# MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD

**Wednesday, 7 August 2019**

**Venue:** Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

<table>
<thead>
<tr>
<th>CMDHB BOARD MEMBERS</th>
<th>CMDHB MANAGEMENT</th>
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<tbody>
<tr>
<td>Mark Gosche – Chairman</td>
<td>Margie Apa – Chief Executive Officer</td>
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<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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<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>Kylie Clegg</td>
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## PART 1 – Items to be considered in public meeting

### AGENDA

**BOARD ONLY SESSION (8.00 – 9.00am)**

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<thead>
<tr>
<th>1. GOVERNANCE</th>
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<tr>
<td>9.10 – 9.15am</td>
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<td>1.1 Apologies</td>
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<td>1.2 Disclosures of Interest</td>
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<td>1.3 Specific Interests</td>
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<td>9.15 – 9.18am</td>
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<td>2.1 Confirmation of Minutes of the Meeting of the Board – 26 June 2019</td>
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<td>9.18 – 9.20am</td>
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<td>2.2 Action Items Register</td>
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<td>9.20 – 9.25am</td>
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<td>2.3 Report on Draft Minutes RDISAC 6 June 2019 – verbal (Colleen Brown)</td>
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<td>9.25 – 9.30am</td>
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<td>2.4 Report on Draft Minutes HAC 17 July 2019 – verbal (Lyn Murphy)</td>
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<td>9.30 – 9.35am</td>
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<td>2.5 Report on Draft Minutes CPHAC 3 July 2019 – verbal (Colleen Brown)</td>
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<th>3. EXECUTIVE REPORTS</th>
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<tr>
<td>9.35 – 9.55am</td>
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<tr>
<td>3.1 Chief Executive Officer’s Report (including HITH Patient Story) (Margie Apa)</td>
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<td>3.1.1 Deep Dive 1 – Obesity in Women’s Health including pregnancy (Sarah Tout, Katherine Sowden &amp; Carl Eagleton)</td>
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<td>3.1.2 Deep Dive 2 – Impact of Body Size on Service Delivery -Obesity &amp; Orthopaedics (Matthew Tomlinson, Michelle McCallum-Jones)</td>
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<td>9.55 – 10.30am</td>
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<td>3.2 Corporate Affairs and Communications Report (Donna Baker)</td>
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<td>10.30 – 11.00am</td>
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<td>3.3 Finance and Corporate Business Report (Margaret White)</td>
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<td>3.4 Health and Safety Performance Report (Elizabeth Jeffs)</td>
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**Morning Tea Break (11.00 – 11.15am)**

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<th>4. FOR INFORMATION</th>
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<tr>
<td>11.15 – 11.25am</td>
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<td>4.1 Workforce Reports (Elizabeth Jeffs)</td>
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<td>11.25 – 11.35am</td>
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<tr>
<td>4.2 Wai 2575 Stage 1 Report (Aroha Haggie/Leigh Henderson)</td>
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<td>11.35 – 11.45am</td>
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<td>4.3 Life Expectancy in Counties Manukau (Gary Jackson)</td>
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<th>5. RESOLUTION TO EXCLUDE THE PUBLIC</th>
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<td>Name</td>
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<tr>
<td>Mark Gosche (Chair)</td>
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<td>Colleen Brown</td>
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<td>Dr Lyn Murphy</td>
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002
# BOARD MEMBERS’ DISCLOSURE OF INTERESTS

**7 August 2019**

*New items in red italics*

<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</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  
• Chairman, Housing Corporation NZ New Zealand Limited |
| Dr Ashraf Choudhary             | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Islands Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Catherine Abel-Pattinson         | • Board Member, Health Promotion Agency  
• Board Member, healthAlliance NZ Ltd.  
• National Party Policy Committee Northern Region  
• Member, NZNO  
• Member, Directors Institute  
• Co-Chair, National Party Health Policy Committee  
• Husband (John Abel-Pattinson):  
  o Director, Blackstone Group Ltd  
  o Director and Shareholder, Blackstone Partners Ltd  
  o Director and Shareholder, Blackstone Treasury Ltd  
  o Director and Shareholder, Bspoke Group Ltd  
  o Director, Barclay Management (2013) Ltd  
  o Director, AZNAC (JAP) Ltd  
  o Director and Shareholder, Chatham Management Ltd  
  o Director and Shareholder, GCA Trustee Ltd  
  o Director, MAFV Ltd  
  o Director and Shareholder, Manaia No. 4 Trustees Ltd  
  o Director and Shareholder, Wolfe No. 1 Ltd  
  o Director, Greenstone Motels Ltd  
  o Director and Shareholder, Silverstone Property Group Ltd  
  o Director, various single purpose property owning companies  
  o Director and Shareholder, Abel-Pattinson Trustee Ltd |
<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</thead>
</table>
| Colleen Brown | • Chair, Disability Connect (Auckland Metropolitan Area)  
• Member, Advisory Committee for Disability Programme Manukau Institute of Technology  
• Member, NZ Down Syndrome Association  
• Husband, Determination Referee for Department of Building and Housing  
• Director, Charlie Starling Production Ltd  
• District Representative, Neighbourhood Support NZ Board  
• Chair, Rawiri Residents Association  
• Director and Shareholder, Travers Brown Trustee Limited |
| Dianne Glenn  | • Member, NZ Institute of Directors  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• 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 Huakina Ltd  
• Chair, Safer Aotearoa Family Violence Prevention Network  
• Lotteries Community (Auckland)  
• Board Member, Counties Manukau Rugby League Zone  
• Member, NZ Maori Council  
• Director & Shareholder, BDO Marketing & Business Solutions Limited  
• Director & Shareholder, Ngatai Bhana Limited  
• Director & Shareholder, Family Care Limited  
• Member, Restorative Justice Aotearoa |
| 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 |
<table>
<thead>
<tr>
<th>Member</th>
<th>Disclosure of Interest</th>
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</table>
| 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  
• Trustee & Beneficiary, Mickyla Trust  
• Trustee & Beneficiary, M&K Investments Trust (includes shareholdings in a number of listed companies but less than 1% of the shares in those companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, NextMinute Holdings Limited). It also includes a shareholding of less than 1% in Orion Health Holdings Limited. Orion Health has commercial. |
| Dr Lyn Murphy       | • Shareholder, Bizness Synergy Training Ltd  
• 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  
• 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*  
• Member, Health Partners Shareholder Review Group  
• Director and Shareholder, Recovery Solutions Services Limited  
• Shareholder, Ayers Snedden Consultants Ltd  
* subsidiaries of Te Urungi o Ngati Kuri Limited |
<table>
<thead>
<tr>
<th>Member</th>
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</table>
| Reece Autagavaia            | • Member, Pacific Lawyers’ Association  
• Member, Labour Party  
• Trustee, Epiphany Pacific Trust  
• Trustee, The Good The Bad Trust  
• Member, Otara-Papatoetoe Local Board  
• Member, District Licensing Committee of Auckland Council  
• Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation  
• **Board of Trustees Member, Holy Cross School** |
| Ken Whelan, Crown Monitor   | • Board Member, Royal District Nursing Service NZ  
• Contracts with Francis Health & GE Healthcare (mainly Australia & Asia)  
• Crown Monitor, Waikato District Health Board |
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<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<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>
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Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday, 26 June 2019

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

PART I – Items considered in public meeting

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

ALSO PRESENT
Margie Apa (Chief Executive Officer)
Margaret White (Chief Financial Officer)
Dr Gloria Johnson (Chief Medical Officer)
Jenny Parr (Chief Nurse and Director Patient & Whaanau Experience)
Dinah Nicholas (Board Secretary)
Donna Baker & Ruth Larsen (Communications)

APOLOGIES
Apologies were received and accepted from George Ngatai, Colleen Brown and Ken Whelan (Crown Monitor).

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
Ms Rowan Quinn from Radio New Zealand attended the public section of this meeting.

WELCOME
Apulu Reece Autagavaia opened the meeting with a prayer.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS
The Disclosures of Interest were noted with the following amendments:

Mark Gosche – Chairman Housing Corporation NZ
Apulu Reece Autagavaia – add Board of Trustee Member, Holy Cross School. Delete Member, Workforce Development Early Childhood Education Advisory Committee.

There were no specific interests to note with regard to the agenda for this meeting.

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

2.1 Minutes of the Meeting of the Board 15 May 2019

Resolution (Moved: Dianne Glenn/Seconded: Catherine Abel-Pattinson)

That the Minutes of the Board Meeting held on the 15 May 2019 be approved.

Carried

2.2 Action Item Register

Noted.

2.3 Minutes Regional Disability Support Advisory Committee – 4 April 2019

The minutes were noted and taken as read.

Ms Glenn advised that it was early days for the new regional committee who are still settling in. Ms Glenn noted that the CM Health representatives on the committee feel there are a number of local issues that are not being addressed and would prefer to have a local DHB meeting and a regional meeting.

It was decided that the four CM Health representatives on the regional committee should meet to discuss how to improve the meeting. There is a regional workplan for 2019 which should provide a basic framework for ongoing meetings.

2.4 Minutes Community & Public Health Advisory Committee – 10 April and Draft 22 May 2019

The minutes were noted and taken as read.

2.5 Minutes Hospital Advisory Committee – 2 May & Draft 5 June 2019

The minutes were noted and taken as read.

Birthing Units - Ms Murphy advised that the Committee were still not convinced about the number of birthing units in Counties Manukau and whether we should be considering rationalising them given the cost of maintenance or alternatively, outsource. A detailed report on birthing units is scheduled to come to the 9 October HAC meeting.

3 EXECUTIVE REPORTS

3.1 Chief Executive’s Report (Margie Apa)

The report was noted and taken as read.

Community Stroke Rehabilitation (Dana Ralph-Smith, Geoff Green & Nick Henzell)

Stroke is the third most common cause of death in non-Maaori women and the fourth most common cause of death in Maaori women and non-Maaori men.

At CM Health, the number of people presenting acutely to Middlemore Hospital with stroke annually has continued to increase overtime from 875 (in 2016) to over 922 (in 2018). However, due to developments in acute treatments, including interventions such as clot retrieval and thrombolysis,
the proportion of these patients who require inpatient rehabilitation has dropped from 36% (in 2016) to 16% (in 2018). Regional developments such as the hyper-acute pathway for patients who suffer a stroke after-hours has meant patients experience less complications following their acute stroke and can be cared for in community settings without the need for inpatient rehabilitation.

Consequently, the stroke patients that are now being seen in inpatient rehabilitation are more complex and require extensive periods of intensive rehabilitation therapy which continues on discharge into the community, as appropriate.

CM Health established the Community Stroke Rehabilitation team in 2005 and was strengthened to include early supported discharge (ESD) in 2013. The NZ Stroke Guidelines currently consider ESD to be best practice for stroke patients and in 2013 during an ESD pilot, the service achieved a 17 day reduction in average length of stay for stroke patients on the programme. Having both a low intensity and high intensity (ESD) model delivered by the same interdisciplinary team is different to other DHBs within NZ. The CM Health team accepts all suitable adult patients and has the most patients in the northern region.

Impact of Body Size on Service Delivery (Dr Gary Jackson)

CM Health has the largest number of those morbidly obese (body mass index >=40) of all DHBs in New Zealand, at 36,000 adults. This is about 8000 higher than expected for our population age, socioeconomic deprivation and ethnicity. Some of the consequences of body size are that service delivery takes longer is more complex and is prone to complications.

Mr Matt Tomlinson, Clinical Head and Ms Michelle McCallum-Jones, Service Manager from the Orthopaedic Department will provide further information at the next Board meeting on the impact of obesity in Orthopaedic services.

3.2 Corporate Affairs and Communications Report (Donna Baker)

The report was noted and taken as read.

How Not to Get Cancer TV programme, hosted by CM Health physician, Dr Richard Barbour, due to air on Tuesday 2 July, TV1 at 8.30am.

Stroke documentary by Attitude TV expected to air October.

Resolution (Moved: Mark Gosche/Seconded: Dianne Glenn)

That the Board:

Receive the Corporate Affairs and Communication Report for the period ending 31 May 2019.

Carried

(Ruth Larsen left the meeting at 11.05am)
3.3  **Health and Safety Performance Report** (Elizabeth Jeffs)

The report was taken as read.

Ms Jeffs to ensure that the data in future reports is reported as statistical control charts so the Board can see what we are doing is having an impact, rather than just a snapshot in time.

Ms Jeffs to look into where the Slips Trips & Falls are occurring (ie) in doorways from wet weather, to ascertain if there are more occurring now that the door mats have been removed from doorways within the hospital.

**Reported Incidents**  Ms Jeffs confirmed that of the 22 reported incidents in May, none were from animal bites.

**Resolution** (Moved: Kylie Clegg/Seconded: Reece Autagavaa)

That the Board:

Receive the Health and Safety Report for the period ending 31 May 2019.

Carried

3.4  **Finance & Corporate Business Report** (Margaret White)

The report was taken as read.

- Closed May and are still forecasting a $43m deficit as the end of year result.
- As from 1 July, we will have the ability to code BMI. We will not be funded for it but is something that is now going to be recorded within the coded event. There is work in progress to ensure all areas are recording BMI so the activity reporting that the Ministry receive mirrors our conversations around the pressures on our system.
- Cash in the bank remains okay.

The Board Chair thanked management for all the work that has been undertaken to get the result down from $53m.

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

That the Board:


Carried
4 DEcision Papers
4.1 1st Draft Northern Region Service Plan (Margie Apa)
The report was taken as read.

The Northern Region Service Plan (NRSP) has been collated by the NRA on behalf of the four northern region DHBs. It has been developed to demonstrate that regional planned work is consistent with the MoH 2019/20 Annual Planning Guidelines, and to provide national assurance that as a region, the DHBs are progressing actions that meet the national expectations for 2019/20.

The first draft NRSP 2019/20 outlines work that will be progressed via regional mechanisms across the DHBs over the coming year and highlights only a subset of the total health plan work that will be progressed within the Northern Region during 2019/20.

The signed-off final Regional Plan will be provided back to each of the Northern Region Boards, for information, in parallel with, or following the submission of the Final NRSP to the MoH, as Board meeting schedules permit.

Resolution (Moved: Mark Gosche/Seconded: Dianne Glenn)

That the Board:

Receive the first draft Regional Service Plan for review and endorsement.

Note this paper was endorsed by the Executive Leadership Team on 4 June to go forward to the Board.

Note that the Northern Region Service Plan is being drafted by the NRA to meet the requirements outlined in MoH guidance.

Note that the attached document is a ‘work in progress’ draft, required to be shared with the Ministry to enable early comment upon the content of our Region’s plan.

Note that further changes are expected to this plan and any feedback from this meeting will be used to influence further versions of the Regional Plan.

Note that, in line with the Regional Governance Manual as previously agreed, delegations for Regional Service plan sign-off to Board Chairs already exist. This will permit the regional plan to be presented to the MoH as a signed-off and finalised document within the current 21 June 2019 target timeframe.

Note that the final Regional Plan will be provided back to each of the Northern Region Boards, for information, once agreed by the DHB Board Chairs via the Regional Governance Group forum.

Approve and reconfirm that delegation of authority for final sign-off of the Regional Service Plan be given to the Regional Governance Group comprising our Region’s DHB Chairs.

Carried
4.2 **Smokefree Policy** (Dr Gary Jackson, Basil Fernandes & Dr Sarah Sharpe)

The paper was taken as read.

Smokefree work continues to be a key population health priority for CM Health. Although smoking prevalence is reducing, stark ethnic inequities remain and current actions are not enough to achieve the Smokefree 2025 goal (5% or less smoking prevalence across all groups), which current estimations predict will be missed by a large margin for Māori and Pacific people.

A change to the CM Health Smokefree Policy is proposed which would allow for vaping in designated outside areas within the CM Health grounds. This would align with the Ministry of Health advice to DHBs to support people who choose to use a vaping product to stop smoking. Background on the issue and the rationale for the proposed changes were presented. Some options for designated vaping areas were outlined for consideration by the Board. Particular attention was given to an option for mental health clients who have a very high smoking prevalence and need sustained support to quit, and to help address our duty of care for these people when they are inpatients. An evidence brief on the benefits and harms associated with vaping was included for Board discussion. Adding vaping to our tool box is another option for people to reduce harm from tobacco.

(Rowan Quinn rejoined the meeting at 11.52am)

**Board comments included:**

- This is not something that I would want to see in our health facilities. Can see what the Ministry of Health is saying in their National Position Statement on vaping (24 April 2019) and we should meet the minimum requirements but we don’t need to lead the way within Health. The data coming out of the United States is very contentious about vaping being unsafe, the additives being put into it, vaping machines blowing up. Most people seem to go back to smoking cigarettes.

- Totally opposed to this. This is just trying to set up a new industry in New Zealand which is uncalled for and totally unacceptable. We are trying to get rid of one evil by bringing in another evil. We should wait for the MoH to update their regulations before considering this. Nobody is arguing against helping people to stop smoking but is this is right option.

- When people vape, will that transmit infectious diseases or influenza.

- Cannot support this now as the current regulations are not strong enough to ensure that no young people/new smokers take up vaping.

- In favour of this. We have a major killer which is use of tobacco which leads to high cancer rates in our population. This is one intervention that doesn’t cost us much to be engaged with to actually have a good public health outcome arise from it. If what we are doing here is providing a degree of hospitality for people to deal with their addiction to smoking through the use of vaping, that is a smart thing to do. As a DHB we have a right to make a call on a public health issue. This is a call on a public health issue and we should make it. We regularly debate a reduction in cancer opportunities yet here we have a very practical thing that has enough control around it and makes sense to encourage people from doing the very thing that creates the end result that we are dealing with in the hospital. It seems odd that we should be worried about that.

- Is this a measure that will make our staff in Tiaho Mai safer. At the moment there are a lot of issues around people not being able to smoke.
• Would we get better engagement from people in our mental health units if we allowed vaping.
• How long will it take for us to understand the health implications of vaping - it has taken a long time for tobacco.
• The UK regulations are very strong.

Dr Sharpe advised that the MoH are updating their regulations later this year.

Dr Jackson confirmed that there is no evidence that smoking or vaping transmits viruses any more or better than normal breathing however, because the vapor is so visible when someone is vaping, you realise the extent of how far someone’s breathe travels.

Dr Johnson confirmed that the evidence for whether or not preventing people from smoking in mental health units really does contribute to aggression and violence is equivocal. It has been used for a long time as an argument against banning smoking in mental health units but we have moved on from that and probably the consensus position is that what is important is to manage effectively any increase in anxiety or irritability that is associated with all of the things that occur when somebody is in a mental health unit. Allowing them to vape will not lead immediately to a reduction in aggression and violence.

The Board invited the Smokefree Team to come back in six-month’s time when there has been enough shift in evidence and there is a clearer picture around regulation to update the Board including the experiences from Mid Central DHB who has recently set up a vaping area on their campus.

Resolution (Moved: Mark Gosche/Seconded: Lyn Murphy)

That the Board:

Receive this report which outlines proposed changes to the CM Health Smokefree Policy.

Agree to defer a decision on allowing vaping areas on CM Health grounds and changes to the Smokefree Policy until more evidence and regulations are available.

Carried

5. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Mark Gosche)

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>
</tr>
</thead>
<tbody>
<tr>
<td>Public Excluded Minutes of 15 May 2019 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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<tr>
<td>Public Excluded Minutes of the Audit Risk &amp; Finance Committee, Hospital Advisory Committee &amp; Public Health Advisory Committee</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>hA Class Share Issue</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>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(ii)]</td>
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<td>19/20 Proposed Capital Plan</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>
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<td>Risk Management Report &amp; Draft Risk Management Policy</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>Confidentiality of Advice by Officials The disclosure of the information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. [Official Information Act 1982 S9(2)(f)(iv)]</td>
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<td>Title</td>
<td>Reason for Withholding</td>
<td>Waiver Basis</td>
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<td>PET CT Supply Agreement</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>Holiday’s Act</td>
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<td>Options for the Future of NZHIH</td>
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<td>Chief Executive’s 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(3)(g)(i)) of the Official Information Act 1982.</td>
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**Carried**
The public meeting closed at 12.35pm.

THE NEXT MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD WILL BE HELD ON WEDNESDAY 7 AUGUST 2019.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 26 JUNE 2019.

BOARD CHAIR

DATE
<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<tr>
<td>26 June 2019</td>
<td>Smokefree Policy</td>
<td>Vaping/Changes to the Smokefree Policy - come in when there has been enough shift in evidence and there is a clearer picture around regulation to update the Board on vaping, including the experiences from Mid Central DHB who has recently set up a vaping area on their campus.</td>
<td>11 December</td>
<td>Gary Jackson/Basil Fernandes</td>
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<td>26 June 2019</td>
<td>Health &amp; Safety Performance Report</td>
<td>Slips Trips &amp; Falls - look into where these are occurring (ie) in doorways from wet weather, to ascertain if there are more occurring now that the door mats have been removed from doorways within the hospital.</td>
<td>7 August/18 September</td>
<td>Elizabeth Jeffs</td>
<td>Work in progress. A full report will be made available on 18 September.</td>
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<tr>
<td>15 May 2019</td>
<td>Health &amp; Safety Performance Report</td>
<td>Spinal Unit – the new security measures that have been implemented at the Otara Spinal Unit to improve staff safety (ie) improved lighting, installation of swipe card access were noted. The Chair was keen to understand whether the staff feel that the measures they requested are working and good enough. Ms Jeffs undertook to check in with the staff at the Spinal Unit and provide feedback in her next Board report.</td>
<td>7 August/18 September</td>
<td>Elizabeth Jeffs</td>
<td>Work in progress. A full report will be made available on 18 September.</td>
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<td>15 May 2019</td>
<td>HQSC Workshop</td>
<td>Schedule a 30-minute educational session on control charts.</td>
<td>11 December</td>
<td>Mary Seddon</td>
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<td>9 April 2019</td>
<td>Health &amp; Safety Performance Report</td>
<td>Aggression &amp; Violence – once there is sufficient data from the Code Orange pilot and other work being undertaken in this area, present a deep dive into this area to the Board.</td>
<td>18 September</td>
<td>Elizabeth Jeffs</td>
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<td>20 February 2019</td>
<td><strong>Health &amp; Safety Performance Report</strong></td>
<td>Aggression &amp; Violence – reporting over the last six-months 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/18 September</td>
<td>Elizabeth Jeffs</td>
<td>Work in progress. A full report will be made available on 18 September.</td>
</tr>
<tr>
<td>20 February 2019</td>
<td><strong>Presentation</strong></td>
<td>Middlemore Foundation CEO – update to the Board</td>
<td>18 September</td>
<td>Sandra Geange</td>
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<tr>
<td>20 February 2019</td>
<td><strong>HAC Minutes 29.1.19</strong></td>
<td><em>Tamaki Oranga Service –</em> an independent review is underway. Review to be made available to the Board &amp; HAC when completed.</td>
<td>7 August</td>
<td>Tess Ahern</td>
<td>Refer Item 3.1 on today’s agenda.</td>
</tr>
</tbody>
</table>
Minutes of the
Regional Disability Support Advisory Committee
Held on Thursday, 6 June 2019 at 1.00am
Senior Citizens Room, Fickling Convention Centre, 546 Mount Albert Road, Three Kings, Auckland

PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Committee Co-Chair)
Jo Agnew (Committee Co-Chair)
Dianne Glenn (CM Health Board Member)
Edward Benson-Cooper (WDHB Board Member)
Gwen Tepania Palmer (ADHB Board Member)
Michelle Atkinson (ADHB Board Member)
Robyn Northey (ADHB Board Member)

ALSO PRESENT

Margie Apa (Chief Executive, CM Health)
Debbie Holdsworth (Director Funding, WDHB & ADHB)
Samantha Dalwood (Disability Advisor, WDHB)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions, CM Health)
Sue Waters (Chief Health Professions Officer, ADHB)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present.

WELCOME

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

1. AGENDA ORDER AND TIMING

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

2. GOVERNANCE

2.1 Apologies

Apologies were received and accepted from Allison Roe, Catherine Abel-Pattinson, Judy McGregor, Katrina Bungard, Dana Ralph-Smith and Gwen Tepania-Palmer for lateness.
2.2 Disclosure of Interests

There were no disclosures of interests to note.

2.3 Disclosure of Specific Interests

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

2.4 Minutes of the Previous Meeting

Confirmation of the Minutes of the Regional Disability Support Advisory Committee meeting held on 4 April 2019.

Resolution (Moved: Michelle Atkinson/Seconded: Dianne Glenn)

That the minutes of the Regional Disability Support Advisory Committee meeting held on 4 April 2019 be approved.

Carried

2.5 Action Items Register

Building & Services Audit – recommend to Boards that these should be undertaken on a regular basis (before the end of the next financial year) and all Metro AKL DHBs should be audited by the same people. The committee would like to see a common approach across DHBs.

2.6. Work Plan

Aligned with the Disability Strategy Implementation Plan. Mr Nand and Ms Dalwood liaise with Ms Tafau in regard to presenters and papers that will be on the agenda. Ms Tafau to provide the correct RDiSAC paper template, with guidelines, for invited attendees to complete.

In terms of the September agenda there will be an Autism presentation. Organisation to be discussed and decided on by Mr Nand and he and Ms Tafau will send an invite to the chosen organisation.

Action

Identifying and employing employees with disabilities – invite HR to attend and provide information around what the three DHBs are doing internally. Ask HR to comment on how we support disabled staff and staff with carer responsibility for disabled people.

Culture of the Organisation and how it support Disability will be good to explore with the HR experts at the next meeting.

The RDiSAC Work Plan was approved by the committee.

Resolution (Moved: Colleen Brown/Seconded: Robyn Northey)

3. STANDING ITEM

3.1 Metro Auckland DHBs Disability Strategy Implementation Plan 2016-2026 – Progress Report (Samantha Dalwood, Disability Advisor, WDHB)
Disability Responsiveness - Mandatory training at CM Health, but not at ADHB/WDHB. ADHB/WDHB to keep reporting that the training is available and monitor the uptake. Mr Nand found the CMDHB training very useful and has been promoting the training to the Allied Health Staff at CM Health. The training is short, only takes about 20 minutes, however it highlights the need to not make assumptions about disabled people and to ask disabled people if they need support or help.

Ms Tepania-Palmer talked to the committee about the similar values of each DHB that align the direction that guides attitude and behaviour of those that provide care. Whaanau stories (lived experiences) as a way to start the RDisAC committee meetings will help to shape the agenda and the discussions that come from that. This type of thing is currently being done at other meetings, including Board and has worked well. Whaanau/Patient experience stories can be found on the HQSC website.

**Action**
Ms Tafau to source the TeRina patient story link from the HSQC website and forward to committee members.

**Outcome 3: Point 8 – Safeguarding Adults Coordinator.** This is WDHBs response to Vulnerable Adults. There has been much consultation around what a Vulnerable Adult is.

The Regional Disability Advisory Committee:

**Received** this progress report.

**Moved:** Colleen Brown/Seconded: Robyn Northey

**Carried**

4. **DISCUSSION**

4.1 **Complexity of Finding Data about Disabled People** (Samantha Dalwood, Disability Advisor, WDHB)

Paper was provided as a starting point for a committee discussion.

The idea was raised about collecting disability information for each patient, in conjunction with the injury/illness that they are being admitted for. This data could be very useful, in particular for an aging population.

Given that the committee has a bit more insight now, where to now with the Data query? An amendment to the National Coding system in order to include the capturing of information from people that wish to identify as having a disability.

Amanda Bleckmann to provide Ms Tafau with a link to the Demographic Report on Clients Allocated the MOH Disability Support Services.

Organisations such as Complex Carers provided information for those disabled persons that have no voice.

**Action**
Ms Bleckmann can provide the necessary links to Ms Tafau for dissemination to the committee.
There is the over 65 funding (DHB) and the under 65 which is looked after by the MoH. The identification of the disability from a coding perspective is the actual issue. NHI matching is where you get the consistent data that enables DHBs/Services to affect change for this with disabilities.

Identifying the most vulnerable and their whaanau is important.

**Action**
Useful for this committee to formulate the questions that need answers and then put them through the various forums that exist in the community as this needs to be a National approach.

**Action**
There is a need for specific questions for Adri Isbister, DDG Disability, prior to her attendance. Committee come prepared to discuss at the September meeting.

In absence of a health needs analysis of disabled people, there is a need to understand experiences from particular groups (Maaori, Maaori and Disabled, Pacific).

**Action**
Invite Taikura Trust to present to this committee on U65 funding. Will be useful for this committee to gain a better understanding of their context and challenges that they may face. An information gathering exercise.

### 4.1.1 Letter to Adri Isbister re Sharing of Data

Ms Isbister is to attend the November meeting.

### 4.2 Community Representation Discussion

General consensus was that this would be helpful but need to determine who and why. It was felt that three community representatives in total was reasonable. This would mean one representative from each DHB. Note: look to fill diversity gaps. Advertise in the papers and keep the Consumer Councils apprised.

**Action**
Half an hour of the next meeting is to be dedicated to determining how this should look and how the committee would go about recruiting. Follow due process and recommend to Boards that this is a consideration for the community representation (keeping in accordance with the TOR and Letter of Expectation for the Minister).

### 5. INFORMATION PAPERS

Ms Bleckmann is to send links to the ASD Guideline summary. It is the only guideline in the world that covers both children and adults.

Child Development Services funding has been approved. MOH has to report back to the minister on how this will impact the sector. MOH currently finalising Communications and then will look to start meeting with DHBs as early as next week. Every child development services will be required to have the full complement of Allied health staff.

Ms Bleckmann advised that there will be no cuts of funding in the disability sector.
6. GENERAL BUSINESS

The UNCRPD Optional Protocol means that if a disabled person has their rights breached under the Convention, they may be able to make a complaint to the United Nations Committee on the Rights of Persons with Disabilities. New Zealand acceded to the Optional Protocol to the Convention on 5 October 2016. It came into force on 4 November 2016.

Action
Ms Tafau to circulate the link to the United Nations guidelines.

Meeting closed at 3.10pm.

The meeting concluded at 3.10pm.


__________________________  ______________________________
Colleen Brown, Committee Co-Chair    Jo Agnew, Committee Co-Chair
Minutes of Counties Manukau District Health Board
Hospital Advisory Committee
Held on 17 July 2019 at 1.30pm
Ko Awatea Room 101, Middlemore Hospital
100 Hospital Road, Otahuhu, Auckland

PART I – Items Considered in Public Meeting

BOARD MEMBERS PRESENT
Dr Lyn Murphy (Chair)
Catherine Abel-Pattinson (Deputy Chair) via conference call
Dr Ashraf Choudhary
Dianne Glenn
George Ngatai
Kylie Clegg

ALSO PRESENT
Margie Apa (Chief Executive)
Dr Gloria Johnson (Chief Medical Officer)
Dr Jenny Parr (Chief Nurse and Director of Patient and Whaanau Experience)
Dr Kate Yang (Executive Advisor, CEO’s Office)
Avinesh Anand (Deputy CFO, Provider)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Teresa Opai (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

APOLOGIES
Colleen Brown

WELCOME
The tour of the Emergency Department commenced at 1.30pm. The meeting commenced at 2.27pm.

Dr Murphy opened the meeting by expressing her thanks to Jeremy Dryden and team for the tour of the Emergency Department, noting that it was very valuable.

Dr Murphy expressed her concern for the safety of the staff, particularly that there was no locked room for patients when required. Mr Ngatai also expressed his concern for staff safety, both in the waiting area and in the physical layout. Dr Parr advised that the staff are provided with personal alarms. Committee members all commented on the 7-minute delay for on-site security to arrive in the ED. Ms Clegg also expressed her concern at the ceiling repair that was required due to sewerage coming through the ceiling, caused by a faulty pipe.

Dr Johnson noted that worldwide, ED’s are experiencing higher levels of drug and alcohol affected patients, often psychotic, presenting to ED and needing to be there for substantial periods of time while they are assessed.
Dr Murphy asked what best practice was. Dr Johnson advised that it was having sufficient staff to manage the people, with the right approach and skills to be able to, if necessary, de-escalate and restrain if required, but also start undertaking an assessment, figure out quickly what they think they are dealing with, then engage an appropriate sedation in order to manage them safely.

Ms Clegg noted that at WDHB security is right by ED which is quite helpful, whereas at Middlemore the security are based further away at reception.

Ms Apa advised that the additional resource required for security to stay within ED is being investigated. This may be achieved either by recruiting additional FTE or taking other duties around the site off existing security given the budget constraints. Ms Apa advised that the new Clinical Director will review the ED design, given the increase in volumes, and determine what additional support may be beneficial.

Dr Johnson commented that the demand by wards for security assistance has also increased.

Dr Johnson noted that the Board had been impressed with the value of having a clerical person at front door to handle the initial triaging and dealing with the non-clinical issues.

Dr Murphy noted the comment made by ED staff about the need for additional CNS staff. Dr Parr advised that additional CNS and doctors are required and whilst there has been some additional resource, CM Health simply can’t afford what is required, given its deficit. Ms Apa advised that confirmed budgets should be available in approx. 8 days and she hoped to be able to confirm some additional resource.

**DISCLOSURE OF INTEREST/SPECIFIC INTERESTS**

There were no Disclosures of Interest to note requiring update.

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

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

2. **BOARD COMMITTEE MINUTES**
   2.1 Minutes of the Hospital Advisory Committee 5 June 2019

   **Resolution** (Moved: Dr Choudhary/Ms Glenn)

   That the Minutes of the Hospital Advisory Committee meeting held on 5 June 2019 be approved.

   **Carried**

   2.2 Action Items Register – Public
   Noted.

   Ms Murphy asked that the See and Treat unit be added to the register for the next meeting.

   **Action: Secretariat to update action register, adding See and Treat unit.**

   2.3 Hospital Advisory Committee Work Plan
   The report was taken as read.
3. PROVIDER ARM PERFORMANCE REPORT
3.1 Executive Summary (Margie Apa)

The report was taken as read.

Ms Apa provided key points for items 3.1 and 3.3:

- The highlights for May are reflecting back some of the increased resources put into Women’s Health. Additional budget is being considered for further outsourcing to address the women on the P3 waitlist. While not life threatening conditions, they are painful and debilitating.

- Good progress on waitlists.

- Flu vaccination rate of CMDHB staff currently at 66% and over the next few weeks should start to see more incremental improvement.

- Over May, Kidz First experienced a jump in ED presentations and complexities, which is earlier than in previous years. There is some concern over how this trend will play out over the next few months.

- Neonatal volumes have had both complexity and a full unit, and are a pressure spot nationally. Neonatal capacity across the country has been escalated to the Ministry and is an area that will be monitored closely.

- Targets have unsurprisingly not been achieved in faster cancer treatment, ophthalmology and ED 6-hour targets. The cancer team have identified the need for additional coordinators, which is being considered as part of the budget process.

- A manager has been added that looks specifically at ophthalmology. Previously, ORL and ophthalmology were overseen by one service manager. As these are areas where deeper dives are required to better understand the challenges and sustainability, having another manager give dedicated attention is expected to improve results. Danny Wu has been engaged back to CMDHB to take a deep dive into supporting the service planning and working with the region in ophthalmology to maximise opportunity of sharing workforces across Auckland and Counties.

- Gastroscopy wait times are of concern. The new budget includes a proposal to outsource which has been agreed and securing those contracts is underway.

- The Minister of Health has announced his support for our second Cath lab and high-dependency dialysis unit. The original planning suggested a 3.5-4 years to build but the team is looking at how it might shave time off that, particularly given Scott, and whether we can package together some of the construction.

Dr Choudhary asked if outsourcing would continue in the interim, given wait times are at 120 days. Mr Nand confirmed outsourcing will continue. Ms Apa noted that the clinical workforce would also have to grow which will take some time.

Dr Johnson advised that all aspects of the Cardiovascular service are under pressure. Ms Apa advised our target is 60% which seems very low for our population and questioned whether our targets are ambitious enough, particularly for Maaori and Pacific Island.

Dr Murphy queried if CM Health would have to resource any increases in target. Ms Apa advised that she didn’t believe it would require extra resource but questioned whether we should incentivise any additional indicators that are added. There is an acceptance that Primary Care understands the national health need and their part in meeting these programmes.

Ms Glenn queried the occupancy levels in ward 35E. Dr Johnson confirmed occupancy of the ward has dropped, and they are still trying to understand the reasons for that. Ms Glenn asked if it could be related to many community retirement villages now having their own dementia units. Dr Johnson confirmed that is possible, combined with the success of the delirium unit and the psychological services which are functioning more effectively.
Dr Murphy queried the typical person being seen in the maternity day assessment clinic. Dr Parr advised that it included reduced foetal movements, raised blood pressure etc where there was a need to monitor more closely. Rather than bringing patients into an acute hospital, they are coming into the day assessment unit and if they then appear to have problems they can transfer them over quickly.

Ms Clegg asked if there was any update from the steering committee on the final report from the Tamaki Oranga review. Dr Parr advised that it had only just been received and hasn’t been seen by ELT as yet. Whether it will come to ELT or to the Clinical Leads is yet to be determined. It has been a very helpful report and some of the recommendations have already been implemented.

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

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

Ms Apa advised that discussion could take place offline with the Chair about the type of reporting the meeting would find useful for the FY2019/20.

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

Mr Anand provided key points:
- Savings are coming from non-clinical admin areas and due to vacancies. CM Health is paying a 60-70% premium for outsourcing. Mr Anand noted that an FTE would achieve at least 50% savings over an agency for a day shift, and more for night shift and weekends.
- Dr Choudhary asked if Mr Anand was pleased with the way CM Health is progressing overall. Mr Anand advised the drive was coming through for the finance team to work with the services and empowering the service managers to make decisions and have the visibility of the financials. More work has to be done by the finance team to sit down with the cost centre managers and CNs and educate them about the budgets.

Ms Apa commented that as each service is reviewed, the savings are becoming more challenging due to the total volume and demand on services and flexibility of the workforce. The biggest driver for outsourcing is capacity and staffing, and it is not helping in financial terms.

Dr Parr advised that the Bureau Efficiency project has been underway since last November and is focussed on trying to reduce the reliance on agency staff, particularly HCA’s. The number of resource nurses on the bureau has increased due to outsourcing for RN’s and the bureau has increased by 30. MIT were contacted as they are local, and 18 HCA’s have been recruited to date after 9 months of their training, who will be able to work nights, weekends and holidays. Work is underway to help CN’s understand their cost drivers within their budgets and how they might be able to work better by allocating nights or weekends first. CM Health is starting to see dividends in terms of reduced agency HCA’s and watch use.

Dr Murphy asked if CM Health regards AUT as local, given its southern campus. Dr Parr advised that CM Health doesn’t have many students from AUT as yet, but AUT have been asked to advise the number of students living locally, so additional placements as possible can be added from them for semester 2.
Ms Apa advised that we are in the final steps of the NZRDA facilitation process. Mr Nand advised that a strike notice was issued 16 July for psychology with a ban on overtime for a month. CM Health currently employ 60 psychologists, most of which work within Mental Health. It is anticipated that the strike notice will not have an impact on day-to-day service delivery for patients as the psychologists traditionally don’t work overtime, but CM Health has asked for LPS support for emergencies such as the Christchurch incident.

Resolution (Moved: Dr Murphy/Seconded: Dr Choudhary)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

4. CORPORATE REPORTS

4.1 Patient Flow – Every Hour Counts (Dr Mary Seddon)
The report was taken as read.

Dr Seddon provided key points:
- MRI waiting list down to 613, a 70% reduction in 6 months.
- A review of the booking and scheduling MSC outpatient service had been completed and a report will come to the next HAC meeting. One of the biggest issues is that a number of Maaori and Pacific Island patients have multiple diseases, but each disease is seen at an individual clinic, with no overall coordination or interplay. Patient initiated or virtual follow-ups would create space to do linked appointments.
- Patient flow is an ongoing challenge and work continues to identify opportunities to improve this.

Ms Glenn commented on the value of Dr Seddon’s report, highlighting issues but offering solutions.

Ms Glenn queried the 31-day delay between an echo referral and being added to the waiting list due to admin process delays, and whether this situation was improving. Mr Nand advised that a new admin solution is being put in place which should improve the situation. Dr Seddon commented that most of it is not technological but cultural, and is excited about the innovations that have come up to trial for the echo waiting list.

Dr Murphy queried the type of questions being asked of the ED admin person. Dr Seddon advised it is can be where to find services, family members trying to visit but not knowing what ward the family member is in, etc. Many visitors and patients arriving from Hospital Road don’t realise the main entrance is at the rear of the hospital. The provision of a blind corridor between ED and the main hospital would avoid having to transit the hospital externally. Dr Murphy suggested we consider better Wayfinding options rather than spending $30k on an admin person. Mr Nand advised that a working group had suggested a phone line that automatically links to reception.

Resolution (Moved: Dr Murphy/Seconded: Ms Glenn)

That the Hospital Advisory Committee:

Note and receive the report.

Carried
4.2 Q3 2018/19 Non-Financial Summary Report (Marianne Scott)

The report was taken as read.

Ms Scott provided key points:
- Q3 report shows success despite the odds.
- The system is under capacity pressure, with elective discharges short by approx. 289.
- There is a regional shortage of private capacity for some electives which are being sent back in volume. The team has started to explore opportunities of leasing space and are looking to urgently invest in capacity and to review hours of operation.
- Regional deep dive is looking at electives and how the region is working overall.
- FCT has pushed out timeframes due to issues with ADHB oncology, but working regionally to resolve those issues.
- There is considerable pressure on cancer nurse coordinators due to volumes.
- ED targets are largely impacted by hospital flow and the team is looking at how flows can be improved. Also looking at the CCDM role and how it can assist.

Dr Murphy queried what was causing the tight private sector capacity. Dr Johnson advised that all DHBs are currently outsourcing to the same private sector partners, and that within metro Auckland, this is causing capacity issues within the private sector. Dr Johnson noted that it takes some time to develop private sector capacity also.

Ms Glenn expressed her concern about oral health and the availability of sweets on the counters at supermarkets.

Resolution (Moved: Dr Murphy/Seconded: Mr Ngatai)

That the Hospital Advisory Committee:

Note and receive the report.

Carried

4.3 Emergency Department Deep Dive - Presentation (Jeremy Dryden)

Mr Dryden provided a presentation to the meeting.

Key points:
- ED has a 6-hour turnaround target. At peak, it can take up to an hour to register a patient. The model is to get patients home same day or next day so they are not taking up a bed on the ward.
- Response time averages 3 hours from arrival to being seen by a doctor or Nurse Specialist, then 2-3 hours to work the patient through, then 4 hours to get the patient to a ward. It can take up to 12 hours to get a patient through to a ward from arrival in ED.
- The biggest issue is to create a staffing model as presentations and peaks change year on year.
- Ed capacity is approx. 10 patients per half hour, anything over that forms a queue.
- There has been a massive increase in paeds to ED this winter, particularly after hours.
- Pacific Island patients mainly come after hours often with serious problems, unlike non-Pacific Island patients who present through the day.
- ED is seeing more medical injuries, genuinely sick people, particularly after hours. Increased behavioural disturbance patients coming through due to a change in Police processes.
• The Emergency Queue poster at door has successfully redirected 800 patients in one month to community care and 3,500 patients since September when the initiative began. This offers a time based incentive for patients and gives them a choice of care.
• Patient flow needs to be executive driven and everyone needs to buy into it.
• Improved visibility of available beds will provide transparency as to where a patient is in the journey.

Dr Choudhary asked how CM Health nursing FTE per ED patient compares with other DHBs. Dr Parr advised the structure of the ED’s don’t compare as they may include MAU, Short Stay Units, and Paediatric Short Stay Units depending on the hospital. Data has been requested from ADHB and WDHB and is currently being unpicked. CCDM has allowed CM Health to staff up the monitoring areas which can be pulled from for resuscitation cover.

Dr Choudhary asked if CM Health charges for the educational support it provides. Mr Dryden advised that it does not, that there is an expectation to train the next generation coming through.

Dr Murphy asked what the non-financial costs were of having a long waitlist. Mr Dryden advised that it was time sitting waiting. Research is expected soon looking across all DHBs which will show where CM Health sits in performance terms and any issues.

Dr Murphy asked if the aggression of the patient increases with the time spent waiting. Mr Dryden confirmed that in the waiting rooms it did and having security sitting there doesn’t stop them.

Dr Murphy asked what level of triage ED saw. Mr Dryden advised that triage 3 was the biggest group, then 4’s and 5’s.

Dr Murphy asked Mr Dryden for his thoughts on the ED entrance vs hospital entrance. Mr Dryden suggested that an improved welcome area and a different wayfinder and/or health navigator to assist would be useful, but the physical area itself is difficult to change.

4.4 National Bowel Screening Programme (Dana Ralph-Smith)
The report was taken as read.

Ms Ralph-Smith provided key points:
• Modelling vs reality is different so that needs to be worked through.
• Participation rate is below the average and strategies have been identified to address this. The biggest thing to make a difference is continued engagement with primary care. A Community lab drop off would also make a difference.
• There are challenges with follow up as this is done by the national centre then handed back to CM Health when they can’t do it, creating double handling. Currently discussing how that process can be streamlined. It probably needs to be locally delivered but CM Health would need funding for that.

Ms Glenn commented that the most important aspect was that 45 patients have been diagnosed due to the programme to date.

Dr Murphy asked if the cost of running the contract was within budget. Ms Ralph-Smith responded that it was, but there is some concern about the next contract which is why she is signalling the modelling is not quite.
Dr Choudhary commented on the table detailing the percentage of kits returned and asked what more could be done to improve this result. Ms Ralph-Smith advised that the community lab drop-off which commences in September should improve the results.

Ms Glenn queried the level of returns between male and female participants. Ms Ralph-Smith advised that was not information she had available but would ask the question.

Ms Abel-Pattinson commented on the 90 days taken for 95% of returns, noting her interest in whether females or males returned the kit more quickly, as this would assist HPA with targeting advertising.

Ms Apa asked Ms Abel-Pattinson if she had any insights from HPA on what she has observed as effective for targeting different groups, in particular Maaori and Pacific. Ms Abel-Pattinson believes that HPA is not getting that information back from any of the DHB’s and encouraged the results to be shared with HPA so that marketing can be changed. Ms Abel-Pattinson advised she could feed back verbally at the next board meeting, but suggested a letter is sent to Tane Cassidy, Acting CEO HPA.

**Action:** Ms Ralph-Smith to prepare letter to HPA.

**Resolution** (Moved: Dr Murphy/Seconded: Ms Clegg)

That the Hospital Advisory Committee:

Note and receive the report.

**Carried**

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

4.5.1 Safety, Experience, Compliance and Measurement Dashboard
The report was taken as read.

4.5.2 Safety, Experience, Compliance and Measurement Dashboard Variance Report
The report was taken as read.

4.5.3 Complaints to HDC Involving DHB’s 01.07.18-30.06.18
The report was taken as read.

4.5.4 Complaints to HDC Involving DHB’s – CM Health 01.07.18-31.12.18
The report was taken as read.

Dr Hughes provided key points:
- CM Health has the lowest complaint rate in the northern region and 6th lowest in the country.
- Similar challenges are being experienced nationally.

Dr Johnson reminded the meeting that the data was based on complaints to HDC, not to CM Health and the low complaint rate reflected our ability to resolve a complaint without escalation to the HDC.
Ms Glenn commented that it appears to be about communication rather than clinical failure. Dr Johnson noted that communication issues is a trend everywhere and is what often causes distress to people, more so than diagnosis or treatment.

Ms Clegg queried whether we get a lie of the land in terms of what isn’t officially complained about, ie: a phone call is made but no official complaint is made. Dr Hughes noted that a lot of this is captured in our in-patient survey free text areas to record areas for improvement. Dr Johnson commented that all phone calls are noted by Feedback Central as a formal complaint, even if no written complaint is made.

Dr Parr noted that there was no ethnicity analysis in the report and asked if we could request it be included in future. Dr Johnson advised that HDC would only have that information second hand from the GP or DHB records as patients do not have to disclose ethnicity in making a complaint.

4.5.5 Analysis of Blue 10+ Zone Data
The report was taken as read.

Dr Hughes provided background to the report:
- In the transition between CM Health’s Physiology Unstable Patient (PUP) score and the new national deterioration score, the Patient at Risk (PAR) team noted patients who deteriorated, so voiced their concern about the scoring of the new national system. These were patients who had a low respiratory rate and low histolic blood pressure, and there was a sense that the new national score didn’t provide an early enough warning. CM Health advised the national organisation that they wished to keep their own thresholds, which they would review. This paper is the outcome of that review.
- The report compares CM Health’s PUP scores vs new national deterioration scores which show a differential for Maaori over the national score. CM Health have advised the Commission they are continuing to use the PUP scoring system and will look at each case where a Maaori patient would have been impacted by the new national scoring system. Dr Hughes will provide further feedback to a future HAC meeting.

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

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

5. INFORMATION PAPERS
5.1 Emergency Department Medicine Integrated Care (Dana Ralph-Smith)
The report was noted and taken as read.

5.2 Surgery, Anaesthesia and Perioperative Services (Mary Burr)
The report was noted and taken as read.

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

5.4 Women’s Health (Mary Burr)
The report was noted and taken as read.
5.5 **Kidz First (Nettie Knetsch)**
The report was noted and taken as read.

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

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

5.8 **Middlemore Central (Ian Dodson, Dr David Hughes)**
The report was noted and taken as read.

**Resolution** (Moved: Dr Murphy/Seconded: Ms Glenn)

That the Hospital Advisory Committee:

Note and receive the reports.

**Carried**

6. **RESOLUTION TO EXCLUDE THE PUBLIC**

**Resolution** (Moved: Dr Murphy/Seconded: Mr Ngatai)

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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| Public Excluded Minutes of 2 May 2019 and Actions | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)] | **Confirmation of Minutes**
As per the resolution from the public section of the minutes, as per the NZPH&D Act. |
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<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Committee to carry out, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Facilities, Engineering and Asset Management 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(3)(g)(i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Committee to carry out, without prejudice or disadvantage, commercial activities.</td>
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</table>

**Carried**

The Public Meeting closed at 4.30 pm.

The next meeting of the Hospital Advisory Committee will be held on Wednesday, 28 August 2019.

Signed as a true and correct record of Counties Manukau District Health Board’s Hospital Advisory Committee meeting held on 17 July 2019.

Dr Lyn Murphy  
Chair  

Date
Minutes of Counties Manukau District Health Board  
Community and Public Health Advisory Committee  
Held on Wednesday, 3 July May 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

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

ALSO PRESENT

Fepulea’i Margie Apa (Chief Executive)  
Dr Campbell Brebner (Chief Medical Advisor, Primary Care)  
Dr Jenny Parr (Chief Nurse and Director of Patient & Whaanau Experience)  
Dr Kate Yang (Executive Advisor to the CE)  
Vicky Tafau (Secretariat)  
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present at this meeting.  
Dr Mariam Parwaiz (CM Health Public Health Registrar) attended as a learning experience.

WELCOME

The meeting commenced at 9.00am with a welcome from the Deputy Chair, Dr Ashraf Choudhary and a karakia from Mr George Ngatai.

1. AGENDA ORDER AND TIMING

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

2. GOVERNANCE

2.1 Apologies
Apologies were received and accepted from Colleen Brown, Fepulea’i Margie Apa and Dr Jenny Parr.

2.2 Register of Interests

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

2.3 Confirmation of the Minutes of the Community and Public Health Advisory Committee meeting held on 27 May 2019.

Resolution (Moved: Ashraf Choudhary/Seconded: Reece Autangavaia)

That the minutes of the Community and Public Health Advisory Committee meeting held on 27 May 2019 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Action Items were noted as being on track.

2.5 CPHAC Workplan 2019

The Workplan was noted as being on target.

3. UPDATE

3.1 ARPHS Update to CPHAC

The paper was taken as read.

ARPHS advised that the measles outbreak is significant. We are at 150 cases, 50% of which have been hospitalised. People are actually presenting to GP or EC two or three times before being identified. Pacific are featuring highly. A whaanau measles pack has been distributed to GPs. The outbreak spread has moved from West Auckland to South Auckland. Vaccination is the key to combating this outbreak. It has been advised that MMR1 vaccinations have been moved from 15 months to 12 months and children that are not vaccinated are being recalled. The MOH is considering a national catch up campaign. Timeliness of vaccinations, especially for those under 2 is critical. Children may well be fully vaccinated by 5yrs but the 15 months and 4yrs vaccinations may not be received on time.

Measles vaccination rate needs to be over 95% in any given ethnicity to prevent outbreaks. The current global issue of concern around vaccinations is creating a problem with reaching the 95% goal.

Healthcare providers must push the MMR at 12 months rather than 15 months and also encourage entire families to be vaccinated.

A syphilis outbreak is tracking to the 2018 numbers. The National Syphilis plan has been released. The small number of congenital syphilis in Counties Manukau is being managed.

Complex cases of tuberculosis in CM Health are being managed.
Meningococcal meningitis is being managed in Counties Manukau. A rise in numbers has been seen in West Auckland, but not South Auckland.

Drinking water standards – not applicable to marae as they’re not networked. The supply is private. Marae are still supported to develop water safety plans.

Meningococcal meningitis: CPHAC wanted to determine if there was something that could be done to prepare for a rise in numbers. ARPHS advised that this is where the social determinants really come into play. Safe and healthy homes for living in, healthy kai and health education is required to keep numbers at a minimum.

CPHAC thanked ARPHS for their attendance and looks forward to seeing them in early 2020.

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

The Community & Public Health Advisory Committee:

Received this update report from ARPHS.

Carried

4. PRESENTATION

4.1 After Hours Care in CM Health (Kate Downson, Programme Manager, Primary Care, CM Health)

Improved urgent access is about supporting an increasing number of people who (perceive or do) have an urgent but non-life-threatening complaint to get quality care, in an appropriate setting, in a timely manner.

Extended GP hours have been communicated by CM Health’s Facebook page and various other methods.

Eight clinics are funded across CMDHB. This number is up from four. Eight funded 5.00pm to 8.00pm weekdays and 8.00am to 8.00pm weekends/public holidays. Four clinics (one in each locality) are funded from 8.00pm up until 11.00pm. Currently CM Health are expecting 120,000 volumes per year.

In areas where there are fully functioning A&E clinics, the number of people enrolled at that clinic using EC at Middlemore are much lower.

To be an Urgent Care clinic, the facility must be accredited and they need to have x-ray onsite or within 200 metres.

This winter has also seen high numbers of gastro.

A Right Care for You promotion has gone out via Healthline, Health Navigator and Health Point.

CPHAC suggested it would be great if GP clinics could post alternative places for care on the doors of their medical facilities when closed.

Ms Dowson talked about the Dashboard. Data sets are able to be matched which gives funders/planners a much clearer and more accurate picture of what is happening in the community.
Improvement Priorities include utilising Clinical Pathways throughout the system for consistent care; accurately referring patients from the community to hospital; accurately discharging patients from the hospital back to the community; increasing use of Primary Options for Acute Care (or rapid response) in both the community and hospital; and creating a feedback loop in a timely manner for those who are seen in the hospital after the community with a high morbidity disease.

*Emergency Q Application Pilot*
This digital info tool has been piloted in ED. Targeted at triage 4 & 5 patients that could have been seen in Primary Care. The app provides wait times in ED as opposed to Primary Care venues. A voucher is given so the patient can attend the Primary Care venue for free. Screens in ED have shown to reduce verbal abuse of staff.

The app feeds into the general database and allows those monitoring it to have a comprehensive view of patients, those taking vouchers and where they then go to.

Ms Powell advised the committee that Pacific Health has run a survey which is currently being analysed. Preliminary information shows several themes have emerged for Pacific: patient was told to come by GP, tried to see GP but no appointment, free (affordability), hours of care, transport available to family during GP hours is limited.

5. **BRIEFING PAPERS**

5.1 **Quarter 3 2018/19 Non-financial Summary Report** (Kitty Neill, Planning Advisor)

The paper was taken as read.

In regard to reporting against our mandatory Ministry targets, the Maternity smoking target has been exceeded for the full financial year.

Colonoscopy targets in the hospital have provided a challenge this quarter. Discharge targets were not met and this was largely due to the medical officer strike.

Oral Health – did not meet the target for any of the three children targets. The dental service for the region is provided by ARDS. It is noted that Counties Manukau youth have worse teeth than those in other areas.

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

The Community & Public Health Advisory Committee:

Received this Quarter 3 2018/19 Non-Financial Summary Report.

Noted and reviewed the results for Quarter 3 progress against draft planned 2018/19 actions and performance expectations, including key challenges and resolution plans for those measures where performance was low.

Noted the appended Northern Region Health Plan Quarter 3 2018/19 summary report provided by the Northern Regional Alliance (Appendix 2).

Carried
5.2 Youth Health (Julia Burgess-Shaw, Service Development Manager Youth Health)

The paper was taken as read.

Ms Burgess-Shaw highlighted the range of services provided to the schools involved. Currently the team is working on growing High School based services. Currently there is a focus on support of school nurses, ensuring they’re working to their fullest scope.

**Action**
CPHAC would like to have a list of schools that CM Health support.

Ministry is funding select decile5 schools. As CM Health currently fund Rosehill College, if CM Health are to receive more Ministry funding it will be passed on to some Decile 6 & 7 schools.

**Action**
CPHAC enquired about the spread of students accessing mental health services across our schools. Sexual and Mental health are the biggest areas of access for students. Information will be provided for a future CPHAC.

Unmet need in the 7 to 10 decile areas shows young people generally have the same health needs; mental health, sexual health, contraception. Physical health is probably more predominant in South Auckland.

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

The Community & Public Health Advisory Committee:

**Received** this report.

**Carried**

6. HEALTHCARE EVIDENCE UPDATE

6.1 Stroke Prevention, Pathophysiology and the Hyperacute Stroke Pathway (Dr Geoff Green, Consultant)

Dr Green advised that stroke is damage to the brain of a vascular cause (blockage or bleed) and 80% are preventable. The biggest risk factor is hypertension (genes, obesity, smoking, alcohol). The second big group (common in our population) is irregular heartbeat (atrial fibrillation). There is a need for these people to be identified.

There are good thrombolysis rates at CM Health. We are at 12% and the target is 10%.

In the acute treatment of stroke, there is an exciting form of treatment called clot retrieval. This treatment is centralised at ADHB, there is a total of 5 professionals that can provide this treatment and it costs approx. $30k per patient.

Stroke is the most common cause of disability in NZ with the estimated cost across the nation sitting at $450M.

Diabetes causes blood vessel disease and angina and this results in an increase for the risk of a stroke.
The early support discharge team need an increase in capacity in order for early entry into rehabilitation. The MDT was centralised. Patients can be seen on the Ward and transitioned to Community Rehab. Evidence is strong for a dedicated stroke rehab team.

6.2 Evidence based treatments for Obesity (Dr Gary Jackson, Director, Population Health Directorate)

<table>
<thead>
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<th>WEIGHT STATUS</th>
<th>BODY MASS INDEX (BMI), kg/m²</th>
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<tbody>
<tr>
<td>Underweight</td>
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<tr>
<td>Normal range</td>
<td>18.5 – 24.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0 – 29.9</td>
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<tr>
<td>Obese</td>
<td>≥ 30</td>
</tr>
<tr>
<td>Obese class I</td>
<td>30.0 – 34.9</td>
</tr>
<tr>
<td>Obese class II</td>
<td>35.0 – 39.9</td>
</tr>
<tr>
<td>Obese class III</td>
<td>≥ 40</td>
</tr>
</tbody>
</table>

BMI stands for body mass index and is a way for us to measure body size.

The classification system for obesity is used in a bid to move away from terms such as morbid obesity which were felt to be stigmatising.

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<th>1.68</th>
<th>1.83</th>
</tr>
</thead>
<tbody>
<tr>
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<td>5ft 6'</td>
<td>6ft</td>
</tr>
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<td>20</td>
<td>46</td>
<td>56</td>
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<td>127</td>
<td>155</td>
<td>184</td>
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</table>

CM Health has more obese people than any other DHB in the country.

In the 1970s people ate approximately 25 kilos of butter per year in NZ. Over the years this has reduced to four kilos per year and CVD has reduced by 90%. NZ is still the highest consumer of butter in the world.
Approximately 150 bariatric surgeries are performed in Counties Manukau per year. Around 40,000 people could benefit from the surgery.

There is also a dilemma for disabled patients that for various reasons are unable to lose the weight.

Good evidence has been seen in other countries that implement a sugar tax. NZ has had a huge pushback on this from sugar lobbyists.

Alcohol is another detrimental factor as it contains empty carbs, is hugely high sugar, and increases the potential to eat more when too much alcohol has been consumed.

Malnutrition is a concern in Counties Manukau and breakfast clubs at schools are one of the initiatives set up to help combat this.

CPHAC asked how much is genetics an issue? Dr Jackson advised that the genetics are set when in uterine. So if the mother is overweight whilst pregnant, this has life-long ramifications for the baby.

Dr Jackson advised that current evidence suggests putting patients on a comprehensive lifestyle intervention made up of these three components; dietary therapy, behavioural modification therapy and exercise.

7. INFORMATION PAPER

7.1 Ministry of Health’s Well Child Tamariki Ora Review

For noting only.

8. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Lyn Murphy/Seconded: Reece Autagavaia)

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

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

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<td>Commercial Activities The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]</td>
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Carried

This first part of the meeting concluded at 11.30am.

Colleen Brown
Committee Chair
Recommendation

It is recommended that the Board:

Receive the Chief Executive’s Report for the period 27th June – 7 August 2019.

Prepared and submitted by: Margie Apa, Chief Executive Officer

Introduction
This report covers the period from 27th June – 7 August 2019.

News and Events

Minister announces approval for $14m investment

The Minister of Health, Hon David Clark, visited Middlemore Hospital to announce the Government’s approval for Counties Manukau Health to invest $14.6 million for two new facilities to provide additional High Dependency Dialysis facilities and a second Cardiac Catheter Laboratory (Cath Lab) at the hospital.

CM Health currently only has one Cath Lab procedure room on-site and we have seen the challenges facing our cardiology and high dependency dialysis services, with over 1500 patients treated in the Cath Lab in the last 12 months. The Cath Lab saves lives and we know that by treating patients early we improve quality of life and reduce the need for further care in the future, so the approval to invest is great news.

The Scott Dialysis Unit is one of the six units at CM Health where either haemodialysis or training for home dialysis takes place. CM Health has the highest number of people on dialysis in the country and this unfortunately continues to grow. Scott Dialysis provides in-centre haemodialysis for acute, complex and high acuity people. Last year, we provided treatment for up to 92 patients per week in a unit that was originally built for a capacity of 80 patients. It speaks to the commitment of our staff who have done so much to make things work, including having the unit running 3 or 4 shifts a day, including now an overnight shift, seven days a week to meet patient needs.

Approval to make this investment means we can plan with confidence to increase capacity, capability and flexibility to meet the ongoing demand for these services and will make a difference for both patients and staff.

Pictured above: Minister of Health David Clark making the announcement
Vaccination training team in Samoa

A contingent of Counties Manukau nurses and support team went to Samoa on a 10-day capacity building mission to provide vaccination training and clinical support for nurses in Samoa.

The initiative is part of the Samoa Health Partnership Programme (SHPP). The programme is country-driven which means that Samoa identifies and determines the support required for the use of allocated funding provided through the NZ Ministry of Foreign Affairs and Trade (MFAT). The Samoa Health Partnership Programme is just one programme managed within the Pacific region by the Pacific Health Development team. The New Zealand Medical Treatment Scheme (NZMTS) scheme is also funded by MFAT and managed by the Pacific Health Development team. In this instance, the contingent was made up of Counties Manukau Health nurses, as well as nurses from Southseas, Auckland City Hospital and private practices who are all fluent in Samoan.

They were based in eight district hospitals on the main islands of Upolu and Savai'i, working alongside nurses in their hospitals, providing on-the-job mentoring and coaching in the areas of vaccination and immunisation.

The programme involves three key components including the Overseas Referral Scheme (ORS) which provides patients with specialist medical treatment not available in their country, Visiting Health Specialists (VHS) who provide medical treatment in the country and Strengthening In-Country Capacity (SCC) providing tailored support to strengthen priority health identified by the country.
Coffee with a Cop

Following the success of the recent staff security forum, Police from the Otahuhu station joined us in Paataka Place for ‘Coffee with a Cop’. The session was held from 10am – 2pm on the 28 June. This was hugely successful with six police staff taking part.

Feedback from both Police and staff was that the sessions were very useful and they enjoyed the opportunity to interact on a social level. Police have indicated that they would like the sessions to become a regular feature, and we are planning another event in August. We are also looking at opportunities of take ‘Coffee with a Cop’ to other locations including MSC and Pukekohe Hospital.

Research Week

Research Week was held on the 1 – 5 July 2019. This was a celebration of health research taking place at Counties Manukau Health, in the hospital as well as in the community.

Now in its fourth year, the event showcased six external speakers, seven research workshops, 37 research presentations, and 17 research posters, with other posters from the Nurse Symposium and Summer Studentships also on display. At the prize giving ceremony, eleven prizes valued at $1,000 for conference expenses were awarded.
Pictured above: Staff enjoy one of the many presentations and lectures given as part of Research Week

Pictured above: Dr Gloria Johnson, Chief Medical Officer, with some winners

**Patient Feedback**

Every month, Feedback Central receives verbal and written feedback from throughout the organisation. The Feedback Central team works hard to co-ordinate fair, simple, speedy, and efficient patient and whaanau centred resolution of all feedback – both good and bad – working in partnership with services across Counties Manukau Health. I want to share with you some messages received from patients these past two months.

"Staff are very caring, kind and professional. They kept me fully informed of all that was going on for me. They were very kind to my visitors. Anything I was unsure of was responded to with utmost professionalism."

"Everyone has been very accommodating. Friendly staff!!"

"Thank you to all the staff on Ward 7 for the wonderful care you have given me while being a patient here. I’ve enjoyed every moment working with you for the betterment of my health. Thank you all - heaps of aroha."

"I am pleased with my operation at the Gynae department, Manukau SuperClinic. True appreciation for all the doctors and everybody involved. Everything was explained so clearly, in detail putting my mind to rest that I’m in good hands. Nurses were very good, helpful, and kind when called. The cleaners were also kind and friendly. All I felt was love, peace, kindness, gentleness and patience... The name SuperClinic says it all."

Counties Manukau District Health Board

7 August 2019
"I am grateful for all staff assistance at Manukau SuperClinic (first floor) when my situation became difficult. I was impressed with the calmness, compassion, commitment and reassurance of the staff, as well as their amazing patience and respect. At all times staff were kind. Thank you for all your support!"

"From the bottom of my heart I’d really like to thank God for bringing these nurses to the hospital who are powerful, warm, loving and who care for anyone who comes through the hospital. I’ve got nothing to say other than I pray you are blessed."

"I attended surgery at the SuperClinic and feel like I was in a world class facility. The level of service from ALL your staff was excellent to say the least. All the staff were kind, polite, professional and calm and, made me feel completely at ease. Keep it up team – you’re doing an outstanding job!"

"The staff were so amazing to my mum during our visit. They explained things so well and clearly and were so gentle with her, we felt well taken care of. Keep up the good work!"

"I was very happy with the service provided and would like to thank the cleaning staff, the nurses and the doctors. I had an awesome stay – thank you to everybody involved for their work."

"I would like to say thanks to all staff. As a resident of Manukau I am proud of this global, reputable levelled hospital. Excellently done! The meal service also was excellent - thank you team."

"It has been a pleasure being here. Thank you to all the doctors and nurses for their care. To the doctors that helped prepare me for surgery - a big thank you! As for the doctor who performed the operation, what a wonderful job he has done. I would recommend anyone to come here as a patient or visitor."

**Deep Dive 1 - Impact of Body Size on Service Delivery**

CM Health has the largest number of those morbidly obese (body mass index >= 40) of all District Health Boards in New Zealand at estimated 36,000 adults. This is about 8,000 higher than expected for our population age, socioeconomic deprivation, and ethnicity. This number is nearly twice as many such people as the next highest District Health Board. Some of the downstream consequences of our population body size are that service delivery takes longer, is more complex, and is prone of complications. For this report, I have asked Dr Sarah Tout, Dr Katherine Sowden and Dr Carl Eagleton to comment on the impact of obesity in Women’s Health.

**Obesity and Women’s Health**

Counties Manukau Health (CM Health) Women’s Health provides a service to all women across the continuum of their lives; this is what makes the service both unique and essential.

The services are provided through Birthing & Assessment, the three Primary Birthing Units, Maternity Wards, and the maternity assessment clinic (MAC), Neonatal intensive care unit (NICU), Antenatal, Colposcopy and Gynaecology clinics, theatre and Maternal Mental Health. We also assist patients with contraception, breast feeding and health literacy especially around birthing. We care holistically for women.

We are a busy and thriving team made up of multiple disciplines and staff of many ethnic and cultural backgrounds. There are team members from the several fields including midwifery, nursing, medicine, occupational therapy, physiotherapy, social work, needs assessment and dieticians as well as enabling support such as human resources, administration and finance.
Body Mass Index

BMI stands for body mass index and is a way for us to measure overweightness. BMI of 20-25 is considered normal range, with a BMI of over 25 being overweight and a BMI over 30 being obese. Obesity is further broken down:

- Class I 30.00 - 34.99
- Class II 35.00 - 39.99
- Class III ≥40.00

This terminology is used in a bid to move away from terms such as morbid obesity which were felt to be stigmatising.

CM Health has the highest rate of obesity of any District Health Board (DHB) in NZ, and this rate is unfortunately rising. In 2008, 54% of the birthing population at CM Health were overweight and by 2018 this had risen to 67%.

Obesity and Maternity

Being overweight or obese at the start of or during pregnancy is recognised as a risk factor for a number of complications, including gestational diabetes, pre-term and post-term birth, induction of labour, caesarean section, macrosomia, stillbirth, and neonatal and maternal death. In addition, it is increasingly being recognised that maternal obesity also increases the risk of childhood and adult obesity in the foetus.

Macrosomia, or when a newborn is significantly larger than average, is not healthy. We diagnose this when a baby has a birth weight that is greater than 90th percentile for their age. Despite some cultural beliefs that a large baby is healthier, babies with macrosomia are at higher risk for complications and of having metabolic issues later in life.

Pregnancy can be complicated by Gestational diabetes, Type 2 or Type 1 diabetes. Both Type 1 and Type 2 diabetes affect glucose and insulin. The main difference is that in Type 1 Diabetes, the pancreas does not produce enough insulin. In Type 2 diabetes, the body does not respond very well to insulin to control sugar. Later on in the disease process of Type 2 diabetes, the pancreas will also stop producing enough insulin.

Gestational Diabetes Mellitus, or GDM, is when a woman who did not have diabetes before she was pregnant, develops high blood glucose during pregnancy. Women who are overweight or obese are at higher risks of developing GDM.
An analysis of 2,779 pregnancies at CMDHB complicated by Gestational or Type 2 diabetes showed:

<table>
<thead>
<tr>
<th>Type</th>
<th>Average BMI</th>
<th>Family history of Diabetes</th>
<th>C-section</th>
<th>Large for Gestational age</th>
<th>Stillbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDM</td>
<td>31.7</td>
<td>50 %</td>
<td>35.8%</td>
<td>16.9%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td>37.1</td>
<td>78%</td>
<td>54%</td>
<td>30.5%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Women with Type 2 diabetes were significantly older, heavier, and more often of Pacific ethnicity than women with GDM. A flow on effect of diabetes complicating pregnancy is that approximately 15% of neonatal unit admissions at CMDHB are secondary to diabetes either due to prematurity, neonatal hypoglycaemia or birth trauma related to macrosomia.

**Obesity and Gynaecology**

Obesity increases the likelihood of many gynaecological conditions including infertility, miscarriage, heavy menstrual bleeding, endometrial cancer, pelvic floor prolapse and urinary incontinence – which is uncontrolled leakage of urine - as well as cardiovascular disease, type 2 diabetes, obstructive sleep apnoea to name a few. Surgery for women who are obese is more complicated, takes significantly longer followed by more complications after surgery; most commonly wound infection. By way of example, in abdominal surgery wound complication rates have been shown to be in the order of 10 times more likely in women with a BMI over 40 than in normal weight women.

Looking after increasing numbers of obese patients is having a major impact on our ability to provide services to our patients in Women’s Health in a number of different ways, from assessment of patients to definitive care and beyond.

**Impact of obesity in gynaecological and maternity services**

There were 6,556 births at Middlemore hospital in 2017, of which 8.6% have had a diagnosis of diabetes in pregnancy, and 27% are were born by caesarean section. There were 172 abdominal hysterectomies (where the uterus is removed through the abdomen) performed in 2017, with 83% classified as operations performed in women who were overweight or obese.

The most common complication following gynaecological surgery and caesarean section is wound infection. This causes delay in recovery, interferes with breastfeeding and bonding time with the new born, can lead to readmission to hospital and can require further intervention as well as a period of prolonged district nursing care.

**Impact on staff**

Our staff treat women with high BMI with professionalism, skill and positive attitude to work with women to reduce BMI when appropriate. However, working with women with high BMI puts greater pressure on staff. Surgery is more physically challenging and takes longer, even for simple diagnostic procedures. Mobilising patients with high BMI puts staff at risk of lifting-related injuries particularly in theatre and special equipment is required such as theatre beds. In the last 12 months there have been several staff injuries with two resulting in ACC supported back to work programs.

**CM Health**

At Counties Manukau Health, we treat all women with dignity, respect and sensitivity. We are continuously developing several technical and professional interpersonal competencies to best care for women with high BMI. For more information on Women’s Health at CM Health, click here.
**Hospital in the Home**

CM Health has developed Hospital in the Home as an alternative acute care pathway enabling patients to receive appropriate hospital-level care in the comfort of their own home and community. The Community Health Teams currently support patients and their whaanau through a range of transition pathways to ensure patients are safely managing at home with appropriate supports in place. This model of care offers flexibility to patients and facilitates greater opportunity to deliver increased healthcare outside of a hospital setting.

Under the Hospital in the Home approach, all patients remain under the duty of care of a senior medical physician employed by CM Health. Patients are visited daily by a senior nurse who provides clinical assessment and treatment based on an individualised care plan and liaises with the responsible medical team. Additional supports can also be provided from our multidisciplinary teams to ensure all medical and social supports are in place to enable the patient to recover within their home environment.

Hospital in the Home has had 102 admissions, with an average length of stay of 5.6 days (compared with acute length of stay at Middlemore Hospital of 6.5 days). The majority of patients had cardiac conditions as the main reason for their admission.

Hospital in the Home offers patients and their whaanau choice in their location of treatment and facilitates a wider variety of acute care that can be safely provided within their own home or community. I will share more updates from this innovative, patient-centred programme in the upcoming months.

![Hospital in the Home Admissions by Ethnicity](chart1)

![Hospital in the Home Admissions by Age Band](chart2)

Pictured above: Rebekah Irwin, Clinical Nurse Director-Primary & Community Services, alongside other members of the Hospital in the Home team
Our People

Launch of Nurse Prescribers

I was pleased to see the launch of nurse prescribers at CM Health on the 5th July 2019. This is an example of how new models of care can enable better staff satisfaction from working at the top of scope, better patient experience, and efficiencies.

Background

In 2013 Nursing Council of New Zealand consulted the profession on three scopes of nurse prescribing. This was well supported by the profession. Following this Nursing Council New Zealand spoke to nursing leaders across New Zealand on what would Registered Nurse Prescribing in Community Health look like and how it would work in practice. CM Health was one of the organisations consulted with and had suggestions of how this could work in practice. The organisation was able to articulate how governance for the programme would be provided and had resources to host a blended learning programme.

The Pilot Programme

A Memorandum of Understanding (MOU) was signed between the three CEO’ s of Nursing Council New Zealand, Family Planning New Zealand and CM Health. The programme was developed with a blended learning approach with a view to doing it well and sharing with other organisations. The programme was audited and approved by Nursing Council New Zealand prior to the start of the course. The programme was provided to nurses in CM Health region applicants worked in primary care, Mana Kidz, Public Health Nursing and Secondary School nursing roles. Following the course all of the nurse’s portfolios were assessed by a panel that included Chief Medical Advisor Primary and Community, Pharmacist, Nurse Practitioner, PHO nurse leader, Nurse Educator and Deputy Chief Nurse. The panel assessed the portfolios for safety to prescribe. The nurses following this approval applied to Nursing Council New Zealand for registration as a registered nurse prescriber in community health. The nurses then reapply three yearly for re-certification in community prescribing to CM Health.

The 33 nurses who completed the 6 month course have been prescribing from a limited schedule of medicines including over the counter medicines and a range of medicines to treat skin, sore throat and other minor illnesses in a normally well population. Prior to being prescribers nurses were using standing orders to access medicines for people. Of the 599 nurse consultations provided in CM Health region 36% were to Maori and 35% to Pacific peoples. The nurses have provided increased access to medicines and are able to now assess patients, using clinical guidelines such as the Auckland Regional Health Pathways develop a nursing diagnosis and using their prescriptive authority provide the medicine identified.

Patients followed up for the evaluation showed that 80% of the patients remembered the medication they were prescribed and 100% would see a nurse prescriber again. GPs were supportive of the nurses stated they saved time to focus on more complex patients they have also noted the nurses have more confidence. The nurses have found increased job satisfaction and are reenergised to continue to be nurses. They have increased confidence in their decision making and feel a more valued member of the health care team. They are safe prescribers with a low error rate compared to other international studies of primary care prescribing.
Pictures above and below: Nurse prescribers with Karyn Sangster, Deputy Chief Nurse, and Minister Jenny Salesa, MP for Manukau East
Orderly Managers

Our orderlies team were recognised on Paanui for their commitment to living Counties Manukau Health values which are: teamwork, kindness, valuing everyone and, excellent.

StepUp

CM Health offers many training courses for our staff. StepUp is a 40 hour course run over 10 weeks designed for staff with no (or few) qualifications and/or increase confidence and/or to improve English literacy and/or Numeracy. It is funded by TEC (Tertiary Education Commission).

Forty-six staff members graduated from this round of StepUp programme. They came from across the organisation and included cleaners, orderlies, ward clerks, mail room workers, rehab assistants, peer support workers and Health Care Assistants.

The graduation was a proud occasion for many, surrounded by family, friends and colleagues. Jo Friend, Charge Nurse Manager (CNM) who attended the graduation said “it was a true celebration where you could actually feel the joy, happiness and amazing Wairua. The format was awesome with early kai and great videos - as they are powerful and speak a thousand words. It was emotional, fun and there was a lot of aroha in that room.”

Margaret Tuala, another CNM said “there was a spirit of respect and humility for the graduates and the facilitator who brought out the best in them. It was great seeing whaanau coming to celebrate and support the success of their loved ones – it was great to see the smile on their faces. Also an acknowledgement goes to the Kaumatua for the great opening and closing with the karakia.”
Pictured above and below: Graduation ceremony for StepUp students
### Performance Summary – Quarter 4 2018/19 (Preliminary Results)

<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Final results</th>
<th>Achievement Quarter 4 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Departments</td>
<td><strong>95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours</strong></td>
<td><strong>NOT ACHIEVED</strong></td>
</tr>
</tbody>
</table>

Previous results:
- Q4 2017/18: 91% (Māori: 90%, Pacific: 90%)
- Q1 2018/19: 84% (Māori: 84%, Pacific: 83%)
- Q2 2018/19: 87% (Māori: 86%, Pacific: 87%)
- Q3 2018/19: 86% (Māori: 85%, Pacific: 86%)

June 2019 (Q4 result): 80% total population (Māori: 80%, Pacific: 80%) (target 95%)

Performance is down on previous quarters and remains significantly below the 95% target.

Barriers to achievement of the target: Increased volumes, resource constraints, lack of inpatient capacity (hospital occupancy)

A review of Emergency Department resources is underway as part of Winter Plan and following a benchmarking exercise of provider (or clinical staffing) resources. Acute presentations are increasing in volume and complexity. In combination with more patients is the lack of inpatient capacity resulting in overcrowding of the ED.

Activity underway to address these barriers and improve performance:
There are multiple initiatives underway to improve patient flow through ED and the hospital, and work towards achievement of the target:

- **Every Hour Counts**: ‘ED flow’ is one of seven quality improvement programmes included in the Every Hour Counts portfolio. Inpatient capacity is currently one of the barriers to achieving the ED target. Currently medical and surgical wards aim to get 30% of patients to the discharge lounge by 11am although results are variable. A home-based ward model of care in acute medicine began in December 2018 with the aim of improving flow to inpatient wards. Under this model purposefully collocated patients are cared for by a team of doctors, nurses and allied health staff based on the ward, rather than by different teams who move around the hospital with the objective of creating geographical efficiencies and avoiding “safari ward rounds”. Progress on this model, however, has been hampered by high hospital occupancy resulting in constrained ability to relocate patients to create efficiencies.
### Performance measure (previous Health Targets)

<table>
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<tr>
<th>Final results</th>
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<tr>
<td><strong>The Emergency Q pilot:</strong> The Emergency Q pilot began in September 2018. Emergency Q is a digital information system designed to help patients make informed choices about the most appropriate care for their condition. Emergency Q aims to alleviate demand pressure on the ED through encouraging eligible patients to attend alternative urgent care providers. Between September 2018 and March 2019, 1,689 (20%) eligible patients chose to use Emergency Q and attend a local A&amp;M clinic for free. Analysis of the full trial results has not yet been completed but positive effects observed and feedback from patients has been positive. Initial feedback from ED staff is that the pilot has made a big impact to our waiting and triage area for both staff and patients and reduced staff abuse due to wait times. An extension for the pilot to continue for a further six months over the winter period has been approved which will provide us with a full year of data through to September 2019. The effectiveness, including cost effectiveness, of the service is currently being evaluated with a final evaluation, covering a full year of utilisation data, to be completed later this year.</td>
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<tr>
<td><strong>Resourcing:</strong> Recruitment of Care Capacity Demand Management (CCDM) FTE has been approved by the DHB and the Ministry of Health and is currently underway.</td>
</tr>
<tr>
<td><strong>ED Trigger Tool:</strong> A trigger tool has been established and work is currently underway with IT to provide a transparent view of the trigger tool and code response to ED capacity. The trigger tool aims to identify early when ED is not coping and enable an escalation plan to be developed to cope with the demand.</td>
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### Elective Surgery*

**Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region: Counties Manukau Health to deliver 20,930 Elective Surgical Discharges (ESD).**

**Previous Results:**
- Q4 2017/18: 101.5%
- Q1 2018/19: 102.1%
- Q2 2018/19: 100.4%
- Q3 2018/19: 98.1%

**YTD May 2019 result (Q4 not yet available):** As at May, actual delivery was 18,514 elective surgical discharges against planned volumes of 19,047. There was a negative variance of 533 (up from 289 in March 2019) or 97.2% of planned.

**Barriers to achievement of the target:**
- Industrial action by resident medial officer (RMO) staff earlier in the year;

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*Counts Manukau District Health Board  7 August 2019  057*
### Performance measure (previous Health Targets)

<table>
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<tr>
<th>Achievement Quarter 4 2018/19</th>
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- High acute volumes causing cancellation of elective theatre lists;
- Staff shortages (particularly anaesthetists); and
- Increasingly tight private sector capacity making access to additional operating capacity and outsourcing difficult.

### Faster Cancer Treatment

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.

**Previous Results:**
- Q4 2017/18: 93%
- Q1 2018/19: 89%
- Q2 2018/19: 85%
- Q3 2018/19: 76%

**June 2019 (Q4, six-month result): 81% (target 90%)**

CM Health’s performance against the 62-day Faster Cancer Treatment (FCT) target has improved slightly in Q4 with a result of 81% (Q3 result was 76%) against a target of 90%. Overall CM Health performance against the Faster Cancer Treatment (FCT) measure has declined since June 2018 with a steep drop off in January and February 2019. In the past three months since April 2019 there has been improvement with performance of 93%. Between January and June 2019, 152 of the 187 eligible patients received their first cancer treatment within 62 days of being referred with a high suspicion of cancer.

**Barriers to achievement of the target:**
The key reasons for breaching the target can be grouped into three categories:
- patient factors (e.g., patient choosing to reschedule or delay appointments),
- clinical factors (e.g., priority of other health matters over cancer),
- capacity factors (e.g., lack of diagnostic procedural capacity, oncology provider FTE, theatre capacity, regional radiation oncology capacity), and system factors (such as administrative errors)

Capacity constraints are by far the largest cause of breach. Four key tumour streams - gynaecology, lower gastrointestinal (GI), lung and head and neck - have been identified as contributing to more than 50% of the total 62 day patient volumes and 80% of the capacity breaches.

**Specific barriers affecting performance include:**
- **Volumes** - volumes entering the 62 day pathway for gynaecology and head and neck tumour streams have more than doubled compared to same date range in the previous year. For gynaecology, the volumes increases in the past 6 months are due to a change in grading practices to bring CMH in line with the region against the FCT business rules. CM Health is the lowest performing DHB in the region for gynaecology.

- **Increased lower gastrointestinal (GI) volumes and competing demands** – both 62 day and 31 day lower GI patients access the same surgical services and resource. With the National Bowel Screening Pilot now in place at CM Health, 31 day volumes are increasing (bowel screening patients are 31 day patients) which in turn places increased pressure and competing demands on outpatient clinics and theatre lists. These competing demands can lead to prioritisation issues where clinical need can be at odds with achieving the target, in instances where 62 day patients are prioritised ahead of 31 days patients in order to meet the FCT target.

A key focus for the cancer services is to ensure that regardless of how a patient has presented to the cancer pathway, they are prioritised according to need. Performance against the 62 day target may be negatively impacted as a result.

- **Regional Radiation Oncology Capacity Constraint** - Capacity constraints in ADHB radiation oncology continue to create additional delays for patients requiring radiation treatment regardless of when they are referred to this service.

- **Stretched Cancer Nurse Coordinator (CNC) resource** – The CNC role is pivotal in navigating patients from entering cancer pathways until they are either excluded or reach cancer treatment. The CNC is responsible for expediting and escalating appointments to ensure this happens in a timely manner.

**Activity underway to address these barriers and improve performance:**

- **Gynaecology tumour stream** - The FCT team is currently working with regional colleagues to review and compare pathways at other Metro Auckland DHBs to try and understand key differences and potential for improvement to CM Health processes.

- **Regional capacity constraint** - Advice from ADHB on options to turnaround radiation oncology wait times is in progress under the governance of the Regional Cancer Board.

- **Maintaining focus on the 62-day target** - The FCT
<table>
<thead>
<tr>
<th>Performance measure (previous Health Targets)</th>
<th>Final results</th>
<th>Achievement Quarter 4 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>team is working hard with all tumour streams to ensure that the 62-day target is kept front of mind regardless of its relative deprioritisation by the MOH.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diagnostics: Improvements in MRI wait times are expected to flow into FCT.</td>
<td></td>
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</tr>
<tr>
<td><strong>Immunisation</strong></td>
<td><strong>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 Maaori and Pacific population groups).</strong></td>
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<tr>
<td>Previous Results:</td>
<td></td>
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<tr>
<td>Q4 2017/18: 93% (Maaori: 84%, Pacific: 94%, Asian: 98%)</td>
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<tr>
<td>Q1 2018/19: 93% (Maaori: 85%, Pacific: 95%, Asian: 98%)</td>
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<tr>
<td>Q2 2018/19: 93% (Maaori: 83%, Pacific: 94%, Asian: 99%)</td>
<td></td>
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<tr>
<td>Q3 2018/19: 92% (Maaori: 83%, Pacific: 95%, Asian: 98%)</td>
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</tr>
<tr>
<td>June 2019 (Q4 result): 93% total population (Maaori: 84%, Pacific: 95%, Asian: 98%) (target 95%)</td>
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<tr>
<td>The total, Maaori and Pacific coverage at eight months have increased by 1% from last quarter with total and Maaori rates remaining below target, and a long-standing equity gap for Maaori unchanged.</td>
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<tr>
<td>Barriers to achievement of the target:</td>
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<tr>
<td>• Increased deferral of appointments – Over Q4 the Immunisation Outreach team stated that many families had competing social and financial needs or were in shared homes lacking privacy to talk or space to immunise meaning that appointments were deferred.</td>
<td></td>
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</tr>
<tr>
<td>• Homelessness and transiency - Issues of homelessness and transiency continue to be a challenge. For example the Outreach Immunisation Services (OIS) team had difficulty contacting families who were originally living in motels but had then moved on without a known forwarding address (“gone no address”).</td>
<td></td>
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<tr>
<td>Activity underway to address these barriers and improve performance:</td>
<td></td>
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<tr>
<td>• New incentives programme – From 1 May 2019 an incentive program addressing inequity in Maaori childhood immunisation coverage has started. The programme supports engagement with families referred to the Outreach Immunisation team by offering an incentive to engage in an appointment at each overdue immunisation event (6 weeks, 3 months and 5 months). The pilot will run for one year and be evaluated.</td>
<td></td>
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<tr>
<td>• Maaori pepe prioritised - OIS prioritise Maaori</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance measure (previous Health Targets)</td>
<td>Final results</td>
<td>Achievement Quarter 4 2018/19</td>
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<td>---------------------------------------------</td>
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<tr>
<td>pepe for home visits and if not engaging or available in the week a Saturday visit is attempted. The team working with Maaori families will stay engaged with them from start to finish, building relationships and supporting their needs.</td>
<td></td>
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<tr>
<td>• <strong>Saturday clinics</strong> – The Saturday clinic is at a free parking venue (Manukau Super Clinic) and provides families with an alternative for immunisation and B4 School checks. This option is offered to all families.</td>
<td></td>
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</tr>
<tr>
<td><strong>Raising Healthy Kids</strong></td>
<td>95% of obese children identified in the Before School Check (B4SC) Programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions</td>
<td>ACHIEVED</td>
</tr>
<tr>
<td></td>
<td>Previous Results:</td>
<td>Trending: ➔ (minimal/no change)</td>
</tr>
<tr>
<td>Q4 2017/18: 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1 2018/19: 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 2018/19: 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 2018/19: 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2019 (Q4 result): 100% total population (Maaori: 100%, Pacific: 100%) (target 95%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td>90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months</td>
<td>NOT ACHIEVED</td>
</tr>
<tr>
<td></td>
<td>Previous Results:</td>
<td>Trending: ➔ (minimal/no change)</td>
</tr>
<tr>
<td>Q4 2017/18: 92% (Maaori: 91%, Pacific: 92%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1 2018/19: 89% (Maaori: 88%, Pacific: 90%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2 2018/19: 89% (Maaori: 88%, Pacific: 89%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3 2018/19: 89% (Maaori: 88%, Pacific: 89%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2019: 88% total population (Maaori: 88%, Pacific: 87%; Asian: 89%) (target 90%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM Health has missed the 90% target in Q4 with a small drop in performance against previous quarters. To note is that this result has been skewed by the performance of one PHO (Alliance Health Plus) who achieved a Q4 result of 66.5% (down from 73.2% in Q3). All other PHOs have met or exceeded the target for all ethnicity groups for Q4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Barriers to achievement of the target:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The reasons for the decline in performance by Alliance Health Plus are currently being investigated and will be addressed with the PHO. We continue to push the importance of this activity with our PHOs and practices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Activity underway to address these barriers and improve performance:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There are multiple activities underway to support achievement of the target, including the following:

- **Active clinical leadership/clinical champions:** Information from the Target Clinical Champion continues to be disseminated to PHOs including promotion of the workshop giving information on vaping at The Royal New Zealand College of General Practitioners conference as well as additional resources from Health Promotion agency such as the new vaping facts website.

Aided by the contributory measure under the Metro Auckland Regional System Level Measures (SLM) Improvement Plan there continues to be an ongoing focus on improving the number of referrals for cessation support to the CM cessation support provider.

- **Active, dedicated management to support ABC activities in General Practice:** All PHOs have committed staff responsible for ensuring this health target is achieved. Most practices have an identified Smokefree target champion who leads practice activity and ensures the practice is aware of their performance and activities that are needed to either reach the target or maintain the current level of performance. Although for most practices this activity is now part of BAU and sustained throughout the year, these staff are used to sustain momentum towards the end of each quarter and year.

**Maternity**

**90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking**

Previous Results:
- Q4 2017/18: 92% (Maori: 94%, Pacific: not reported)
- Q1 2018/19: 92% (Maori: 93%, Pacific: not reported)
- Q2 2018/19: 96% (Maori: 98%, Pacific: not reported)
- Q3 2018/19: 94% (Maori: 99%, Pacific: not reported)

June 2019 (Q4 result): 98% total population (Maori: 98%, Pacific: not reported)

**ACHIEVED**

**Trending:** ➔ (minimal/no change)
OBESITY IN ORTHOPAEDICS at CM Health

The CM Health Orthopaedic service delivers care to **8,000 inpatients** per annum of which **60% are acute and 40% planned surgical care** with **28,000 outpatient attendances** per annum of those

<table>
<thead>
<tr>
<th>BMI CATEGORY CODE</th>
<th>BMI CATEGORY DESCRIPTION</th>
<th>TOTAL</th>
<th>% OF TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 18.5</td>
<td>Underweight</td>
<td>20</td>
<td>1%</td>
</tr>
<tr>
<td>18.5-24.9</td>
<td>Healthy weight</td>
<td>442</td>
<td>21%</td>
</tr>
<tr>
<td>25-29.9</td>
<td>Overweight</td>
<td>620</td>
<td>30%</td>
</tr>
<tr>
<td>30-34.9</td>
<td>Obese (class I)</td>
<td>480</td>
<td>23%</td>
</tr>
<tr>
<td>35.0-39.9</td>
<td>Obese (class II)</td>
<td>264</td>
<td>13%</td>
</tr>
<tr>
<td>More Than 40</td>
<td>Obese (class III): extreme obesity</td>
<td>274</td>
<td>13%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>2100</td>
<td></td>
</tr>
</tbody>
</table>

Ownership impacts on both adults wellbeing and lifestyle and children can have **life long disabilities**

Research shows infection rates for hip joint replacements are **5 times higher** with need for revision surgery, prolonged IV antibiotics and impact on life and employment

**Increased LOS** thoracic spine 11 day average to 248

**Increased length of stay**

Unable to weight bear, wheelchair needs, home modifications, discharge delays
Lower back pain
Spinal injury care is difficult to manage
Pressure injuries occur when immobile
Difficulty examining axial problems in the spine and pelvis

Hip pain, wear, Osteoarthritis
Paediatric hip dislocations and overloaded growth plates give way

Knee pain, wear and tear, Osteoarthritis, joint, ligament, tendon injuries.

Increase of normal 50 kg weight through one foot to 200 kg when walking.
Loss of sensation
Complications of diabetes - skin breakdown.
Ankle pain and injuries

Falls risk with inability to self correct when falling
Reduced mobility with increased aids required
High risk of Deep Vein Thrombosis
Difficulties with discharge planning post surgery

Adult - Girth measurement

1m

Reduced mobility with increased aids required
High risk of Deep Vein Thrombosis
Difficulties with discharge planning post surgery

Increased mobility when walking.
High risk of Deep Vein Thrombosis
Difficulties with discharge planning post surgery

Lower back pain
Spinal injury care is difficult to manage
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Hip pain, wear, Osteoarthritis
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Increase of normal 50 kg weight through one foot to 200 kg when walking.
Loss of sensation
Complications of diabetes - skin breakdown.
Ankle pain and injuries

Adult - Girth measurement

1m
Paediatric Obesity

**Theatre Issues**
- Imaging reduction
- Difficulty ventilating supine
- Risks to holding in lateral position
- Instrument length
- Implant choice and durability
- Weight limits of tables now 300 kg
- 2 operating tables tied together
- Increased theatre time

**Ward issues**
- Pressure injuries with high cost
- Wound care and multiple surgical interventions
- Staff Injuries
- Increased and changed staffing model
CM Health residents have much lower rates of orthopaedics inpatient use and first specialist assessments (FSAs) than the national average. CM Health residents' rates are similar to Auckland DHBs residents, despite large differences in obesity rates and deprivation (and thence private medical insurance coverage).

Adjusting for diabetes rates and age, CM Health residents have 19% less orthopaedics inpatient use and 33% less outpatient visits than the national average. [Diabetes used as a proxy for obesity to risk-adjust. No deprivation adjustment, so differences are conservative]
Information Paper
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 31 May – 30 June 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 31 May – 30 June 2019.

External Communications

Proactive Media

A number of positive stories were promoted through the CM Health website including a media release on mental health and addiction support in schools, how the bowel screening programme saved a local man’s life (resulted in media coverage on Stuff and Pacific media), the reflections of a former burns nurse who had been in the job for more than 30 years and a Counties Manukau-led vaccination training team to Samoa (which resulted in multiple media requests from national and international media).

Influenza and Measles

Communications facilitated a number of queries in relation to influenza and measles, working with the Auckland Regional Public Health Service as appropriate.

Vaccination Training Team in Samoa

A number of media queries were facilitated in relation to CM-led mission to Samoa to provide vaccination training. GM Pacific Health was interviewed by Radio NZ, Radio Australia and Stuff.

Facilities

Communications facilitated a number of requests from Radio New Zealand in relation to the Scott building, window air leakage and weathertightness issues.

Proactive Releases and Website Stories

- CM Health providing mental health and addiction support in schools and primary care
- Better wound care for CM Health patients
- CM leads Vaccination Training Team to Samoa
- Former burns nurse reflects on more than 33 years on the job
- Manurewa local owes life to bowel screening test
- Low cost dental care soon available to CM residents
**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.

There have been a number of requests related to the current Measles outbreak, and to Cancer Services capacity, performance and wait times. While the media remains the largest group of requestors, we are beginning to see increased requests from political and lobby groups, as well as some NGO/ voluntary agencies.

The routine six-monthly compliance data has been submitted to the State Services Commission (SSC). Based on SSC methods, for the 6 month period there were 93 new requests logged compared to 112 in Jun-Dec 2018, with 84 responses completed in the 6 months; (including 8 that were received in Dec 2018/ completed in Jan 2019). This is an average of 15 per month. There were 2 overdue responses, resulting in a 98% result for SSC reporting, with no complaints to the Ombudsman. Full results for all State Sector agencies performance on Official Information Act requirements will be published by the SCC in August.

Where possible, following advice from the Ombudsman, with large volume requests we are moving to notifying a decision on release before the 20-days due date, and indicating that material will follow where a delay is likely due to collation/ preparation of material. We’ve also moved to providing greater context/ explanations on initial responses, with the hope this will reduce dissatisfaction with responses.

CM Health, like most DHBs, proactively publishes OIA responses after release on our website, as data-objects. This enables all our published responses to be searched/ filtered. A recent analysis of our proactive publication of previous OIA responses shows that of the 84 completed responses from January to June 2019, we will publish 74 on the DHB website. Since January 2019, our publicly released OIAs have been accessed via our website over 1000 times. The most searched for category is Mental Health, followed by Harm to Staff. The top five most viewed responses have been:

- **Wait times**
- **Wait times in ED**
- **Recruitment / staffing**
- **Gender affirming health services**
- **RMO recruitment**

More information on the OIA process and a form to submit requests is available:


Copies of recent OIA releases on common topics are also now on the website.

Routine Sector Communications

Connect+

Work is underway to develop the spring edition of Connect+. This edition is due to be published in the first week of September, which will include features on our Security Team and what CM Health has been doing to improve the safety of our staff. It will also cover changes to the leadership team, Minister’s visit and values and equity.

Internal Communications

Scott Reclad

Work is progressing on the Scott reclad project. Internal communications continues to work closely with the Facilities and Engineering team to develop timely communications that impact staff, patients and visitors.

Facilities Induction Video

Work is underway to develop an induction video for new contractors that will help support the GM Facilities, Engineering and Asset Management. We are working with our Channels colleagues to script and produce a highly effective product.

Brand Guidelines

The Brand Guidelines and Style Guide have now been completed. Communicating these new, easy to use guides will be undertaken in the next reporting period.
CEOs Awards (Local Heroes)

Work is now underway with the HR team on the implementation of the CEO awards. It is expected these will be held bi-monthly, starting around September 2019. The purpose of these awards is to recognise staff who have gone above and beyond for patients, their families or colleagues.

Security Campaign

Internal communications continues to participate in all security meetings, and have issued two updates to staff on new security fencing and plans for the installation of electric gates at Middlemore Train Station.

Coffee with a Cop

Coffee with a Cop is a Community Police initiative to connect with communities and strengthen relationships. Two videos were produced to support this initiative which was held in Paataka Place on 28 June 2019. This was successful and extremely popular with both CM Police and staff. Future visits are being planned for the Manukau SuperClinic, Pukekohe Hospital and Spinal Unit.

Flu Campaign

We continue to promote the importance of vaccination and scripted and produced a video of David Holland, Infectious Diseases Consultant, urging people to get vaccinated.

Matariki

Internal communications worked in collaboration with the stakeholder and engagement team to promote Matariki through the Daily Dose and poster production.

Patient Experience

Internal communications have been working with the patient experience team to develop a communications plan to support their proposed calendar of events (June - Dec). Work on the Quality Accounts is underway and to date the Chair and Chief Executive Foreword has been written and approved.

National Volunteer Week

This year’s theme was “Whiria te tangata – weaving the people together.” The week was promoted through Daily Dose and two volunteer stories were shared; the selfless fruit donation volunteer and a story about Middlemore Foundation volunteer Ben – a volunteer who loves serving his community. National Volunteer Week is about thanking the volunteers who volunteer their time to help us provide a great service to our patients and their whaanau.

Staff Forum Middlemore Hospital 19 June 2019

In this forum the CEO and Chief Information Security Officer from healthAlliance presented about the importance of keeping safe online and how best to do so. Representatives from the Social Wellbeing Board, Ann Sears and Ann Willkie, spoke about their roles. Dr Gary Jackson also took to the podium to communicate about the current Measles outbreak.
Team Counties Blogs

During June, the following Team Counties blogs were published:
- MRI reduces waiting list from 2169 patients to 878 in three months
- A local, patient-centred approach to an international issue

Care Capacity Demand Management (CCDM) and Trendcare

The communication plan was approved at the June CCDM Council meeting. A clear and simple eNewsletter template was developed, which was well received. Regular updates have appeared in the Daily Dose.

The Design Team

For the month of June, designs were created and approved for National Volunteer Week, Coffee with a Cop, Measles Outbreak and others as below:

Stakeholders & Communities

Measles Outbreak

The following information has been shared with the following teams/organisations to distribute to their networks/patients:

<table>
<thead>
<tr>
<th>ARPHS</th>
<th>Local Community Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>PHOs</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Internal Staff (Daily Dose &amp; Paanui)</td>
</tr>
<tr>
<td>Maaori Team</td>
<td>Immunisation Team (Child Youth and Maternity)</td>
</tr>
<tr>
<td>Pacific Team</td>
<td>Primary Care Team</td>
</tr>
<tr>
<td>District Health Nurses</td>
<td>Middlemore Central Team</td>
</tr>
<tr>
<td>Infection Control Team</td>
<td></td>
</tr>
</tbody>
</table>

Media

- **11 June**: Dr David Holland on RNZ organised by our external communications team.
- **12 June**: Public health Nurse Elizabeth Tiumalu on PMN 531
- **13 June**: Dr Christopher Hopkins on Radio Tarana (Copy of audio available on request)
Videos

Regional Pacific Nurse Case Manager Arieta Fa’apesolo Mu’aulama and Fanau Ola Senior Social Worker Sitela Vimahi, videos in English, Tongan and Samoan. These videos were used on www.stuff.co.nz to accompany a stuff story on immunisation.

Social Media

We have three social media tiles and three videos (above) that we have been utilising on our social media channels to promote immunisation, as well tips for whaanau on what to do. We’ve also been sharing content from Auckland, Waitemata DHBs and ARPHS.

Winter/Flu Campaign

We continue to promote ‘the right care for you’ campaign at community networking groups, and promoting the flu vaccine. Local nurse Liz Tiumalu was on PMN 531 to promote the flu immunisation with a focus on children in early June and Dr Shankar Sankaran promoted flu immunisation with a focus on elderly in late June.

Every Hour Counts

We continue our support for the Every Hour Counts programme with a new screensaver encouraging staff to make ‘Every Hour Count’ and also by featuring Team Counties Blog success stories such as: A local, patient centred approach to an international issue and MRI reduces waiting list from 2,129 patients to 878 in three months, in the Team Counties Blog.

Pacific Peoples Fono

Members of the team attended the Ministry for Pacific Peoples Fono for Pacific service providers in Counties Manukau to identify priority areas for our community, now and into the future. The top five areas of concern in order of priority were: an adequate standard of living; equal inclusion and participation in society; adequate housing; freedom from violence; and physical and mental health.

The Asian Regional Network Inc (TANI)

Members of the team attended this network meeting to hear a presentation by Dr. Jed Montayre, Senior Lecturer Nursing at AUT on the Korean community in Auckland which is now the third largest Asian ethnicity in Auckland.

Asian Health

The team arranged for Asian Health Gain Advisor Kitty Ko, in partnership with TANI, to present the free information session ‘Understanding the NZ Health System’ at the Citizens Advice Bureau (CAB) Pakuranga-Eastern Manukau. More than 20 people attended; information was provided in English, Mandarin and Cantonese, with a Q&A at the end. Resources were provided to CAB to share with their clients.

Papakura Community Network

We attended the Papakura Community Network meeting, hosted by Skills Update in Takanini, where the team talked about the Flu vaccination campaign and the Papakura Birthing Unit as an option for women in the area to have their babies. We utilised the Manukau Network Meeting to help socialise our projects (particularly Winter/flu comms), as well as making network connections. We attended the Papatoetoe Community Network meeting in the Sikh temple, which was a valuable opportunity to liaise and understand the needs of this community.
**Drive Consumer Hui**

Other engagement work included participating in the Drive Consumer Hui about the latest updates and challenges for our population on the topic of mental health, and the Counties Manukau Kindergarten Association Open Day.

**Faletoa**

The team supported Mental Health and Addictions in the launch of Faletoa, a new service which ensures appropriate support for our Pacific service users and their whaanau, with internal and stakeholder communications about the service including social media content.

**Matariki**

Comms managed the Matariki decoration competition which received 14 entries from across our services including Pukekohe hospital, our three birthing units, Manukau SuperClinic and Surgery Centre, Tiaho Mai and our community based mental health services as well as our MMH Wards. Comms also managed the Matariki Quiz which received 269 entries.

**Diabetes Retinal Screening**

The Primary Care team is working on increasing our retinal screening rates from 60% to 90% for eligible people with diabetes, particularly for those who ‘did not attend’ or we have not been able to contact. We are supporting the team with redeveloping some of the service’s patient letters and collateral.

**Franklin Family Support Trust Volunteer Transport Programme**

The team supported the Falls Prevention team’s communications around discontinuing this programme in the Pukekohe area by providing letters for local practices and patients, information sheet and script for Franklin Family Support Trust when talking with affected patients of the service.

**Community Birthing Units Campaign**

We are finalising the communications plan around promoting our community birthing units and developing the following resources: three social media tiles, poster, interactive board (completed-used for the Matariki activities), Paanui banner, Facebook banner, pregnancy antenatal wananga promo video, and Botany Downs Birthing Unit video. As well as the Papakura Birthing Unit video, this will all go live at the end of July. We are finalising budget for radio and print adverts and organising the Pukekohe Birthing Unit video.

**SUDI Prevention Campaign – SUDI calculator soft launch for phase 1**

We are supporting our internal communications team and the SUDI team on socialising the new SUDI calculator within the Women’s Health team. Currently we are in the process of finalising the strategy and communications plan for phase 1 of the roll-out.

**Preterm Birth Resources – Regional Initiative**

We are supporting Women’s Health on this regional initiative with Auckland, Northland, and Waitemata DHBs. A pamphlet has been created and is in the processes of getting the content signed-off. We will then work with our internal communications team in the design of the pamphlet.
Long Acting Reversible Contraception (LARC)

With CM Health receiving additional funding to provide LARCs to our community, the project team has identified a need to build greater understanding of LARCs, the benefits and how to access them. The comms team is supporting the project team with a comms strategy to support this need.

Mailhouse Project

We are supporting the Ko Awatea Mailhouse Project team to inform staff and patients about the changes proposed for collecting email addresses to send patient information and letters electronically. Two posters promoted the new service via our internal channels and we created a webpage with FAQ. This project is in partnership with Auckland and Waitemata DHBs and we have shared the developed resources with them.

Helpline Poster

We are currently in the process of helping the Manukau Locality team put together a helpline poster for the Welcome Room at the Awhinatia site. Some of the organisations included will be Alcohol and Drug Helpline Healthline, Quit Line, Suicide crisis, Mental Health, Gambling, Anxiety helpline, and many others.

Published Proactive Stories

- **Integrated Locality Care**: how four integrated locality care (ILoC) teams are supporting primary care professionals to respond more effectively to mental health and addiction needs of clients.
- **New Dental Facility**: The new University of Otago Dental clinic is on target to be completed before the start of the academic year in 2020 and will provide low-cost dental care to our residents.
- **Bowel Screening Programme**: Local Manurewa man Sila Wilson helped promote the programme in the community, particularly our Pacific whaanau. The story was picked up by Stuff and had interest from local Pacific radio.

Proactive Story in the Works

- **My Kitchen Rules**: We are currently preparing a story on Te Rito Ora’s My Kitchen Rules programme – helping whaanau with young tamariki learn how to cook healthy kai on a budget. We’re confirming a time to interview a local mother who’s done the programme. This story will be used across all our channels and potentially pitched to local media.

Video Production’s

- **Men’s Health Week**: A video with Dr David Schaaf on the importance of tane to look after their health was published across our social media channels.
- **Botany Downs Birthing Unit**: We filmed the promotional video with a local mother who birthed at the unit, which also includes the Charge Midwife, and other staff at the unit. We are looking to launch the video during the Community Birthing Units promotion at the end of July.
- **Pregnancy Antenatal Wananga Promotion**: A short video of the facilitators of the wananga to promote on our social media channels on upcoming sessions. Turuki Healthcare, (the providers of these sessions). Wananga have already shared the video on their Facebook page.
Digital Channels

Website ([www.countiesmanukau.health.nz](http://www.countiesmanukau.health.nz))

After an increased period of traffic in May, we see a return to normal numbers.

**Audience Growth Metrics**

![Figure 1 Web Site Data Metrics from Google Analytics](image)

**Social Media**

June was a good month for our social channels, with all channels growing in size across the board. With fewer posts than the last period we do see a small drop in impressions, but per-post numbers don’t change too much. It was particularly pleasing to see that our Instagram audience has grown by 6.6%.

<table>
<thead>
<tr>
<th>Social Media</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>16,817</td>
<td>+0.44%</td>
<td>46</td>
<td>131,578</td>
<td>2,860</td>
<td>13,713</td>
<td>298</td>
<td>9,799</td>
</tr>
<tr>
<td>CM Health Twitter</td>
<td>2,702</td>
<td>+0.56%</td>
<td>14</td>
<td>12,726</td>
<td>909</td>
<td>63</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>CM Health LinkedIn</td>
<td>7,187</td>
<td>+2.66%</td>
<td>12</td>
<td>20,420</td>
<td>1,701</td>
<td>1,503</td>
<td>125</td>
<td>1,214</td>
</tr>
<tr>
<td>CM Health Instagram</td>
<td>546</td>
<td>+6.6%</td>
<td>15</td>
<td>6,772</td>
<td>451</td>
<td>308</td>
<td>20</td>
<td>83</td>
</tr>
</tbody>
</table>

**Totals**

<table>
<thead>
<tr>
<th>Change (vs. last growth)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Facebook Fans</td>
<td>-38.34%</td>
</tr>
<tr>
<td>New Twitter Followers</td>
<td>-11.76%</td>
</tr>
<tr>
<td>New LinkedIn Followers</td>
<td>+80.52%</td>
</tr>
<tr>
<td>New Instagram Fans</td>
<td>--</td>
</tr>
<tr>
<td>Total Fans Gained</td>
<td>+28.75%</td>
</tr>
</tbody>
</table>

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**CM Health Facebook**
This was another solid period for Facebook following our merge. We see some good engagement rates on posts. It’s also good to see a blend of staff/recruitment content and community-focused content among the high-engagement top posts. This demonstrates that our audience is adapting well to the change.

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><img src="image1.png" alt="Image" /></td>
<td>&quot;[At Counties Manukau Health] there is a huge support network, and it feels like a wider whaanau. They already install so much of the kaupapa, Te Ao Maori values that we all hold close and dear to our hearts.&quot;</td>
<td>575</td>
<td>25</td>
<td>30.55%</td>
<td>6,353</td>
</tr>
<tr>
<td><img src="image2.png" alt="Image" /></td>
<td>Three years ago Dr Mataroria Lyndon’s life was on the cusp of massive change. The Lead Clinical advisor for Maori Health at Counties Manukau Health had put the final touches on his PhD in Medical Education and helped to launch Ko Awatea’s Health Equity Campaign.</td>
<td>438</td>
<td>26</td>
<td>25.12%</td>
<td>6,369</td>
</tr>
<tr>
<td><img src="image3.png" alt="Image" /></td>
<td>WIN A WAHAKURA! To kick off Matariki, we’ve got a cool prize to giveaway! Know someone who is about to have a baby or just had one? Want to hook them up with a wahakura...</td>
<td>394</td>
<td>145</td>
<td>13.58%</td>
<td>8,099</td>
</tr>
</tbody>
</table>

CM Health LinkedIn

LinkedIn continues to be our fastest growing channel; we saw a 2.6% increase in followers this period, as well as some big engagement numbers on our posts. Our OT entry to practice message amassed a huge 23.9% engagement rate.

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><img src="image4.png" alt="Image" /></td>
<td>Last week our Chief of Allied Health &amp; Scientific Professions, Clinical Director Allied Health &amp; Professional Lead for Occupational Therapy, and Undergraduate &amp; Entry to Practice Coordinator (Occupational Therapy) were among...</td>
<td>38</td>
<td>0</td>
<td>23.90%</td>
<td>3,080</td>
</tr>
<tr>
<td><img src="image5.png" alt="Image" /></td>
<td>Three years ago Dr Mataroria Lyndon’s life was on the cusp of massive change. The Lead Clinical advisor for Maori Health at Counties Manukau Health had put the final touches...</td>
<td>76</td>
<td>9</td>
<td>6.65%</td>
<td>4,044</td>
</tr>
<tr>
<td><img src="image6.png" alt="Image" /></td>
<td>Join the team! Counties Manukau Health in Auckland, New Zealand is currently seeking applications from exceptional Radiographers with experience in any medical imaging modalities. Permanent, fixed term and casual positions are available. Whether you are a few years...</td>
<td>18</td>
<td>0</td>
<td>5.27%</td>
<td>1,328</td>
</tr>
</tbody>
</table>

CM Health Instagram

This was a good period for our relatively new Instagram channel. It was great to see around 18% of our reach coming from accounts that do not currently follow us. It’s also promising to see that, despite a small drop, we’re still sitting above the industry average engagement rate (3%).
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>Congratulations to our newly crowned Miss Samoa NZ, Fonoifafo Nancy McFarland-Seumanu. Fono works as a Kidz First Public Health Nurse serving in the Otara community and has plans to use this platform to further promote...</td>
<td>46</td>
<td>2</td>
<td>7.09%</td>
<td>663</td>
</tr>
<tr>
<td></td>
<td>The Mangere Health Centre had a special visit last week from Prime Minister Jacinda Ardern who was at the centre to discuss the Wellbeing Budget. Here’s a photo of community midwives Siobhan, Kathy and Catherine with the PM. Catherine said they talked to the PM about midwifery relationships with the women they care for.</td>
<td>33</td>
<td>0</td>
<td>7.50%</td>
<td>440</td>
</tr>
<tr>
<td></td>
<td>Our Programme W&amp;AT! team were recently at Tangaroa College talking with Year 13 students who take part in the Health Science Academy - a programme encouraging and supporting Pacific students to choose science as...</td>
<td>27</td>
<td>2</td>
<td>6.36%</td>
<td>456</td>
</tr>
</tbody>
</table>

Figure 11 LinkedIn Top Posts by engagement

CM Health Twitter
Twitter experienced a slight drop in engagement this period. With slightly fewer posts this is not surprising. Climate change and sustainability messaging was popular this period. Messaging celebrating our nurses and support staff arriving in Samoa was also popular.

Figure 10 Top 4 Tweets by impressions

Social Listening

Peaks:
- 10 June:
  o Remediation work at Middlemore Hospital
  o CMH Plan to introduce TrendCare
- 20 June: Serious assault at Mangere Bridge.
Figure 12 Social volume, sentiment and sources
Figure 13 Social reach and hours

Reach (Social)

06/01/2019 to 06/30/2019

- wordpress.com
  "The passenger on the motorbike has died...
  44.4M

- wordpress.com
  "The passenger on the motorbike has died...
  44.4M

- stuff.co.nz
  After sustaining life threatening burns, th...
  843.2K

- stuff.co.nz
  Police were notified of an incident on Ru...
  843.2K

- stuff.co.nz
  Both were taken to Middlemore Hospital...
  843.2K

Reach

06/01/2019 to 06/30/2019 (Social)

0 - 6h  6 - 12h  12 - 1...  18 - 0h

Hours

06/01/2019 to 06/30/2019 (Social)
Figure 14 social influence, topics and weekdays
News/Media Listening
Peaks

- 3 June: Fatal Crash, Port Waikato.
- 6 June:
  - Dog owner violently assaulted. Treated in Middlemore Hospital.
  - Middlemore Hospital recladding problems.
- 10 June: Couple shot in Mangere, taken to Middlemore.
- 13 June:
  - Kakapos to get scanned at Middlemore Hospital.
  - Serious workplace injury in Takanini. Patient to Middlemore Hospital.
  - Wellbeing budget report mentioning Middlemore Hospital construction work.
- 18 June: Measles spike in South Auckland.
- 20 June: Serious assault at Mangere Bridge.
- 26 June:
  - Middlemore Hospital staff being escorted to staff carpark
  - Dairy shopkeeper assaulted, treated at Middlemore Hospital
- 28 June: Person seriously injured in police chase.

Figure 15 social volume, sentiment and sources
Figure 16 hours and reach
Figure 17 influence, topics, and weekdays

- Influence (News) from 06/01/2019 to 06/30/2019
  - Legacy.com: 80/100
  - Commons.wikimedia.org: 79/100
  - Msn.com: 72/100
  - Naws.com.au: 76/100
  - Radiotelevision.co.nz: 67/100
  - Tribunnews.com: 69/100
  - Marketscreener.com: 67/100

- Topics from 06/01/2019 to 06/30/2019
  - Says
  - New
  - Time
  - Work
  - Hospital
  - South
  - Year
  - Make
  - Auckland
  - Services
  - Need
  - Said
  - Two
  - Zealand

- Weekdays from 06/01/2019 to 06/30/2019
  - Monday: 150
  - Tuesday/Wednesday/Thursday: 100
  - Friday: 100
  - Saturday: 50
  - Sunday: 0

Counts Manukau District Health Board 7 August 2019 083
Information Paper
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Receive that this paper noting that it presents an overview of the latest available financial position as presented to the Audit Risk and Finance Committee at their meeting on 17 July 2019.

Submitted by: Margaret White – Chief Financial Officer

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>AMHU</td>
<td>Acute Mental Health Unit</td>
</tr>
<tr>
<td>ARC</td>
<td>Age Residential Care</td>
</tr>
<tr>
<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
</tr>
<tr>
<td>BOY</td>
<td>Balance of Year</td>
</tr>
<tr>
<td>COC</td>
<td>Cause of Change</td>
</tr>
<tr>
<td>CCDM</td>
<td>Care Capacity Demand Management</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CIC</td>
<td>Capital Investment Committee</td>
</tr>
<tr>
<td>CIO</td>
<td>Chief Information Officer</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community &amp; Public Health Advisory</td>
</tr>
<tr>
<td>CTU</td>
<td>Council of Trade Union</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>FPIM</td>
<td>Finance Procurement &amp; Information</td>
</tr>
<tr>
<td>FSA</td>
<td>First Specialist Appointment</td>
</tr>
<tr>
<td>HOP</td>
<td>Health of Older People</td>
</tr>
<tr>
<td>ICR</td>
<td>Investment Confidence Rating</td>
</tr>
<tr>
<td>ICT</td>
<td>Information &amp; Communication</td>
</tr>
<tr>
<td>IDF</td>
<td>Inter District Flows</td>
</tr>
<tr>
<td>LSL</td>
<td>Long Service Leave</td>
</tr>
<tr>
<td>MBIE</td>
<td>Ministry of Business, Innovation &amp;</td>
</tr>
<tr>
<td>MECA</td>
<td>Multi-Employer Collective Agreement</td>
</tr>
<tr>
<td>MERAS</td>
<td>New Zealand College of Midwives</td>
</tr>
<tr>
<td>MMCT</td>
<td>Middlemore Clinical Trials</td>
</tr>
<tr>
<td>MMF</td>
<td>Middlemore Foundation</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NZHPL</td>
<td>New Zealand Health Partnerships Limited</td>
</tr>
<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
</tr>
<tr>
<td>PAYE</td>
<td>Pay As You Earn</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>PSA</td>
<td>The New Zealand Public Service Association</td>
</tr>
<tr>
<td>PVS</td>
<td>Price Volume Schedule</td>
</tr>
<tr>
<td>RISSP</td>
<td>Regional Information Systems Strategic Plan</td>
</tr>
<tr>
<td>SABR</td>
<td>Stereo Ablative Radiotherapy</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>

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 17 July 2019.

1.0 31 May Summary Financial Result

CM Health produced a $667k favourable result against budget for May 2019, YTD $7.8M favourable (refer Table 1 below).

The YTD result is primarily driven by upsides for ACC levy, reduced finance charges (namely interest and depreciation) associated with delay in capital spend, and the impact of vacancies (Management & Admin positions held vacant and the impact of delay to recruit to clinical roles), part offset by delayed savings, under delivery of Electives (workforce and impact of industrial action) and additional costs for SMO cover during industrial action.
### Table 1: Statement of Performance by Operating Arm for the period ended 31 May 2019

<table>
<thead>
<tr>
<th></th>
<th>May 2019</th>
<th>YTD</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>YTD</td>
<td>Full Year</td>
</tr>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
</tr>
<tr>
<td>Hospital Provider</td>
<td>(2,426)</td>
<td>(4,285)</td>
<td>1,859</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>(2,791)</td>
<td>(2,752)</td>
<td>(39)</td>
</tr>
<tr>
<td>Provider</td>
<td>(5,217)</td>
<td>(7,037)</td>
<td>1,820</td>
</tr>
<tr>
<td>Funder</td>
<td>(1,809)</td>
<td>(770)</td>
<td>(1,039)</td>
</tr>
<tr>
<td>Governance</td>
<td>(132)</td>
<td>(18)</td>
<td>(115)</td>
</tr>
<tr>
<td>Surplus / (deficit)</td>
<td>(7,157)</td>
<td>(7,824)</td>
<td>667</td>
</tr>
</tbody>
</table>

**Provider**

Hospital Provider Position is $1.859m favourable (YTD $11.990m favourable) to budget. The key drivers remain reduced costs (vs. budget) associated with volumes lower than contract (refer table 2 Volume Summary), the favourable impact of management and admin vacancies held and delay to recruit clinical roles (as detailed in table 3 FTE), together with additional revenue from ACC and Tahitian burns.

Integrated care is on Budget YTD.

**Funder**

The Funder Arm is $1.039m unfavourable (YTD $5.234m unfavourable) to budget. The YTD result primarily reflects additional IDF outflows together with delays to secure savings plan revenue initiatives, greater than Budget PHO & Laboratory volumes all offset by Mental and HOP underspends. The favourable month result includes Mental Health underspend claw back from the Provider Arm.

**Governance**

Governance Arm is $115k unfavourable (YTD $1.004k favourable) to budget driven by a combination of vacancies and gains on sale of assets. These gains are partly offset by unbudgeted costs including savings plan, consulting of $191k, Crown Monitor costs of $33k, NRA fees $291k unfavourable YTD and Board approved legal fees $174k.

**2018/19 Savings Plan**

Consistent with YTD trends the 2018/19 savings plan remains behind target, primarily offset by a deliberate hold on management and admin roles and delays to recruit to clinical roles. Services are now working to confirm the work plan for 2019/20.

**Volume Summary**

Month and YTD acute volumes remain on trend reflecting higher acute demand. May acute volumes have seen an increase in activity month-on-month, reflecting increased activity through the front door driven by the colder temperatures over the last few weeks. The 3 day RMO industrial action during May has contributed to reduced volumes against contract.

YTD Elective volumes reflect acute pressure across the system, ongoing staff shortages and RDA industrial action.

Note that the volumes (table 2) reflect CM Health activity delivered for patients from all DHBs.
Winter Plan as well as cover required for unplanned leave. Budgeted but delayed savings of month due to unbudgeted initiatives including CCDM (funded), E-Vitals, E-prescribing and the Vacancies in Allied Health, Support staff and Management and Admin continue across system.

29.42FTE and a Stat Day Credit Adjustment during the month of approximately 32FTE has contributed to this variance.

Table 2: Volumes for the period ended 31 May 2019

<table>
<thead>
<tr>
<th>Performance vs Contract</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td>General Medicine Inpatients</td>
<td>1,410</td>
<td>1,409</td>
</tr>
<tr>
<td>General Surgery Inpatients</td>
<td>843</td>
<td>929</td>
</tr>
<tr>
<td>Orthopaedic Inpatients</td>
<td>660</td>
<td>727</td>
</tr>
<tr>
<td>Maternity Inpatients</td>
<td>628</td>
<td>653</td>
</tr>
<tr>
<td>Plastic &amp; Burns - Inpatients</td>
<td>409</td>
<td>542</td>
</tr>
<tr>
<td>Emergency Medical Services Inpatients</td>
<td>412</td>
<td>421</td>
</tr>
<tr>
<td>Secondary Neonatal</td>
<td>416</td>
<td>330</td>
</tr>
<tr>
<td>Cardiology - Inpatients</td>
<td>296</td>
<td>286</td>
</tr>
<tr>
<td>Paediatric Medicine Inpatients</td>
<td>240</td>
<td>208</td>
</tr>
<tr>
<td>Respiratory - Inpatients</td>
<td>171</td>
<td>160</td>
</tr>
<tr>
<td>Gynaecology Inpatients</td>
<td>155</td>
<td>154</td>
</tr>
<tr>
<td>Gastroenterology - Inpatients</td>
<td>110</td>
<td>93</td>
</tr>
<tr>
<td>All Others</td>
<td>437</td>
<td>341</td>
</tr>
<tr>
<td>Sub-total ACUTE WIES</td>
<td>6,187</td>
<td>6,253</td>
</tr>
<tr>
<td>Orthopaedic Inpatients</td>
<td>459</td>
<td>486</td>
</tr>
<tr>
<td>General Surgery Inpatients</td>
<td>323</td>
<td>382</td>
</tr>
<tr>
<td>Plastic &amp; Burns - Inpatients</td>
<td>250</td>
<td>277</td>
</tr>
<tr>
<td>Gynaecology Inpatients</td>
<td>119</td>
<td>131</td>
</tr>
<tr>
<td>ORL Inpatients</td>
<td>107</td>
<td>134</td>
</tr>
<tr>
<td>Ophthalmology Inpatients</td>
<td>143</td>
<td>152</td>
</tr>
<tr>
<td>Skin lesions</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>Cardiology - Inpatients</td>
<td>40</td>
<td>46</td>
</tr>
<tr>
<td>Urology - Inpatients</td>
<td>28</td>
<td>37</td>
</tr>
<tr>
<td>All Others</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Sub-total Elective WIES</td>
<td>1,501</td>
<td>1,702</td>
</tr>
<tr>
<td>Total WIES</td>
<td>7,689</td>
<td>7,955</td>
</tr>
</tbody>
</table>

ED Discharges

<table>
<thead>
<tr>
<th>Performance vs Last Year</th>
<th>Month</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>YTD</td>
</tr>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
</tr>
<tr>
<td>Acute WIES</td>
<td>6,187</td>
<td>6,181</td>
</tr>
<tr>
<td>Elective WIES</td>
<td>1,501</td>
<td>1,834</td>
</tr>
<tr>
<td>Acute Discharges</td>
<td>7,843</td>
<td>7,412</td>
</tr>
<tr>
<td>Elective Discharges</td>
<td>1,501</td>
<td>1,834</td>
</tr>
<tr>
<td>Births</td>
<td>662</td>
<td>653</td>
</tr>
<tr>
<td>ED Discharges</td>
<td>10,418</td>
<td>9,662</td>
</tr>
<tr>
<td>FSA Volumes</td>
<td>5,608</td>
<td>5,624</td>
</tr>
<tr>
<td>FU Volumes</td>
<td>12,473</td>
<td>12,508</td>
</tr>
</tbody>
</table>

Note that procedural volumes are not included in the above table

FTE

The 112FTE unfavourable variance for May reflects an over allocation of nursing staff during the month due to unbudgeted initiatives including CCDM (funded), E-Vitals, E-prescribing and the Winter Plan as well as cover required for unplanned leave. Budgeted but delayed savings of 29.42FTE and a Stat Day Credit Adjustment during the month of approximately 32FTE has contributed to this variance.

Vacancies in Allied Health, Support staff and Management and Admin continue across system.
Table 3: FTE (Accruals Basis) for the period ended 31 May 2019

<table>
<thead>
<tr>
<th>FTE (including Outsourced)</th>
<th>Month</th>
<th>YTD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var FTE</td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Personnel</td>
<td>933</td>
<td>914</td>
<td>(19)</td>
</tr>
<tr>
<td>Nursing Personnel</td>
<td>3,094</td>
<td>2,919</td>
<td>(175)</td>
</tr>
<tr>
<td>Allied Health Personnel</td>
<td>1,146</td>
<td>1,200</td>
<td>53</td>
</tr>
<tr>
<td>Support Personnel</td>
<td>524</td>
<td>556</td>
<td>32</td>
</tr>
<tr>
<td>Management/Administration Personnel</td>
<td>982</td>
<td>1,014</td>
<td>33</td>
</tr>
<tr>
<td>Sub-total Personnel</td>
<td>6,679</td>
<td>6,603</td>
<td>(76)</td>
</tr>
<tr>
<td>Outsourced services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Personnel</td>
<td>20</td>
<td>12</td>
<td>(8)</td>
</tr>
<tr>
<td>Nursing Personnel</td>
<td>29</td>
<td>6</td>
<td>(24)</td>
</tr>
<tr>
<td>Allied Health Personnel</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Support Personnel</td>
<td>6</td>
<td>0</td>
<td>(6)</td>
</tr>
<tr>
<td>Management/Administration Personnel</td>
<td>22</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Sub-total Outsourced FTE</td>
<td>79</td>
<td>43</td>
<td>(36)</td>
</tr>
<tr>
<td>Total Net FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>953</td>
<td>926</td>
<td>(26)</td>
</tr>
<tr>
<td>Nursing</td>
<td>3,124</td>
<td>2,925</td>
<td>(199)</td>
</tr>
<tr>
<td>Allied Health</td>
<td>1,148</td>
<td>1,202</td>
<td>54</td>
</tr>
<tr>
<td>Support</td>
<td>530</td>
<td>556</td>
<td>26</td>
</tr>
<tr>
<td>Management/Administration</td>
<td>1,004</td>
<td>1,037</td>
<td>33</td>
</tr>
<tr>
<td>Total Net FTE</td>
<td>6,758</td>
<td>6,645</td>
<td>(112)</td>
</tr>
</tbody>
</table>

The full Financial Variance Report for the period ended 31 May 2019 is presented in Appendix 1 of this report.
Appendix 1 – Full Financial Report for the period ended 31 May 2019

YTD 31 May 2019 the consolidated result is $7.808m favourable to budget.

Table 4: Statement of Revenue and Expenditure for the period ended 31 May 2019

<table>
<thead>
<tr>
<th>Net Result</th>
<th>May 2019</th>
<th>Full Year Budget</th>
<th>Month</th>
<th>Year to Date</th>
<th>Budget as at 30 May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Act</td>
<td>Bud</td>
<td>Var</td>
</tr>
<tr>
<td></td>
<td>$000</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>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>142,368</td>
<td>140,737</td>
<td>1,630</td>
<td>1,551,643</td>
<td>2,328</td>
</tr>
<tr>
<td>Other Revenue</td>
<td>3,227</td>
<td>2,963</td>
<td>265</td>
<td>39,256</td>
<td>6,524</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>145,595</td>
<td>143,700</td>
<td>1,895</td>
<td>1,590,899</td>
<td>8,851</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>58,854</td>
<td>59,760</td>
<td>906</td>
<td>611,086</td>
<td>17,479</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,668</td>
<td>996</td>
<td>(672)</td>
<td>19,051</td>
<td>(8,135)</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>6,545</td>
<td>5,927</td>
<td>(618)</td>
<td>68,317</td>
<td>(4,097)</td>
</tr>
<tr>
<td>Funder Provider Payments</td>
<td>62,238</td>
<td>61,076</td>
<td>(1,162)</td>
<td>680,939</td>
<td>(8,987)</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>11,633</td>
<td>10,749</td>
<td>(883)</td>
<td>114,325</td>
<td>(424)</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>6,337</td>
<td>6,746</td>
<td>409</td>
<td>73,583</td>
<td>853</td>
</tr>
<tr>
<td>Operating Expenditure</td>
<td>147,275</td>
<td>145,254</td>
<td>(2,021)</td>
<td>1,567,301</td>
<td>(3,311)</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>(1,679)</td>
<td>(1,554)</td>
<td>(126)</td>
<td>23,598</td>
<td>5,540</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,942</td>
<td>3,163</td>
<td>221</td>
<td>33,264</td>
<td>1,528</td>
</tr>
<tr>
<td>Interest</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>2,536</td>
<td>3,108</td>
<td>572</td>
<td>33,444</td>
<td>740</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(7,157)</td>
<td>(7,824)</td>
<td>667</td>
<td>(43,111)</td>
<td>7,808</td>
</tr>
</tbody>
</table>

Commentary on Major Variances:

**Crown Revenue**

May 2019 month was $1.630m favourable to budget (YTD $2.328m favourable), reflecting the following:

- Delay to secure savings plan revenue initiatives $445k unfavourable (YTD $4.9m unfavourable);
- Mental Health and Health of Older People unbudgeted pay equity $457k favourable (YTD $4.5m favourable) with matching additional costs in provider payments;
- IDF inflows adjustment to contract YTD $2.1m favourable;
- Additional ACC arrears revenue YTD $1.301m favourable;
- HWNZ training costs, invoiced ahead of plan $19k unfavourable (YTD $602k favourable);
- Breast screen revenue adjustment $63k unfavourable (YTD $493k unfavourable); and
- Bowel screening volumes variance to contract $5k favourable (YTD $588k unfavourable).

**Elective Programme Revenue**
- As at 31 May 2019 the elective programme is tracking 4.4% (1,077 WIES) behind contract (see table 8 below), reflecting an adverse position of $5.46M unfavourable YTD.
- The variance is driven by YTD volumes lower than contract in general surgery, ENT services, Gynaecology and Ophthalmology.
- The CM Health elective programme volume unfavourable variance is driven by Anaesthetic Consultant shortfalls, Day of Surgery cancellations and the impact of the RDA strikes, highlighting a risk of not achieving our elective programme volumes balance of year.
- A level of additional outsourcing has been approved to meet the MOH elective discharge target to mitigate the introduction of capped volumes for skin lesion activity for the year.

The current full year forecast (YE 30/6/19) for the Elective Programme is an under delivery of $992k, being an under delivery of $5.9m in the Elective Initiative washed up by over delivery of $5.0m in the Ambulatory Initiative.

**Table 5: Elective Programme Caseweights for the period ended 31 May 2019**

<table>
<thead>
<tr>
<th>Caseweights - CWD</th>
<th>May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Dental treatment (DRGs)</strong></td>
<td>570 611 (41)</td>
</tr>
<tr>
<td><strong>Cardiology – Inpatient Services (DRGs)</strong></td>
<td>1,932 2,064 (133)</td>
</tr>
<tr>
<td><strong>Skin Lesions</strong></td>
<td>287 279 8</td>
</tr>
<tr>
<td><strong>General Surgery - Inpatient Services (DRGs)</strong></td>
<td>4,152 4,572 (420)</td>
</tr>
<tr>
<td><strong>Cardiothoracic - Inpatient Services (DRGs)</strong></td>
<td>2,348 2,065 283</td>
</tr>
<tr>
<td><strong>Ear, Nose and Throat - Inpatient Services (DRGs)</strong></td>
<td>1,446 1,796 (350)</td>
</tr>
<tr>
<td><strong>Gynaecology - Inpatient Services (DRGs)</strong></td>
<td>1,486 1,656 (170)</td>
</tr>
<tr>
<td><strong>Neurosurgery</strong></td>
<td>593 609 (16)</td>
</tr>
<tr>
<td><strong>Ophthalmology - Inpatient Services (DRGs)</strong></td>
<td>1,559 1,776 (217)</td>
</tr>
<tr>
<td><strong>Paediatric Surgical Services (DRGs)</strong></td>
<td>5,244 5,117 127</td>
</tr>
<tr>
<td><strong>Plastic &amp; Burns - Inpatient Services (DRGs)</strong></td>
<td>354 371 (18)</td>
</tr>
<tr>
<td><strong>Urology - Inpatient Services (DRGs)</strong></td>
<td>2,251 2,316 (65)</td>
</tr>
<tr>
<td><strong>Vascular Surgery - Inpatient Services (DRGs)</strong></td>
<td>993 1,099 (106)</td>
</tr>
<tr>
<td><strong>Total includes Inpatient Dental/Cardiology</strong></td>
<td>23,296 24,373 (1,078) (4.4%)</td>
</tr>
<tr>
<td><strong>Price per CWD</strong></td>
<td>$ 5,068.12</td>
</tr>
<tr>
<td><strong>Elective Programme (Deficit) / Surplus</strong></td>
<td>$ (5,461,632)</td>
</tr>
</tbody>
</table>

**Other Revenue**
May 2019 month was $265k favourable to budget (YTD $6.524m favourable), reflecting the following:
- Favourable timing of Pacific contract revenue (offset by cost) $126k favourable (YTD $1.726m favourable);
- Retail pharmacy sales $161k favourable (YTD $864k favourable), reflecting growth in sales (offset by COGs);
• Tahitian burns additional billing $123k unfavourable (YTD $1.040m favourable), reflecting higher demand in 2019;
• Interest received $87k favourable (YTD $967k favourable) due to better than Budget cash position;
• Research grants received from MMCT YTD $584k favourable;
• Bad debts recovered $436k favourable; and
• Child and Youth donations from MMF YTD 849k favourable.

**Personnel and Outsourced Personnel**

Net personnel costs for May are $234k favourable (YTD $9.344m favourable), reflecting the following:

• Continued vacancies across the services (combination of lower acute demand and services holding vacancies where appropriate) and the impact of industrial action has resulted in FTE and dollar costs under budget, with partial offsets in YTD unrealised savings and outsourced personnel.

The May YTD result also includes the following adjustments:

• SMO Claims for four RDA strikes $2.147m unfavourable;
• Accrue stat days credits provision $671k unfavourable;
• Release of ACC Levy provision following confirmation of ACC employer status $2.827m YTD favourable;
• Accrual for LSL and Gatruities in line with expected year end actuarial valuation $2.0m unfavourable; and
• Favourable timing release of residual balances of settled MECA’s (ETU, PSA AH, PSA Nursing, ETU & NZNO) of $1.26m.

High utilisation of bureau, both internal and external have been used to cover existing vacancies and annual leave during the year. Clinical bureau engagement is driven mainly by demand in General Medicine, additional theatre sessions in Orthopaedic and Plastic Surgery as well as specials and watches required in the Burns Unit.

Actual FTE’s including outsourced were 75 FTE favourable YTD.

**Outsourced services**

Outsourced Services were $618k unfavourable (YTD $4.097m unfavourable) driven by the following:

• Pacific contract costs higher than budget, offset by revenue, $17k unfavourable (YTD $1.410m unfavourable);
• An agreed overspend in Surgical services to meet the MOH Elective contract, $157k unfavourable (YTD $1.307m unfavourable); and
• An increased YTD MRI outsourcing due to staff shortages and delayed implementation of new machines, $254k unfavourable (YTD $1.475m unfavourable). Note that additional MRI outsourcing of $1.6m has been included in the forecast result.

**Provider Payments**

May was $1.162m unfavourable to budget (YTD $8.987m unfavourable), reflecting the following:

• IDF wash up provisioning greater than budget, primarily ADHB $1m unfavourable (YTD $9.8m unfavourable);
• Mental Health unbudgeted pay equity $500k (YTD $4.5m unfavourable), offset by revenue;
• Maori Health savings target shortfall $67k unfavourable (YTD $631k unfavourable), and the remaining balance being partly offset by additional revenue; and
• offset by Mental Health & HOP underspends $900k favourable (YTD $6.3m favourable.)

Clinical supplies
May was $141k unfavourable (YTD $459k favourable) reflecting the following:
• Demand driven volume related reduced spend, in part due to the RDA strikes and outsourcing of clinical procedures have contributed to the favourable variance in clinical supplies, largely in cancer drugs, renal fluids, bloods, diagnostics, shunts & stents as well as prostheses; and
• Unrealised savings in Provider of $294k month (YTD $3.1m unfavourable) and unbudgeted costs associated with additional Tahitian Burns patients offset by lower clinical equipment leasing costs $57k favourable (YTD $1.018m favourable).

Infrastructure costs
May was $409k favourable to budget (YTD $853k favourable), reflecting the following:
• Cost of goods sold increase due to higher pharmacy sales (offset by revenue) $187k (YTD $916k);
• Offset by gain on sale of land in August 2018 (YTD $377k) that was not accounted for in 2017/18; and
• Unrealised Provider Arm savings $185k unfavourable (YTD $1.4m), related to Lambie Drive property leases, infrastructure costs attributed to bed closures and environmental sustainability.

Table 6: Statement of Financial Position as at 31 May 2019

<table>
<thead>
<tr>
<th></th>
<th>Act 000 $</th>
<th>Budget 000 $</th>
<th>Var 000 $</th>
<th>Apr-19 000 $</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>20,543</td>
<td>(28,057)</td>
<td>48,600</td>
<td>47,812</td>
<td>(27,269)</td>
</tr>
<tr>
<td>Trust</td>
<td>838</td>
<td>833</td>
<td>5</td>
<td>2,843</td>
<td>(2,005)</td>
</tr>
<tr>
<td>Prepayments</td>
<td>1,540</td>
<td>637</td>
<td>903</td>
<td>1,745</td>
<td>(205)</td>
</tr>
<tr>
<td>Debtors</td>
<td>59,085</td>
<td>59,850</td>
<td>(765)</td>
<td>54,951</td>
<td>4,134</td>
</tr>
<tr>
<td>Inventory</td>
<td>8,512</td>
<td>8,515</td>
<td>(3)</td>
<td>8,113</td>
<td>399</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>95,846</td>
<td>47,106</td>
<td>48,740</td>
<td>120,792</td>
<td>(24,946)</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>677,889</td>
<td>687,556</td>
<td>(9,667)</td>
<td>676,268</td>
<td>1,621</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>4,163</td>
<td>4,178</td>
<td>(15)</td>
<td>4,162</td>
<td>1</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>2,375</td>
<td>4,850</td>
<td>(2,475)</td>
<td>2,557</td>
<td>(182)</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>899,333</td>
<td>911,521</td>
<td>(12,188)</td>
<td>897,893</td>
<td>1,440</td>
</tr>
<tr>
<td><strong>Accum. Depreciation</strong></td>
<td>(210,135)</td>
<td>(216,176)</td>
<td>6,041</td>
<td>(207,374)</td>
<td>(2,761)</td>
</tr>
</tbody>
</table>
### Net Cost

<table>
<thead>
<tr>
<th></th>
<th>689,198</th>
<th>695,345</th>
<th>(6,147)</th>
<th>690,519</th>
<th>(1,321)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work In-progress</td>
<td>33,456</td>
<td>58,609</td>
<td>(25,153)</td>
<td>46,942</td>
<td>(13,486)</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>722,654</td>
<td>753,954</td>
<td>(31,300)</td>
<td>737,461</td>
<td>(14,807)</td>
</tr>
<tr>
<td>Investments in Assoc</td>
<td>58,407</td>
<td>57,012</td>
<td>1,395</td>
<td>46,445</td>
<td>11,962</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>876,907</td>
<td>858,072</td>
<td>18,835</td>
<td>904,698</td>
<td>(27,791)</td>
</tr>
</tbody>
</table>

### Current Liabilities

<table>
<thead>
<tr>
<th></th>
<th>108,058</th>
<th>97,947</th>
<th>10,111</th>
<th>118,593</th>
<th>(10,535)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creditors</td>
<td>10,948</td>
<td>6,429</td>
<td>4,519</td>
<td>11,481</td>
<td>(533)</td>
</tr>
<tr>
<td>Income in Advance</td>
<td>15,207</td>
<td>14,574</td>
<td>633</td>
<td>17,599</td>
<td>(2,392)</td>
</tr>
<tr>
<td>GST and PAYE</td>
<td>14,693</td>
<td>14,275</td>
<td>418</td>
<td>21,955</td>
<td>(7,262)</td>
</tr>
<tr>
<td>Payroll Accrual &amp; Clearing</td>
<td>120,873</td>
<td>110,599</td>
<td>10,274</td>
<td>118,700</td>
<td>2,173</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>269,779</td>
<td>243,824</td>
<td>25,955</td>
<td>288,328</td>
<td>(18,549)</td>
</tr>
</tbody>
</table>

### Working Capital

<table>
<thead>
<tr>
<th></th>
<th>(173,933)</th>
<th>(196,718)</th>
<th>22,785</th>
<th>(167,536)</th>
<th>(6,397)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>607,128</td>
<td>614,248</td>
<td>(7,120)</td>
<td>616,370</td>
<td>(9,242)</td>
</tr>
</tbody>
</table>

### Non-Current Liabilities

<table>
<thead>
<tr>
<th></th>
<th>22,948</th>
<th>22,948</th>
<th>-</th>
<th>22,948</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Provisions</td>
<td>836</td>
<td>832</td>
<td>4</td>
<td>2,801</td>
<td>(1,965)</td>
</tr>
<tr>
<td>Trust and Special Funds</td>
<td>1,035</td>
<td>1,155</td>
<td>(120)</td>
<td>1,155</td>
<td>(120)</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>24,819</td>
<td>24,935</td>
<td>(116)</td>
<td>26,904</td>
<td>(2,085)</td>
</tr>
</tbody>
</table>

### Crown Equity

<table>
<thead>
<tr>
<th></th>
<th>408,990</th>
<th>423,796</th>
<th>(14,806)</th>
<th>408,990</th>
<th>-</th>
</tr>
</thead>
<tbody>
<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>(118,076)</td>
<td>(125,884)</td>
<td>7,808</td>
<td>(110,919)</td>
<td>(7,157)</td>
</tr>
<tr>
<td><strong>Total Crown Equity</strong></td>
<td>582,309</td>
<td>589,313</td>
<td>(7,004)</td>
<td>589,466</td>
<td>(7,157)</td>
</tr>
<tr>
<td><strong>Net Funds Employed</strong></td>
<td>607,128</td>
<td>614,248</td>
<td>(7,120)</td>
<td>616,370</td>
<td>(9,242)</td>
</tr>
</tbody>
</table>

**Commentary on Major Variances:**

- Closing bank was $48.6m favourable to budget. Net cash flows from operations (revenue, expenses and payroll) were $32.062m unfavourable to budget. (refer cash flow variance explanation for further details).

- Net Fixed Assets and Investment in Associates are $29.905m lower than budget reflecting timing of major capital projects spend (including an assumption regarding IT assets planned to be transferred to healthAlliance in September 2018 however the workings regarding the transfer are still in progress).

- Creditors are $10.111m favourable to Budget due to timing differences in Accounts Payable.
• Income In Advance was higher than Budget by $4.519m largely due to recovery of a bond for the AMHU Project now transferred from Accrued Creditors, and timing of revenue received.

• Employee entitlements were $10.274m lower than budget mainly reflecting timing of payroll accruals.

• The favourable working capital variance to Budget of $22.785m is mostly attributable to the timing matters detailed above.

• Crown equity variance of $14.806m reflects the delay in commencing Stage 2 of AMHU, resulting in less than forecast drawdowns in our equity injection funding.
Table 7: Statement of Cash flow for the period ended 31 May 2019

<table>
<thead>
<tr>
<th>Month</th>
<th>Act  $ 000</th>
<th>Budget $ 000</th>
<th>Var  $ 000</th>
<th>Act  $ 000</th>
<th>Budget $ 000</th>
<th>Var  $ 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash flows from Operating activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Revenue</td>
<td>137,696</td>
<td>138,583</td>
<td>(887)</td>
<td>1,553,468</td>
<td>1,545,916</td>
<td>7,552</td>
</tr>
<tr>
<td>Other</td>
<td>3,087</td>
<td>2,901</td>
<td>186</td>
<td>37,678</td>
<td>32,100</td>
<td>5,578</td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>(101,219)</td>
<td>(94,811)</td>
<td>(6,408)</td>
<td>(962,628)</td>
<td>(960,588)</td>
<td>(2,040)</td>
</tr>
<tr>
<td>Employees</td>
<td>(64,061)</td>
<td>(58,392)</td>
<td>(5,669)</td>
<td>(598,310)</td>
<td>(620,328)</td>
<td>22,018</td>
</tr>
<tr>
<td>Capital charge</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(18,545)</td>
<td>(18,646)</td>
<td>101</td>
</tr>
<tr>
<td>Net cash from Operations</td>
<td>(24,497)</td>
<td>(11,719)</td>
<td>(12,778)</td>
<td>11,663</td>
<td>(21,546)</td>
<td>33,209</td>
</tr>
<tr>
<td>Cash flows from Investing activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was applied to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed assets</td>
<td>(2,853)</td>
<td>(4,518)</td>
<td>1,665</td>
<td>(25,594)</td>
<td>(53,721)</td>
<td>28,127</td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>(100)</td>
<td>100</td>
<td>(447)</td>
<td>(3,273)</td>
<td>2,826</td>
</tr>
<tr>
<td>Interest rec.</td>
<td>145</td>
<td>59</td>
<td>86</td>
<td>1,608</td>
<td>642</td>
<td>966</td>
</tr>
<tr>
<td>Restricted &amp; Trust Funds</td>
<td>(2,109)</td>
<td>-</td>
<td>(2,109)</td>
<td>(2,118)</td>
<td>1,978</td>
<td>(4,096)</td>
</tr>
<tr>
<td>Net cash from Investing</td>
<td>(4,817)</td>
<td>(4,559)</td>
<td>(258)</td>
<td>(26,551)</td>
<td>(54,374)</td>
<td>27,823</td>
</tr>
<tr>
<td>Cash flows from Financing activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash was provided from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Asset</td>
<td>40</td>
<td>-</td>
<td>40</td>
<td>396</td>
<td>-</td>
<td>396</td>
</tr>
<tr>
<td>Crown Equity funding/other reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,779</td>
<td>16,580</td>
<td>(14,801)</td>
</tr>
<tr>
<td>Net cash from Financing</td>
<td>40</td>
<td>-</td>
<td>40</td>
<td>2,175</td>
<td>16,580</td>
<td>(14,405)</td>
</tr>
<tr>
<td>Net increase / (decrease)</td>
<td>(29,274)</td>
<td>(16,278)</td>
<td>(12,996)</td>
<td>(12,713)</td>
<td>(59,340)</td>
<td>46,627</td>
</tr>
<tr>
<td>Opening cash</td>
<td>50,663</td>
<td>(11,771)</td>
<td>62,434</td>
<td>34,102</td>
<td>31,291</td>
<td>2,811</td>
</tr>
<tr>
<td>Closing cash</td>
<td>21,389</td>
<td>(28,049)</td>
<td>49,438</td>
<td>21,389</td>
<td>(28,049)</td>
<td>49,438</td>
</tr>
<tr>
<td>Reconciliation Summary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>(7,157)</td>
<td>(7,825)</td>
<td>667</td>
<td>(43,110)</td>
<td>(50,917)</td>
<td>7,808</td>
</tr>
<tr>
<td>Add/(Less) non-cash items</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,941</td>
<td>3,164</td>
<td>(221)</td>
<td>33,272</td>
<td>34,793</td>
<td>(1,521)</td>
</tr>
<tr>
<td></td>
<td>(4,214)</td>
<td>(4,661)</td>
<td>446</td>
<td>(9,838)</td>
<td>(16,124)</td>
<td>6,287</td>
</tr>
<tr>
<td>Add/(Less) items</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classified as Investing or Financing activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain on Disposal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Add/(Less) Movements in Financial Position items

<table>
<thead>
<tr>
<th></th>
<th>(40)</th>
<th>-</th>
<th>(40)</th>
<th>(922)</th>
<th>-</th>
<th>(922)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debtor and Other Receivables</td>
<td>3,929</td>
<td>(2,215)</td>
<td>6,144</td>
<td>3,538</td>
<td>(4,042)</td>
<td>7,580</td>
</tr>
<tr>
<td>Inventories</td>
<td>399</td>
<td>(50)</td>
<td>449</td>
<td>(15)</td>
<td>12</td>
<td>(27)</td>
</tr>
<tr>
<td>Creditors</td>
<td>5,110</td>
<td>(4,793)</td>
<td>9,904</td>
<td>(2,210)</td>
<td>(1,392)</td>
<td>(819)</td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>(29,681)</td>
<td>-</td>
<td>(29,681)</td>
<td>21,110</td>
<td>-</td>
<td>21,110</td>
</tr>
<tr>
<td>Net Cash flow from Operations</td>
<td>(20,243)</td>
<td>(7,058)</td>
<td>(13,184)</td>
<td>22,423</td>
<td>(5,422)</td>
<td>27,844</td>
</tr>
</tbody>
</table>

Commentary on Major Variances for the month:

- Payments to suppliers were $6.408m higher than budget mainly as a result of variations to the planned timing of supplier payments in the budget.

- Employee Payments were $5.669m unfavourable to budget representing the timing of the payment of payroll accruals and vacancies.

- Fixed Assets $1.665m favourable to budget representing the delayed timing of capital spend for major capital projects.

- Restricted and Trust Funds was unfavourable to Budget by $2.109m as the trust funds have now been set aside for transfer to the Alice Nelson Charitable Trust.
Recommendation

It is recommended that the Board:

**Receive** the Health and Safety report for the period ending 30 June 2019.

**Note** this report was endorsed by the Executive Leadership Team on 23 July to go forward to the Board.

**Prepared and submitted by:** Gillian Purkis, Health and Safety Business Partner, Health and Safety and Elizabeth Jeffs, Director Human Resource.

**Glossary for Monthly Performance Scorecard and Report**

<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost time incidents</td>
<td>Any injury claim resulting in lost time.</td>
</tr>
<tr>
<td>Lost time injury Frequency Rate</td>
<td>No of lost time Injuries per million hours worked.</td>
</tr>
<tr>
<td>LTIFR (Lost Time Injury Frequency Rate)</td>
<td>( \text{LTIFR} = \frac{\text{Number of Lost Time Injuries}}{\text{Hours Worked}} \times 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>LTISR (Lost Time Injury Severity Rate)</td>
<td>( \text{LTISR} = \frac{\text{Number of Lost Hours}}{\text{Hours Worked}} \times 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. (b) any admission to hospital for immediate treatment (c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance (d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals. (e) any other injury/illness declared by regulations to be notifiable.</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 capsizes; 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 Health screening for new employees.</td>
<td></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.e.g 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>Abbreviation</th>
<th>Full Form</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>F&amp;E</td>
<td>Facilities and Engineering</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>HSR NZQA</td>
<td>Health and Safety Representative New Zealand Qualifications Authority</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>OHN</td>
<td>Occupational Health Nurse</td>
</tr>
<tr>
<td>OHP</td>
<td>Occupational Health Physician</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 was one notifiable event in June 2019. Apparently a patient sustained a possible electric shock when plugging in a water cooler that had been unplugged and plug left in puddle. There was no ill effect experienced by the individual and investigation completed at local level with recommendations made to minimize risk of reoccurrence.

- **2019 Staff Influenza Vaccination Programme**
  Increase in completion rate to 65% as at 30 June 2019 tracking behind National target of 80%, the programme is continuing in the service areas through the 137 peer vaccinators and supplemented with the OHN team.

- **H&S Induction training**
  - E-learning module development underway expected roll out in September. Designed to replace the Welcome Day generic session.
  - Induction H&S currently delivered via pre-commencement online module and supported in service with the H&S induction handbook.
• **Incident Reporting in June:**
  June incidents increased from 98 in May to 105. Of the 105, 18 related to BBFE incidents and 22 the ‘other category’ with a continued trend of staff either hitting into stationery/ moving objects, insect bites and burn/ scalds. Remainder of incidents are spread across the remaining incident types, with an increase in moving and handling incidents from 15 in May to 18, decrease in aggression and violence incidents of 16 compared to 20 in May and a significant increase in slips, trips, falls incidents of 15 compared to 10 in May 2019.

**Current Issues Update**

• **Worker Participation Agreement**
  This has been signed by all parties and the Unions and H&S are meeting to discuss the structure and reporting mechanisms for the Safety Committees.

• **Safe365**
  This is an online safety management tool being implemented by Department and Services. Information about Safe365 is available in the resource section.
Health and Safety Performance Scorecard

Lagging Indicators

<table>
<thead>
<tr>
<th>Number of Reported Incidents</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>Contractors</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Visitors</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Number of Injury claims</td>
<td>30</td>
<td>&lt;35</td>
</tr>
<tr>
<td>Lost time incidents</td>
<td>5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Lost time injury frequency rate</td>
<td>13.76</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Cost of Injury claims</td>
<td>$5,840</td>
<td>-</td>
</tr>
<tr>
<td>Lost time injury severity rate</td>
<td>544.4</td>
<td>&lt;630</td>
</tr>
</tbody>
</table>

Number of Notifiable Events

| Patients | 1 | - |

Predominant Incident Profile

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBFE</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Aggression and Violence</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Slips/ Trips/ Falls</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Leading Indicators

<table>
<thead>
<tr>
<th>Pre employment health screening completed</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Staff flu vaccination uptake</td>
<td>65%</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievement Criteria</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>On target or better</td>
<td>Achieved</td>
</tr>
<tr>
<td>95-99.9%</td>
<td>0.1-5% away from target</td>
</tr>
<tr>
<td>90-94.9%</td>
<td>5.1-10% away from target*</td>
</tr>
<tr>
<td>&lt;90%</td>
<td>&gt;10% away from target**</td>
</tr>
</tbody>
</table>

Indicators in Red

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTIFR</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Indicators in Blue

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Counties Manukau District Health Board

099
The LTIFR rolling average figure of 13.8 is consistent with the May. There has been a slight decrease on the March figure of 14.7 contrasting with the low February figure. The February individual monthly variance is due to the bulk loading of costs that represent lost time for previous months which should be averaged out across a longer period. The rolling average figure remains reasonably constant.

Discussions and action by WellNZ in backdating the correct LTI figure to appropriate months still to be completed to represent the monthly totals more accurately. The 12 month rolling figure continues to be a more accurate gauge of performance rather than individual month results.

Severity still remains lower during the December to May 2019 period than the October to November peak in 2018.
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>241.37</td>
<td>21,833.36</td>
<td>30,341.74</td>
<td>13,237.69</td>
<td>65,412.79</td>
</tr>
</tbody>
</table>

Key Health and Safety Risks

CM Heath Key H&S risks management update, including key initiatives to reduce/manage risk.

<table>
<thead>
<tr>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk is well managed – all significant actions complete</td>
</tr>
<tr>
<td>Risk is well managed - some minor actions to be completed</td>
</tr>
<tr>
<td>Risk is being managed and has some significant actions underway</td>
</tr>
<tr>
<td>Risk is being managed and has some significant actions yet to progress</td>
</tr>
</tbody>
</table>

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

**Previous Report Action**
- 3 incidents in April within Tiaho Mai were reviewed by Service Manager and actions to change placement of staff workstations within the open client area should reduce the opportunity for further incidents.
- However, an incident occurred in May which appears to be similar.

**Current Action**
- Incidents in Tiaho Mai reviewed with Service Managers, confirmation received that changing placements of workstations has occurred and importance of situational awareness discussed with staff.
- The MH team reviewed incidents at a weekly meeting.

### Risk: Contractor Management

**Previous Action Point**
- F&E have taken over the management of Contractor Management and are currently recruiting a Contract Manager.
- Facilities are implementing Safe365 which will enable access to the Safe365 data of contractors.
- Health Alliance and the Auckland DHBs have set up fortnightly meetings to review shared responsibilities.

**Current Action**
- Remains a risk that is being managed by F&E.

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

**Previous Action Point**
- ACC Workplace Injury Prevention Grant application unsuccessful, awaiting feedback on this decision.
- Analysis underway of options to develop programme for 2020 delivery and will consider ACC feedback in this.

**Current Action**
- Initial meeting held with Provider Company to look at option to provide game-based learning specific to the hospital environment. Demo will shortly be available with feedback / briefing document.
### Risk: Blood and Body Fluid Exposure (BBFE)

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Report being prepared by Business Analyst to understand if there are key trends associated with the BBFE’s with report in July/August Board report.</td>
<td>• Report delayed due to staff personal circumstances aiming to provide for September Board report.</td>
</tr>
<tr>
<td>• BBFE reported total incidents increased from 13 the total of in April to 18 in May 2019.</td>
<td></td>
</tr>
</tbody>
</table>

### Risk: Occupational Health and Safety - Slips, Trips and Falls

<table>
<thead>
<tr>
<th>Previous Report Action</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Environmental factors contributed to falls, such as wet surfaces.</td>
<td>• Environmental factors contributed to falls, such as wet surfaces.</td>
</tr>
<tr>
<td>• Reported total incidents increased from 7 the total of in April to 10 in May 2019.</td>
<td>• Reported total incidents increased from 10 the total of in May to 15 in June 2019.</td>
</tr>
</tbody>
</table>

### Risk: Compliance - Health & Safety Training Framework

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• H&amp;S Leadership module delivered by EMA facilitator received positive feedback with 2 further sessions booked for July and October cohorts.</td>
<td>• Filming for online induction view and weekly progress meetings underway.</td>
</tr>
<tr>
<td>• H&amp;S Representative training session completed with 16 staff trained. All cohort passed the NZQA unit standard at first attempt.</td>
<td></td>
</tr>
<tr>
<td>• Further work on E-module induction video with initial module launch expected in September.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Flu campaign – 60% of staff have been vaccinated which is 4,384 people.</td>
<td>• Meeting held with Universities partners to discuss their students providing wellness checks for our staff in conjunction with OHSS. Positive response received and plan to provide wellbeing checks for Cleaning and Orderly staff later this year after finalising details i.e. protocols, themes etc.</td>
</tr>
<tr>
<td>• All Independent Vaccinators and Peer vaccinators in place and delivering flu vaccinations.</td>
<td>• Wellbeing Booklet under production.</td>
</tr>
<tr>
<td>• Increase in measles vaccinations and enquiries relating to outbreak of measles cases both presenting at ED and in the community. Information communicated to staff via Daily Dose and OHN team.</td>
<td>• Emerging Leaders Resilience for Staff project presented at various forums.</td>
</tr>
<tr>
<td>• Flu campaign – 65% of staff have been vaccinated which is 4,759 people.</td>
<td>• Flu campaign – 65% of staff have been vaccinated which is 4,759 people.</td>
</tr>
</tbody>
</table>

### Risk: Physical environment (ventilation, lighting, noise, equipment)

<table>
<thead>
<tr>
<th>Previous Action Point</th>
<th>Current Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Guidance and advice have been provided on various environmental issues.</td>
<td>• OHSS currently working with F&amp;E on environmental monitoring and symptom review after concerns about possible detrimental exposure for staff located on Level 1, Colvin Complex expressed. Awaiting results of monitoring and review.</td>
</tr>
<tr>
<td>Risk: Compliance - Worker Participation</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Previous Action Point</strong></td>
<td><strong>Current Action</strong></td>
</tr>
<tr>
<td>• Signatures from participating Union Organisers being received.</td>
<td>• Worker Participation Agreement (WPA) now signed and published.</td>
</tr>
<tr>
<td>• Worker Participation Agreement Document, once signed, will be reviewed by the GM’s/Service Managers then presented to the Executive H&amp;S Committee when finalized.</td>
<td>• Policy, framework with suggested communication pathways to implement and embed the WPA presented to the GM’s/Service Managers on 12/07/2019.</td>
</tr>
<tr>
<td>• Work in progress to provide tools for successful implementation and ongoing promotion of worker participation.</td>
<td>• Presentation to Senior Leadership Team.</td>
</tr>
</tbody>
</table>
Reported Incidents

Rolling year-on-year monthly comparison:
Previous 13 months – 115.3
Current 13 months – 121.7
June monthly figures year on year appear to be consistent with a decrease in June 2019. Overall the average has increased which represents the increased reporting on A&V, M&H and BBFE incidents.

Key Observations:
- **BBFE (19)**: Highest reported incident category. Slight increase from the May figure of 18. OHN investigating trend/causation through follow up with services and individuals. Highest incidents continue to occur within SAP service reviewing causation factors to identify areas for improvement.
- **Other (22)**: The same as the May figure. Causation profile:
  - Hitting stationary/falling/moving object: 7
  - Bite/sting by insect/spider: 3
  - Burn/scald: 3
  - Trapped between/by moving object: 2
  - Laceration/cut/tear: 1
  - Cleanliness of facility: 1
  - Crushed/ pushed/ stepped on: 1
  - Entrance/ exit blocked/ obstructed: 1
  - Theft - actual: 1
  - Theft - alleged: 1
  - Equipment/ supplies failure: 1
- **Moving and Handling (18)**: Remains in top three incident rates. Slight increase from the May figure of 15. 6 of the reported incidents occurred within SAP services.
- **Aggression and Violence (16)**: Remains in top three incident rates. Slight decreased from May figure of 20. 7 of the reported incidents occurred within MH services. ED continuing capture of incidents within the Code Orange initiative with higher risk incidents being reported within Riskpro.
- **Slip/Trip/Fall (15)**: Increase from May figure of 10. 5 of the reported incidents occurred within ARHOP. Wet weather conditions can be contributing factor to the increase in reported incidents.
BBFE (Blood or Body Fluid Exposure)

Rolling year-on-year monthly comparison:

Previous 13 months – 24
Current 13 months – 25

- BBFE incidents significantly lower than last 13 months of reporting: 32 (2018).
- SAP service continues to have the highest number of incidents at 9, with follow up discussions happening with the service. CCS has the second highest number of reported incidents at 7. Inattention/ distraction highest cause of incidents overall.
- OHSS tracking trends and following up with services to reduce reoccurrence.
- Causation profile:
  - Inattention/ distraction: 9
  - Patient condition/ acts of others: 4
  - Unsafe position/ posture/ hold: 2
  - Defective tools/equipment: 1
  - Job factor: 1
  - Other: 1
  - Policy/ Safety rule violation: 1

Moving and Handling

Rolling year-on-year monthly comparison:

Previous 13 months – 22
Current 13 months – 21.2

- Moving and Handling incidents consistent with the last 25 months of reporting: 22 (2017) and 19 (2018).
- SAP services have the highest number of incidents at 6.
- H&S team working with non-clinical teams to review M&H training requirements.
- Causation profile:
  - Action/behaviour of employee or patient/affiliate: 5
  - Awkward position/ posture: 5
  - Human factors: 3
  - Lifting/ handling/ carrying: 2
  - Slipped/ tripped/ stumbled while moving and object: 2
  - Repetitive handling/ movement: 1
**Aggression and Violence**

**Rolling year-on-year monthly comparison:**
- Previous 13 months – 28.2
- Current 13 months – 28.4

- Reported incidents significantly lower than last 13 months of reporting: 32 (2018).
- ED tracking ‘Code Orange’ trial working with Security Services to better control elevated behaviour.
- MH services have the highest number of reported incidents at 7, with initiatives identified between services, security and H&S to raise awareness and address immediate issues.

- Caution profile:
  - Assault – physical: 6
  - Behaviour – aggressive/ threatening: 3
  - Assault – verbal/ gesture: 2
  - Behaviour – inappropriate: 2
  - Hit/ bitten / scratched by person: 2
  - Behaviour – violent: 1

---

**Slips, Trips and Falls**

**Rolling year-on-year monthly comparison:**
- Previous 13 months – 14
- Current 13 months – 12.2

- Slips, Trips and Falls incidents consistent with the last 25 months of reporting: 13 (2017) and 13 (2018).
- ARHOP services have the highest number of incidents at 5.

- Caution profile:
  - Slipped/ tripped/ stumbled: 7
  - Surface – slippery/ wet: 3
  - Action/behaviour of patient/ visitor: 2
  - Collapse: 1
  - Human factors: 1
  - Job factors/ work arrangement/ organization: 1
Reported Incidents Summarised by Workforce and Division

Case and Claims Management:

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

Total claims for June period at 188 has decreased from 289 as reported in May 2019. The ratio of accepted and pending remains the same at approximately 40% indicating more than half of the claims are more complex to assess and may require referral to OHP for confirmation.

ACC Audit reviewed CMH and WellNZ Case Management and confirmed that our claim processing and management is aligned with ACC tertiary accreditation guidelines.

Noted that the declined cases have decreased to 5 in June with 15 noted in May 2019.

Vaccinations:

Vaccinations administered as part of the pre-employment screening and staff influenza vaccination programme has resulted in full utilization of OHN clinics.

Education/information programme on Measles immunity via Daily Dose and OHN support resulted in increase in MMR vaccinations and proactive immunity testing. This initiative in response to the increase in Measles in New Zealand and cases presenting in EMIC.

Flu vaccinations have been given at time of other immunization/pre-employment screening. Staff Influenza Vaccination Programme corridor clinics came to an end in the beginning of June 2019.
programme is continuing in the service areas through the 137 peer vaccinators and supplemented with the OHN team.

Clinic Appointments:

OHP appointments are high, with full clinics delivering services to:
- Staff returning from injury (RTW/Fitness to work) together with ergonomic evaluations in service.
- Increase in referrals/complexity of cases resulting in longer close out periods.
- OHN clinics are full with PEHS vaccinations; increase in MMR vaccinations and flu vaccinations due to launch of Staff Influenza Vaccination Programme.

Staff non-attendance at clinic appointments has decreased although still high at 9% of total appointments. OHN follow up phone calls to identify key reasons for DNA with illness being a contributing factor.
Summary of Employee Assistance Programme Usage at Counties Manukau DHB – 01/07/18 to 30/06/19
Provided by EAPworks

Consideration is advised of:
- Comparison of usage with other DHBs and other general users to see if our demographics are reflective of others.
- Review of communications about this service.

**Work/Personal Split**

The overall total number of employees who sought help through EAP during the previous 12 months was **405**, made up of **126** employees identifying work related issues as their primary presenting issue and **279** as non-work issues.

**Work/Personal Totals over Time**
Ethnicity Categories

In the year to date the most frequent users of the service within each demographic category has been identified as:

The Ethnicity category **European** representing **51%** of the total identified usage.

Occupational Categories

The occupational category **Clinical** representing **69%** of the total identified usage.
Gender Categories

The gender category **Female** representing 88% of the total identified.

Age Categories

The Age category **31 ~ 50 yrs.** representing 53% of the total identified usage.
Recommendation

It is recommended that the Board:

Receive the Maaori & Pasifika quarterly workforce reports (January to March 2019 data).

Note this report was endorsed by the Executive Leadership Team on 23 July to go forward to the Board.

Prepared and submitted by: Elizabeth Jeffs, Director Human Resources

<table>
<thead>
<tr>
<th>Financial Implications</th>
<th>HR Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Purpose

The Board requested to review the Maaori & Pasifika quarterly workforce reports.

Summary

Maaori workforce
- The number of Maaori RMOs employed in the region has dropped from 93 in the previous quarter to 83 in the current quarter. The decrease is distributed across metro Auckland DHBs (3 in WDHB, 4 in ADHB & 3 in CMDHB). This means 86 additional Maaori RMOs are needed in the region to meet the 2025 target.

Pasifika workforce
- The number of Pacific midwives employed at Counties Manukau DHB has halved this quarter (from 9 in previous quarter to 4 in current quarter). This is compounded by the fact that the overall number of midwives for Counties Manukau DHB also increased from 156 previous quarter to 189 this quarter (21%), which means the extra Pacific midwives needed for Counties Manukau DHB increased from 24 previous quarter to 36 this quarter.

An opportunity may be to centralise the Maaori & Pacific workforce development functions within Learning & Development. Strategically it makes sense and whilst we get some significant value out of being aligned across different directorates, we could do a lot more working together.

Appendices

1. Workforce Ethnicity Pacific Report January to March 2019 data
2. Workforce Ethnicity Maaori Report January to March 2019 data
Report Observation:

Midwives: The number of Pacific midwives employed at Counties Manukau DHB has halved this quarter (from 9 in previous quarter to 4 in current quarter). This is compounded by the fact that the overall number of midwives for Counties Manukau DHB also increased from 156 previous quarter to 189 this quarter (21%), which means the extra Pacific midwives needed for Counties Manukau DHB increased from 24 previous quarter to 36 this quarter.

Current Quarter Snapshot - % Pacific Employed

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>2.4%</td>
<td>3.2%</td>
<td>3.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Nurse</td>
<td>1.0%</td>
<td>2.2%</td>
<td>6.3%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Midwife</td>
<td>0.0%</td>
<td>2.4%</td>
<td>0.0%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>0.0%</td>
<td>0.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Dietitian</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.0%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0.0%</td>
<td>3.5%</td>
<td>0.8%</td>
<td>2.2%</td>
</tr>
<tr>
<td>All Workforce</td>
<td>1.0%</td>
<td>5.3%</td>
<td>8.4%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

(1) 2025% Pacific target is 2.4%.

2025% Pacific target is 2.4%.

(1) Dental Therapist for Waitemata, Auckland, and Counties Manukau all have the different target of 12% due to Waitemata operating a metro Auckland dental service and would employ dental therapists for the metro DHBs.

Current Quarter New Starts and Leavers

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>-2</td>
<td>2</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>-1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>-1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>-2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietitian</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0</td>
<td>1</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>All Workforce</td>
<td>-3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Auckland

<table>
<thead>
<tr>
<th>Workforce Group</th>
<th>Northland</th>
<th>Waitemata</th>
<th>Auckland</th>
<th>Counties Manukau</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>-4</td>
<td>5</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>-5</td>
<td>1</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>-5</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>-1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietitian</td>
<td>-1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0</td>
<td>1</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>All Workforce</td>
<td>-28</td>
<td>28</td>
<td></td>
<td>32</td>
</tr>
</tbody>
</table>

(2) Net changes are the combination of new starts, leavers and other reasons such as retrospective change in ethnicity recorded for existing employees.
Notes

1. Data is sourced from HWIP data extracts submitted by DHBs to DHBSS.
2. Figures and calculations of percentages are based on headcount, not FTE.
3. The target is based on the working age population projection (aged between 20 and 64) for the year 2025, sourced from MoH Population Projection 2018 Update.
4. Only permanent employees are included. Casuals, locums and employees with zero contract hours are excluded. Casual employee is identified by field 'Paid Employment Status' and locum is identified by field 'Job Title'.
5. Employees left during the current quarter is counted in the leavers but not the total employed workforce for the quarter.
6. Where employees have secondary positions within the same ANZSCO code and identifiable by the same employee number, it is counted only once.
7. Employees with unknown ethnicity is excluded from the denominator in the calculation of percentage by ethnicity and deriving the extra required.
8. Dental therapists in metro DHBs are mostly employed at Waitakere. The target and extra required for this group is based on the ethnicity distribution of the metro Auckland population.

Workforce Groups

The workforce groupings are based on ANZSCO codes, mapped by DHBSS to the major workforce groups. The mapping table can be obtained from the Central TAS template named ‘DHB-Self-analysis-template-YYYY-QX.xlsx’

ANZSCO codes for Priority workforce group are:

<table>
<thead>
<tr>
<th>Grouping</th>
<th>ANZSCO Code &amp; Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMQ</td>
<td>253112 Resident Medical Officer</td>
</tr>
<tr>
<td>Nurse</td>
<td>134212 Nursing Clinical Director, 254211 Nurse Educator, 254212 Nurse Researcher, 254311 Nurse Manager, 254412 Nurse Practitioner, 254442 Registered Nurse (Aged Care), 254413 Registered Nurse (Child &amp; Family Health), 254414 Registered Nurse (Community Health), 254415 Registered Nurse (Critical Care &amp; Emergency), 254416 Registered Nurse (Developmental Disability), 254417 Registered Nurse (Disability &amp; Rehabilitation), 254418 Registered Nurse (Medical), 254421 Registered Nurse (Medical Practice), 254422 Registered Nurse (Mental Health), 254423 Registered Nurse (Perioperative), 254424 Registered Nurse (Surgical), 254425 Registered Nurse (Paediatrics), 254499 Registered Nurses nec, 411411 Enrolled Nurse, 411412 Mothercraft Nurse</td>
</tr>
<tr>
<td>Midwife</td>
<td>254111 Midwife</td>
</tr>
<tr>
<td>Dental Therapist</td>
<td>411214 Dental Therapist</td>
</tr>
<tr>
<td>Dietitian</td>
<td>251111 Dietitian</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>252411 Occupational Therapist</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>252511 Physiotherapist</td>
</tr>
</tbody>
</table>

Ethnicity

1. Population projections contain ethnicity groups of Māori, Pacific, Asian and Other.
2. The HWIP data extracts submitted by DHBs to DHBSS are grouped to match the population projections (i.e. Māori, Pacific, Asian, Other).
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<tbody>
<tr>
<td>Māori</td>
<td>21 Māori</td>
</tr>
<tr>
<td>Pacific</td>
<td>30 Pacific Island NFD, 31 Samoan, 32 Cook Island Māori, 33 Tongan, 34 Niuean, 35 Tokelauan, 36 Fijian, 37 Other Pacific Island</td>
</tr>
<tr>
<td>Asian</td>
<td>40 Asian NFD, 41 Southeast Asian, 42 Chinese, 43 Indian, 44 Other Asian</td>
</tr>
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<td>10 European NFD, 11 NZ European/Pakeha, 12 Other European, 51 Middle Eastern, 52 Latin America/Hispanic, 53 African, 54 Other MELAA, 61 Other</td>
</tr>
<tr>
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RMOs: The number of Māori RMOs employed in the region has dropped from 93 in the previous quarter to 83 in the current quarter. The decrease is distributed across metro Auckland DHBs (3 in WDHB, 4 in ADHB & 3 in CMDHB). This means 86 additional Maori RMOs are needed in the region to meet the 2025 target.
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</tr>
<tr>
<td>Ethnicity Not Stated</td>
<td>94 unknown dimension , 95 Declined to state , 97 Unspecified , 99 Not stated , No value recorded</td>
</tr>
</tbody>
</table>
Recommendation

It is recommended that the Board:

Receive the report noting the key recommendations of the Tribunal.

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

Prepared and submitted by: Leigh Henderson, Interim GM Maaori on behalf of Aroha Haggie, Director Funding and Health Equity.

Purpose

The purpose of this paper is to update the Executive Leadership Team (ELT) on the progress of the WAI 2575 - Health Services and Outcomes Kaupapa Inquiry following the Waitangi Tribunal release of the stage one report on Primary Care.

Background

Wai 2575 - the Health Services and Outcomes Inquiry will hear all claims concerning grievances relating to health services and outcomes and which are of national significance. There are currently over 200 claims seeking to participate in the inquiry and there is currently no cut-off date for the filing of claims. The Tribunal has agreed to hear claimants who clearly specify eligible health-related grievances in their statements of claim and notify their intention to participate in the inquiry.

In December 2017, the Presiding Officer confirmed that Wai 2575 will proceed on a phased and thematic basis, with health related-issues to be heard in stages according to priority. Stage one (with hearings running from October to December 2018 and closings likely in March 2019) will inquire into aspects of primary care. Stage two will cover three priority areas encompassing mental health (including suicide and self-harm), Maaori with disabilities, and issues of alcohol, tobacco, and substance abuse.

Stage One Report (Primary Care)

The Waitangi Tribunal has released Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. The Health Services and Outcomes Kaupapa Inquiry is an ongoing inquiry into the ways the Crown has responded to health inequities experienced by Maaori.

The stage one report addresses two claims concerning the ways the primary health care system in New Zealand has been legislated, administered, funded and held to account by the Crown since the passing of the New Zealand Public Health and Disability Act 2000 (The Act). The Act laid out a new structure for the health care system centred on the creation of district health boards to deliver health care to distinct populations.

The report acknowledges that Maaori saw great potential in the reforms to primary health care introduced by the Act and the 2002 Primary Health Care Strategy, and were optimistic that the reforms would improve Maaori health outcomes. Those reforms introduced new statutory and strategic commitments to Maaori health, and created primary health organisations, or PHOs, to coordinate delivery of primary health care
services. Maaori saw PHOs as an opportunity to exercise tino rangatiratanga guaranteed under the Treaty by controlling the design and delivery of primary health care for their communities.

However, all parties in the stage one inquiry, including the Crown, acknowledged the situation has not substantially improved since 2000: Maaori continue to experience the worst health outcomes of any population group in New Zealand. The Tribunal found that the reforms ushered in by the Act in 2000 failed to consistently state a commitment to achieving equity of health outcomes for Maaori.

**Reporting Findings**

In the report, the Tribunal identified serious Treaty breaches concerning the way the Crown holds the primary health care sector to account and reports on its performance, finding that there were few mechanisms in place to ensure accountability and that those mechanisms that did exist were rarely used in relation to Maaori health.

The Tribunal further found the Crown fails to ensure that Maaori have adequate decision-making authority and influence when it comes to the design and delivery of primary health care services. It found that the Act’s provision for Maaori representatives on district health boards does not fully reflect the principle of partnership, and that no other Treaty-consistent partnership arrangements exist at the district health board level. Further, the Crown fails to properly resource and support Maaori-controlled PHOs and health providers to deliver quality health care to Maaori communities, in breach of the Treaty principles.

**Tribunal Recommendations**

Based on its deliberations in this report, the Tribunal has recommended that the Act and its associated policies and strategies be amended to: give effect to the Treaty principles and ensure that those principles are part of what guides the primary health care sector; and include an objective for the health sector to achieve equitable health outcomes for Maaori.

The Tribunal has made an interim recommendation that the Crown and the stage one claimant’s work together to further assess the extent of the problems in primary health care, and co-design a set of solutions. Claimant groups broadly suggested creating a national, Maaori-controlled agency, organisation, or collective, which would have substantial oversight and control of Maaori health-related spending and policy. The Tribunal has suggested that these proposals be the starting point for the conversations between the Crown and the parties.

The Tribunal has directed that the Crown and the claimants inform the Tribunal of the progress of these discussions by 20 January 2020. The Tribunal has reserved the right to issue further recommendations in response to the responses from parties.

**Stage Two Report (Mental Health, Disability, Alcohol and Other Drugs)**

Stage two will cover three priority areas encompassing mental health (including suicide and self-harm), Maaori with disabilities, and issues of alcohol, tobacco, and substance abuse. Research for stage two of the Health Services and Outcomes Kaupapa Inquiry is currently underway and due for completion in late 2019.

**Appendix**

1. Wai2575 Stage 1 Full Report (*located in the Diligent Resource Centre*)
Recommendation

It is recommended that the Board:

Receive this paper for their information.

Note this paper was endorsed by the Executive Leadership Team on 16 July to go forward to the Board.

Prepared and submitted by: Dr Wing Cheuk Chan (Public Health Physician), Dean Papaconstantinou (Statistician) and Dr Doone Winnard (Clinical Director, Population Health) on behalf of Dr Gary Jackson (Director, Population Health Directorate).

Executive Summary

The overall life expectancy at birth in Counties Manukau (CM) was 81.7 years in 2018. The improvement of 1.5 years in life expectancy from 2009 to 2018 was similar to the national average (1.4 years) over the same time period. There was an increase in life expectancy of 4.2 and 2.1 years for Māori and Pacific people in CM respectively from 2009 to 2018 compared to an improvement of life expectancy of 0.9 years in the Non-Māori, Non-Pacific group. However, looking at longer term trends, based on a three year average trend that smooths out the sizable swings in life expectancy from year to year, from 2000-2002 to 2016-2018, there was only 1.6 years’ improvement in LE for Pacific people living in CM compared to 4.1 years of LE gain for Māori and 3.3 years gain for non-Māori and non-Pacific groups. This lack of improvement for Pacific peoples is a significant concern. The most likely explanation for this is the very high obesity rates in Pacific people, and subsequent diabetes and other related conditions.

In 2018, the gap of life expectancy between Māori (LE=75.3) and the Non-Māori, Non-Pacific group in Counties Manukau (LE=84.0) was 9 years. The gap between Pacific (LE=76.6) and Non-Māori, Non-Pacific was 7 years. Within the Non-Māori, Non-Pacific group, the Asian life expectancy was 86.6 in 2018. The life expectancy gap between Māori and the New Zealand European/Other group was 8 years. While this is a reduction in the gap for Māori, it remains an unacceptable inequity and a breach of Te Tiriti o Waitangi commitments and responsibilities. The gap between Pacific and the New Zealand European/Other group was 7 years, an unacceptable inequity and as noted, worryingly static.

The latest Global Burden of Disease has confirmed New Zealand residents are living longer in healthy life years as well as longer in unhealthy life years. The improvement in healthy life expectancy has grown more slowly than the improvement in life expectancy. Multiple morbidity is likely to be increasingly common with continual improvement of survival faster than reduction in morbidity.

After describing in more detail life expectancy trends and related mortality data, this paper outlines potential actions to further improve healthy life expectancy and reduce equity gaps, to inform DHB planning. While this paper focuses primarily on life expectancy, we note that actions to improve healthy life expectancy need to address areas of ill health such as mental health and musculoskeletal conditions, which impact morbidity and quality of life to a greater extent than length of life per se, and the importance of investment early in the life course to provide equitable opportunities for positive life outcomes. These are important complementary considerations for DHB planning and prioritisation.
Methods

Life expectancy at birth in 2018 refers to the average number of years that a new born child is expected to live, if they were born in 2018 and experienced the 2018 age specific mortality rates over the rest of their life.

This update is based on the 2018 provisional mortality data supplied by the Ministry of Health. As in previous years, at the time of data extract (in this instance June 2019), the number of deaths in 2018 were not considered to be complete. The shortfall in infant deaths because of late registration means when those deaths are registered and included in next year’s data, it is expected to decrease life expectancy estimates in the latest year by about 0.2-0.3 years, based on the degree of late registration historically. Therefore, the latest 2018 life expectancy estimate may be a slight over-estimate and should be interpreted as part of a longer term trend. It also means the trend figures here may differ slightly from previous reports.

The life expectancy estimates are calculated based on date of death in a calendar year rather than based on year of registration of death. The life expectancy estimates in this report are calculated using Chiang II (life table) methodology up to 90+ year age bands, similar to the methods used by Statistics New Zealand.

Computation of healthy life expectancy is complex. How ‘healthy’ life is defined is obviously a value judgement and will differ between people. Technical definitions are available for the methods used in the Global Burden of Disease (GBD) study which estimates healthy life years; these methods essentially draw on groups of people rating quality of life in various states of ill-health. Direct estimates for healthy life years are not available at a DHB level. For this report, estimates directly taken from the Global Burden of Disease study for New Zealand are used as a reference.1

Life expectancy is a summary measure of mortality; age specific mortality rates are used to demonstrate mortality trends in specific age bands by ethnicity. The WHO population standard was used to calculate age standardised mortality rates.2

Results

Life Expectancy

The overall life expectancy at birth in Counties Manukau (CM) was 81.7 years in 2018. This represents an increase of 1.5 years from 2009 to 2018. There was an increase in life expectancy of 4.2 and 2.1 years for Maaori and Pacific people respectively from 2009 to 2018 compared to an improvement of life expectancy of 0.9 years in the Non-Maaori, Non-Pacific group.

In 2018, the gap of life expectancy between Maaori (LE=75.3) and the Non-Maaori, Non-Pacific group in Counties Manukau (LE=84.0) was 9 years. The gap between Pacific (LE=76.6) and Non-Maaori, Non-Pacific was 7 years. Within the Non-Maaori, Non-Pacific group, the Asian life expectancy was 86.6 in 2018. The high life expectancy experienced by Asian may be related to the ‘healthy migrant’ effect. The life expectancy gap between Maaori and the New Zealand European/Other group was 8 years. The gap between Pacific and the New Zealand European/Other group was 7 years.
Figure 1: Life expectancy at birth in Counties Manukau Health from 2000 to 2018 by ethnicity

Data source: Mortality Collection, Ministry of Health (MOH); Estimated populations by DHB (2018 edition), Statistics New Zealand (SNZ)

Figure 2 provides a three-year average trend that smooths out the sizable swings in life expectancy from year to year. The closing of the gap between Māori and Pacific is a little more evident, as is the very slow closing of the gap to the European and Other population.

Figure 2: Life expectancy at birth in Counties Manukau Health from 2000 to 2018 by ethnicity (3 year average)

Data source: Mortality Collection, MOH; Estimated populations by DHB (2018 edition), SNZ

Looking at longer term trends based on the three-year average, from 2000-2002 to 2016-2018, there was only 1.6 years’ improvement in LE for Pacific people living in CM compared to 4.1 years of LE gain for Māori and 3.3 years gain for non-Māori and non-Pacific groups.
The improvement in life expectancy at birth in Counties Manukau is generally in parallel to New Zealand national trends overall, sitting slightly below as shown in Figure 3. Given the high levels of socioeconomic deprivation in CM, this is a higher rate than might have been expected.

Figure 3: Life expectancy at birth in Counties Manukau Health and in New Zealand overall from 2000 to 2018

![Figure 3: Life expectancy at birth in Counties Manukau Health and in New Zealand overall from 2000 to 2018](image)

Data source: Mortality Collection, MOH; Estimated populations by DHB (2018 edition), SNZ

Consistent with previous reports, Non-Maori Non-Pacific people domiciled in CM have a marginally higher life expectancy compared to their national counterparts. However, Maori and Pacific life expectancy were marginally lower than the national counterparts (Figure 4).

Figure 4: Life expectancy at birth, CM Health compared to New Zealand average by ethnicity, 2000 to 2018

![Figure 4: Life expectancy at birth, CM Health compared to New Zealand average by ethnicity, 2000 to 2018](image)

Data source: Mortality Collection, MOH; Estimated populations by DHB (2018 edition), SNZ
The gender difference in life expectancy continues to narrow in Counties Manukau (Figure 5). This appears to relate to a slowing of improvement for women. The life expectancy at birth for males in Counties Manukau in 2018 was estimated to be 80.0 years compared to 83.3 years for females.

*Figure 5: Life expectancy at birth in Counties Manukau from 2000 to 2018 by gender*

Data source: Mortality Collection, MOH; Estimated populations by DHB (2018 edition), SNZ

**Age standardised mortality rate**

Consistent with the life expectancy trends, age standardised mortality rates of CM Māori, Pacific and overall parallel that of their New Zealand counterparts overall (Figure 6). Note of course the different aspect – lower is better for mortality, versus higher being better for life expectancy! Similar to life expectancy trends, the relatively modest fall in age standardised mortality rates for Pacific people in Counties Manukau is of concern. The most likely explanation for this is the very high obesity rates in Pacific people, and subsequent diabetes and other related conditions. Asian had the lowest age standardised mortality rate in CM, at 219 deaths per 100,000 population in 2018.
Figure 6: Age standardised mortality rates from 2000 to 2018 (direct method WHO standard population)

Data source: Mortality Collection, MOH; Estimated populations by DHB (2018 edition), SNZ

**Age specific mortality rates**

Age specific mortality analyses demonstrate that mortality in CM has been falling consistently across all age bands since 2000 except for 85 and over age group (Table 1). The increase in mortality in the 85 year old group may also suggest people who were 85 in 2018 have more morbidities than the people who were 85 or above in 2000.

**Table 1: Comparing age specific mortality rates in CM in selected time period between 2000 and 2018 (absolute difference in age specific rates per 100,000)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Change in mortality rate between 2013 and 2018</th>
<th>Change in mortality rate between 2009 and 2018</th>
<th>Change in mortality rate between 2000 and 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-14</td>
<td>-32</td>
<td>-40</td>
<td>-48</td>
</tr>
<tr>
<td>15-24</td>
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<td>35-44</td>
<td>18</td>
<td>-19</td>
<td>-38</td>
</tr>
<tr>
<td>45-54</td>
<td>-28</td>
<td>-48</td>
<td>-40</td>
</tr>
<tr>
<td>55-64</td>
<td>-42</td>
<td>-44</td>
<td>-240</td>
</tr>
<tr>
<td>65-74</td>
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<tr>
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<td>85+</td>
<td>804</td>
<td>1,327</td>
<td>902</td>
</tr>
<tr>
<td>Age Standardised (WHO)</td>
<td>-21</td>
<td>-47</td>
<td>-116</td>
</tr>
</tbody>
</table>

As shown in Table 2 below, there has been a rise in mortality rate in the 25 to 44 year old age group for Maaori in CM since 2000, and there has been little or no fall in the mortality rate in 25 to 54 year old Pacific group.
### Table 2: Comparing age specific mortality rates in CM by ethnicity in selected time period between 2000 and 2018 (absolute difference in age specific rates per 100,000)

<table>
<thead>
<tr>
<th>Age</th>
<th>CM Maori Change in mortality rate between 2013 and 2018</th>
<th>CM Pacific Change in mortality rate between 2013 and 2018</th>
<th>CM Maori Change in mortality rate between 2009 and 2018</th>
<th>CM Pacific Change in mortality rate between 2009 and 2018</th>
<th>CM Maori Change in mortality rate between 2000 and 2018</th>
<th>CM Pacific Change in mortality rate between 2000 and 2018</th>
</tr>
</thead>
<tbody>
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<td>25-34</td>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>CM Asian Change in mortality rate between 2013 and 2018</th>
<th>CM NZ European and others Change in mortality rate between 2013 and 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-14</td>
<td>-42</td>
<td>-24</td>
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<tr>
<td>15-24</td>
<td>-28</td>
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<tr>
<td>25-34</td>
<td>29</td>
<td>-48</td>
</tr>
<tr>
<td>35-44</td>
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<td>6</td>
</tr>
<tr>
<td>45-54</td>
<td>-11</td>
<td>-6</td>
</tr>
<tr>
<td>55-64</td>
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<td>18</td>
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<tr>
<td>75-84</td>
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<td>1,460</td>
</tr>
<tr>
<td>Age Standardised (WHO)</td>
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<td>-9</td>
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Consistent with the Counties Manukau age specific mortality trend, there has been a consistent fall in age specific mortality in all age groups in New Zealand since 2000 (Table 3)
The increase in age specific mortality in CM are consistent with those seen for New Zealand for Maaori aged 25-44 and Pacific people from 25-54, and are of concern (Table 4). Causes of death analyses may provide further insights into this pattern.

Table 3: Comparing age specific mortality rates in New Zealand in selected time period between 2000 and 2018 (absolute difference in age specific rates per 100,000)

<table>
<thead>
<tr>
<th>Age</th>
<th>Change in mortality rate between 2013 and 2018</th>
<th>Change in mortality rate between 2009 and 2018</th>
<th>Change in mortality rate between 2000 and 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>00-14</td>
<td>-5</td>
<td>-15</td>
<td>-29</td>
</tr>
<tr>
<td>15-24</td>
<td>-2</td>
<td>-13</td>
<td>-21</td>
</tr>
<tr>
<td>25-34</td>
<td>6</td>
<td>-11</td>
<td>-34</td>
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<tr>
<td>35-44</td>
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<td>-10</td>
<td>-22</td>
</tr>
<tr>
<td>45-54</td>
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<td>-59</td>
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<tr>
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<td>Age</td>
<td>NZ Maori Change in mortality rate between 2013 and 2018</td>
<td>NZ Maori Change in mortality rate between 2009 and 2018</td>
<td>NZ Maori Change in mortality rate between 2000 and 2018</td>
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<td>-286</td>
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<thead>
<tr>
<th>Age</th>
<th>NZ Asian Change in mortality rate between 2013 and 2018</th>
<th>NZ Asian Change in mortality rate between 2009 and 2018</th>
<th>NZ Asian Change in mortality rate between 2000 and 2018</th>
<th>New Zealand others Change in mortality rate between 2013 and 2018</th>
<th>New Zealand others Change in mortality rate between 2009 and 2018</th>
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</tr>
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<tbody>
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<td>-19</td>
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<td>-22</td>
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<td>25-34</td>
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<td>45-54</td>
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<td>55-64</td>
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<td>-12</td>
<td>-43</td>
<td>-113</td>
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</tr>
</tbody>
</table>
One of the key drivers of life expectancy is infant mortality. There has been a modest overall fall in age specific mortality rate in the first year of life from 2000-02 to 2016-18. However, Maaori and Pacific mortality rates at aged 0 to 1 in Counties Manukau were 43% and 20% higher than the national Maaori and Pacific rates in 2016-18. Overall, mortality rate at aged 0-1 in Counties Manukau were 48% higher than the national counterparts in 2016-18.

*Figure 7: Age specific mortality rate at aged 0-1 by ethnicity in Counties Manukau (3 year average) per 100,000*

*Figure 8: Age specific mortality rate at aged 0-1 by ethnicity in New Zealand (3 year average) per 100,000*
Healthy Life Expectancy

The global burden of disease study has recently updated their life expectancy and healthy life expectancy estimates for 2017. Results are only reported at the national level. While the rate of improvement in New Zealand for both life expectancy and healthy life expectancy from 1990 to 2013 is one of the fastest in the developed world, the rate of improvement in New Zealand lags behind that of Singapore. In 2017, Singapore had the highest estimated healthy life expectancy for both males and females in the world.

Table 5: Estimated Life expectancy and Healthy Life expectancy (HALE) at birth for selected countries in 1990 and 2017 for both gender combined

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy at birth 1990</th>
<th>Life expectancy at birth 2017</th>
<th>Improvement in 27 years</th>
<th>Healthy Life expectancy at birth (HALE) 1990</th>
<th>Healthy Life expectancy at birth (HALE) 2017</th>
<th>Improvement in 27 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>75.4 (75.2 to 75.5)</td>
<td>81.6 (81.2 to 82.1)</td>
<td>6.2</td>
<td>64.7 (61.6 to 67.3)</td>
<td>69.1 (65.4 to 72.2)</td>
<td>4.4</td>
</tr>
<tr>
<td>Japan</td>
<td>79.3 (79.3 to 79.3)</td>
<td>84.2 (84 to 84.4)</td>
<td>4.9</td>
<td>69.7 (66.9 to 72)</td>
<td>73.1 (69.9 to 75.9)</td>
<td>3.4</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>75.8 (75.7 to 75.8)</td>
<td>81.2 (80.9 to 81.1)</td>
<td>5.4</td>
<td>65.7 (62.9 to 68.2)</td>
<td>69.3 (66 to 72.1)</td>
<td>3.6</td>
</tr>
<tr>
<td>Australia</td>
<td>76.9 (76.8 to 76.9)</td>
<td>82.4 (81.5 to 83.2)</td>
<td>5.5</td>
<td>66.1 (63 to 68.7)</td>
<td>70.2 (66.6 to 73.1)</td>
<td>4.1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>77.8 (77.7 to 77.9)</td>
<td>84.0 (83.5 to 84.4)</td>
<td>6.2</td>
<td>67.1 (64.1 to 69.7)</td>
<td>72.0 (68.6 to 75)</td>
<td>4.9</td>
</tr>
<tr>
<td>United States</td>
<td>75.6 (75.6 to 75.6)</td>
<td>78.6 (78.4 to 78.8)</td>
<td>3.0</td>
<td>64.7 (61.6 to 67.4)</td>
<td>66.6 (63.3 to 69.5)</td>
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<tr>
<td>Singapore</td>
<td>76.1 (76 to 76.2)</td>
<td>84.8 (84.3 to 85.3)</td>
<td>8.7</td>
<td>67.1 (64.4 to 69.3)</td>
<td>74.2 (71.2 to 76.8)</td>
<td>7.1</td>
</tr>
<tr>
<td>China</td>
<td>68.7 (68.1 to 69.2)</td>
<td>77.1 (76.7 to 77.4)</td>
<td>8.4</td>
<td>60.9 (58.8 to 62.8)</td>
<td>68.1 (65.6 to 70.3)</td>
<td>7.2</td>
</tr>
</tbody>
</table>
Expansion of Morbidity

Consistent with previous reports and the vast majority of countries in the world, the improvement in estimated healthy life expectancy for NZ has grown more slowly than the improvement in life expectancy. This means both men and women are living longer with some degree of impairment of their health (as defined by the burden of disease work) than previously – on average in 2017 healthy life expectancy for women was approximately 13.5 years less than their life expectancy and men 10.4 years less, compared with 10.4 and 9.7 years in 1990 (Tables 2 & 3). This has important implications for health and disability service planning because the increased duration of unhealthy life years is associated with higher health service utilisation overall. Expansion of morbidity also raises questions about the optimal balance of investment in prevention, risk factor modifications and treatment related services. New Zealand Burden of Disease Study has highlighted mental health and musculoskeletal conditions as major causes of disability in New Zealand.3

Despite substantial health care spending in the United States with a predominant focus on the treatment end of illnesses, the improvement in both life expectancy and healthy life expectancy in that country has been very disappointing. Females in China had longer healthy life expectancy than females in United States, partly related to the fact that Chinese women have a very low smoking prevalence. This demonstrates the potential life years gain from a smoke free society compared to expensive high end medical interventions.

Table 6: Estimated Life expectancy at birth for selected countries by gender in 1990 and 2017

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy at birth (females)</th>
<th>Life expectancy at birth (males)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1990</td>
<td>2017</td>
</tr>
<tr>
<td>New Zealand</td>
<td>78.1</td>
<td>83.6</td>
</tr>
<tr>
<td>Japan</td>
<td>82.2</td>
<td>87.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>78.5</td>
<td>82.7</td>
</tr>
<tr>
<td>Australia</td>
<td>80.0</td>
<td>84.6</td>
</tr>
<tr>
<td>Switzerland</td>
<td>81.1</td>
<td>85.7</td>
</tr>
<tr>
<td>United States</td>
<td>79.0</td>
<td>81.1</td>
</tr>
<tr>
<td>Singapore</td>
<td>78.8</td>
<td>87.6</td>
</tr>
<tr>
<td>China</td>
<td>70.7</td>
<td>79.9</td>
</tr>
</tbody>
</table>
Table 7: Estimated healthy life expectancy at birth for selected countries by gender in 1990 and 2017

<table>
<thead>
<tr>
<th>Country</th>
<th>Healthy Life expectancy at birth (females)</th>
<th>Healthy Life expectancy at birth (males)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1990</td>
<td>2017</td>
</tr>
<tr>
<td>New Zealand</td>
<td>66.3</td>
<td>70.1</td>
</tr>
<tr>
<td>Japan</td>
<td>71.2</td>
<td>74.6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>67.3</td>
<td>70.0</td>
</tr>
<tr>
<td>Australia</td>
<td>68.4</td>
<td>71.7</td>
</tr>
<tr>
<td>Switzerland</td>
<td>69.0</td>
<td>72.7</td>
</tr>
<tr>
<td>United States</td>
<td>66.8</td>
<td>67.9</td>
</tr>
<tr>
<td>Singapore</td>
<td>68.5</td>
<td>75.8</td>
</tr>
<tr>
<td>China</td>
<td>61.9</td>
<td>69.7</td>
</tr>
</tbody>
</table>

People living longer in unhealthy life years also means that people may survive longer with more complex morbidities - multi-morbidity is likely to be increasingly common.
Discussion

In order to continue to advance population health gain equitably, a range of coordinated and complementary approaches are needed. These approaches include structural or policy interventions that create healthier environments, that enable the healthy behaviours to be the easy option to take up, and behaviours once taken up that are sustainable. Legislation and regulations have been shown to be the most cost effective interventions to promote and protect health. Tobacco control, alcohol harm minimisation, improved nutrition and physical activity have been highlighted as areas with great potential to increase healthy life expectancy and narrow health inequities. Coordinated inter-sectoral actions that address the social and economic determinants of health along with health system responses will be needed to optimise the potential of healthy environmental policies.

While life expectancy of Maaori in Counties Manukau has been improving faster than the European/Other group, there is still an 8 years life expectancy gap. Actions to reduce smoking prevalence, and the prevention and management of cardiovascular and renal risk factors including diabetes are key areas to reduce amenable mortality.

Improvement of Pacific life expectancy has been minimal overall in the past 19 years; obesity, diabetes, tobacco smoking, cardiovascular risk factors remain the key areas on which to focus. The increase in age specific mortality in the young Maaori and Pacific people aged groups 25-54 may merit further investigation. Newly emerging adverse risk factors internationally could be considered, such as an increased prevalence of substance abuse.

The investment mix between primary prevention, risk factor modifications, treatment, and end of life care should ideally be considered as part of a continuum to limit planning within an isolated scope, without actively considering the potential trade-offs elsewhere.

Previous amenable mortality analyses reported that about half of all Maaori and Pacific deaths are potentially avoidable. The amendable proportions are likely significantly under reported because by definition, there is an assumption that all deaths beyond 75 were not preventable. However, a substantial proportion of recent life year gains come from reductions in mortality in those aged 75 or above. Recent Statistics NZ period life tables demonstrate that 75% of life years gained at birth between 2012-14 and 2016-2018 for females (and 80% for males), were related to the improvement of life expectancy after 75 years of age. Comparing life expectancy at birth and at age 75, between 2000-2002 and 2016-2018, the proportion of life year gains from reducing mortality over 75 years of age was less extreme, at 48% for females and 53% for males.

An average 75 year old female and male in New Zealand are estimated to live for 13.5 years and 12.0 years respectively. Many preventive and treatment interventions have an impact on mortality in people of older age groups; however, many recommendations for primary prevention and risk factor modification end at 75 years of age. For example current guidelines deem cardiovascular risk factor management to be discretionary for people beyond 75 years of age, but invasive secondary and tertiary hospital treatments are often offered routinely for cardiovascular disease by default for people aged over 75 unless there are specific contra-indications.

The recent Global Burden of Disease Study reported an impressive improvement of healthy life years gained in Singapore. There may be much learning from health systems in Singapore as well as the wider regulatory policies.
Potential actions to consider to further improve healthy life expectancy and reduce equity gaps may include:

<table>
<thead>
<tr>
<th>Areas of interest</th>
<th>Possible role of government and/or Ministry of Health</th>
<th>Possible role for DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco control</td>
<td>• Further strengthening legislation and regulation including tobacco excise increases</td>
<td>• Engagement with local intersectoral work to enact smoke free policies (e.g. with Council and Local Boards)</td>
</tr>
<tr>
<td></td>
<td>• Raising smoking age</td>
<td>• Strong culturally appropriate smoking cessation support services</td>
</tr>
<tr>
<td></td>
<td>• Enhancing Smoke Free Environments Act</td>
<td>• Enhanced evaluation and support of long-term outcomes of smoking cessation support services</td>
</tr>
<tr>
<td></td>
<td>• Guidelines/expectation that every health service contact is an opportunity to support behavioural change.</td>
<td>• Support primary health care to provide systematic cessation support</td>
</tr>
<tr>
<td></td>
<td>• Engagement with local intersectoral work to enact smoke free policies (e.g. with Council and Local Boards)</td>
<td>• Support community leadership for a tobacco free generation</td>
</tr>
<tr>
<td>Nutrition/ Physical activity</td>
<td>• Sugar-sweetened beverage tax</td>
<td>• Support inter-sectoral stakeholders to further enhance healthy environments</td>
</tr>
<tr>
<td></td>
<td>• Develop and implement healthy environment policies to promote physical activity and healthy eating</td>
<td>• Leadership by example in implementation of healthy food and drink policies</td>
</tr>
<tr>
<td></td>
<td>• Limit marketing and sponsorship of unhealthy food and drinks to children</td>
<td>• Encourage community settings to implement healthy food and drink policies</td>
</tr>
<tr>
<td>Optimising health service investment mix</td>
<td>• Provide leadership and infrastructure with mandate to support wider prioritisation decisions of health services</td>
<td>• Service planning to actively consider the entire person’s journey and opportunity cost related to primary prevention, risk factor modifications, treatment, and end of life care</td>
</tr>
<tr>
<td>Limiting alcohol and substance abuse</td>
<td>• Legislation and regulation in reducing availability that is temporal, spatial and age based</td>
<td>• Enhancing linkage to rehab and support services</td>
</tr>
<tr>
<td></td>
<td>• Reduced advertising and sponsorship, particularly youth exposure</td>
<td>• Further support system wide alcohol harm minimisation programme, including systematic implementation of alcohol harm reduction brief interventions</td>
</tr>
<tr>
<td>Clinical Guidelines</td>
<td>• Re-establish a clinical guidelines group</td>
<td>• Consider further analyses on adverse trends in substance abuse</td>
</tr>
<tr>
<td></td>
<td>• Implementation of guidelines supported by an electronic clinical pathway and information technology tools</td>
<td>• Better defining the roles of compulsory treatment</td>
</tr>
<tr>
<td></td>
<td>• Support clinical audits to inform quality improvement</td>
<td>• Participation in regional and national guideline development</td>
</tr>
<tr>
<td></td>
<td>• Change management support to reduce unexplained service gaps</td>
<td></td>
</tr>
</tbody>
</table>

Counties Manukau District Health Board 7 August 2019

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| Active identification of service gaps of proven interventions | • National leadership in defining clinical actionable indicators  
• Health technology assessment and implementation | • Better use of routine data  
• Participation in regional and national implementation planning |
| Reducing barriers to health services | • Review of primary care capitation weightings, co-payment amounts  
• Addressing health literacy demands across the system, and improving cultural competency resources | • Consider reduction of costs barriers for target populations with a focus to equity such as co-payment, transport.  
• Publicly accessible list of primary care, afterhours and pharmaceutical dispensing fees |

This paper focuses primarily on life expectancy, but we note that actions to improve healthy life expectancy need to address areas of ill health such as mental health and musculoskeletal conditions, which impact morbidity and quality of life to a greater extent than length of life per se, and the importance of investment early in the life course to provide equitable opportunities for positive life outcomes.
References


Counties Manukau District Health Board Meeting
Resolution to Exclude the Public

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

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

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

<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>
</table>
| Chief Executive’s Report                 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. | 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)] |
| 19/20 Budget                            | 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. | Confidentiality of Advice by Officials
The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and Officials. [Official Information Act 1982 S9(2)(f)(iv)] |
| University of Otago Dental School – Vector Easement Agreement | 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 & Negotiations
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i)&(j)] |
| Funding for Auckland Regional Public Health Service | 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
The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i)] |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Exceptional Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onelink Proposed Contract Variation</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)(ii)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>NZHP Statement of Performance Expectation</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)(ii)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>External Audit 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(3)(g)(ii)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Bad Debt Write Off</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)(ii)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Summary 19/20 PHO Flexible Funding Pool Expenditure Plans</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)(ii)) of the Official Information Act 1982.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
</tbody>
</table>

**Commercial Activities & Negotiations**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations.

[Official Information Act 1982 S9(2)(i)&(j)]

**Confidentiality of Advice by Officials**

The disclosure of information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and Officials.

[Official Information Act 1982 S9(2)(f)(iv)]

**Privacy**

The disclosure of the information would not be in the public interest because of the need to protect the privacy of natural persons.

[Official Information Act 1982 S9(2)(a)]

**Commercial Position**

The disclosure of the information would be likely to prejudice the commercial position of the person who supplied or who is the subject of the information.

[Official Information Act 1982 S9(2)(b)(iii)]
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH&amp;A NGO Procurement</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>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
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<tr>
<td>Commercial Activities &amp; Negotiations</td>
<td>The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities and negotiations.</td>
<td>[Official Information Act 1982 S9(2)(i)&amp;(j)]</td>
</tr>
<tr>
<td>Public Excluded Minutes of 26 June 2019 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.</td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
</tr>
<tr>
<td>Confirmation of Minutes</td>
<td>As per the resolution from the public section of the minutes, as per the NZPH&amp;D Act.</td>
<td></td>
</tr>
<tr>
<td>Public Excluded Minutes of the Audit Risk &amp; Finance Committee, Hospital Advisory Committee &amp; Community &amp; Public Health Advisory Committee</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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