the Board:

Receive the Community Water Fluoridation Position Statement.

Note that the Community & Public Health Advisory Committee (CPHAC) recommended this paper to proceed to the Board for final approval on 5 December 2018.

Endorse the Position Statement on Community Water Fluoridation as set out in Appendix 1.

Prepared by: Auckland Regional Public Health Service: Julia Peters (Clinical Director), David Sinclair (Medical Officer of Health), Delvina Gorton (Senior Policy Analyst); Auckland Regional Dental Service: Sathananthan Kanagaratnam (Clinical Director), Dr Helen Tane (Professional Leader); Auckland Regional Dental and Oral Health: Hugh Trengrove (Service Clinical Director); Counties Manukau Health: Doone Winnard (Clinical Director Population Health), Philippa Anderson (Public Health Physician), Carmel Ellis (General Manager Integrated Child, Youth & Maternity), Aroha Haggie (General Manager Māori Health Development); Auckland & Waitematā DHBs: Karen Bartholomew (Director Health Outcomes), Ruth Bijl (Funding & Development Manager Womens/Child & Youth Health), Stacey Strang (Programme Manager Child & Maternity), Riki Nia Nia (General Manager Māori Health), Shayne Wijohn (Māori Portfolio Manager)

Endorsed by: Margie Apa (Chief Executive), Doone Winnard (Clinical Director Population Health), Philippa Anderson (Public Health Physician), Carmel Ellis (General Manager, Integrated Child, Youth and Maternity), Aroha Haggie (General Manager, Māori Health Development)

Glossary

RSNZ/OPMCSA: Royal Society of New Zealand and the Office of the Prime Minister’s Chief Science Advisor

Purpose

The Health (Fluoridation of Drinking Water) Amendment Bill proposes a transfer of decision-making on community water fluoridation from Territorial Authorities to District Health Boards (DHBs). The Select Committee Report was presented to Parliament in May 2017 and the Bill is waiting for its second reading.

A joint Auckland region DHB position will confirm that oral health is a key priority for equity and will provide transparency on the DHB’s position on community water fluoridation prior to any Board decision on fluoridation.

This is an issue of public health significance. There are substantial inequities in oral health outcomes. Community water fluoridation is equally available to all people in our communities on reticulated water supplies, and has the most benefit for people experiencing higher rates of tooth decay. It is therefore a pro-equity strategy to improve oral health.
Executive Summary

Fluoride is a trace element widely present in soil, food and water. Community water fluoridation adjusts the level of naturally-occurring fluoride in drinking water to an optimal level for protection against tooth decay. The New Zealand Oral Health Survey shows that New Zealanders living in areas with community water fluoridation have significantly less lifetime risk of tooth decay than those in non-fluoridated areas. This is supported by numerous reviews of international data.

Community water fluoridation is an effective, safe, equitable, and highly cost-saving strategy for improving dental health. It has been safely implemented in New Zealand, and around the world, for over sixty years. A review by the Royal Society of New Zealand and the Office of the Prime Minister’s Chief Science Advisor (RSNZ/OPMCSA) concluded that community water fluoridation creates no health risks and provides protection against tooth decay at the concentration recommended by the New Zealand Ministry of Health. The courts have established the legality of community water fluoridation and that it is not medication.

DHBs role in reducing the burden of tooth decay

The Health and Disability Act 2000 requires District Health Boards (DHBs) to improve, promote, and protect the health of communities. Tooth decay is the most prevalent chronic and irreversible disease in New Zealand, responsible for one per cent of all health loss.

DHBs are also required to improve Māori health and reduce inequities in health status. Children and adults from lower socio-economic areas, in which Māori and Pacific peoples are over-represented, have higher rates of tooth decay and untreated tooth decay. Community water fluoridation is socially equitable. It reaches all households on fluoridated community water supplies regardless of income, ethnicity, or age. Thus, the greatest benefits are likely to be for children from lower socio-economic communities.

Children bear a significant burden from tooth decay. Direct effects include pain, infection, disfigurement, loss of sleep, altered behaviour, and missed school. Longer term it can adversely affect growth, development and general health. Tooth decay is a leading cause of avoidable hospital admissions for children. Over 7% of hospital admissions for children aged up to 14 years are for dental conditions. Children aged 3-4 years have significantly higher rates of admission to hospital than any other age group.

While the greatest benefits in oral health may be for children, the benefits of community water fluoridation continue throughout the lifespan. For older adults, drinking fluoridated water is associated with less root decay and greater retention of natural teeth into old age.¹¹

**Community water fluoridation in the northern region (Auckland and Northland)**

Three out of five New Zealanders receive fluoridated drinking water.¹² In the three Auckland DHB regions, approximately 85% of the population are on Watercare’s reticulated (piped) water supply. The remaining 15% have individual rainwater supplies, or small bore or surface water supplies.

Nearly all Aucklanders on a reticulated water supply receive fluoridated water. The non-fluoridated areas are typically the satellite towns, such as Warkworth and Helensville, and Onehunga (for historic reasons). Pokeno and Tuakau (in the Counties Manukau DHB but Waikato District Council area) receive Watercare’s fluoridated water supply.¹³

In the Northland DHB region, half the population is on reticulated community water supplies and none are fluoridated. Fluoridation of community water supplies was trialled in Kaikohe and Kaitaia in 2007-2009. Despite leading to improved dental outcomes for children over that time frame, the community voted against its continuation.¹⁴ This is in contrast to Auckland, where 88% of those surveyed in 2014 either supported or were neutral about adjusting levels of fluoride in drinking water.¹⁵

Rural communities who are not on reticulated supplies rely on fluoridated toothpaste, fluoride varnishes and/or fluoride supplements. Māori are more likely than non-Māori to live in non-fluoridated areas.¹⁶

**Community water fluoridation delivers population health benefits**

Fluoride is a nutrient essential to human health.¹⁷ New Zealand has lower levels of fluoride than other parts of the world.¹⁸ It is naturally present in water and food, with common food sources being tea, beer, grain-based foods such as bread, and animal products.¹⁹ When teeth are developing, fluoride acts systemically through incorporation into tooth enamel. For permanent teeth, it acts topically when fluoridated water and saliva pass around the teeth.²⁰ ²¹

International and New Zealand data shows that community water fluoridation is associated with fewer decayed, missing and filled teeth; and fewer children with tooth decay.²² ²³ ²⁴ ²⁵ ²⁶ ²⁷ The New Zealand

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¹³ Available from: http://www.ehinz.ac.nz/indicators/drinking-water-quality/access-to-fluoridated-drinking-water/


Oral Health Survey found a 40% reduction in risk of tooth decay in fluoridated compared to non-fluoridated areas.\(^{28}\)

**Community water fluoridation is safe**

The safety of community water fluoridation has been studied extensively over many years.\(^{29}\)\(^ {30}\)\(^ {31}\)\(^ {32}\)\(^ {33}\)\(^ {34}\) The review by RSNZ/OPMCSA found:

“From a medical and public health perspective, water fluoridation at the levels used in New Zealand poses no significant health risks and is effective at reducing the prevalence and severity of tooth decay in the communities where it is used”.\(^ {35}\)

They also found that:

“... no effects on brain development, cancer risk or cardiovascular or metabolic risk have been substantiated, and the safety margins are such that no subset of the population is at risk because of fluoridation”.

The only substantiated potential adverse effect of fluoride at levels used in New Zealand is dental fluorosis. This is a mild cosmetic issue causing white flecks on the teeth. The Oral Health Survey found a low prevalence of mild to moderate fluorosis, often difficult to see, and no cases of severe fluorosis.\(^ {36}\) The level of fluoridation set in New Zealand’s Drinking Water Standards 2005 is well below the threshold where severe fluorosis would occur.\(^ {37}\)

The RSNZ/OPMCSA report concludes that it is safe to use fluoridated water with infant formula. A low level of mild fluorosis has been found in both areas with fluoridated and non-fluoridated water supplies,

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indicating fluoridated toothpaste as a contributing source. The consensus expert opinion is that the benefit of fluoride in formula-fed children exceeds the small risk of minor fluorosis that may occur.

The Health (Fluoridation of Drinking Water) Amendment Bill would transfer decision-making on fluoridation to DHBs

Public Health Units are currently required by their service specifications to “engag[e] with councils to promote water fluoridation as a safe, effective mechanism to reduce the burden of dental decay.” Public Health Units provide public health services for DHBs. The Health (Fluoridation of Drinking Water) Amendment Bill, if passed, will transfer decision-making on adjusting levels of fluoride in community water supplies from territorial authorities to DHBs. The aim of the Bill is for more consistency in fluoridation decisions across New Zealand and to extend community water fluoridation coverage.

The Bill would authorise DHBs to direct local authorities whether or not to fluoridate water supplies owned by the local authority. For water supplies which are already fluoridated, the Bill would require water fluoridation to continue unless directed otherwise by the DHB. Where a water supply crosses DHB boundaries, as with most of Auckland’s metropolitan water supply, any change in fluoridation must be approved by all affected DHBs.

The legality and ethics of community water fluoridation have been well considered not only by the courts but by organisations such as the UK Nuffield Council on Bioethics. The courts in New Zealand have ruled that community water fluoridation is lawful, and is not medication. The Nuffield ethics review found that community water fluoridation contributed to the central goals of public health stewardship by reducing inequities, reducing disease through environmental measures, and benefiting child health. Nevertheless, the review recommended the ethics and effects of both fluoridating and not fluoridating community water supplies be considered when local decisions are made, in a similar way to decisions about water chlorination.

This paper is not seeking a decision on whether or not community water fluoridation is extended in Auckland. The purpose of the position statement is to confirm oral health as a key equity priority, to provide transparency on the DHBs’ position, and support the Ministry of Health’s position on community water fluoridation. Manawhenua have provided support for the DHBs’ community water fluoridation position statement. Any consideration of changes to community water fluoridation would only occur if the Bill is passed, and should be undertaken through collaboration with iwi and Māori health providers.

Conclusion

Adjusting levels of fluoride in community water supplies is recommended internationally and has been safely implemented in New Zealand for over sixty years.

Fluoridation of community water supplies delivers better health and saves money. It is particularly beneficial for low-income families for whom there are disparities in dental health.

References

The courts have supported the legality of fluoridating community water supplies and ruled that it is not medication.

Adjusting levels of fluoride in drinking water to recommended fluoride levels is an effective and safe measure to improve the oral health of everyone in our communities.

Appendix

1. Community Water Fluoridation Position Statement
APPENDIX 1: Community Water Fluoridation Position Statement

Community water fluoridation is a safe and effective way to reduce tooth decay for everyone in our communities. The District Health Board (DHB) supports fluoridating community water supplies to the level recommended by the Ministry of Health.

<table>
<thead>
<tr>
<th>Position statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The DHB <strong>acknowledges</strong> that tooth decay is an important population health issue that causes significant avoidable harm and health inequities.</td>
</tr>
<tr>
<td>2. The DHB <strong>supports</strong> the Ministry of Health’s position that community water fluoridation is an important, safe and effective component of a population health approach to protect against tooth decay.</td>
</tr>
<tr>
<td>3. The DHB <strong>supports</strong> fluoridating community water supplies to the level recommended by the Ministry of Health.</td>
</tr>
<tr>
<td>4. The DHB <strong>notes</strong> these recommendations are based on scientific evidence that community water fluoridation:</td>
</tr>
<tr>
<td>• Is established best practice both in New Zealand and internationally</td>
</tr>
<tr>
<td>• Is effective at reducing tooth decay</td>
</tr>
<tr>
<td>• Is safe at recommended levels of fluoridation</td>
</tr>
<tr>
<td>• Is cost saving in community water supplies for more than 1000 people</td>
</tr>
<tr>
<td>• Has an important role in reducing inequities in tooth decay as it reaches all groups in a community equally</td>
</tr>
<tr>
<td>• Has been found by the Courts to be legal and not a medication.</td>
</tr>
</tbody>
</table>

Rationale for the DHB’s position

Fluoride is a trace element naturally present in food and water. It plays an important role in preventing tooth decay. New Zealand’s natural fluoride levels are lower than in other parts of the world.

Tooth decay is the most prevalent chronic and irreversible disease in New Zealand, responsible for one per cent of all health loss. Community water fluoridation adjusts the natural content of fluoride in water to a level that helps prevent tooth decay. It does this by:
• making tooth enamel more resistant to decay
• interfering with the growth of bacteria that cause cavities
• repairing the early stages of tooth decay.

Community water fluoridation is an effective, safe, and highly cost-saving strategy for improving oral health. It has been used to varying degrees in New Zealand since 1954. Children and young people in areas with fluoridated water have a 40 per cent reduction in risk of dental decay. The scientific consensus is clear that community water fluoridation at recommended levels benefits dental health and is safe. The Ministry of Health recommends 0.7 to 1ppm fluoride in drinking water as a level that improves oral health and is well below thresholds where severe fluorosis could occur.

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There are substantial inequities in oral health outcomes; oral health is a key equity priority for the DHB. This is demonstrated in rates of tooth extraction due to decay, infection or disease, which are one-and-a-half to two times higher for Māori and Pacific adults, and for people living in the most socio-economically deprived areas.\textsuperscript{52} Inequities in rates of tooth extraction are even greater for Māori and Pacific children. Admissions to hospital for dental care show similar inequities.\textsuperscript{53} The greatest benefits of community water fluoridation are for lower socio-economic communities who have higher rates of tooth decay.\textsuperscript{54}

Community water fluoridation is international best-practice. It is recommended by the World Health Organization and many other organisations around the world as one of the most effective public health measures for prevention of dental decay. There is no health risk from community water fluoridation at the concentration recommended by the New Zealand Ministry of Health.\textsuperscript{55}

Most of Auckland’s reticulated water has been fluoridated for many years, covering 85% of the region’s water supply. No water supplies in Northland are fluoridated.

**Legal rulings support community water fluoridation**

The High Court, Court of Appeal, and Supreme Court in New Zealand have made judgments on community water fluoridation in recent court cases.\textsuperscript{56} Together, these judgments have established that:

- Local authorities have the statutory authority to fluoridate water supplies
- Community water fluoridation is legal and permitted by Part 2A of the Health Act 1956
- Community water fluoridation is not medical treatment for the purposes of section 11 of the New Zealand Bill of Rights Act 1990, and even if it were, community water fluoridation is justified under section 5 of the Bill of Rights
- Fluoride added to community water supplies at recommended levels are not medicines in terms of the Medicines Act 1981


\textsuperscript{52}Ministry of Health. (2016). Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health

\textsuperscript{53}Whyman R, Mahoney EK, Stanley J, Morrison D. (2012). Admissions to New Zealand Public Hospitals for Dental Care


Community water fluoridation is consistent with Māori values

Te Aō Marama, the NZ Māori Dental Association, supports fluoridation of reticulated water supplies. It states that fluoridation does not “diminish the mauri of water, because it improves health and wellbeing for all.”57 The DHB’s position statement has the support of manawhenua.

Community water fluoridation is cost-effective

Community water fluoridation is highly cost-effective for water supplies serving more than 1,000 people. On average, each dollar invested in fluoridation in New Zealand saves nine dollars. Thus, fluoridation provides health gains and a net return to society.58 59

Community water fluoridation is one component of dental health

Community water fluoridation is one important component of good dental health. Ideally it is combined with twice-daily teeth brushing with fluoridated toothpaste, regular dental checks, and healthy eating with reduced consumption of sugars.60

Conclusion

Adjusting levels of fluoride in drinking water supplies is recommended internationally and has been safely implemented in New Zealand for over sixty years.

The Courts have supported the legality of adjusting levels of fluoride in community water supplies.

Fluoridation of community water supplies delivers better health and saves money.

It is particularly beneficial for low-income families and individuals for whom there are disparities in oral health.

59 Moore D et al. (2017). The costs and benefits of water fluoridation in NZ. BMC Oral Health 17:134
Resolution

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

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

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

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Excluded Minutes of 20 February 2019 and Actions</td>
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| Procurement of Primary Birthing Unit Services | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
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| Ratification of Circular Resolution – Health Finance Procurement & Information | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
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| B4 School Checks Presentation | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | Commercial Activities  
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