Waitemata
District Health Board
Best Care for Everyone

BOARD MEETING

Wednesday 11 July 2018

11am

AGENDA

Items to be considered in public meeting

VENUE

Waitemata DHB Boardroom
Level 1, 15 Shea Terrace
Takapuna

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of Life

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

MEETING OF THE BOARD
11 July 2018

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Tce, Takapuna **Time: 11.00am**

WDHB BOARD MEMBERS	WDHB MANAGEMENT
Judy McGregor – WDHB Board Chair	Dale Bramley - Chief Executive Officer
Max Abbott - WDHB Board Member	Robert Paine - Chief Financial Officer and Head of Corporate Services
Edward Benson-Cooper – WDHB Board Member	Andrew Brant - Deputy Chief Executive Officer and Chief Medical Officer
Kylie Clegg – WDHB Board Deputy Chair	Debbie Holdsworth - Director Funding
Sandra Coney - WDHB Board Member	Jocelyn Peach - Director of Nursing and Midwifery
Warren Flaunty - WDHB Board Member	Cath Cronin - Director of Hospital Services
James Le Fevre - WDHB Board Member	Tamzin Brott - Director of Allied Health
Matire Harwood - WDHB Board Member	Fiona McCarthy - Director Human Resources
Brian Neeson – WDHB Board Member	Peta Molloy - Board Secretary
Morris Pita - WDHB Board Member	
Allison Roe - WDHB Board Member	

APOLOGIES: Andrew Brant

REGISTER OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

PART 1 – Items to be considered in public meeting

AGENDA

	1.	**AGENDA ORDER AND TIMING**
	2.	**BOARD MINUTES**
11.00am	2.1	Confirmation of Minutes of the Meeting of the Board (30/05/18) Actions arising from previous meetings
	3.	**CHAIR REPORT**
	4.	**EXECUTIVE REPORTS**
11.05am	4.1	Chief Executive Officer's Report
11.15am	4.2	Health and Safety Report
11.20am	4.3	Communications Report
	5.	**DECISION ITEM**
11.25am	5.1	Establishment of Waitemata DHB Consumer Council
	6.	**PERFORMANCE REPORT**
11.40am	6.1	Financial Performance
	7.	**COMMITTEE REPORTS**
11.50am	7.1	Minutes from the Hospital Advisory Committee Meeting (09/05/18)
	8.	**INFORMATION PAPERS**
11.55am	8.1	Governments Expectations on Employment Relations in State Sector
12.05pm	8.2	Equity Framework
12.15pm	8.3	Car Parking Charges at Waitemata DHB
12.30pm	8.4	Health and Safety Marker Report
12.35pm	8.5	Engagement Strategy
12.45pm	8.6	Statement of Performance Expectations
12.50pm	8.7	System Level Measures
12.55pm	**9.**	**GENERAL BUSINESS**
1.00pm	**10.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Waitemata District Health Board

Board Member Attendance Schedule 2018

NAME	Mar	Apr	May	Jul	Aug	Oct	Nov	Dec
Kylie Clegg (Chair)	✔	✔	✔					
Max Abbott	✔	✔	✔					
Edward Benson-Cooper	✔	✔	✔					
Sandra Coney	✔	✔	✔					
Warren Flaunty	✔	✔	✔					
James Le Fevre	✔	×	✔					
Matire Harwood	×	✔	✔					
Brian Neeson	✔	✔	✔					
Morris Pita	✔	✔	✔					
Allison Roe	✔	✔	✔					

× Apologies given
****Attended part of the meeting only***
 # Absent on Board business
^ Leave of Absence

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Judy McGregor (Board Chair)	Head of School, Social Science and Public Policy - Auckland University of Technology Associate Dean Post Graduate - Faculty of Culture and Society Member - AUT's Academic board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women's Centre Life Member - Hauturu Little Barrier Island Supporters' Trust	28/06/18
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board member - Rotary National Science and Technology Forum Trust	19/03/14
Edward Benson-Cooper	Chiropractor - Milford, Auckland (with private practice commitments)	07/12/16
Kylie Clegg (Deputy Chair)	Trustee - Well Foundation Director - Auckland Transport Director - Sport New Zealand Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary - M&K Investments Trust (includes a share of less than 1% in Orion Health Group). Orion Health Group has commercial contracts with Waitemata DHB and healthAlliance	03/07/18
Sandra Coney	Member - Waitakere Ranges Local Board, Auckland Council Patron - Women's Health Action Trust Member - Portage Licensing Trust Member - West Auckland Trusts Services	15/12/16
Warren Flaunty	Member - Henderson–Massey Local Board Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Director - Life Pharmacy Northwest Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd	06/06/18
Dr Matire Harwood	Senior Lecturer - Auckland University Director - Ngarongoa Limited, which is contractor providing services to National Hauora Coalition GP at Papakura Marae Health Clinic Advisory Committee Member - State Foundation NZ (Maori Health) Member Te Ora, Maori Medical Practitioners Step-daughter is a surgical registrar at Waitemata DHB	10/05/18

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
James Le Fevre	Board Member - Auckland District Health Board Emergency Physician - Auckland Adults Emergency Department Trustee - Three Harbours Foundation Member - Medical Protection Society Member - ACEM Hospital Overcrowding Subcommittee Member - Northern Regional Clinical Practice Committee Shareholder - Pacific Edge Ltd DHB Representative (Auckland and Waitemata DHBs) - Air Ambulance Co-design Procurement Governance Board James' wife is an employee of the Waitemata DHB, Department of Anaesthesia and Perioperative Medicine and a Medico-Legal Advisor for the Medical Protection Society	20/06/18
Brian Neeson	Member - Upper Harbour Local Board Member - Human Rights Review Tribunal Member - Auckland District Licensing Committee Managing Director - BK & VS Neeson Limited Managing Director - Apollo Property Investments Limited Property Development Consultant Brian's son-in-law is employed by the Housing Corporation and is undertaking work for Unitec related to its Mt Albert site development.	18/04/18
Morris Pita	Owner/operator - Shea Pita and Associates Limited Shareholder - Turuki Pharmacy Limited Member - Eden Park Trust Board Shareholder and Director of Healthcare Applications Limited Morris' wife is a: Board member - Northland District Health Board Board member - Auckland District Health Board Director - Healthcare Applications Limited	18/06/18
Allison Roe	Chairperson - Matakana Coast Trail Trust Member - Rodney Local Board, Auckland Council	02/11/16

2.1 Confirmation of Minutes of the Board meeting held on 30 May 2018

Recommendation:

That the Minutes of the Board meeting held on 30 May 2018 be approved.

Minutes of the meeting of the Waitemata District Health Board

Wednesday, 30 May 2018

held at Boardroom, Level 1, 15 Shea Tce,
Takapuna, commencing at 9.54 am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Kylie Clegg (Board chair)
Max Abbott
Edward Benson Cooper
Sandra Coney
James Le Fevre
Warren Flaunty
Dr Matire Harwood
Brian Neeson
Morris Pita
Allison Roe

ALSO PRESENT:

Dale Bramley (Chief Executive Officer)
Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Debbie Holdsworth (Director, Funding)
Jocelyn Peach (Director of Nursing and Midwifery, Emergency Systems Planner)
Tamzin Brott (Director of Allied Health, Scientific and Technical Professions)
Fiona McCarthy (Director Human Resources)
Karen Bartholomew (Director Health Outcomes)
Peta Molloy (Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Sue Claridge, Auckland Women's Health Council

There were no media representatives present.

WELCOME

The Board Chair welcomed the Board members and all those present at the meeting.

APOLOGIES:

No apologies were received.

DISCLOSURE OF INTERESTS

Morris Pita restated his disclosed interest for Shea Pita and Associates, re-declaring that his wife has undertaken work with the DHB's Maori Health Team. He advised that he is not involved with the work, but understands that it completes 20 June 2018. He noted that his

wife is also doing some work with Te Ha Oranga which is a Ngati Whatua health provider and funded by Corrections; Te Ha Oranga also has a contract with the DHB.

Morris Pita also declared his interest with items 3.14 ('Safe Transfer of Patients from the Emergency Department to Urgent Care Clinics') and 3.15 ('Ministerial Waiver for EmergencyQ') of the public excluded agenda, advising that he had not received the papers and he will step out of the meeting for the discussion and decisions of these items. Morris' interest is that he is a director and shareholder in Healthcare Applications Limited that provides an EmergencyQ app to Waitemata DHB as a pilot from mid-2016 to the present.

James Le Fevre advised that because of his registered interests as an Emergency Physician at Auckland DHB related to item3.14 ('Safe Transfer of Patients from the Emergency Department to Urgent Care Clinics') of the confidential agenda. He noted that there was no transactional interest in this item. The Board Chair advised and it was agreed that James Le Fevre would step out of the meeting for the discussion of this item.

With regard to item 3.3 of the public excluded agenda (related to primary care), Matire Harwood advised that she was contracted at a Primary Health Organisation to provide clinical advice on their performance for the National Hauora Coalition. It was agreed at the Chair's directive that Matire Harwood would step out of the meeting and not participate in the discussion or decision making for this item.

It was noted that Brian Neeson had not received item 3.1 (related to the Mason Clinic) of the public excluded agenda due to his previously disclosed interest related to his son-in-laws employment with the Housing Corporation, who are involved with Unitec and the development of its Carrington site in Mt Albert. It was agreed that Brian will step out of the meeting for the discussion and decision making of this item.

1 AGENDA ORDER AND TIMING

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

Kylie Clegg acknowledged the appointment of the DHB's new Chair, Professor Judy McGregor. She advised that Professor McGregor takes office on 10th June 2018 and the DHB looks forward to welcoming her. Professor McGregor has an extensive background and has been in dialogue with both Kylie and the Chief Executive in the lead up to her taking office.

2 BOARD MINUTES

2.1 Confirmation of Minutes of the Meeting of the Board (18/04/18) (agenda pages 6-15)

Resolution (Moved Brian Neeson/Seconded Sandra Coney)

That the Minutes of the Board meeting held on 18 April 2018 be approved.

Carried

Actions arising from previous meetings (agenda pages 16)

It was noted that Board members will be provided with access to the online induction programme for staff.

2.2 Circular Resolution (26/04/18) – Approval of the Draft 2018/19 Statement of Performance Expectations (agenda pages 17)

Resolution (Moved Max Abbott/Seconded Sandra Coney)

That the Board:

a) **Notes that the Waitemata DHB has not yet received funding or planning advice for the 2018/19 year, resulting in a delay to development of its Annual Plan including the Statement of Performance Expectations.**

b) **Notes the legislative requirement under the Crown Entities Act to submit a draft Statement of Performance Expectations to the Minister of Health for review no later than two months before the start of the financial year to which they apply.**

c) **Notes that the Manager Planning and Health Intelligence (Waitemata DHB) has advised the Ministry of Health under separate cover that the DHB is not submitting financial or Annual Plan information at this time.**

d) **Approves submission to the Ministry of Health of the Draft Waitemata DHB 2018/19 Statement of Performance Expectations (with caveats around the need to update information once advice is received from the Ministry of Health) to meet legislative requirements under the Crown Entities Act.**

Carried

3 EXECUTIVE REPORTS

3.1 Chief Executive's Report (agenda pages 18-38)

Dale Bramley summarised this report, noting the recent visit from the Prime Minister who met many staff and visited Clinical areas. He also acknowledged the appointment of the new Board Chair Judy McGregor, who will take office on 10 June.

Matters covered in discussion or response to questions included:

- The Chief Executive spoke about the funding envelope received and advised that the total apportion for the DHB is $549million (an increase from $439million the prior year). There was a funding increase of 3.4 per cent for the entire country.
- In response to a question from Max Abbott about the proposed increase to pay for nurses; the Chief Executive advised that the DHB is cognisant of any potential impacts an increase may have, it is understood that there will be some assistance from the Government around any settlement reached.
- The Board Chair noted a presentation she had received on *blockchain* and suggested that i3 could review it and look at what it could mean for an organisation such as the DHB.
- Sandra Coney noted the update provided on the major storm that struck Auckland overnight on 10 April (page 22 of the agenda) and the subsequent impact on loss of power for many residents. She queried whether Vector had formally apologised for the ongoing outages and/or communicated with the DHB on this issue. Jocelyn Peach advised that a review is being undertaken, which will look at the response in general and as a region, identifying areas that could be done better. She advised that Civil Defence Auckland is completing the review and the terms of reference can be provided. It was

noted that Vector has a list of medically vulnerable people who have registered themselves, most being long term oxygen users; it is up to individuals to register. The DHB when responding to events such as this uses its range of networks to ensure vulnerable people within its services are contacted and supported as appropriate; there is no central list due to the volume and complexity of maintaining that. The Chief Executive noted the importance of ensuring the DHB does not devolve its responsibility and does what is needed for its vulnerable patients.

The report was received.

3.2 Health and Safety Performance Report (agenda pages 39-57)

Fiona McCarthy (Director of Human Resources) and Michael Field (General Manager, Occupational Health and Safety) were present for this time.

Fiona McCarthy introduced this item. In response to a question raised, she advised that with regard to section 6 'key health and safety risks' and the length of time taken for risks and mitigations to be completed that it is approximately 52 per cent completed in greater than a 12 month period and 47 per cent completed in less than 12 months. She also advised that with regard to the update provided on the risk 'hazardous substances and new organisms' (page 43 of the agenda) that the senior management team had approved the pilot for internal transfer system of hazardous waste. The pilot commences in June 2018.

Matters covered in discussion and response to questions included:

- Michael Field provided an update on the flu vaccination rate to-date being 48.5 per cent. He noted that the DHB had a new model for vaccinations this year with a team of 140 vaccinators throughout both hospitals. There is a three week period of roving vaccinators and two clinics being run every day. It was noted that communication material for staff is focussed on protecting the DHBs vulnerable patients.
- That the increase in reported incidents of aggression is in part to more compliant reporting as well as it being a key priority. It was also noted that historically some criteria was not being reported and is now, which impacted the data.
- In addition to levels of aggressive incidents, Michael Field noted that work had been undertaken by security operations nationally which has shown the level of aggression is increasing. Up to 90 per cent of aggression is by people who are not aware of what they are doing; incidents by people who are impaired by drugs and alcohol are captured as such. Categories will be amended to with intent, without intent and partial intent (drug and alcohol use). Sandra Coney requested that data be provided on gender for aggressive incidents. She noted her concern that there are increasing levels of aggression towards staff (and society in general) and that it is unacceptable that staff are exposed to violence by people they are trying to help.
- It was agreed that a paper would be provided on the DHB's policy and mitigation in place for dealing with aggressive incidents and the 'code orange' process. To be included in the paper is the number of times police are called to incidents on the hospital sites.
- The Board Chair acknowledged the information provided on bullying and harassment. It was requested and noted that a paper would be presented to the Board on the DHB bullying and harassment policy.

The report was received.

3.3 Communications Report (agenda pages 58-67)

Matthew Rogers (Director of Communications) summarised this item.

The report was received.

4 DECISION ITEMS

4.1 Integrating Governance, Leadership and Planning Arrangements for Maori Health (agenda pages 68-71)

Gwen Tepania-Palmer (Chair Auckland DHB and Lead Chair, Maori Health for the metro Auckland DHBs) and Roger Perkins (Executive Head, Chief Executive's Office)

The Board Chair welcomed Gwen Tepania-Palmer to the meeting.

Gwen Tepania-Palmer introduced the report, noting the times of change and transition as well as the important gains made in collaboration among the metro-Auckland DHBs.

Resolution (Moved Morris Pita/Seconded James Le Fevre)

That the Board:

1. **Note that, because of changes in Board leadership, there have been delays in implementing decisions taken by the Boards of the Auckland, Counties Manukau and Waitemata DHBs at their meetings on 1 November 2017, 6 December 2017 and 8 November 2017 respectively in respect of the governance, leadership and planning arrangements for Maori health across the metro Auckland DHBs.**
2. **Note that the interim Chairs of Auckland and Waitemata DHBs, together with the Chief Executives of the metro Auckland DHBs, recently met to discuss best ways forward in the light of Recommendation 1 above and agreed that:**
    a) **As soon as all three new Board Chairs are in place (by 10 June), the Chairs will be asked to appoint members of the new MHAC, in accordance with decisions 2-3 of the Waitemata DHB Board resolution 08 November 2017. A first meeting of MHAC will then be able to be scheduled.**
    b) **The extension of the role of the Chief Advisor Tikanga for both Auckland and Waitemata DHBs to include Counties Manukau DHB should be placed on hold for the time-being until Counties Manukau DHB and Manawhenua signal they are ready for this extension.**
    c) **Dr Bramley, as lead Chief Executive Officer for Maori health across the metro Auckland DHBs, will consult with Maori Health Advisory Committee (MHAC), once established, on a suitable process for the recruitment and appointment of a Director, Maori Health Services. Assuming MHAC favours a single Director of Maori Health Services across the metro Auckland DHBs, Dr Bramley will lead the appointment panel for the position and invite the other metro Auckland Chief Executives to join the panel, should they wish to do so.**

d) **As an interim measure, and recognising that the process contemplated in 3 (see the 'comment' section of the report) may take a number of months, Counties Manukau DHB should immediately move to fill its vacant position of General Manager Maori Health on a fixed term basis of 12-18 months.**

e) **A further update should be provided to all three metro Auckland DHB Boards once tangible progress has been made with steps 1-4 outlined in the 'comment' section of the report.**

3. **Note that, as provided by the New Zealand Public Health and Disability Act 2000, appointments to staff positions, as contemplated in Recommendation 2 (c) above, are the preserve of a Chief Executive not a Board or Board Committee.**

4. **Endorse the actions set out in Recommendation 2 above, subject to the Minister of Health first being advised of the intention to create a combined MHAC and the Boards of the metro Auckland DHBs considering any feedback that he may have.**

Carried

Gwen acknowledged the recent appointment of Pat Snedden as Chair of the Auckland DHB. She thanked everyone for their support over the past few months in her role as interim Chair, acknowledging Kylie Clegg and that it had been a privilege and honour to work with her. Kylie thanked Gwen for her comments as well as for her support and wise counsel and all that she had done for Auckland DHB.

4.2 2018/19 Annual Plan Approach (agenda pages 72-77)

Wendy Bennett (Planning and Health Intelligence Manager) presented this item.

Matters covered in discussion and response to questions included:

- That there will be the opportunity for updates and a review of the 2018/19 Annual Plan, the final draft is expected to be completed by October 2018.
- With regard to the Minister of Health's expectation of planning for 2018/19 and the future related to addressing climate change; it was noted that the DHB has a sustainability officer and that the Ministry has a number of requirements in this area. The level of detail required will be looked at.
- That with regard to the Ministry of Health exploring life course approaches to understand population performance it was advised that this is to be identified in the plan by way of significant activities that contribute to population health trough each stage of life.

Resolution (Moved James Le Fevre/Seconded Matire Harwood)

That the Board:

a) **Note the compressed timetable to deliver a first draft of the 2018/19 Annual Plan to the Ministry of Health by 16 July.**

b) **Approve the approach to annual planning for 2018/19 which will require a compressed process to develop and collate the first draft to be presented to the 11 July Board meeting to review and also to gain approval to submit to the Ministry of Health.**

c) **Approve delegation of any amendment or last minute changes to the Annual Plan, Statement of Performance Expectations and Statement of Intent be delegated to the Board Chair and the Chief Executive.**

d) **Note the recently released national planning guidance, including updates and changes**

   a. **The Ministry is exploring life course approaches to understand population performance.**
   b. **Increased focus on equity.**
   c. **Additional priority sections: Public delivery of health services, Climate change, Waste disposal, Budget 18 initiatives (once confirmed), Cross-government targets (once confirmed).**
   d. **All of the Health Targets are under review and information as to which will continue in 2018/19 is still to be confirmed.**

Carried

4.3 Amendment to Official Information Act Policy - Charging (agenda pages 78-104)

Matthew Rogers (Director Communications) and Amanda Mark (Legal Counsel) were present for this item.

Mathew Rogers summarised the paper and provided the background to the policy. He advised that the Ombudsman had criticised the charging provisions in the DHB's current policy and made recommendations for the DHB to amend it. The DHB's policy has subsequently been amended and the Ombudsman's office has advised that the amendments address the concerns raised.

Matters covered in discussion and response to questions included:

- That consideration in the way information is provided can reduce time in responding to an information request; the DHB is generous in its interpretation of a request.
- That implementation of the national framework for proactive disclosure of information is scheduled for 1 July 2018.
- Noting that the new Minister of Health's office has advised that they do not expect to receive all OIA responses as they are released. There is a process whereby the Ministry of Health is informed. In a situation where it is considered a response must be brought to the Minister of Health's attention directly, that will occur.
- The policy will be corrected to read Ministry of Health rather than 'Minister's office'.

The Board Chair thanked Matt Rogers and his team for the work they undertake and the expertise they provide in responding to Official Information Act requests.

Resolution (Moved Max Abbott/Seconded Allison Roe)

That the Board:

a) **Notes the Ombudsman's decision in relation to complaints by the NZ Herald and the Wireless.**
b) **Approves the amendment of the sections of the Official Information Act policy dealing with charging for substantial collation or research and in particular, the deletion of the provision for charging if more than five hours collation or research.**

Carried

4.4 Appointment of Catherine Abel-Pattinson to healthAlliance NZ Limited Board (agenda page 105)

A copy of Catherine Abel-Pattinson's bio was tabled.

The Board Chair summarised the paper.

Andrew Brant advised that a review was underway to look at how IT is being governed as a collective amongst the northern region DHBs. It was noted that this recommendation put to the Board on the Counties Manukau Health representative for the healthAlliance Board does not impact the review.

Resolution (Moved Brian Neeson/Seconded Max Abbott)

That the Board:

a) **Note that Lee Mathias' term as the Counties Manukau DHB Chair concluded in December 2016.**

b) **Note that Counties Manukau DHB has proposed that Catherine Abel-Pattinson, Counties Manukau DHB Board Member be appointed as a Director of healthAlliance NZ Ltd, to replace Lee Mathias.**

c) **Approve the appointment of Catherine Abel-Pattinson, Counties Manukau DHB Board Member, as a director of healthAlliance NZ Ltd.**

Carried

5 PERFORMANCE REPORTS

5.1 Financial Performance (agenda pages 106-113)

Robert Paine (Chief Financial Officer and Head of Corporate Services) summarised this item.

The Board Chair acknowledged the work undertaken on the DHB's financial performance.

The report was noted.

6 COMMITTEE REPORTS

6.1 Minutes from the Hospital Advisory Committee (28/03/18) (agenda page 114-121)

James Le Fevre (Chair, Hospital Advisory Committee) summarised the minutes.

The minutes of the Hospital Advisory Committee were noted.

6.2 Draft Minutes from the Community and Public Health Advisory Committee (04/04/18) (agenda page 122-128)

Warren flaunty (Deputy Chair, Auckland DHB and Waitemata DHB Community and Public Health Advisory Committee) summarised the draft minutes; of particular note was the verbal

presentation to the Committee from representatives of both the Hibiscus Hospice and the North Shore Hospice Trust and their strengthened strategic partnership established.

The minutes of the Community and Public Advisory Committee were noted.

7. INFORMATION PAPERS

7.1 Health and Safety Marker Report - Update (agenda pages 129-148)

Fiona McCarthy (Director of Human Resources) summarised this item.

In response to a comment from James Le Fevre about the performance classification of the 'health of workers,' Fiona advised that work continues on the indicators.

The report was received.

7.2 Briefing on Waitemata DHB Activity in the Minister of Health's priority areas (agenda page 149-164)

Dr Karen Bartholomew (Director Health Outcomes), Tim Wood (Deputy Director Funding) and Ruth Bijl (Manager Child, Women and Youth) were present for this item.

Karen Bartholomew summarised the paper, noting that the Minister of Health had signalled key priority areas some time ago. The priority areas were well aligned with work underway in the DHB. Specific areas of planning guidance are still to be confirmed and the report presented to the Board is high level information on the current work programme.

Matters covered in discussion and response to questions included:

- Noting that one of the Minister of Health's priorities is improving access to primary care. The DHB has been working on high needs populations and improving access to after hours; this may need to be revisited once the policy for improving access to primary care is in place. The DHB is also undertaking work around diabetes management that has a strong focus on addressing the needs of Maori and Pacific people. There is also a broader practice of improving systems in primary care to be more efficient in the way care is delivered and a focus on key safety issues; this work should align with the Minister's priority in this area.
- Debbie Holdsworth noted that it was pleasing to see the emphasis on the wellbeing of children and the focus on the first 1000 days of a child's life; the DHB had work underway in this area that is well aligned to the Minister's priority in this area.
- It was noted that the current health targets are in place until the end of June 2018 and are under review.
- The Chief Executive referred to the health system review recently announced, the terms of reference have been provided by the Ministry of Health. The review is substantial and will be detailed; the final review will not be released until 2020.
- Sandra Coney referred to the update provided on the 'Government Inquiry into Mental Health and Addiction 2018' (page 158 of the agenda) and requested the Board members be provided with a copy of the Waitemata DHB's stocktake report referenced.
- Sandra Coney queried the Board members policy on attending workshops and the like in areas of interest. The Board Chair noted that there is a policy in place. The Chief Executive advised that invitations can be extended to Board members for any official lectures or events that are in an open forum.

- In response to a question from Morris Pita about the reference to the Asian Benchmarking Report and addressing the needs of responding to a broader population group, it was noted that health literacy includes an understanding of how the broader system works and includes work on how to respond to changing demographics.

The report was noted.

8. GENERAL BUSINESS

Waitakere Hospital Car Parking Fees

The Board Chair tabled a letter from the Chair of Waitakere Health Link about car parking fees on the Waitakere Hospital site. It was recommended that management review the letter and report back to the Board on matters raised.

9. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 165-172)

It was noted that item 20 should be referred to 'Ministerial Waiver for EmergencyQ', with this correction the recommendation was agreed.

Resolution (Moved Warren Flaunty/Seconded Edward Benson-Cooper)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Minutes of Meeting of the Board - Public Excluded (18/04/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Recommendations from the Audit and Finance Committee – Public Excluded (09/05/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations.

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		[Official Information Act 1982 S.9 (2) (j)]
3. Minutes of the Audit and Finance Committee – Public Excluded (28/03/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4. Minutes of the Hospital Advisory Committee – Public Excluded (28/03/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
5. Minutes from The Three Harbours Health Foundation (08/11/17)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act
6. Mason Clinic Site Update	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
7. 2018/19 Colonoscopy and Gastroscopy Outsourcing	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
8. Contract Renewal and Value Increases	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
9. Settlement of Auckland DHB DRG price and non-DRG Ophthalmology IDFs for 2016/17	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
10. Recycling of Capital	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	**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.

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	(except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	[Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
11. 2018/19 Asset Performance Measures	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
12. 2018/19 Capital Investment Plan	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
13. New Zealand Health Partnerships Proposed Annual Procurement Plan FY18-19	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which

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		if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
14. New Zealand Health Partnerships Statement of Performance Expectations 2018/19		**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 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
15. Lease Renewal	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
16. Lease Renewal	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	**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.

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	(except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	[Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
17. Lease Renewal	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
18. Asset Condition Survey	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
19. Safe Transfer of Patients from ED	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available:

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		i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
20. Ministerial Waiver for EmergencyQ	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
21. Hospice 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
23. Compassionate Funding 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]

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24. Compassionate Funding Decision	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
27. Board Decision Implementation 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	As per the resolutions from the open section of minutes of the relevant meetings as they relate to particular items in terms of NZPH&D Act 2000.

GENERAL BUSINESS

There were no items of general business.

11.49am – Karen Bartholomew retired from the meeting.

The open meeting concluded at 11.49 am.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATA DISTRICT HEALTH BOARD - BOARD MEETING HELD ON 30 MAY 2018

_____CHAIR

Actions Arising and Carried Forward from Previous Board Meetings as at 05 July 2018

Meeting Date	Agenda Ref	Topic	Person Responsible	Expected Report back	Comment
30/05/18	3.1	Civil Defence Auckland review of response to major storm in Auckland overnight 10 April 2018 Board members to be provided with a copy of the review Terms of Reference	Jocelyn Peach		Terms of reference emailed to the Board.
30/05/18	7.2	Government Inquiry into Mental Health and Addiction 2018 Board members to be provided with a copy of the Waitemata DHB's stocktake report.	Susanna Galea		A copy of the report has been provided in the resource centre of Diligent Boardbooks.

3. Waitemata District Health Board - Chair's Report

Recommendation

That the report be received.

Prepared by: Professor Judy McGregor (Board Chair)

Key activities for Board information

National DHB Chairs and Chief Executives Meeting, June 14, Wellington

Key elements were comments that it was good to have Auckland back at the Chairs' table. Chairs discussed whether the Institute of Directors' module for improving governance practices was superior to others. Six DHBs are using the module. However, it is short on equity considerations so may be less useful for Waitemata DHB. While this was my first meeting I think the Auckland Chairs collectively were frustrated at the format of the meeting with a long IT presentation from the Ministry of Health and the lack of action points that emerged from discussions. The Minister, David Clark, attended and spoke to the industrial action by nurses and other groups in the sector.

Sir Brian Roche, a Ministerial Advisory Group (MAG) representative attended and it is intended that MAG has a finite life.

Briefing on Northern Region Long Term Investment Plan (NRLTIP) Metro Auckland DHB Chairs, June 15, Penrose

Three Chief Executives briefed the three new chairs on the NRLTIP and there is strong commitment in principle to the joined-up approach based on an outstanding evidentially-based report. The three metro chairs talk by phone and will start regular calls with Northland DHB later this week (Friday 13 July).

Ministry of Health 2018/19 Annual Plan Workshop, Waitemata DHB, 3 July, Wellington

Described as a "kitchen table conversation" with the new Director General, Dr Ashley Bloomfield, and six senior MoH executives, this was an opportunity to workshop the 2018/19 annual plan. The DG genuinely listened and it is clear that new, constructive relationships are being forged between the MoH and DHBs. The Waitemata DHB Chief Executive and senior leadership team ran through the Government's four key health priorities: equity, child health, mental health and primary care and outlined current Waitemata DHB key programmes of work, areas of focus and investment priorities in these priority areas. It was an opportunity for Dale to emphasis the critical nature of the Mason Clinic decision and the ECIB (Elective Capacity Inpatient Beds) case for North Shore Hospital. There was discussion around a wider communications strategy with the Minister involved for disseminating the NRLTIP. Financial sustainability was a sub text of the meeting.

Site visits

I have visited a number of sites at North Shore and Waitakere Hospitals and met with members of the innovation group as well as other senior clinical and professional staff as well as the executives who have made time for me. I am extremely grateful for everyone's interest in ensuring that I have an understanding of the complexity and scope of the health sector. I am grateful to those who have prepared briefings and made the time to talk with me. Superior induction!

Audit and Finance Committee and Board member meetings

I have met with both Tony Norman and Norman Wong who have agreed to remain as chair and deputy chair of the Audit and Finance Committee for the calendar year which is extremely useful. I have met with James Le Fevre and Morris Pita as board members and have met several times with Kylie Clegg whose handover has been immaculate. I'm anxious to meet with other Board members who are interested as I get to grips with the Chair's role.

Inaugural Matariki awards, July 4, Whenua Pupuke

I had the pleasure of attending the inaugural Matāriki Awards on 4 July at Whenua Pupuke, North Shore Hospital. This event was sponsored and organised by Dame Naida Galvish as General Manager for Tikanga and Riki Nia Nia as General Manager for Maori Health as a way to recognise all staff across the organisation, working to improve health outcomes for Māori. One of our board priorities is to reduce inequities in the health system and this awards programme highlighted those using our organisational values to achieve this. Individuals and teams were celebrated for introducing initiatives, making systemic improvements or for simply working with a more culturally-appropriate attitude which boosted engagement within our Māori community. About 60 people and whānau attended the event including Chief Executive Dr Dale Bramley.

Judy McGregor.

4.1 Chief Executive's Report

Recommendation:

That the Chief Executive's Report be received.

Prepared by: Dr Dale Bramley (Chief Executive Officer)

1. News and events summary

A number of events of significance took place across the DHB over the past six weeks

- Our new Chair, Judy McGregor, was officially welcomed at a special ceremony on 20 June. Fellow Board members, the Executive Leadership Team and members of Judy's family gathered in the Waitemata Room at Whenua Pupuke to mark the start of her term as Chair, which began on 10 June. Judy has already met a number of our clinical leaders and service managers during her orientation to our DHB and has signalled that she wishes to continue meeting our staff as she familiarises herself with the work the Waitemata DHB team does on behalf of our community. We all look forward to continuing to work with Judy. A very warm Waitemata welcome.

Chair Judy McGregor speaks at the official welcoming ceremony on 20 June.

- On 13 June, our DHB played a role in a major Government announcement about further investment in drug and alcohol rehabilitation services for Aucklanders. The Prime Minister, Rt Hon Jacinda Ardern, and the Minister of Health, Hon Dr David Clark, announced a $16.7 million investment in new addiction treatment facilities that will see extra floor space added to

Auckland City Mission's innovative HomeGround development in the central city. This will pave the way for the relocation of the city's only dedicated inpatient medical detoxification service, operated by our own Community Alcohol and Drug Service (CADS) from its present site at Pitman House in Point Chevalier. The investment will enable the highest level of ongoing care and support to those seeking to overcome alcohol and drug-dependency issues, who are among the most marginalised and vulnerable people in our community. It is proposed that CADS' medical detoxification team would work from the HomeGround site once construction is completed in 2020. The opportunity for our mental health clinicians and other specialist staff to provide medical detoxification care in a modern, purpose-built facility right alongside other services offered by the City Mission is a major step forward in how this type of treatment is delivered. It will help to address the sustained high demand in Auckland for detoxification services. It also presents the opportunity for a new co-located model of care with other services that has the potential to reduce unnecessary ED presentations and hospital admissions. A full business case will be coming to the Board in due course.

http://www.waitematadhb.govt.nz/assets/Documents/news/media-releases/2018/Combined-detoxification-investment-announcement-welcome.pdf

- During National Volunteer Week (17– 23 June), the Waitemata DHB Volunteer programme was announced as runner-up in the Outstanding Achievement Team (Healthcare) award category in the Minister of Health's national awards. Volunteers Sandra Collecutt and Michael Cairns-Cowan, along with Volunteer Coordinator Genevieve Kabuya, were in Wellington for the ceremony.

Sandra Collecut, Genevieve Kabuya, Minister of Health Hon Dr David Clark and Michael Cairns-Cowan

- The 2018 CEO Lecture Series begins next month and we are fortunate to have secured two high-profile speakers to deliver separate addresses to our staff. The Minister of Health, Hon Dr David Clark, will present the first address on 1 August. Although Dr Clark delivered a speech when the

Prime Minister visited on 18 May, this will be the first opportunity for the Waitemata DHB workforce to hear from the Minister in detail about his plans for the health portfolio. The address will include a question and answer session. On 28 August, we will host former Prime Minister Helen Clark for a moderated discussion with our Chair, Judy McGregor. This promises to be a chance for staff to hear some fascinating insights from the former PM about her time in office and her subsequent work with the United Nations.

- In June, Waitemata became the only DHB in the country to achieve the distinction of holding two prestigious accreditations recognising our work on environmental sustainability and reducing our carbon footprint. Waitemata DHB was awarded the international Certified Emissions Measurement and Reduction Scheme (CEMARS) accreditation due to our efforts on recycling, sensible waste disposal and energy consumption. The CEMARS programme operates in multiple countries – offering large organisations a formal framework to monitor, measure and reduce their greenhouse gas emissions. Waitemata staff have long been encouraged to do their bit and are frequently issued with handy tips to help the DHB in our ongoing efforts to be environmentally friendly and sustainable. Bin options in the staff cafeteria ensure staff recycle wherever possible, minimising the amount of waste going to landfill. Energy conservation is another example and receives major consideration in peak seasonal periods when staff are encouraged to use heating and cooling devices wisely. Similarly, staff are invited to explore alternate travel arrangement to and from work in a bid to reduce traffic congestion. A trial currently underway offers them the opportunity to hire leased vehicles within the DHB's pool fleet for after-hours use at a reduced rate. Both North Shore and Waitakere hospitals are already Enviro-Mark Gold certified through Enviro-Mark Solutions, reflecting international best practice around environmental responsibility.

CEO Dr Dale Bramley and Sustainability Manager William Van Ausdal receive the DHB's CEMARS accreditation.

http://www.waitematadhb.govt.nz/assets/Documents/news/media-releases/2018/A-certified-approach-to-clean-and-green-at-Waitemata-DHB-.pdf

- On 31 May, our DHB launched a stop-smoking programme aimed at pregnant women. Jointly launched with Auckland DHB, this is a training initiative for health professionals that will ultimately connect pregnant smokers with local services to help them quit. The Effective Stop Smoking Conversations with Pregnant Women Online Programme was launched at North Shore Hospital during World Smokefree Day and includes videos, advice and pointers for all health professionals who work with women during pregnancy and through the immediate post-natal period. It is especially tailored to help them with conversations in Maori and Pacific communities where smoking rates are disproportionately higher than the rest of the population. The programme gives health professionals extra assistance to identify any barriers pregnant women have to quitting smoking and also helps them turn various conversational cues into opportunities to discuss stopping smoking, which is a potentially life-saving decision for themselves and their babies. The comprehensive and interactive training package will be made available to a diverse range of health sector workers, including GPs, midwives, lead maternity carers, Plunket and family planning workers. Ministry of Health figures collated between 2011 and 2015 show around 1,000 pregnant smokers register with maternity providers across Waitemata and Auckland DHBs every year. Around three quarters of them are of Maori or Pacific ethnicity.

  http://www.waitematadhb.govt.nz/assets/Documents/news/media-releases/2018/Stop-smoking-training-programme-aimed-at-pregnant-women.pdf

- The Health Research Council of New Zealand has announced a panel of health sector leaders to establish the country's first set of national health research priorities. I have been asked to be one of 13 members selected to sit on this panel, which includes health researchers, innovators, advisors and experts in the delivery of healthcare services. This development group will gather and weigh input from stakeholders across the health, science and innovation sectors to ensure the process of setting priorities is inclusive and serves the needs of the country's diverse populations and communities. A set of strategic investment areas are expected to be announced in early 2019, guiding national research work through until 2027.

- In May, we achieved our equal-highest-ever hand hygiene compliance rating of 90%. This was a tremendous result demonstrating our ongoing focus on patient safety. It was pleasing to see a number of wards and units recording 100% compliance. While there is still room for further improvement, a large number of clinical areas exceeded the national target of 80% hand hygiene compliance.

- In late June, Waitemata DHB launched a new programme providing a holistic approach to child health. Awhi Tamariki is a new early intervention health assessment and education programme being introduced into five Waitemata schools, seeing our public health nurses working to prevent common illnesses. It will help detect illnesses such as Group A Streptococcal throat infections, ear infections and dental issues when children start primary school. It builds on the previously established rheumatic fever screening programme and complements the current B4 School Checks focusing on meeting unidentified health need, behavioural and developmental progress. Awhi Tamariki enables public health nurses to assess new entrant children for issues with ears, skin, oral health and respiratory systems. It also includes education to children, teachers and whānau helping them identify health concerns and equipping them with skills to prevent illness.

  http://www.waitematadhb.govt.nz/assets/Documents/news/media-releases/2018/Awhi-tamariki.pdf

- *Creating a culture of appreciation*

A further 63 staff have been recognised in the CEO Awards, launched in mid-2014 to celebrate those staff, nominated by their colleagues and patients, who demonstrate our organisational values through their work. Each staff member whose nomination is considered worthy of acknowledgement receives a personalised letter of thanks, a certificate of appreciation and a small gift. Staff acknowledged with a CEO Award since the last Board meeting include:

Pani Pāora-Chamberlin – Taurawhiri, Māori Mental Health. Nominated by Sarah Hera Kinred.

"Pani goes over and above what is required as a taurawhiri. On more than one occasion, Pani has been able to locate tangata whai i te ora that haven't been able to be located. He uses his strong whanaungatanga that he worked hard to establish and this enables the safe transportation of whānau back to base to be seen by the doctor. Pani is dedicated to serving our Māori people and will go over and above to ensure the hauora (health) of our people. Ngā mihi kau atu ana e Pani!!"

Ali Roper - Therapy Assistant, Community West Therapies. Nominated by Mary Ellen Powdrell.

"Ali is an exceptional example of a staff member and person who consistently lives the Waitemata DHB values. She genuinely cares for patient and staff alike and it is a real pleasure having her on our team. She's one in a million!"

Peyton Wolfgramm - Learning and Development Consultant, Learning and Development. Nominated by Susan Rae.

"Peyton has assisted me in receiving coaching following my participation in the Management Foundations course last year. Workload prevented me from doing this in a timely manner and Peyton kindly nudged and supported me to get the application process completed. She truly embodies the DHB values of 'with Compassion,' 'Better Best Brilliant' and 'Connected'.

Johnny Siaosi - Consumer Support Worker, Pacific Mental Health and Addictions Service. Nominated by Astrid Smith.

"Johnny is one of the most compassionate people I have ever met. I feel privileged to work alongside him and I hope that he will be recognised for the enormous amount of work he does in our community, particularly with our Pacific people."

Stephanie Williams and Melanie Adriaansen - Medical Laboratory Scientists, Laboratory Services. Nominated by Tim Wood and Lis Cowling.

"Stephanie and Melanie have both provided the training and installation of the Rural Point of Care Testing equipment and systems with the DHB rural General Practice teams. The general practice (GP) teams have greatly appreciated the enthusiastic, supportive and friendly manner in which they have provided the training. The GP teams have expressed their gratitude for Stephanie's and Melanie's approach for a programme that will positively impact the care of the people living in our rural communities."

Debbie Blackburn - Team Leader, Service Administration Support. Nominated by Rebecca Hammond.

"Debbie has a can do attitude, is always positive and friendly. She is willing to help and is super-responsive to questions and queries, never making you feel like it is too much trouble despite her large workload."

Rose Smart - Research Support, Research and Knowledge Centre. Nominated by Nicolette Hansen.

"Rose does an amazing job of organising, setting up and running the Waitemata Health Excellence Awards, the preliminary rounds and supporting the entrants with their presentations."

Lisa Chittenden - HCA and Administration Clerk, Waiatarau Mental Health Unit. Nominated by Louise Jamieson.

"Lisa is a valuable asset to our unit. She is always courteous, compassionate and diligent with all that she does. She goes above her expected duties to ensure the unit is running smoothly, clients are comfortable and all are valued."

Di Franich - Enrolled Nurse, Waitakere Day Stay. Nominated by Ben Edwards and Juliette Wood.

"Di is always helpful and professional. She has a lovely compassionate manner and a strong teamwork ethic. It is a pleasure working with her."

Ana Kumia-Johnston – Cleaner, Clinical Support. Nominated by Shelley Vaudrey.

"Ana is now achieving a pass on weekly cleaning audits. She has also recognised health and safety risks and brought them to the attention of the CNM. Ana is pleasant, acts on requests and works hard to achieve Better, Best Brilliant on ADU. Thank you, Ana!"

Wendy Fagan - Pharmacy Assistant, Inpatient Pharmacy NSH. Nominated by Ariel Hubbert.

"Wendy is a great example of why the Inpatient Pharmacy department is such a great team to work in. She understands that doing the job well is about more than getting tasks done. She cares about those around her and it shows. Wendy recently organised and spoke at a memorial for our friend and colleague. This also involved her inviting our colleague's family and supporting them on the day. Throughout this, she considered other people's needs and not just her own."

Cathy Thompson - Registered Nurse, Transit Care. Nominated by Nitashna Bhagat and the Waitakere Radiology team.

"For being exceptionally helpful to the Radiology team. Cathy shows initiative and supports our radiology team with our busy workload. It's a pleasure working with her. Thank you so much for helping radiology staff members over and above your call of duty."

Judith Stanfield - Registered Nurse, Assessment and Diagnostic. Nominated by Melissa Hoffman.

"For her outstanding care of frail elderly patients, getting them dressed, moving early and ensuring they are getting the appropriate care and assessments."

Sam Brens - Programme Coordinator, Mason Clinic. Nominated by Lesley Turner.

"For developing and facilitating forensic specific sensory modulation training and supporting changes of practice."

Aroha Holt - Occupational Therapist, Community Team Forensics. Nominated by Lesley Turner.

"For developing and facilitating forensic specific sensory modulation training and supporting changes of practice."

Karine Harrop - Registered Nurse, Outpatients North Shore. Nominated by Xu Cui.

"Karine is a very experienced nurse with a lot of skills and knowledge that enable her to support other team members. Karine recently came in early to ensure that the team were knowledgeable and confident in their practice. Because of her help and support, clinics run smoothly and efficiently."

Renae Johnston - Registered Nurse, CADs Community and Home Detox Service. Nominated by Paraic McCormack.

"For being kind, caring and compassionate with patients and going above and beyond the call of duty in providing an excellent service. Thank you Renae for being a wonderful colleague within the Medical Detox Services and for going the extra mile."

Keryn Wilson - Charge Nurse Manager, CADs Medical Detox Service. Nominated by Paraic McCormack.

"Keryn is an awesome colleague, nurse and manager. She seamlessly absorbed the role of ward administrator when an admin officer role was decommissioned. She does everything without complaint. She rises to every occasion, providing an excellent, kind and non-judgmental service to our vulnerable clientele. She is always supportive of the staff in her team."

Joanne Young - Social Worker, Inpatient West Therapies. Nominated by Tess Gatchalian.

"For her great leadership that inspires the Social Work team in the west to become the best and the most brilliant in our work. Joanne leads by example and works with so much compassion and enthusiasm for both her patients and colleagues. We are so happy to have Joanne in our team."

Sharlene Sheppard - Registered Nurse, Child and Family North. Nominated by Megan Lyell.

"Sharlene has overcome huge challenges but remains professional, compassionate, and focused. She supports her colleagues in a very gentle way and always delivers child-focused care. Recently, she helped a 12-year-old girl overcome her fear of injections to have her vaccination at school. This girl came back and gave Sharlene a hug at the end of the programme to thank her for her care. This shows how well Sharlene builds rapport with young people and that she is incredibly valuable to our team."

Dr Lauren Child – Registrar, Haematology. Nominated by Wendy Matthew.

"Lauren is one of the kindest doctors I have ever worked alongside. Her communication skills are excellent when talking with patients and their families. She is an example of all the DHB values and the DHB is lucky to have her."

Dr Anna Elinder-Camburn – SMO, Specialty Medicine. Nominated by Wendy Matthew.

"Dr Elinder really helped me out in the ED department with a haematology patient and his wife. She was so compassionate to the patient and his distressed wife. She provided such a kind explanation to the wife that really helped her to deal with the situation."

Joanna Kim - Cultural Support Worker, Asian Health. Nominated by Grace Ryu.

"Joanna showed her compassion in her daily practice. She is very supportive of both her colleagues and her clients. Joanna is always caring and helping others."

Dr Rick Cutfield - SMO, NSH Diabetes Service. Nominated by Wendy Matthew.

"Dr Cutfield has always had the most beautiful bedside manner. However, this week he excelled himself. We had a young 37-year-old woman who was dying and the way he spoke to her and her family was amazing."

Dr Ewan Glassey – Registrar, General Medical. Nominated by Wendy Matthew.

"We had a young 37-year-old woman who was dying and Dr Glassey showed such kindness and empathy."

Lauren Burgess - Occupational Therapist, Isa Lei Services. Nominated by Dilrukshi De Silva.

"For her outstanding contribution to clinical work in Takanga A Fohe. Her passion for work and empathy for clients and families is admirable."

Choon Chieh - Occupational Therapist, Marinoto youth and Child West. Nominated by Kay Brightley.

"Choon is so organised and efficient and has a 'can-do' attitude. She is modest and compassionate, embodying what it means to be of service in the DHB. I am so grateful for her presence in my working life."

Kevin Kubendran - Clinical Engineering Technician, Hospital Operations. Nominated by Sally Nelson.

"For his willingness to help identify problems we have had with some of our equipment and finding solutions to repair and return them in a fully functioning state. Kevin shows commitment to his work and his helpfulness and pleasant manner encompasses the value that everyone matters."

Antoinette Heath - Recruitment Consultant, Recruitment. Nominated by Vanessa Aplin.

"Toni is one of the most compassionate, generous people I know. She has given her time and money to donate numerous quantities of food, baby formula etc. to St Vincent De Paul House – a charity based in Northcote. Toni cares for others and lives our Waitemata DHB values."

Francesca Menday - Administration Clerk, Forensics Management. Nominated by Sam Brens.

"For her tireless work effort and professionalism that she displays on a daily basis. Francesca manages her workload and deadlines through constant interruptions, while maintaining an upbeat attitude and sunny outlook."

Vanessa Trotman – Physiotherapist, EDARS. Nominated by Julia Frelan.

"I would like to give the thumbs-up to Vanessa and Caroline who have kept a steady ship in the west office with the ups and downs of our new service since EDARS started a couple of years ago. It has been a pleasure working with them both."

Caroline Hutchinson - Occupational Therapist, EDARS. Nominated by Julia Frelan.

"I would like to give the thumbs-up to Vanessa and Caroline who have kept a steady ship in the west office with the ups and downs of our new service since EDARS started a couple of years ago. It has been a pleasure working with them both."

Una Reynolds - Registered Nurse, ICU. Nominated by Ellen Burch.

"Una is always there when you need someone as a sounding board, when you're unsure where to start or when you just need a strong cup of tea. She is proactive, communicative and supportive of her colleagues and incredibly kind and compassionate with patients. I feel privileged to have been able to work with Una."

Dr Paraic McCormack - Medical Officer, Detox Centre. Nominated by Keryn Wilson.

"Paraic is a wonderful colleague and doctor. He gives freely of his time, often going above and beyond what is required of him. He is non-judgemental, caring, compassionate and mentors others. He does an awesome job and our clients are very fortunate to have him on their side when so many are not."

Cathy Thompson - Transit Nurse, Surgical and Ambulatory. Nominated by Nitashna Bhagat.

"For being exceptionally helpful to the Radiology team. Cathy shows initiative and supports our radiology team with our busy workload. It's a pleasure working with her. Thank you so much for helping radiology staff members over and above your call of duty."

Kirsten Ter Braak - Charge Nurse Manager, Ward 14. Nominated by Nitashna Bhagat.

"Kirsten embodies our WDHB values in her leadership and daily interactions. There is never a time when Kirsten is too busy to listen to a patient or family member's concerns and she accords the same respect and support to her staff. Kirsten demonstrates professionalism, commitment and dedication in her role as our CNM. A kind, caring and humble leader."

Marie Arellano - Clinical Support Coordinator, Research and Knowledge Centre. Nominated by Rose Smart.

"Marie is a compassionate and hardworking team member who is always a pleasure to work with. Marie recently completed an exceptional piece of work using her coding skills to deliver new functionality to the CeDSS site."

Maria Lourdes Escandor – Cleaner, Clinical Support Services. Nominated by Medeline Viana.

"Maria is quite industrious and she always maintains the cleanliness in the ward. She works every day in our ward to keep our working environment clean, safe and hygienic. Nothing is too much for Maria and she's always willing to help all the staff as well as the patients and relatives in any way she can."

Keshena Bennetts and Jessica Klippenstein - Social Workers, Marinoto Youth and Child North. Nominated by Heloise Pilling.

"Keshena and Jessica have done an amazing job connecting with our community. They are delivering an anxiety group from a community facility allowing increased access to families who would struggle to attend the hospital site."

Anne-Marie Jeffries - Occupational Therapist, Inpatient North Therapies. Nominated by Sonya Wilson.

"For Anne-Marie's excellent work as a casual Occupational Therapist at Waitakere - she is much appreciated!"

Michelle Theyers - Social Worker, Methadone Services. Nominated by Soulisone Sayarath.

"Michelle's compassion and empathy for the complex clients that she works with is clearly evident in the work that she does. She is a true embodiment of the Waitemata DHB values 'with compassion' and 'everybody matters'."

Albert Renaldi – Engineer, Biomedical Hospital Operations. Nominated by Michael Smith.

"Albert is very pleasant, approachable and reliable. He delivers an outstanding service and shows great understanding about how the equipment is required back to the department in a timely fashion. On several occasions, he has come through to ensure the service gets what it needs and ultimately, that the patient receives the optimal care."

Paul Sullivan – Healthcare Assistant, Ward 10. Nominated by the Ward 10 team.

"Paul is our 'go to guy' on our ward for any issues we have. Anything that needs fixing, changing or getting. You name it and he will endeavour to do it or get it done. Nothing is too much trouble and he does it with a smile, every time. Paul, we really appreciate your connectedness and your compassionate nature."

Simone Marsh - Health Care Assistant, Emergency Care Centre. Nominated by Sinead O'Malley.

"I love the way Simone is always available and willing to help when needed. She has a calm and gentle presence with our patients and it seems that nothing is too much trouble for her. She's such a valued member of the team and I know this sentiment is shared by all who work with her. Thank you so much Simone for all you do!"

Gitaben Patel – Cleaner, Clinical Support Services. Nominated by Trixina Smith.

"Our area has been cleaned efficiently. Gita vacuums the whole area and works at this task so the carpet is cleaned thoroughly. It is great to have a pleasant person doing this valued work."

Theresia Bottema - Patient Care Assistant, Outpatients North Shore. Nominated by Diane Leithead.

"Theresia always works extra-time in her own time to ensure the clinics are set up in a timely manner which enables clinics to start on time and run smoothly. Theresia's time management and organisational skills are exemplary and she is a great support to the nursing team and doctors."

Colleen Jagger - Patient Care Assistant, Outpatients North Shore. Nominated by Diane Leithead.

"Colleen's skills and flexibility between clerical and patient care are above and beyond those expected and desired of her role. Colleen's clinical knowledge-base means that many tasks are completed on time every time. Colleen is able to adapt to a variety of situations and roles that may be required of her during the day and ensures the clinics run smoothly and efficiently."

Jasmin O'Sullivan - Clerical Worker Clinical, Clinical Records. Nominated by Danielle Hacking.

"Jasmin goes above and beyond to ensure people receive the clinical records that they have requested. She works part-time and has the entire research and audit community to respond to. She is friendly and polite and must be a huge asset to her team. Thank you Jasmin for doing your job so efficiently with such a friendly manner, you really are a star!"

Dr Chandra Ramanathan – Psychiatrist, Community MH West 1. Nominated by Ambi Cherian.

"Dr Ramanathan is a humble psychiatrist who is compassionate, caring and kind. He has an outstanding willingness to spend time educating patients and their families about diagnosis and recommended treatments. He always goes above and beyond to provide the best care possible."

Mags Ross – Manager, CADs Central. Nominated by Jason Cabral-Tarry.

"Mags is supportive, friendly, approachable, always positive and pragmatic during meetings and projects with colleagues. She has brought valuable knowledge and experience to improve quality at CADS and strongly 'lives the values' through her leadership and collegiality with everyone here."

Vicky Brackstone - Social Worker, North Therapies. Nominated by Petra Fowler.

"Vicky has gone so many extra miles for months to assist a client's safety and well-being, regularly weighing up his vulnerability and risks with his abilities to care for himself. She has showed a great ability to balance compassion, ethical decisions and professionalism in response to the client's needs."

Rachel Prasad, Cathrene Orot, Micheline Habarugira, Michelle Soppitt, Brittany Fraser and Jinky Cos - Health Care Assistants, Bureau. Nominated by Dr Jacqui Gore.

"For showing such high levels of compassion and care to our patient while an inpatient on the medical wards. Their commitment and dedication was a crucial element to our patient's full recovery."

Neroli Blight - Specialty Nurse, Urology. Nominated by Susan Rae.

"Neroli is performing above and beyond what I would expect given such a short timeframe. She uses her initiative, anticipates issues and escalates these as required. She also works quickly to defuse upset patients and their families. Neroli embodies the DHB values of 'Better Best Brilliant', 'With Compassion' and 'Connected'."

Stephanie van Zyl - Operations Manager, Department of Anaesthesia and Perioperative Management. Nominated by Charles McFarlan.

"Stephanie leads with a clear dedication to her role and a calm approach to maintaining cross-discipline relationships. Stephanie also simply looks after the people around her."

Ciska Kritzinger - Senior Physiotherapist, Community West Therapies. Nominated by Mary Ellen Powdrell.

"Ciska is consistently caring, knowledgeable, fair and approachable for both staff and patients. Her enthusiasm and dedication is unwavering and infectious! We are so lucky to have you in the team."

Karen Jansen-Stephenson - Management Accountant, Corporate. Nominated by Simon Watts.

"Karen has successfully led the PO First Oracle project that has gone live this week. She has undertaken a comprehensive project roll-out including the provision of training, troubleshooting, support and guidance to a large number of oracle users across the Waitemata DHB. A real great example of being 'Connected'."

Racheal Perry - Registered Nurse, Child and Family West. Nominated by El Mann.

"Racheal supported our mutual client to have his vital treatment during the school holidays and in my absence. An awesome supportive colleague and much more than that, she also cares for his siblings when they also need unexpected care and attention. She's an amazing RN, a pocket rocket and such a fantastic example of collaborative support for our young clients in the community!"

2. Upcoming events

Looking toward the upcoming months, we can expect to see:

- 2018 CEO Lecture Series addresses by Minister of Health Hon David Clark on 1 August and moderated discussion with former PM Helen Clark on 28 August.
- Further progress on the replacement of CT scanners at Waitakere Hospital, with installation of the second new scanner scheduled for late 2018.
- Progress on a new CT scanner for North Shore Hospital.
- Awaiting the decision of the Capital Investment Committee on the much-needed expansion of our Elective Services Centre and upgrade to North Shore Hospital business case.
- Matariki Awards were to be held at Whenua Pupuke on 4 July at the time of preparing this report.

3. Future Focus

The Leapfrog programme was established as a means to support a focused, intensive burst to take a large leap in moving the DHB from where we are to where we want to be.

The programme consists of a small number of strategic organisation-wide projects that are resourced to achieve significant change and impact on health outcomes and patient/family experience.

The intended benefits are to move these projects along at a faster pace with top-level support for the significant changes required, giving greater visibility and attention to those projects identified as being important in achieving the DHB's priorities and purpose as well as instilling the culture of improvement and innovation.

The new version of the MyPatientList app has been rolled out significantly around the hospitals. This version has resolved previous technical issues. A further planned upgrade will add new features that our staff have requested and will significantly extend its use and usability.

The Outpatient work is proceeding well, with work on the collection and validation of email addresses from our patients underway in collaboration with Auckland DHB. General Surgery, ORL and Orthopaedics are using 'SOS cards' for patients who are not booked a follow-up appointment but are able to get one if needed within a defined period.

Interim telehealth technology licenses have been set up as part of the regional procurement process, which allows a small number of our clinicians to test video consultations for follow-up appointments with patients who do not need to, or are not able to, attend in person hospital clinics. In this interim phase, we will develop appropriate processes and patient communications and then look to scale it up across the organisation. This should make a huge difference to patients who currently struggle to attend hospital outpatient clinics due to travel, time off work or caregiving and other reasons.

Our Data Discovery team of analysts continue to do great work in developing dashboards and applications with clinicians and services. To date, 23 apps have been published and 16 are in development. The community of developers is growing, with three other staff members (two of them clinicians) having published apps.

Internal (and intra-DHB) eReferrals are now being extensively used, with more than 5100 sent and a significant drop in typed/scanned and uploaded referrals.

4. Outcomes discussion

This month, I have asked Michael Walsh from the Health Outcomes team to provide a summary of cancer registrations and deaths within Waitemata DHB.

Introduction

This summary of cancer in Waitemata District Health Board covers cancer registrations to 2016 and cancer deaths to 2015 (latest data available). It presents information about new cases of primary cancer diagnosed and reported to the New Zealand Cancer Registry. It also presents information on deaths of Waitemata DHB residents that were registered in New Zealand where cancer was recorded as the underlying cause of death. Note that mortality data containing an underlying cause of death is often only available two years after the death is registered. This delay allows for coronial processes to be completed.

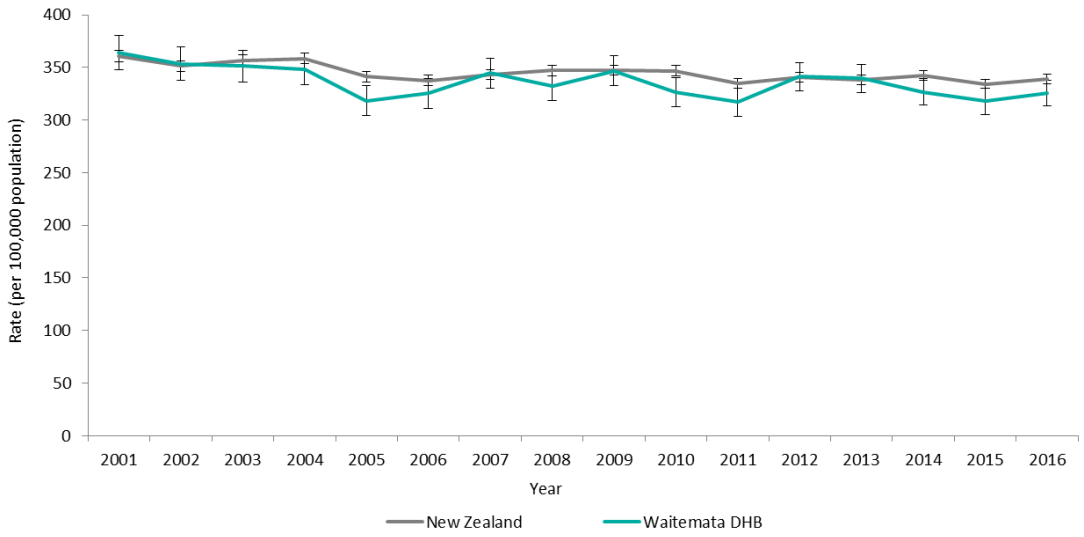
Key Highlights

- Registration rates for cancer in Waitemata DHB have declined by 10% since 2001 (compared to 6% nationally).
- Prostate cancer in males and breast cancer in females are the most-frequently registered cancers.
- Cancer deaths make up around a third of all deaths of Waitemata DHB residents.
- Waitemata DHB has among the lowest mortality rate from cancer of any DHB and is consistently lower than the New Zealand rate. The overall mortality rate has declined by 17% since 2001.
- The age-standardised mortality rate in the Waitemata DHB Māori population for all cancers is lower than the New Zealand rate.
- Lung cancer is the leading cause of cancer death in the Waitemata DHB population and is the leading avoidable cause of the life expectancy gap in the Māori population.
- Waitemata DHB has the highest five-year total cancer survival rate of any DHB.

Cancer registrations (2016)

- There were 2,757 new registrations of cancer of Waitemata residents in 2016.
- The age-standardised registration rate in 2016 was 325.5 per 100,000 population. This was slightly lower than the New Zealand rate of 338.8 per 100,000 population. However, the lower rate in Waitemata DHB was not statistically significant. In 2016, Waitemata DHB had the sixth-lowest age-standardised cancer registration rate of all DHBs.
- Since 2001, the age-standardised cancer registration rate has declined by 10% in Waitemata and 6% nationally. However, the overall number of cancer registrations has increased by 38% over this time period.
- More than half of all cancers where registered in males (1,438, 52.2%).
- Among males, the most-commonly registered cancers were prostate (399, 27.7%), melanoma (213, 14.8%), colorectal (175, 12.2%) and lung (105, 7.3%).
- Among females, the most-commonly registered cancers were breast (382, 29.0%), colorectal (173, 13.1%), melanoma (142, 10.8%) and lung, (126, 9.6%).
- Half of all cancers were registered among those aged 65 years and older.

Figure 1: Age-standardised cancer registration rates for Waitemata DHB and New Zealand, 2001 to 2016



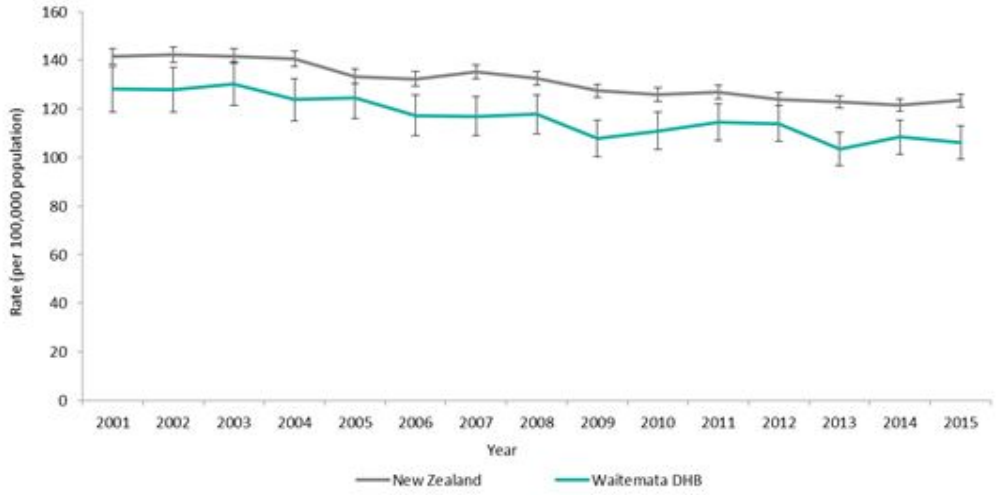
Cancer registrations – Ethnicity (2016)

- There were 143 cancers registered in the Māori population of Waitemata DHB with the most commonly registered cancer being lung and female breast (24 registrations each) followed by colorectal (18 registrations).
- There were 123 cancers registered in the Pacific population of Waitemata DHB with the most commonly registered cancer being prostate (20 registrations) followed by female breast (19 registrations) and uterus (10 registrations).
- There were 261 cancers registered in the Asian population of Waitemata DHB with the most commonly registered cancers being breast (44 registrations) followed by colorectal (36 registrations) and lung (34 registrations).
- There were 2,230 cancers registered in the European and Other population of Waitemata DHB with the most commonly registered cancers being melanoma (347 registrations) followed by prostate (338 registrations) and female breast (295 registrations)

Cancer mortality (2015)

- There were 969 deaths due to cancer of Waitemata DHB residents registered in 2015 (31.9% of all deaths).
- The age-standardised mortality rate was 106.2 per 100,000 population. This was lower than the New Zealand rate of 123.4 per 100,000 population. The lower rate in Waitemata DHB compared with the national rate in 2015 was statistically significantly. In 2015, Waitemata DHB had the second-lowest age-standardised cancer mortality rate among all DHBs.
- Since 2001, the age-standardised mortality rate from cancer has declined 17.1% in Waitemata DHB and 12.9% nationally, despite the number of cancer deaths increasing by 31% over this same period.
- More than half of all cancer deaths were in males (510, 52.6%).
- For males, the most-common cancer deaths were from lung (77, 15.1%), prostate (76, 14.9%), colorectal (75, 14.7%) and melanoma (32, 6.3%).
- For females, the most-common cancer deaths were from lung (85, 18.5%), breast (74, 16.1%), colorectal (54, 11.8%) and pancreatic, (35, 7.6%).
- Three-quarters of cancer deaths were among those aged 65 years and older.

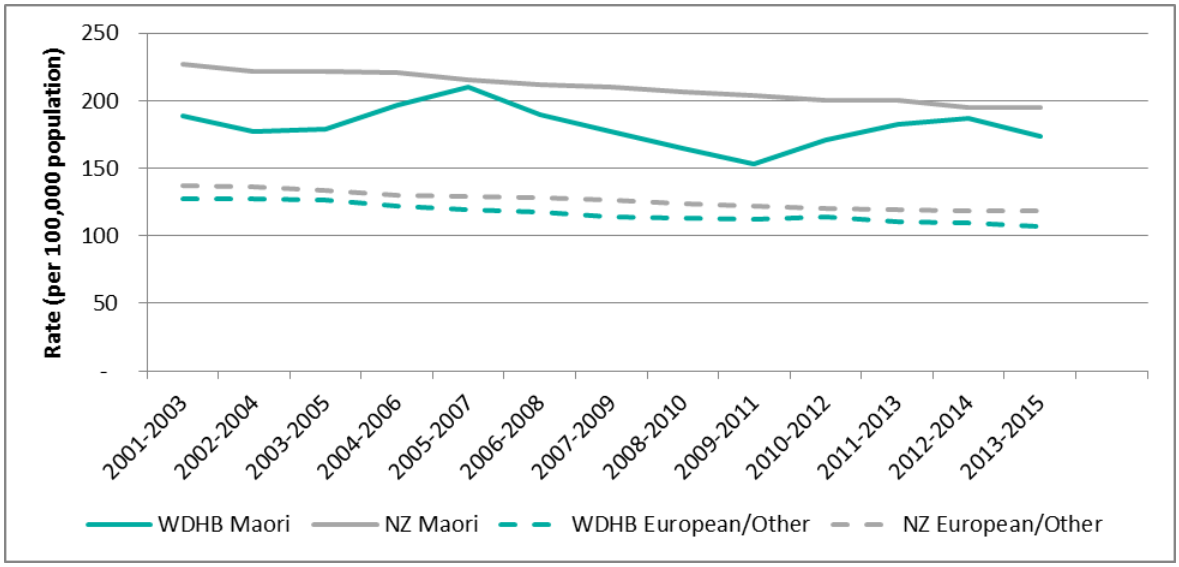
Figure 2: Age standardised cancer mortality rate for Waitemata DHB and New Zealand, 2001 to 2015



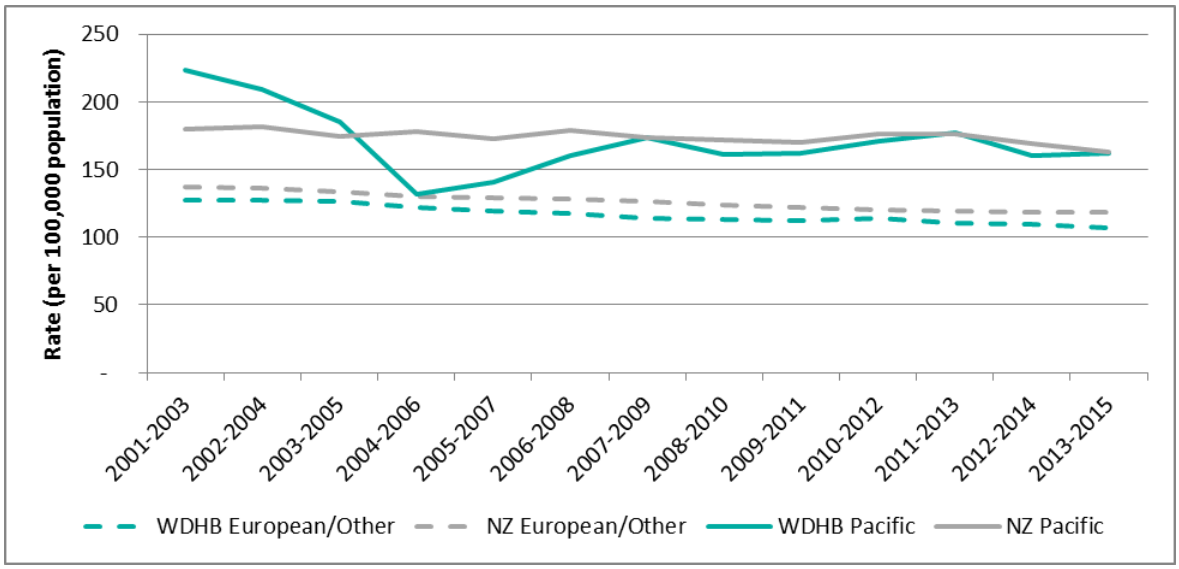
Cancer mortality – Ethnicity (2015)

- There were 64 deaths from cancer in the Māori population of Waitemata DHB, with the most-common cancer death being lung (18 deaths) followed by female breast (six deaths). The age-standardised mortality rate in the Māori population for all cancers was 173.5 per 100,000 Māori population (2013-15), this is lower than the New Zealand age-standardised rate of 195.2 per 100,000 Māori population.
- There were 54 deaths from cancer in the Pacific population of Waitemata DHB, with the most-common cancer death being lung (12 deaths) followed by female breast (seven deaths). The age-standardised mortality rate in the Pacific population for all cancers was 162.1 per 100,000 Pacific population (2013-15), this is very similar to the New Zealand Pacific rate of 163.0 per 100,000 pacific population.
- There were 58 deaths from cancer in the Asian population of Waitemata DHB, with the most-common cancer death being lung (13 deaths) followed by colorectal (nine deaths). The age-standardised mortality rate in the Asian population for all cancers was 58.4 per 100,000 Asian population (2013-15), this is slightly lower than the New Zealand age-standardised rate of 62.4 per 100,000 Asian population.
- There were 793 deaths from cancer in the European and Other population of Waitemata DHB, with the most-common cancer death being lung (119 deaths) followed by colorectal (110 deaths). The age-standardised mortality rate in the European and Other population for all cancers was 106.4 per 100,000 European and Other population (2013-15), this is lower than the New Zealand age-standardised rate of 118.1 per 100,000 European and Other population.

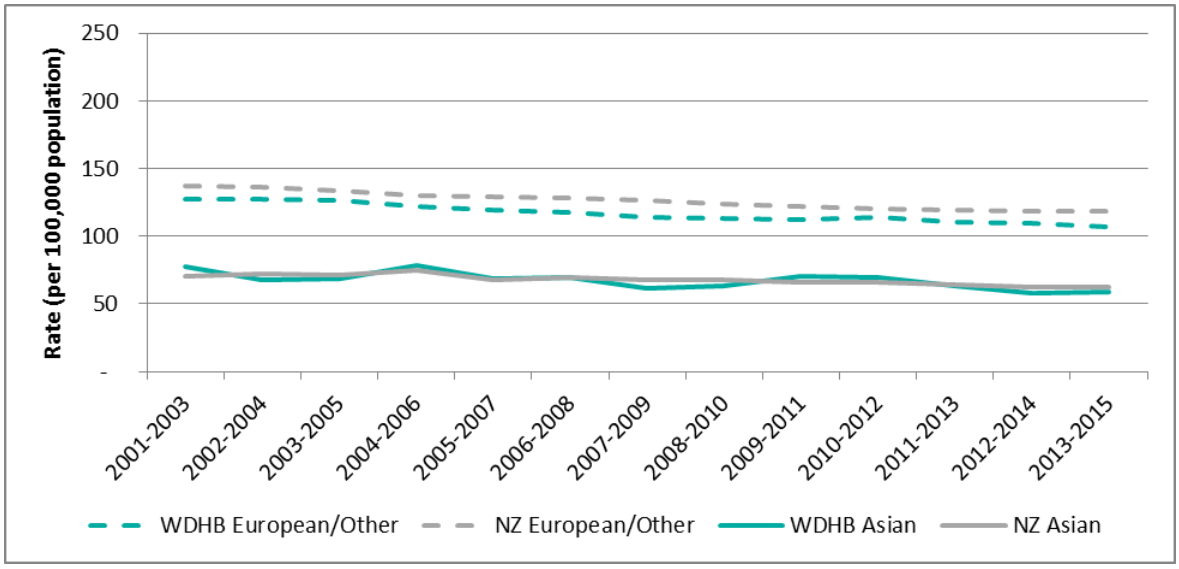
Age-standardised cancer mortality rate for **Maori vs European/Other**, Waitemata DHB and New Zealand 2001-03 to 20013-15



Age-standardised cancer mortality rate for **Pacific people vs European/Other**, Waitemata DHB and New Zealand 2001-03 to 20013-15



Age-standardised cancer mortality rate for **Asian people vs European/Other**, Waitemata DHB and New Zealand 2001-03 to 20013-15



Drivers of Waitemata DHB's lower mortality

Previous analysis has shown that the lower mortality rates from cancer within the Waitemata DHB population are related to age, ethnicity and socioeconomic deprivation.

Age: The age profile of the Waitemata DHB population is younger than New Zealand and accounts for 40% of the difference in the crude cancer mortality rate between Waitemata DHB and New Zealand. Age is a known risk factor for cancer as cancer is a disease largely associated with ageing; so the longer one lives, the greater that person's risk for developing the disease.

Ethnicity: The ethnicity profile of the Waitemata DHB population accounts for 15% of the difference in the crude cancer mortality rate between Waitemata DHB and New Zealand. Some cancers are known to occur more frequently in some ethnic groups compared with others. For example, Europeans have a higher incidence of bladder cancer than other ethnicities. Despite the observed differences, the variation across ethnicities is still not clearly understood.

Deprivation/socioeconomic status: The deprivation profile of the Waitemata DHB population accounts for 45% of the difference in the crude cancer mortality rate between Waitemata DHB and New Zealand. The Waitemata population has more of its population living in less deprived areas than that of New Zealand. Socioeconomic factors influence cancer risk factors, such as tobacco and alcohol use, poor nutrition, low physical activity and obesity. Income and education can influence access to appropriate early detection, treatment and palliative care services.

Cancer survival

Survival refers to the length of time lived after an initial diagnosis of cancer. Survival is one of the key indicators of the impact of cancer on society. It is a valuable way of measuring the success of cancer control in a population. Among Waitemata DHB residents that had a newly diagnosed cancer registered between 2013 and 2014, the five-year total cancer survival rate was 68%. It is important to note that survival rates vary by cancer type, ranging from around 93% for prostate, breast and melanoma to 19% for lung.

Contribution of avoidable cancer to the life-expectancy gap

Life-expectancy decomposition analysis allows inequalities in life-expectancy (life-expectancy gap) to be attributed to different causes of mortality. In 2012-14, the life-expectancy gap between the non-Māori/non-Pacific population and the Māori population in Waitemata DHB was 6.4 years. It was estimated that around 1.3 years of this gap was due to higher mortality rates at a younger age from avoidable cancers namely lung cancer (0.8 years), stomach cancer (0.2 years) and female breast cancer (0.2 years). Lung cancer in itself is the leading avoidable condition in Māori that is contributing to the life-expectancy gap. Lower mortality rates in Māori from colorectal cancer and melanoma had a positive impact on the Māori life-expectancy gap.

In the Pacific population, the life-expectancy gap in 2012-14 was 5.3 years, of which 0.8 years were estimated to be as a result higher mortality rates at a younger age from avoidable cancers. Unlike Māori, lung cancer in the Pacific population contributes only 0.3 years to the life-expectancy gap. Similarly to Māori, lower mortality rates from colorectal cancer and melanoma had a positive impact on the Pacific life-expectancy gap.

Figure 3: Contribution of the leading causes of mortality to the life-expectancy gap in 2012-14 (6.4 years) between Waitemata DHB Māori and Non-Māori/Non-Pacific

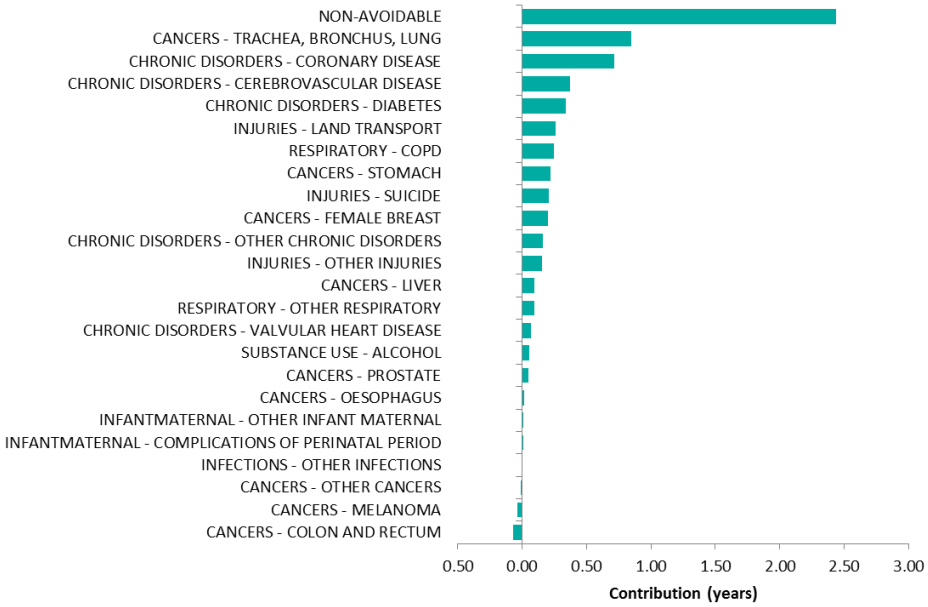
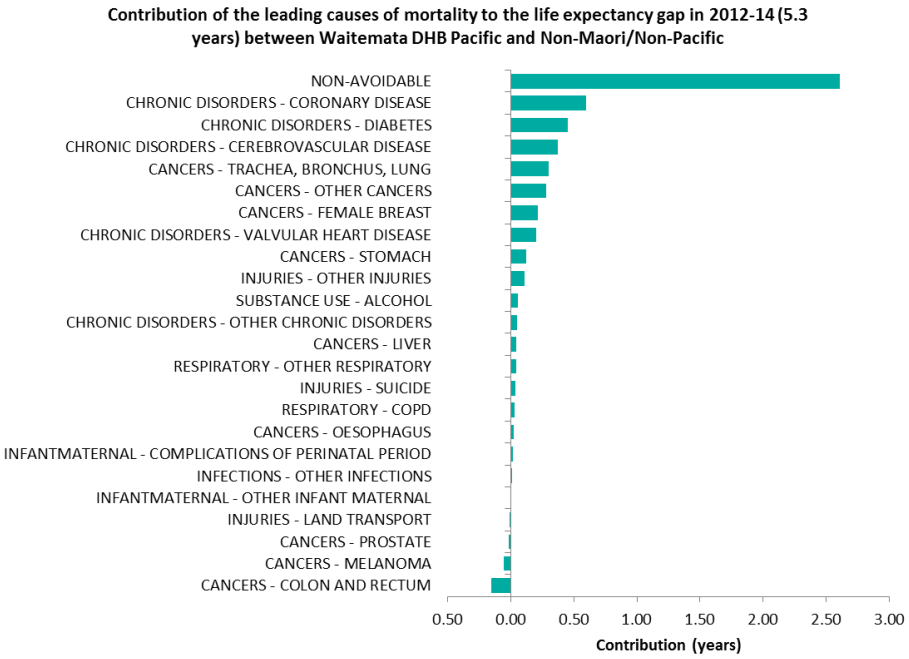


Figure 4: Contribution of the leading causes of mortality to the life expectancy gap in 2012-14 (5.3 years) between Waitemata DHB Pacific and Non-Māori/Non-Pacific



5. Board performance priorities

The following provides a summary of the work underway to deliver on the DHB's priorities:

Relief of suffering

Progress: ✔

Patient Experience

National Inpatient Survey

The national inpatient survey results are below:

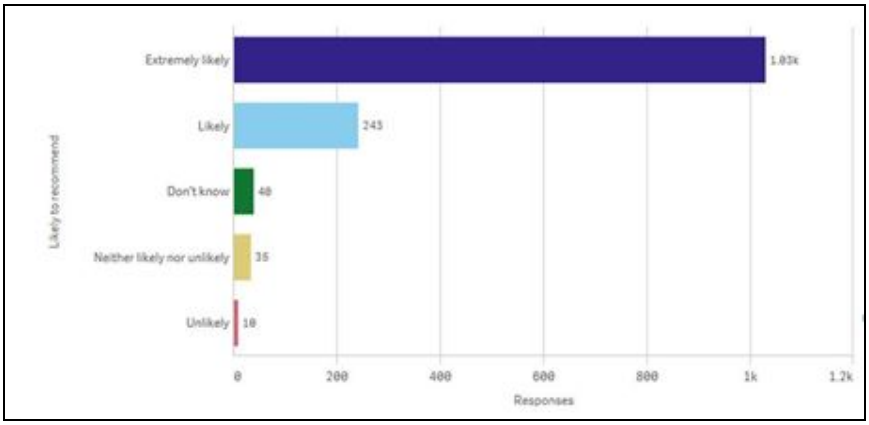
Year and Quarter	Total Surveys	Communication	Partnership	Coordination	Needs
Jan – Mar 2018	139	8.3	8.3	8.1	8.5
Overall 2017		**8.4**	**8.4**	**8.3**	**8.6**
***Oct - Dec 2017**	-	n/a	n/a	n/a	n/a
Jul – Sep 2017	127	8.5	8.4	8.5	8.8
Apr – Jun 2017	120	8.2	8.4	8.2	8.3
Jan - Mar 2017	147	8.3	8.3	8.3	8.7

National Survey Results (non-weighted results) **Anomaly with survey methodology*

Friends and Family Test

In May 2018, the response rate for the Friends and Family Test (FFT) remained high, with feedback from 1,360 people. The Net Promoter Score (NPS) was 73, up by one point on the previous month. The NPS score continues to track well above the DHB target of 65.

Waitemata DHB overall NPS



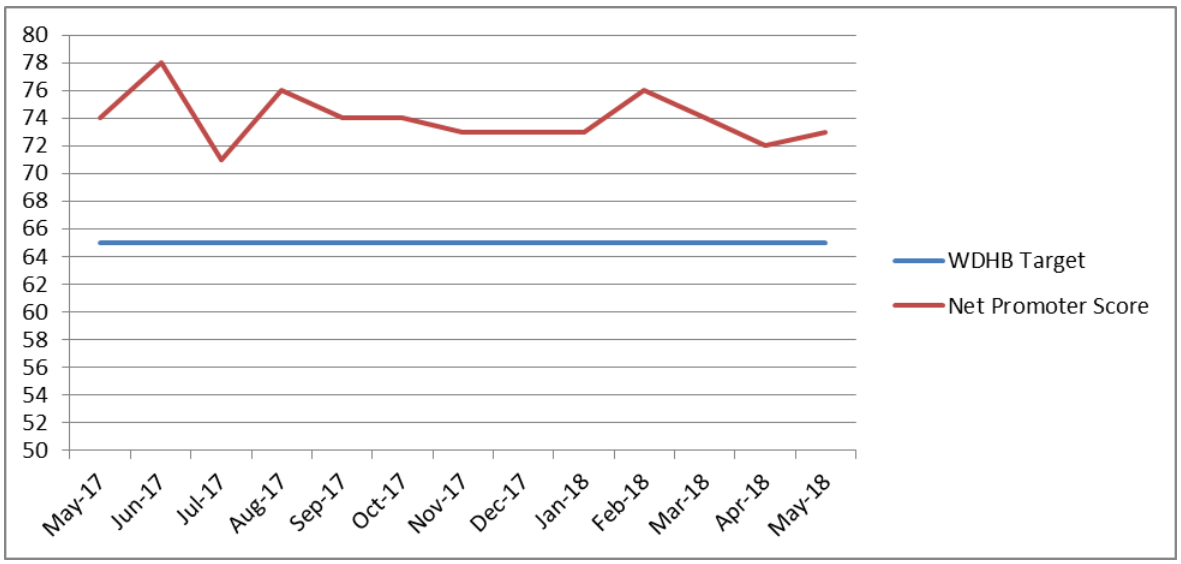
Waitemata DHB overall FFT results

FFT Overview by Month & Year -

Month & Year	Surveys	How likely are you to recommend our ward?	Did we see you promptly?	Did we listen and explain?	Did we show care and respect?	Did we meet your expectations?	Welcoming and friendly?
Totals	**1,371**	**73**	**70**	**80**	**88**	**77**	**88**
May-2018	1,371	73	70	80	88	77	88

Waitemata DHB FFT results (each question)

Net Promoter Score over time



Waitemata DHB Net Promoter Score over time

Total Responses and NPS to Friends and Family Test by ethnicity

May-18	Māori	Overall Asian	Overall Pacific	Other
Responses	97	96	68	258
NPS	82	77	75	78

NPS by ethnicity

All ethnicities have recorded an improvement in May. For Maori, the NPS score has increased 10 points from 72 in March to 82 in May. Asian has also increased nine points from 68 in April to 77 in May.

Volunteer Update

Green Coats Volunteers (Front of House) (A)	Other allocated Volunteers (B)	Volunteers on boarded awaiting allocation (C)	Total volunteers available (D) (A) + (B) + (C) =(D)
59	127	17	203

Volunteers Recruitment

Volunteer numbers increased by 23 from the previous month. A recent initiative with West Lake Boys School will commence on 30 June, seeing 24 students managing the weekend volunteer service by participating in a roster supporting patient wayfinding and patient experience surveying. These volunteers are in addition to the total volunteer numbers above.

Facilities

Major capital projects need strong regional support and alignment. The Northern Region has developed a Long-Term Investment Plan (LTIP) to guide all significant future capital investments in the region. The Board will be regularly updated on this work.

The Waitemata DHB capital projects programme has been reviewed to identify projects that can be delivered under the DHB's funding, with the remainder forming part of a programme of projects requiring Government funding. Ministerial Program Business Cases are being developed and are anticipated to be; ECIB, Sustainable Inpatient Services (North Shore), Sustainable Outpatient Services, Infrastructure, Waitakere Hospital Development and Mason Clinic. Projects that cannot be delivered under DHB funding have been placed on-hold pending review for inclusion in the Ministerial Programme Business Cases.

The Board will be regularly updated on this work going forward.

Waitakere radiology development
Construction of stage two started in February as planned and is progressing as scheduled, with the sluice room, ultrasound room and equipment room now complete. Work is due to be completed in November.

North Shore Hospital third CT scanner
The business case for this project was approved by Audit and Finance on 28 March. The project has two streams: the construction and installation of the third CT and the placement of a digital X-ray in the North Shore Hospital Emergency Department. The Digital X-ray in ED is expected to go-live in November. The programme for this has construction starting in September to avoid the winter peak. The third CT is expected to go-live in April 2019. This project is dependent on the NSH replacement X-ray project.

Surgical pathology upgrade
This project has been completed, with go-live on 25 May.

Special Care Baby Unit (SCBU) Waitakere Hospital and North Shore Hospital
Funding options are being explored with the Well foundation.

Diagnostic Breast Service
A paper is being presented to PIC asking for endorsement to complete detailed design and to proceed to submission of a full business case. The timeline for this project will be spread over two financial years.

Elective Capacity and Inpatient Beds (ECIB)
The business case for four additional theatres, four endoscopy rooms and 60 beds adjacent and connected to ESC was submitted to CIC for approval. In response to a CIC request, high-level re-scoping has taken place looking into providing an additional eight theatres and 150 beds. A further response from CIC is awaited.

North Shore Hospital Development (Sustainable Inpatient Services)
The strategic assessment was submitted to CIC in December 2017. This project links closely with the infrastructure projects and is listed as a key project to address the regional shortfall of beds within the Northern Regional Long Term Investment Plan. A response from CIC is awaited.

Better Outcomes ✔

Progress: On track

Achieving the health targets – May 2018

- **Shorter waits in Emergency Departments – 96% (target 95%)**
- **Improved Access to Elective Surgery – 107% (target 100%)**
- **Increased immunisation (eight-month-old) – 92% (target 95%)**
- **Better help for smokers to quit - Maternity – 93% (target 90%)**
- **Raising healthy kids – 99% (target 95%)**
- **Faster Cancer Treatment (62 days) – 95% (target 90%)**

Health Quality and Safety Markers – May 2018

Falls
Falls risk assessment audits that inform the Health Quality and Safety Commission data continue and are conducted monthly. Overall, Acute and Emergency Medicine completed 88% of falls risk assessments, Specialist Medicine and Health of Older People completed 100% and Surgical and Ambulatory completed 98% on admission. Of those, Acute and Emergency Medicine completed 64%, Specialist Medicine and Health of Older People completed 79% and Surgical and Ambulatory completed 70% within eight hours of admission (against a target of 90%).

Hand Hygiene
As per the News and Events section, Waitemata DHB's Hand Hygiene Compliance Audit result for May 2018 was a record 90%. This exceeds the national target of 80% compliance.

Healthcare-Associated Infections
The CLAB insertion bundle was used in ICU on 100% of occasions in May 2018. The insertion bundle compliance also exceeds the national target of 90%.

Māori Health

Matāriki Awards
We received a fantastic response to the call for submissions for our Matāriki Awards, with more than 20 submissions across Waitemata and Auckland DHBs. Judging has been completed and, at the time of writing, we were preparing to announce the Waitemata winners on 4 July.

Cultural Intelligence app – Ake Ake
The cultural intelligence app, Ake Ake, will soon be launched. We are excited about the development of this new tool for our staff as it is the first of its kind in the country and will help open up access on a daily basis to useful cultural intelligence and make its practical application much easier.

CEO Scorecard

Waitemata DHB Monthly Performance Scorecard

CEO Scorecard
May 2018
2017/18

Health Targets

		Actual	Target		Trend	
a.	Better help for smokers to quit - maternity	93%	90%	●		▲
a.	Better help for smokers to quit - primary care	87%	90%	●		▲
	Improved Access to Elective Surgery - WDHB	107%	100%	●		--
	Shorter Waits in ED	96%	95%	●		▼
	Faster cancer treatment (62 days)	95%	90%	●		▲
	Increased immunisation (8-month old)	92%	95%	●		▲
	Raising Healthy kids	99%	95%	●		--

Provider Arm - Service Delivery

	Waiting Times	Actual	Target		Trend	
	ESPI					
	ESPI 1 - 90% OP Referrals processed w/n 10 days	*Compliant*				
	ESPI 2 - % patients waiting > 4 months for FSA	*Compliant*				
	ESPI 5 - % patients not treated within 4 months	*Compliant*				
	Diagnostics					
	% of CT scans done within 6 weeks	71%	95%	●		▼
	% of MRI scans done within 6 weeks	62%	90%	●		--
	Urgent diagnostic colonoscopy (14 days)	95%	90%	●		▼
	Diagnostic colonoscopy (42 days)	65%	70%	●		▼
	Surveillance colonoscopy (84 days)	75%	70%	●		▼
	Patient Flow					
	Elective Surgical Discharges (YTD)					
	Elective Discharges - Total	18,750	18,991	●		▲
	Elective Discharges - Provider Arm	13,086	13,073	●		▼
	Elective Discharges - IDF Outflow	5,664	5,918	●		▼
	Efficiency					
	Outpatient DNA rate (FSA + FUs)	8%	<10%	●		--
a.	Average Length of Stay - Electives	1.50 days	<1.5 days	●		--
a.	Average Length of Stay - Acutes	2.73 days	<2.5 days	●		▲

Best Care

	Patient Experience	Actual	Target		Trend	
	Complaint Average Response Time	13 days	<14 days	●		--
	Net Promoter Score FFT	73	65	●		▲
a.	**HQSC Quality and Safety Markers - Quarterly**					
	Older patients assessed for falling risk	96%	90%	●		▼
	Older patients assessed as significant fall risk with care plan	95%	90%	●		--
	Good hand hygiene practice	89%	80%	●		▲
	Occasions insertion bundle used - ICU	99%	90%	●		▼
	Occasions maintenance bundle used - ICU	95%	90%	●		▼
e.	Surgical site infection rate per 100 procedures	0.9	<0.8	●		▼
b.	Antibiotic in the right time	*96%*	*100%*	●		▼
	Improving outcomes					
	Better help for smokers to quit - hospitalised	99%	95%	●		--
h.	Ambulatory Sensitive Hospitalisation rate (ASH) 0-4	*5425.7*	*5643*	●		▼
f.	Annual amenable mortality rate (per 100 000)	*62.9*	*72.4*	●		▲
	Population coverage/Access					
a.	Cervical Screening	73%	80%	●		▼
a.	Breast screening	66%	70%	●		--
c.	Bowel Screening Participation					
	- Round 3	*48%*	*60%*	●		▼
	Treatment					
a.	HSMR (Source: Health Round Tables)	0.81	<1.04	●		▲
a.	Surgical intervention rates (per 10,000 pop)					
	- Angioplasty	15.8	12.5	●		▼
	- Angiography	42.1	34.7	●		▼
	- Major joints	26.3	21	●		▼
	- Cataract	43.9	27	●		▼
g.	# NOF patients to theatre (48 hours)	*86%*	*85%*	●		▼
a.	ST elevation MI receiving PCI (120 mins)	84%	80%	●		▼
	AT&R referrals assessed (2 working days)	96%	90%	●		▲

Managing our Business

	Staff Experience	Actual	Target		Trend	
	Sick leave rate	3.3%	<3.6%	●		▲
d.	Turnover rate - external	13%	8-12%	●		--
	Lost time injury frequency rate (per 100 00 hours worked)	18	<2	●		▼
	Financial Result					
	Expense/Revenue (YTD Total)	1,577,248 k	1,577,447 k	●		▼

Major Capital Programmes	Time	Budget	Quality
Elective Capacity and Inpatient beds (TBC)	●	●	●
CT scanner Waitakere - Stage 1	●	●	●
CT scanner Waitakere - Stage 2	●	●	●
Mason Clinic Tanekaha replacement	●	●	●
Ward 6/7 renovation (Dec/Jan 2018)	●	●	●

Maori Scorecard

	Health Targets - Monthly	Actual	Target		Trend	
	Shorter Waits in ED	97%	95%	●		--
	Increased immunisation (8-month old)	86%	95%	●		--
	Better help for smokers to quit - hospitalised	98%	95%	●		▼
	Faster cancer treatment (62 days)	91%	90%	●		▼
	Quality and Safety Markers - Monthly					
	Older patients assessed for falling risk	100%	90%	●		▲
	Older patients assessed as significant fall risk with care plan	100%	90%	●		--
g.	# NOF patients to theatre (48 hours)	*100%*	*85%*	●		--

	Health Targets - Quarterly	Actual	Target		Trend	
a.	Better help for smokers to quit - maternity	87%	90%	●		▼
	Better help for smokers to quit - primary care	87%	90%	●		
	Raising Healthy kids	100%	95%	●		--
i.	**Quality and Safety Markers - Quarterly**					
	Surgical site infection rate per 100 procedures	0	0.8	●	—	--

How to read

Performance indicators:

- ● Achieved/ On track
- ● Substantially Achieved but off target
- ● Not Achieved but progress made
- ● Not Achieved/ Off track

Trend indicators:

- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. Small data range may result small variations perceived to be large.

a. Reported quarterly - Mar Q3 17/18
b. Dec Q2 2017/18 prelim (latest HQSC data available).
c. Bowel Screening Round 3 data Dec Q2 201718 (participation rate for invites Jan - Dec 2017).
d. Employees taking positions outside of the hospital/DHB
e. Prelim data Mar Q3 17/18
f. Annual data - latest available 2015
g. Coding dep, rolling 3 mths - April 2018
h. Reported quarterly - Dec Q2 17/18
i. Reported quarterly - latest available, Sep Q1 17/18

A question?

Contact: Victoria Child - victoria.child@waitematadhb.govt.nz - Reporting Analyst, Planning & Health Intelligence, Planning, Funding and Health Outcomes, Waitemata & Auckland DHBs Team

4.2 Health and Safety Performance Report

Recommendation:

1. **That the Board receives the report.**
2. **That the Board approved the new Lost Time Injury Frequency Rate (LTIFR) rolling 12 month average target.**

Prepared by: Michael Field (Group Manager, Occupational Health and Safety Service)
Endorsed by: Fiona McCarthy (Director, Human Resources)

1. Purpose of report

The purpose of the Health and Safety report is to provide quarterly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Waitemata DHB.

2. Strategic Alignment

Community, whanau and patient centred model of care	This report comments on issues and risks that impact on patient care and organisational culture.
Emphasis and investment on both treatment and keeping people health	This report comments on organisational health information via incidents, health monitoring and leave information.
Intelligence and insight	The report provides information and insight into workplace incidents and what Waitemata DHB is doing to respond to these and other workplace risks.
Evidence informed decision making and practice	The leading and lagging indicator dashboard is based on current best practise indicators and targets.
Outward focus and flexible, service orientation	Health, safety and wellbeing risks and programmes are inherently focused on staff, patients, visitors, students and contractors. All strategic and operational work programmes and policy decisions are discussed with relevant services such as site visits and approaches to reduce risks.
Operational and financial sustainability	As appropriate, programmes of work will outline how services will ensure operational or financial sustainability, how measures of success are set and value and return on investment is monitored.

3. Overview of current health, safety and wellbeing activity for July 2018

3.1 Safety and Security Training framework

Work to progress a DHB wide safety and security training framework is underway with the following work complete or in progress:

DHB wide training

- CALM communication module – complete and available to all staff.
- Foundations of safety and security online education module – due to complete in July.

Advanced training for specific areas:

- Resilience building face to face training in pilot for areas where aggression incidents occur. The pilot has been developed through EAPWorks, our Employee Assistance Programme provider.
- Attendance at Managing Aggressive and Partially Aggressive People (MAPA) pilot with Auckland DHB due on 4 – 5 July. The DHB will be assessing this course for application across specific services experiencing aggression incidents.

Specialised training

- Security teams have specifically designed orientation and training to enable responses to security incidents.
- Specialist Mental Health and Addictions are revising their current calming and restraint training in line with national Safe Practice Effective Communication (SPEC) training programme.

3.2 Update on the health and safety request for proposal

Arrangements to write and submit the Request for Proposal (RFP) with healthAlliance are underway, with draft requirements now being sent to the other Auckland Region DHB Health and Safety managers for input. healthAlliance has confirmed their formal approval to join us on the RFP process and resulting contract.

It is estimated that the RFP will be released by the end of July (a one month delay due to technical funding approval) and the resulting responses assessed by the end of September.

3.3 Progress with the Hazardous Substances and New Organisms (HSNO) work plan

3.3.1 Hazardous substances waste removal

A pilot is due to commence in July, where specially trained orderlies will trial processes to remove hazardous substances waste from services to appropriate dangerous goods facilities. The trial will take six weeks and the evaluation of the trial and recommendations will be overseen by the Senior Management Team.

3.3.2 The Hazardous Substances and New Organisms (HSNO) database

The HSNO database has been migrated from Microsoft Excel into an online electronic system housed within the Hazard Register. This allows all staff to access the full database at any time. Additional benefits of this change include:

- Departments can create their own HSNO inventory in a compliant format and on a familiar platform.
- As the program is linked to the Hazard Register system, each department is capable of assessing risks specific to their own inventories.

While migrating the HSNO database to the online platform, we also fully reviewed each product (now standing at 434 different chemicals and products, with additional chemicals still being added).

We have also developed an easy to read Product Safety Card template, which allows staff to quickly ascertain the critical product information, rather than them having to reference the lengthy, and often

confusing, Safety Data Sheets (SDS) the manufacturers provide. Work is on-going to create these for each chemical and/or product.

3.4 Performance Scorecard

*** The target at end of flu campaign is 60%**

Notes on changes to Scorecard and targets:
A review of international best-practice has been completed and the results are reflected in the updated Scorecard indicators above. The targets for the 'number of injury claims' and the number of 'lost time incidents' have been removed, as these are static targets which do not allow for changes to staff numbers and the hours worked; however we have retained the monthly numbers for your information.

International best practice is to report the Lost Time Injury Frequency Rate (LTIFR) as a 12 month rolling average, rather than on a month by month basis, to ensure the trend is easily identified. New Zealand specific data is not available; however the rolling 12 month average for LTIFR in the healthcare industry in Australia is currently 10. As a note, the healthcare industry in Australia has the highest LTIFR of all reported industries and it is assumed the same would be true in New Zealand. A target of 10 is recommended.

This target would be reviewed on an annual basis, in line with our performance, with any recommended changes being reported to the Board for approval.

Indicators in red	Comment
• Pre-employment screening completed prior to commencement 60% compared with target of 70%	A number of staff commenced employment prior to the completion of the pre-employment screening and each manager has been followed up and reminded of the required process. This is currently not mandatory across Waitemata DHB, with a trial operational for Specialist Mental Health and Addictions Division and Corporate only. Resource to roll out mandatory training across the DHB is in discussion.

4. Work related injury Claim Data for May 2018

Outlined below is our injury claim data for May. Work injury claim data is for all work injuries currently managed by the DHB, including injuries that may have been incurred in previous years, up to and including injuries for May 2018.

High accident events account for approximately 74% of the claims as follows:

- Manual handling - 41%
- Slips, trips and falls - 25%
- Aggression - 7%

INJURY CLAIM DATA

Total: Injury Claim Report for May 2018				
Lost days	**Treatment cost**	**Weekly compensation costs (80% of salary)**	**Staff cover cost**	**Total**
Number of lost days for month	$ total for month	$ total for month	$total cover cost for month	Total $ cost for month
208	$ 49,378.46	$ 33,409.40	$41,761.75	$124,549.61

5. Key Health and Safety Risks

The table below outlines our key health and safety risks together with commentary on the current status/ issues related to that risk, our performance level and any actions to address issues.

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

Approximately 11 actions have been in progress for over 12 months, although some of these, e.g. rostering solutions have a long lead in timeframe. Of these, four are Facilities and Development projects with approved CAPEX, all of which are now actively progressing. Eight actions have been in progress and are due to complete in 6-12 months.

Risk: Aggression-physical and verbal	
Previous Report Action	**Current Action**
Community Worker Alarm Project: Pilot evaluation has commenced and on target to meet May due date. Complete: 75% An indepth study has been commissioned to review aggression data in new ways to better understand where else we may put in place initiatives to improve. Due end April 2018.	Community Worker Alarm Project: Pilot evaluation has been completed and a recommendations paper is being drafted. Complete: 100% In depth data study has commenced and will now complete in June. Complete: 20%

Risk: Aggression-physical and verbal	
Previous Report Action	**Current Action**
Resulting work streams will be reported through this section. Complete: 10% Online security and safety training in development. Due May 2018. Complete: 60% Complete pilot course to help staff thrive in challenging work situations. Due June 2018 Complete: 50% ED workplace safety work streams: Complete: 10%	Online security and safety training has been implemented (CALM training) with online foundation training is due in July. Complete: 80% No change: pilot course to be redeveloped before being run again. Due June 2018 Complete: 50% ED workplace safety work streams: Complete: 30%

Risk: Blood and Body Fluid Incidents (BBFA)	
Previous Report Action	**Current Action**
Needleless Systems: Data reviewed on areas with Blood and Body Fluid Events (BBFE) and needless systems. Two areas identified for follow up via the OH&SS team. Any work streams identified will be reported through this section. Complete 80%	Needleless Systems: Data reviewed on areas with Blood and Body Fluid Events (BBFE) and needless systems. Two areas identified for follow up via the OH&SS team. Work has commenced with BD, our supplier of sharps bins and needleless systems, to audit high incident areas. Any work streams identified will be reported through this section. Complete 85%

Risk: Hazardous Substances and New Organisms (HSNO)	
Previous Report Action	**Current Action**
HSNO audits: Focus has shifted onto newly released legislation and the resulting changes to policies and procedures. HSNO audits will recommence once all policy changes have been finalised. Audits completed: 43% The business case for the Dangerous Goods store will be presented to the Board in 2021. An interim facility is due for installation in 2019, and management process has been developed. Complete: 25% The DHB is discussing how best to transfer internal hazardous waste to the dangerous goods store (North Shore Hospital) and the dangerous goods cabinets (at Waitakere Hospital). Paper to pilot an internal transfer system is due to the senior management team in May. Complete: 20%	No change as on hold to ensure we have completed all policy changes to align with the new HSNO regulations. Audits will resume by the end of July 2018. Audits completed: 43% No change. Paper to pilot an internal transfer system has been approved and the trial is currently being organised. Complete: 25%

Risk: Manual and Patient Handling
On-going actions Meetings with managers will continue to be held to discuss moving and handling requirements including training, to provide support to services. Additionally, where services are unable to release resources, due to workload, special training sessions are being scheduled via OH&SS.

Risk: Health and Wellbeing (stress, fatigue, depression)	
Previous Report Action	**Current Action**
Healthy Workplaces: The review of the new toolkit on bullying has been complete and we are due to add these to templates and circulate for review by June. Complete: 70% Work on safe and healthy rostering is in progress for 15 Resident Doctor rosters to comply with the MECA; and centralisation of ward Nursing rosters: Centralisation of nursing rosters: Complete: 70% (Due 2019) RMO rosters: Complete 60% (Due December 2018) Mindfulness Discussion on scoping an integrated and multimedia approach to mindfulness training is underway. Complete 30% Shift work, sleep and fatigue Work on introduction of general guidance for managing sleep and fatigue is in draft. Meetings with professions are planned throughout March to understand what shift work and afterhours materials would be of value to staff. General guidance on sleep has been published Complete 100%	Healthy Workplaces: The toolkit is complete and templates are in design phase. Due to complete July. Complete: 80% Centralisation of nursing rosters: Complete: 70% (Due 2019) RMO rosters: Complete 66% (Due December 2018) No change: A stocktake on current resources and internal training opportunities is underway. Complete: 30% Meetings with professions are planned to understand what shift work and afterhours materials would be of value to staff. Due date extended to May 2018. Complete: 30%

Risk: Physical environment (ventilation, lighting, equipment)	
Previous Report Action	**Current Action**
Helipad: No change. Hazard signage has been arranged and installed by OH&SS to fencing surrounding the helipad and separate signage placed outside of the doors facing the helipad from Whenua Pupuke. Final enhancement of helipad is being prioritised alongside other capital projects. Complete: 80%	CAPEX is approved. Work commences in late June to replace lighting and helipad painting. Installation imminent. Complete: 80% Loading Docks: In progress: CAPEX has been

Risk: Physical environment (ventilation, lighting, equipment)	
Previous Report Action	**Current Action**
Loading Docks: CAPEX has been approved to finalise the design and tender stage. A Business Case will go the Executive Leadership Team in May. The construction has an estimated start date of July/August subject to building consent. Planning complete: 75% Pedestrian Crossings: Designs are complete. The painting of the pedestrian crossings will take 2-3 months (July/August) weather depending. The Waitakere roading /pathway design tender due in June/July for an estimated commencement in August subject to consent. Planning complete: 65%	approved to finalise the design and tender stage. A Business Case is due to the Executive Leadership Team in July. The construction has an estimated start date of August/September subject to building consent. Planning complete: 85% Pedestrian Crossings: The CAPEX for the Design of the North Shore Hospital pedestrian crossings programme of works has been approved on 25 June with a business case due to the Executive Leadership Team in July. The Waitakere roading/pathway design tender is due in June/July for an estimated commencement in August subject to consent. Planning complete: 75% Additional Security Door Access, North Shore Hospital: A CAPEX has been approved and an order for the new door completed. Estimated completion of the project is September/October 2018. Long lead items (door) will be received by August 2018. Planning complete: 100% Installation complete: 10%

Risk: Contractor and Procurement Management	
Previous Report Action	**Current Action**
Asbestos Register: This project has one stage to complete: **Stage 2**: A volunteer is due to commence the transfer of information into the database this month. Due by May 2018 Complete: 40% BIEMS Upgrade: Upgrade progressing with final delivery expected in July 2018. Procurement Complete: 100% Delivery Complete: 5% Contractor management process alignment: This work has now been fully scoped and a resource assigned to progress alignment of current contractor procurement policies, processes, project management and performance practises, which will be implemented between May and July 2018. Processes will be re-assessed in every	Asbestos Register: This project has one stage to complete: **Stage 2**: A volunteer has commenced for the transfer of information into the database. This is a large piece of work, so is expected to continue until completion in October/November. Complete: 40% BIEMS Upgrade: No Change as not yet due. Upgrade progressing with final delivery expected in June/July 2018. A mobile app is being developed to enable submission of BEIMS away from the office. This is due to roll out end 2018. Procurement Complete: 100% Delivery Complete: 25% Contractor management process alignment: No Change as not yet due. This work has now been fully scoped and a resource assigned to progress alignment of current contractor procurement policies, processes, project management and performance practises, which will be implemented between May and July 2018. Processes will be

Risk: Contractor and Procurement Management	
Previous Report Action	**Current Action**
six months to ensure continuous quality improvement. The processes will be embedded over the following 12 months with the first audit planned for 2019/20. Complete: 55%	re-assessed in every six months to ensure continuous quality improvement. The processes will be embedded over the following 12 months with the first audit planned for 2019/20. Complete: 65%

Risk: Slips trips and Falls
On-going actions Communications continue to be developed and released regarding Slips, Trips and Falls hazards, focussed heavily on staff rushing to complete tasks. Ongoing. Each incident of this type is followed up by OH&SS, with any corrective actions tracked to completion. Ongoing.

6. Stakeholder feedback

6.1 healthAlliance Collaboration

We continue to work closely with healthAlliance to ensure that processes are in place and in use, including Waitemata DHB specific inductions, for healthAlliance contractors carrying out work on our sites. healthAlliance have also confirmed their full approval to join our RFP for dedicated Health and Safety software, which will greatly assist in our alignment of systems, processes and incident reporting.

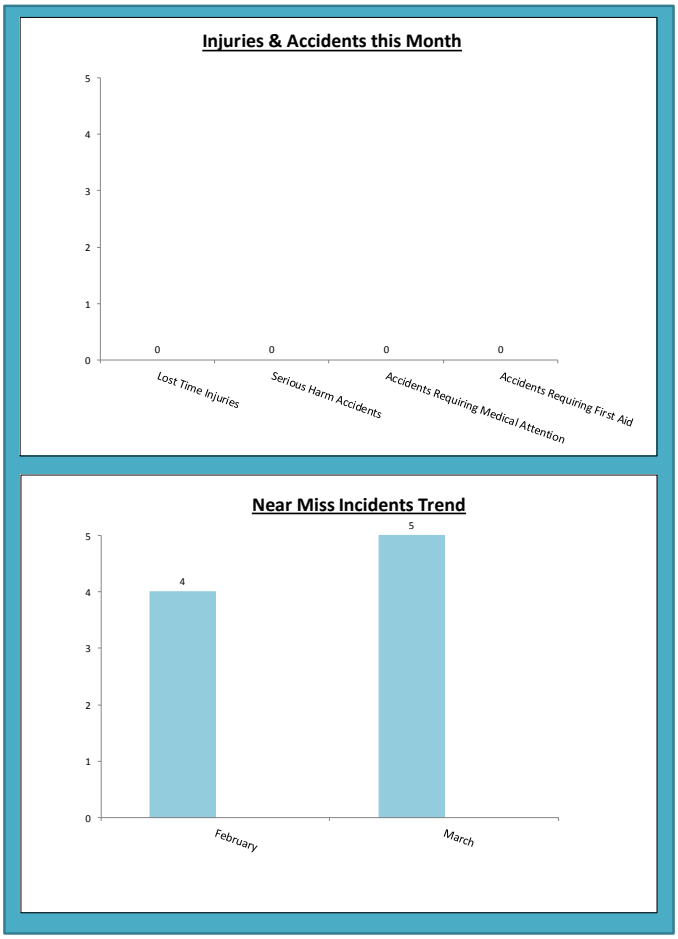
6.2 Regional Collaboration

With the commencement of the new Health and Safety Manager for Auckland DHB, work in aligning our reporting, especially relating to statistics, is underway. We are also sharing information, reporting and toolkits with regional and national teams.

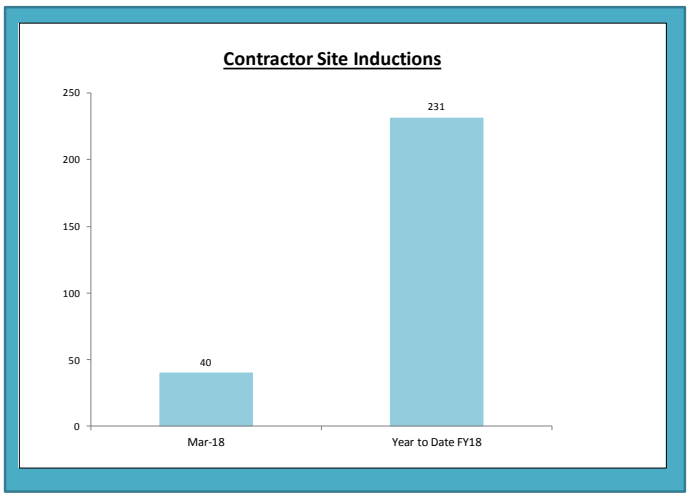
6.3 Facilities and Development Related Contractor Incident Reporting – March 2018

In March 2018, Facilities and Development related contractor incidents included five near miss events, all of which were minor in nature.

In all five instances, the contractors completed investigations and ensured all corrective actions and opportunities for improvement were actioned. Records of this close out process are recorded by Facilities and Development for future auditing and record purposes and included as Health and Safety meeting agenda items for the wider Facilities and Development group to ensure visibility and learnings are shared.



Outlined below is information on key Faciliies and Development health and safety key performance indicators for major construction projects:



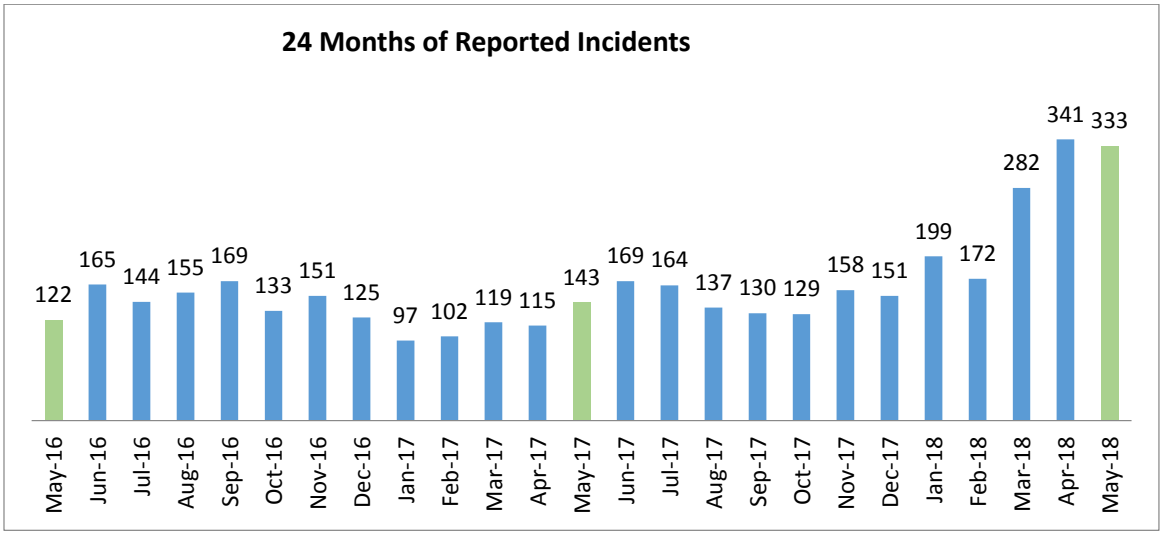
7. Health and Safety Events May 2018

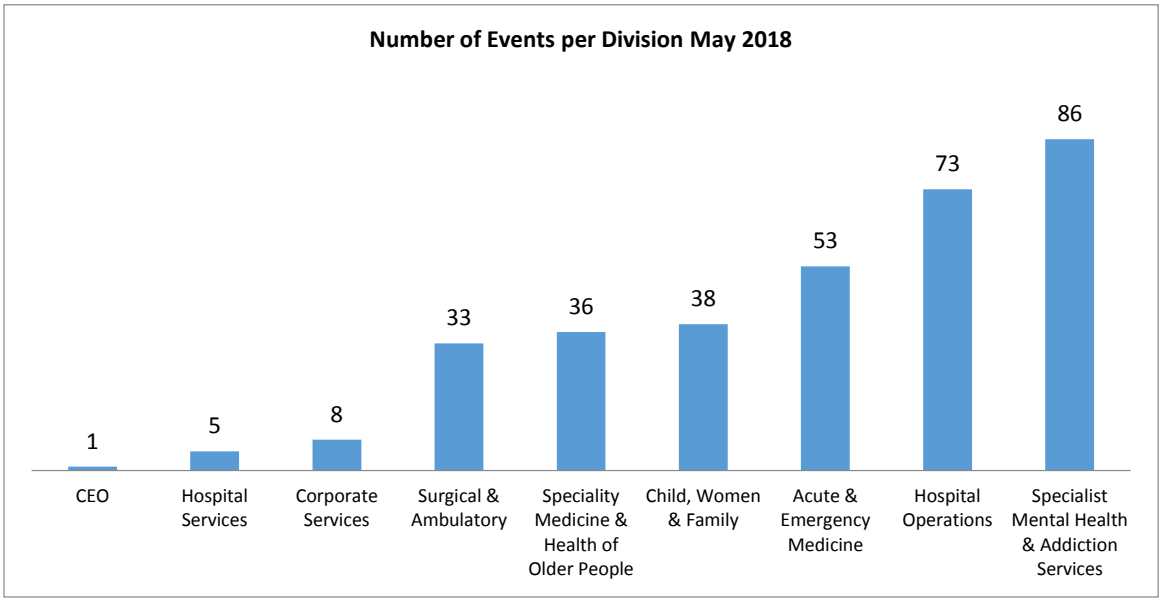
Rolling year-on-year monthly average comparison:
Previous 12 months – 135 (average)
Current 12 months – 197 (average)

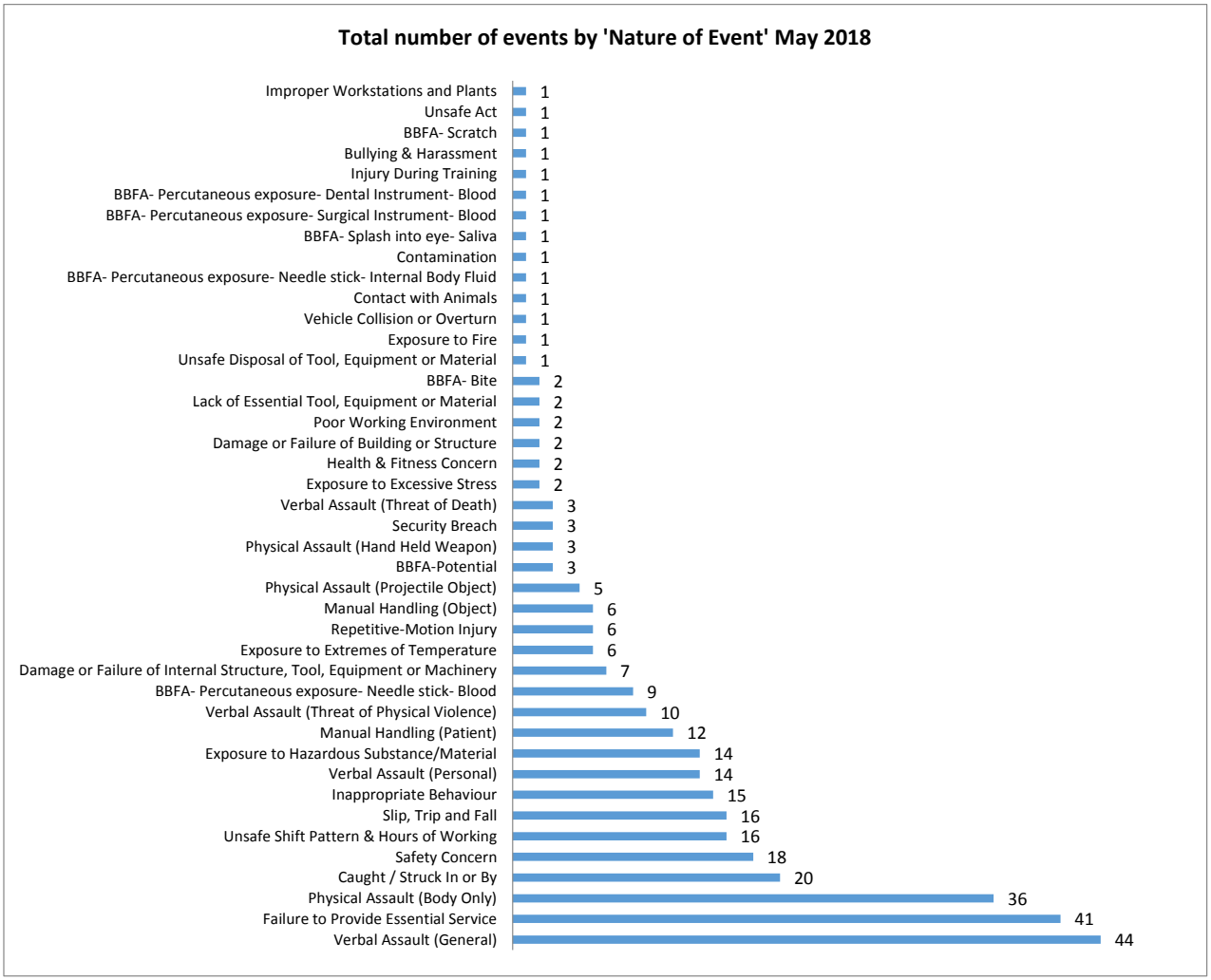
Current Period:
The number of reported events during the month of May was 333. With the additional security incidents we are now receiving, our new monthly average is 340 incidents, in comparison to 135 incidents for the previous 12 months.

Rolling 12 month analysis:
In March we became aware of a new category of security incident which has now been made available to include in our event reporting. This has resulted in the overall number of events and near misses being made visible. Incidents at a low level are followed up by managers and incidents at a medium and high level are followed up by the Occupational Health and Safety Service.

The graphs below note all event types, including environmental and people related events:







8. Notifiable Events for May 2018

Month Reported to WSNZ	Type of Incident	Injury Sustained	Outcome Recommendations Controls
Nil			

9. Top three Incident types that cause harm

Physical Assaults; Slips, Trips and Falls; and Moving and Handling
The main types of incidents that cause harm to our staff and the management of these hazards and risks are outlined in the following tables:

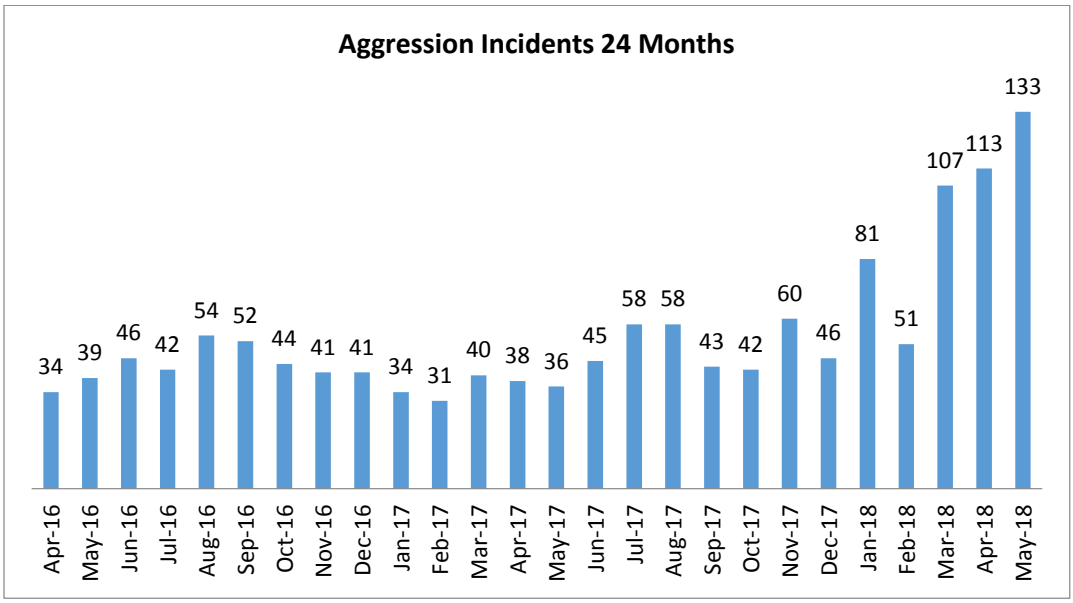
9.1. Aggression

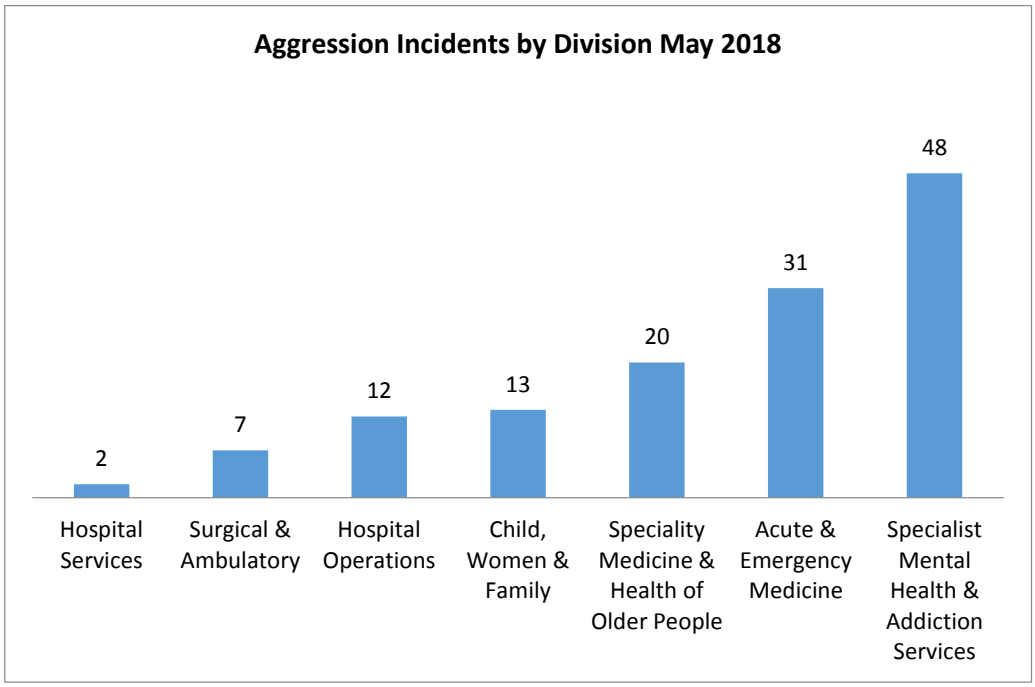
Rolling year-on-year monthly average comparison:
Previous 12 months – 42
Current 12 months – 70
May 2018 – 133

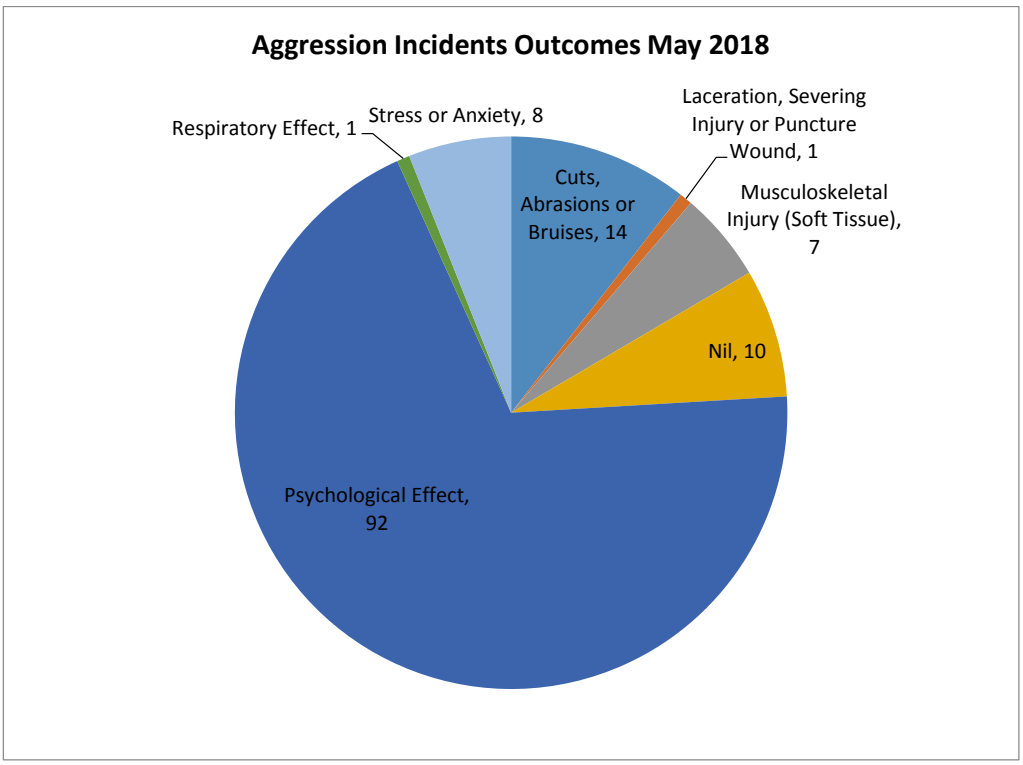
Rolling 12 month trend analysis
Aggression related incidents remain of high concern, with an increase in incidents due to an additional category of security incidents being made visible. We continue to encourage staff to report incident and near misses.

Actions
Significant actions are in place to better understand and manage aggression incidents including ongoing review and improvement of clinical triage, assessment and treatment processes; new security and safety training (See section 3 for details); specific Emergency Department workstreams; review of data to better understand areas to focus workstreams; investigation of all incidents; introduction of new risk assessment templates for aggression risks and hazards; completion of reviews of all public reception areas; completion of key deep dive audits and implementation of findings.

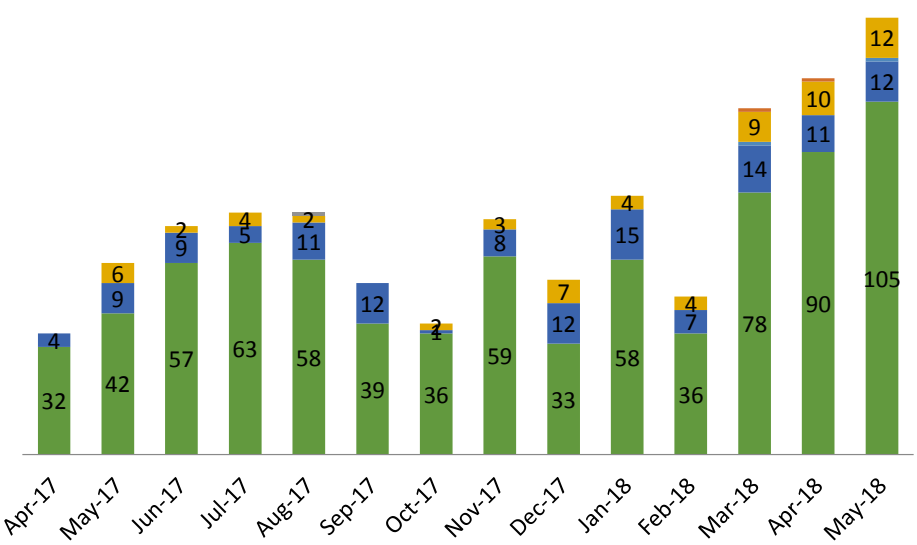
OH&SS continue to meet regularly with both the PSA and NZNO and collaborate on areas of high incidents/ risks.




Aggression Incidents by Division May 2018
2
7
12
13
20
31
48
Hospital Services
Surgical & Ambulatory
Hospital Operations
Child, Women & Family
Speciality Medicine & Health of Older People
Acute & Emergency Medicine
Specialist Mental Health & Addiction Services


Aggression Incidents Outcomes May 2018
Respiratory Effect, 1
Stress or Anxiety, 8
Laceration, Severing Injury or Puncture Wound, 1
Cuts, Abrasions or Bruises, 14
Musculoskeletal Injury (Soft Tissue), 7
Nil, 10
Psychological Effect, 92

The following tables show the number of physical and verbal assaults directed at staff and how many are generated by patients, visitors or other staff. The information below tells us that almost 100% of aggression incidents were generated by patients or visitors. This information should be viewed in the context that over 60% of these incidents are clinically derived and are likely due to the effects of the patient illness, or their treatment pathway.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Community Member					1									
Contractor												1	1	
Employee		6	2	4	2		2	3	7	4	4	9	10	12
Student												1		1
Visitor	4	9	9	5	11	12	1	8	12	15	7	14	11	12
Patient	32	42	57	63	58	39	36	59	33	58	36	78	90	105

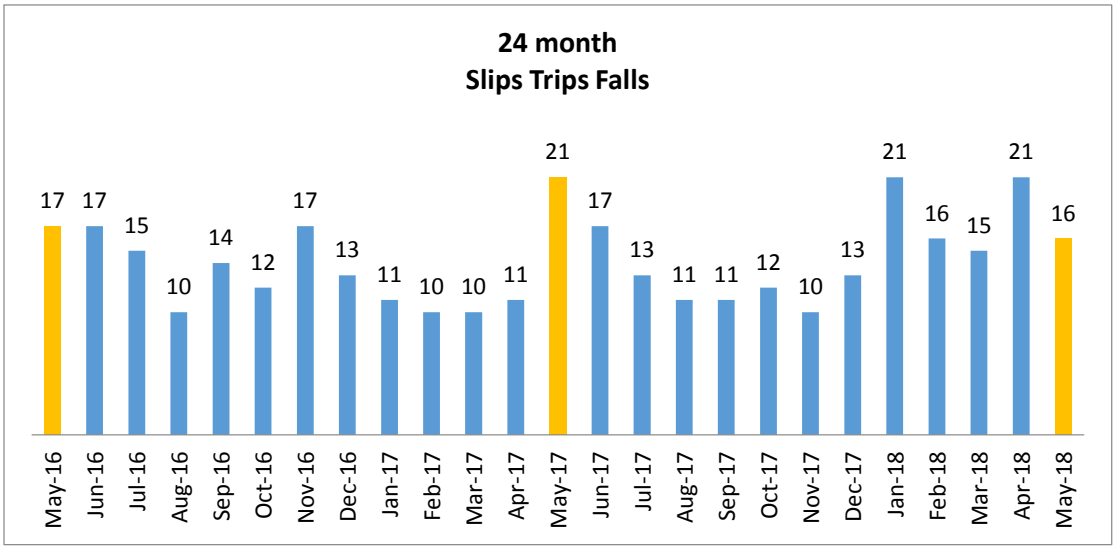
9.2 Slips, Trips and Falls

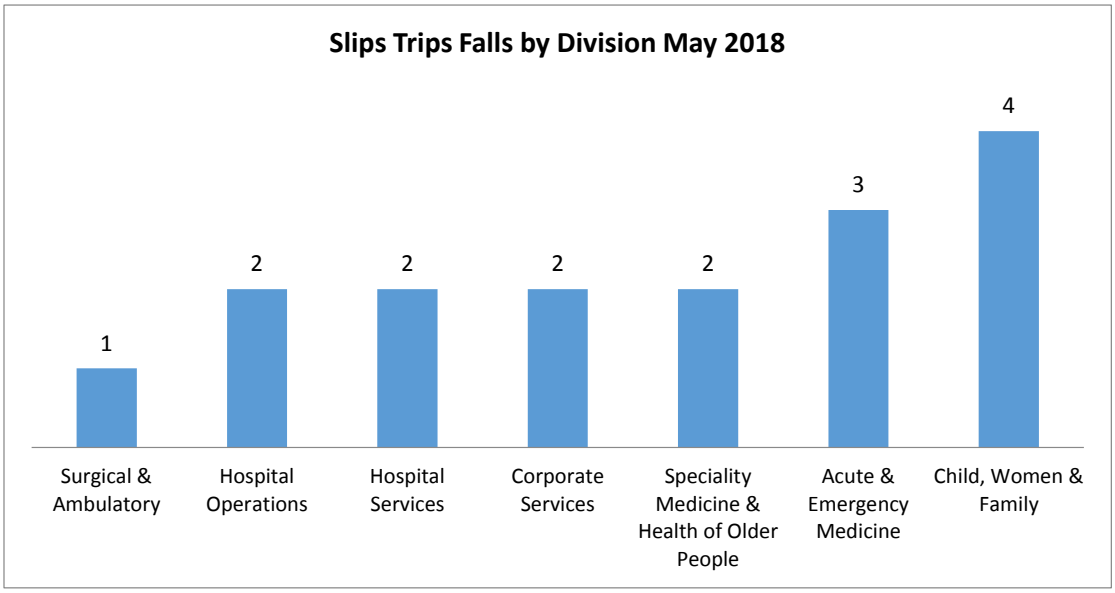
Rolling year-on-year monthly average comparison

Previous 12 months – 13.41

Current 12 months – 14.6

May 2018 – 16

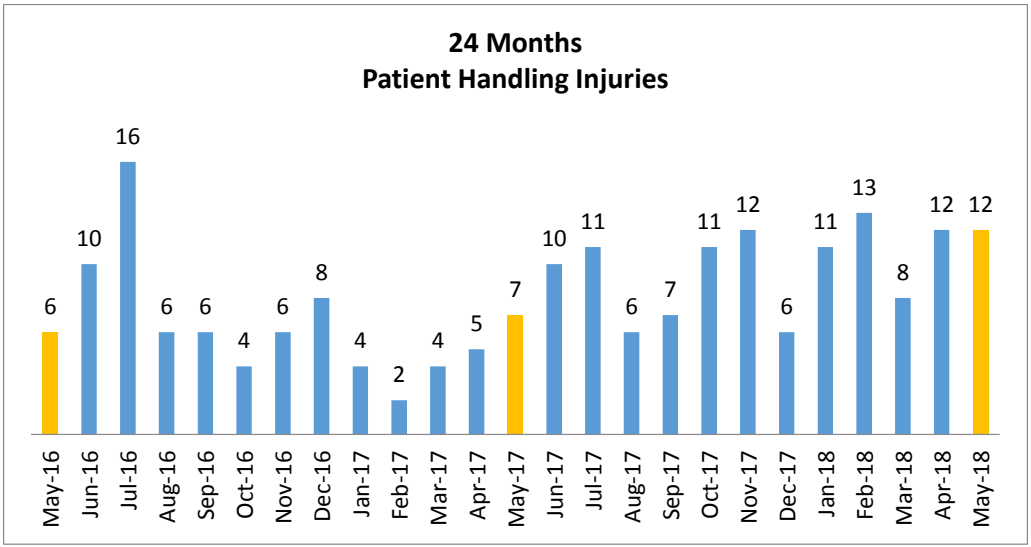




9.3 Moving and Handling

Rolling year-on-year monthly average comparison

Previous 12 months – 6.5
Current 12 months – 9.9
May 2018 – 12



10. Additional Occupational Health and Safety Activities May 2018

To provide an overview of the total workload and services provided by the Occupational Health and Safety Service, the below has been included.

Vaccinations administered (excludes flu)	129	15 minutes per vaccination
Blood & Body Fluid Exposure (BBFEs)	21	1 hour per incident
Contact traces and number of staff involved	4 involving 18 staff	30 minutes per staff member
Workstation assessments	2	1 hour per assessment
Management referrals	10	1 hour per referral
Number of incident reports being followed-up	154	Between 1 and 3 hours per incident

Appendix 1

Glossary for Monthly Performance Scorecard and Report

Injury Claims	A claim resulting from a workplace injury.
Lost time incidents	Any injury claim resulting in lost time.
Lost time injury Frequency Rate (rolling 12 month average)	Number of lost time injuries, divided by total hours worked, multiplied by 1,000,000 hours.
Notifiable Injury/illness	(a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations. (b) any admission to hospital for immediate treatment. (c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance. (d) any serious infection (including occupational zoonoses) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals. (e) any other injury/illness declared by regulations to be notifiable.
Notifiable Incident	An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident.
Notifiable Event	Death of a person, notifiable injury or illness or a notifiable incident.
Pre- Employment Screening	Health screening for new employees.
Significant Hazard (Instead of a definition, all hazards are risk rated to determine how serious they are under the new legislation)	A hazard with the potential to cause serious harm.
Psychosocial Risk	Aspects of the design and management of work, and its social and organisational contexts, which have the potential for causing psychological or physical harm.
Patients who are away without leave (AWOLs)	Patients under the Mental Health (compulsory Assessment and Treatment) Act 1992, who leave Waitemata DHB premises without prescribed or approved leave.
PCBU	Person Conducting Business or Undertaking.
Officer	Person occupying the position of a director of a company or includes any other person occupying a position in relation to the business or undertaking that allows the person to exercise

	significant influence over the management of the business or undertaking.
Worker	An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer.
Reasonably Practicable	Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters, e.g. the likelihood of the hazard/risk occurring; 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.
HSNO	Hazardous Substances and New Organisms.
OH&SS	Occupational Health and Safety Service.

4.3 Communications Report

Recommendation:

That the report be received.

Prepared by: Matthew Rogers (Director Communications)

Communications support

The communications team provided advice and support to the following projects/campaigns/issues/ events over the last six weeks:

- Coordination of release of OIA responses re the weather-tightness of DHB facilities
- Responses to Ombudsman regarding OIA investigations
- Implementation of national DHB agreement on proactive disclosure of OIA responses
- Preparation of internal and external communications material for national nursing strike
- Coordination of visit by Prime Minister and Minister of Health on 18 May
- Launch of effective stop smoking conversations with pregnant women online training programme
- Kōrero Mao – Talk to Me campaign
- Review submission to Government Inquiry into Mental Health and Addiction
- HDC reactive press material
- Oracle PO First change programme
- Bowel screening programme promotion
- Nursing Awards
- National Volunteers Week
- Staff flu vaccination programme
- Nutrition and hydration awareness promotion
- Matariki Awards promotion
- Comms support for Kia Ora Hauora career workforce programme
- Cultural App – Ake Ake launch and promotion
- Health literacy symposium
- Onboarding experience for new employees
- Promotion of organisational values, including SMT walkabouts
- Ongoing publication of messages via the Medinz primary care communications platform
- Health Heroes
- Safety in Practice campaign promotion
- Herceptin treatment anniversary
- Establishment of mental health staff newsletter
- Pasifika Week 2018
- Promotion of Inpatient Snapshot initiative
- Promotion of wifi infusion pumps
- 2018 CEO Lecture Series coordination
- Coordination of responses to ‘Dear Dale’ emails to the CEO from DHB staff
- Review of content for submission to health sector publications
- Ongoing weekly internal communication via StaffNet and Waitemata Weekly
- Ongoing management of Official Information Act responses

- Liaison with Well Foundation Marketing and Communications
- Ongoing liaison with Metro Auckland DHB communications leads
- Ongoing after-hours and weekend media line cover and senior management communications support
- Proof-read leaflets, booklets and brochures for various departments
- Ongoing compilation and distribution of proactive media material
- Ongoing social media strategy, activity and issues management
- Event photography
- Drafting of correspondence from the corporate office
- CEO Board Report
- Review of copy for DHB website
- Management of DHB general all-user screen saver content
- Approval of all-user staff emails
- Weekly Board briefing
- Fortnightly *A Note From the CEO* email to all staff
- Weekly National Health Targets and clinically-led metrics updated and communicated

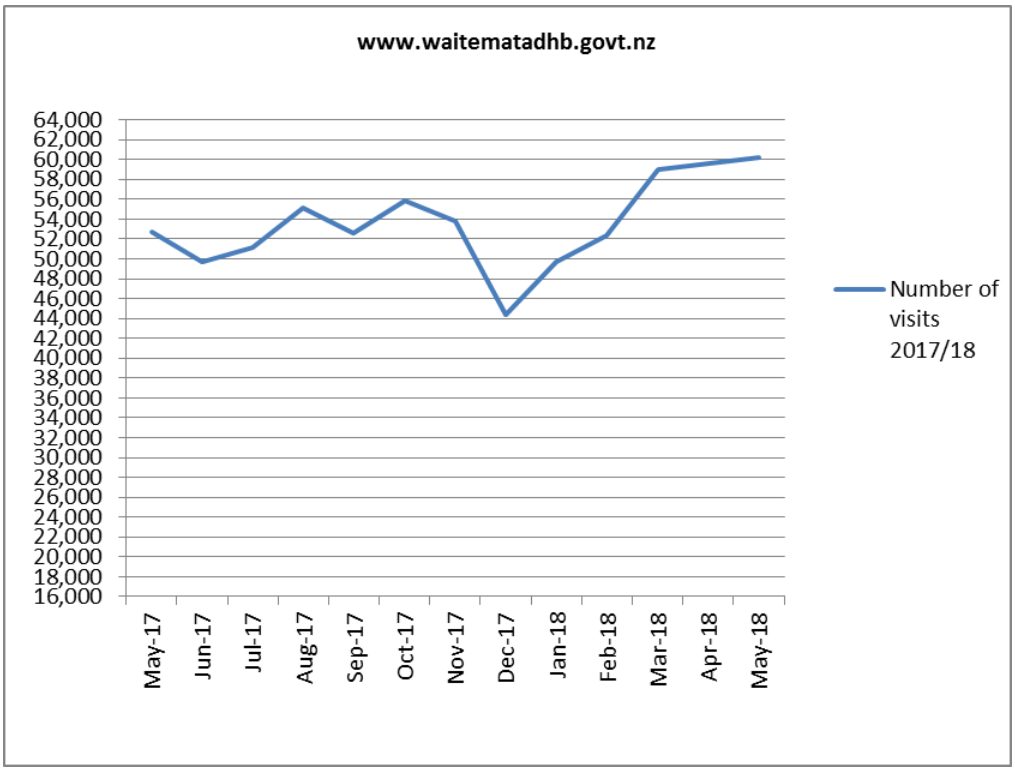
Waitemata DHB website – Google Analytics Statistics

Waitemata DHB website

Number of visits	**May 2018**	**May 2017**
Total visits to this site	60,238 (+14.3%)	52,675
New Zealand	56,927	49,777
Australia	767	991
USA	380	327
United Kingdom	250	297

Top areas	**May 2018**	**May 2017**
Waitemata DHB staff page	30,579	25,356
Home page	14,393	15,949
North Shore Hospital	6,717	7,016
Waitakere Hospital	3,032	2,946
Contact us	2,661	2,598

Traffic sources	**May 2018**	**May 2017**
Search traffic	73%	74%
Direct traffic	22%	20%
Referral traffic	5%	6%



Social media

Facebook

Waitemata DHB Facebook page likes have increased by 45.3% since June 2017, with 3,841* current likes (2,643 likes - June 2017).

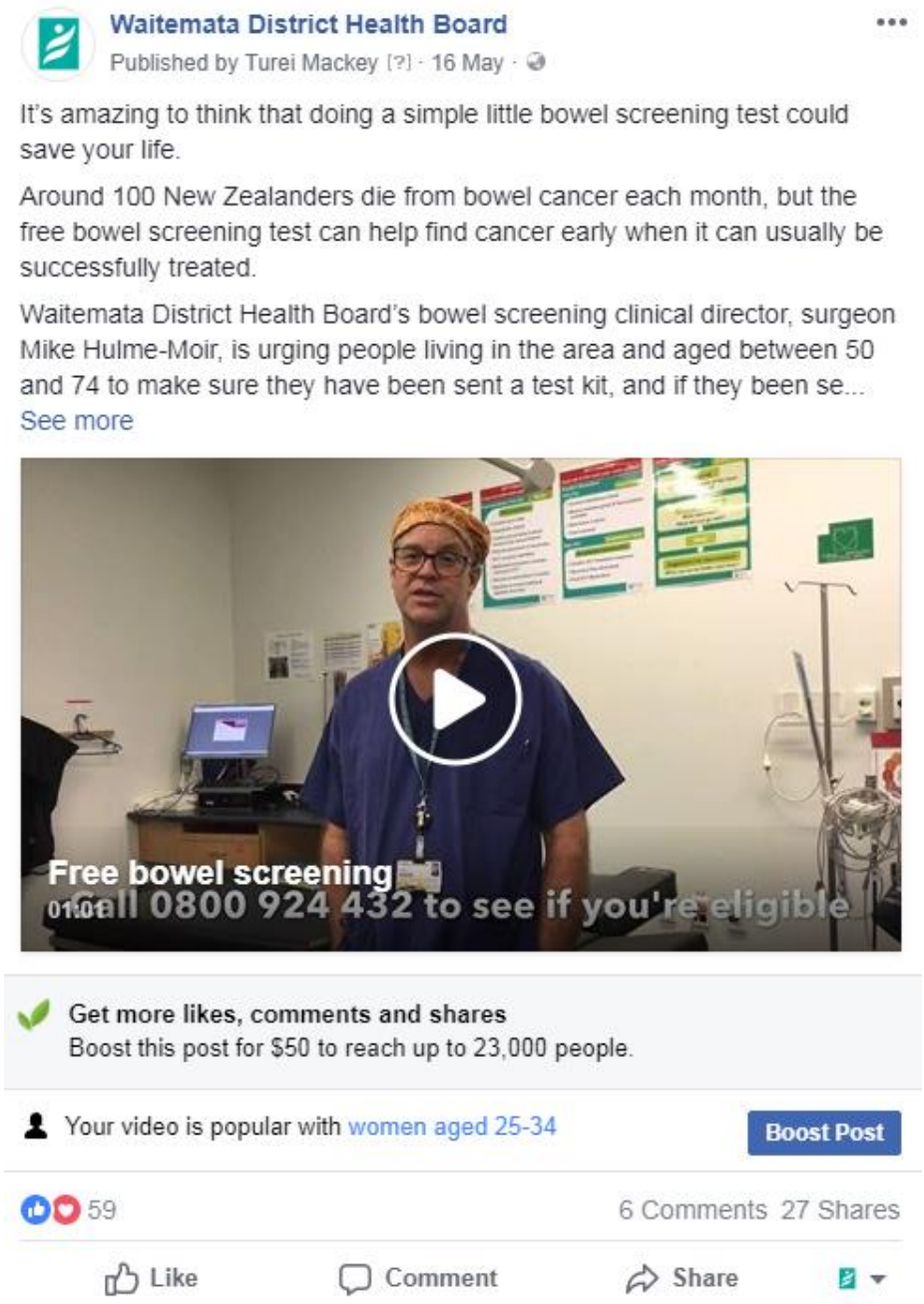
Waitemata DHB Facebook review numbers have increased by 10.8% since June 2017. Waitemata DHB Facebook star rating - 4.4/5 from 225 reviews* (4.3/5 from 203 reviews June 2017).

Total audience reach between 1 May 2018 and 31 May 2018 was 112,800.

Top three posts between 1 May 2018 and 31 May 2018:

1. Prime Minister visits Waitemata DHB (Audience reach: 8,286)

2. Bowel screening saves lives (Audience reach: 7,588, video views: 3,601)



3. Call for more knitted clothes for premature babies (Audience reach: 6,797)

Twitter

Waitemata DHB Twitter followers have grown by 16.23% since June 2017, with 2,220 current followers* (1,910 followers as at June 2017).

Total audience reach between 1 May 2018 and 31 May 2018 was 28,200.

Top tweet between 1 May 2018 and 31 May 2018:

New Zealand Pink Shirt Day

*As at 25 June 2018

OIAs received

A total of 27 new OIA requests were received between 15 May and 26 June 2018:

- T. Nichol (NZ Herald) - Number of sexual assault / harassment complaints received from 2013 – 2017.
- N. Smith (TVNZ) - Average wait times for patients to be seen by a clinical psychologist.
- E. Russell (NZ Herald) - Number of women in labour turned away from maternity ward for last five years and reasons why.
- P. Pennington (RNZ) - Total cost of construction work for ED department upgrade at Waitakere Hospital opened in August 2016.
- P. Pennington (RNZ) - Copy of any report or advisory by the DHB or consultant since 2011 regarding weather-tightness of building assets.
- G. Fraser (FYI website) - Questions regarding services and treatments available for transgender patients.
- E. Russell (NZ Herald) - Policy if maternity ward is full, number of times maternity ward has been full, number of beds, number of staff and number of complaints.
- H. Martin (Stuff) - Days operating in excess of 100 percent of bed capacity and correspondence to the Board or MOH about concerns.
- S. Mitchell (Stuff) - Assaults of hospital staff by patients over the last three years.
- H. Martin (Stuff) - Wait times at ED and for patients diagnosed with cancer.
- M. Cook (Pharmacy Today) - Cost of pharmacy sector consultation for new community services agreement.
- C. McCulloch (RNZ) - What information if any was provided to Housing NZ about a patient in 2015.
- L. Allen (advocate) - Full medical record of a patient and any reports/internal investigations.
- M. Dobbyn (NZRDA) - Number of vacant surgical and surgical subspecialty positions as at 11 June.
- N. Hanlon (advocate) Various questions and stats regarding treatment of patients at Marinoto North Mental Health Service and decision-making on the care of a patient.
- H. Martin (Stuff) - The longest a patient was recorded as waiting or being treated in the ED before they were admitted in the past year.
- T. Brown (RNZ) - Number of referrals from Department of Corrections to mental health services during last five years.
- Name withheld to protect privacy - Information regarding previous complaints made in relation to daughter.
- S. Lake - Number of bariatric surgeries performed 2016/17.
- R. Warriner (Walsh Trust) - Employment support for people with mental health needs, including questions around individual placement and support.
- A. Tonks (NZ Drug Foundation) - Has MethCon been contracted to do any work in the past two years?
- N. Jones (NZ Herald) - List of incidents where documents or other materials have been mistakenly left unaccompanied in public.
- A. Woods (NZ Herald) - Wait times including average, longest and shortest individual and initial appointment with specialists.
- N. Jones (NZ Herald) - List of buildings/facilities needing remediation work, new buildings planned, copies of reports.
- J. Tamihere (Te Whanau O Waipareira) – After-hours care details, including strategies to respond to population growth and stats regarding use of vouchers.
- H. Martin (Stuff) - Reports of physical attacks against staff members 2017/18.
- N. Akoorie (NZ Herald) - Number of non-resident births in past five years and costs of those births.

Media Clippings – 12 May – 22 June 2018

Positive	**+**
Neutral	**0**
Negative	**-**

Page no.	**Channel**	
34	Bowel Screening – have you been invited?	+
35	Crucial care for newborn twins	+

Page no.	**Dominion Post**	
61	GP avoiders must be tackled	+

Page no.	**Nor West News**	
14	Waitemata DHB trials video meeting clinics	+
18	Flu season: Health staff slow to jab	-
53	Call for zero suicides in care	-
55	DHBs tackle sudden infant death in Maori	+
78	Bethells emergency	0
87	Sat for hours as blood dripped	-
100	Hard to spot A & E time wasters	0

Page no.	**North Harbour News**	
23	Text messages support for diabetes	+
32	Health research 'crucial', says dad	+
81	Miracle escape in 'baby scoop' era	+

Page no.	**North Shore Times**	
1	Drinking app studied	+
8	DHB trials teleclinics	+
11	Friend pays colleague's rent	0
22	Text messages provide support for diabetes	+
27	Paid parking	0
36	DHBs tackle infant death in Maori babies	+
42	Paid parking proposal 'criminal'	0
57	Funds for new manikin	+
72	Parking frustration	0
76	'Baby scoop' miracle	+
79	Destined for neonatal care	+
85	Parking traps residents	0
89	What's on – Medicine talk	+
102	Hard to spot A & E time wasters	0

Page no.	**NZ Doctor**	
16	Rural SLATs: Slicing up the rural funding pie	0
48	Snarled-up referrals at DHB lead to breaches of patients' rights – HDC	-
49	Teleconsult trial boosts productivity, honing doctor's 'webside' manner	+

Page no.	**NZ Herald / Weekend Herald**	
2	Prime Minister: Budget's all about 'rebuilding'	0
24	Frantic health board bosses: We can't cope	0
28	Clinic rejects movie library fears	-
47	No policy to tip off HNZ says DHB	-
67	Rest home bills questioned	0
93	Look-alike infant helps nurses save tiny patients	+
98	Separate ward essential	-

Page no.	**Otago Daily Times**	
26	Man swept from motorbike by wire	0

Page no.	**Rodney Times**	
5	App to help problem drinkers	+
7	DHB trials teleclinics for patient meetings	+
12	Friend's selfless act	0
15	Text messages provide support for diabetes	+
38	DHBs tackle infant deaths	+
44	Paid parking proposal 'criminal'	0
73	Rodney hospital	0
83	Miracle escape in 'baby scoop' era	+
91	Wounded man waits as the 'healthy' seen	-
96	Hard to spot the time wasters at the hospital A & E	0

Page no.	**The Press Christchurch**	
59	Call to close mental health's 'revolving door'	-
65	GP avoiders must be tackled	+

Page no.	**Waikato Times**	
63	GP avoiders must be tackled	+
70	Miracle escape in 'baby scoop' era	+

Page no.	**Western Leader**	
3	Problem drinkers wanted for app	+
9	DHB trials video appointments	+
20	Most health staff not vaccinated	-
30	DHB: Don't clog up hospital A&E	+
40	Did the state fail Rua?	-
45	What's On – craft market	0
51	Call for zero suicides in care	-
58	New DHB initiative	+

Page no.	**Western Leader**	
69	Bowel Screening – have you been invited?	+
74	Sat for hours as blood dripped	-
95	Hard to see time wasters	0
99	DHB staff go green	+

TOTAL:

Positive +	**32**
Neutral 0	**19**
Negative -	**13**
Total items	**64**

5.1 Establishment of Waitemata DHB Consumer Council

Recommendation:

That the Board:

a) **Approves the establishment of a Consumer Council that is accountable to the Waitemata DHB Senior Management Team and reports to the Hospital Advisory Committee and Clinical Governance Board.**

b) **Approves the proposed terms of reference for the Consumer Council (refer Appendix 1).**

c) **Notes the Consumer Council will give advice and make recommendations in the design, planning and delivery of high quality, safe and accessible health care services for the Waitemata community.**

d) **Notes the establishment of the Consumer Council supports Waitemata DHB's commitment to comply with the 2017/18 DHB annual plan guidelines "commit to either establish or maintain a consumer council (or similar) to advise the DHB".**

e) **Notes the costs expected to be incurred by the Consumer Council, ie $72k, will be included in the DHB's operational budget for 2018/19.**

f) **Notes the Health Links contracts are due to expire in June 2018. The establishment of the Consumer Council will inform the future functions and contributions included in the community engagement contracts.**

Prepared by: David Price (Director of Patient Experience) and Carol Hayward (Community Engagement Manager), Jacky Bush (Quality and Risk Manager) and Jarrard O'Brien (Associate Director Institute of Innovation and Improvement)
Endorsed by: Dr Andrew Brant (Deputy Chief Executive and Chief Medical Officer), Dr Debbie Holdsworth (Director Funding), Cath Cronin (Director Hospital Services), Dr Penny Andrew (Associate Director of Institute of Innovation and Improvement), Robert Paine (Chief Finance Officer and Head of Corporate Services) and Health Link North Board and Waitakere Health Link Board.

Glossary

Community	-	Community can be defined by place, identity and shared interest. For the purposes of this proposal, a community member is anyone who may be interested and/or affected by a health-related activity, proposal or decision to be made.
Consumer	-	A consumer can be patients or service users and their families or whānau.
Consumer representative	-	A consumer representative is a person with experiences of healthcare provision relevant to the project or management group. A consumer representative provides advice based on either his/her own personal experience of services or care, or on behalf of others.

1. Executive Summary

Improving patient experience and patient outcomes are strategic goals for the DHB. This paper outlines a recommendation to establish a Consumer Council at Waitemata DHB. The Council will support achievement of these goals and complement the DHB's long standing commitment to consumer and community engagement.

The annual planning DHB priorities guidelines for 2016/17 and 2017/18 include an expectation for DHBs to establish a Consumer Council (or similar). Advice from the Health Quality and Safety Commission indicates DHBs have increased efforts to implement community councils. Indications are all DHBs now having a consumer council in place, or are in the process of establishing one. For example Auckland DHB is currently recruiting for members of its Patient and Whānau Centred Care Board, their equivalent of a consumer council.

Waitemata DHB's 2017/18 Annual Plan indicated that a Community Council would be established by December 2017. This commitment has provided the opportunity to consider how this type of mechanism could best contribute to existing consumer and community engagement functions. It also provides an opportunity to consider how the Council could best contribute to improving patient clinical quality and safety, an area where there is room for improvement in how the DHB incorporates the consumer voice.

A series of discussions with Waitakere Health Link and Health Link North were undertaken to consider the governance, representation, responsibilities and accountabilities of the proposed Waitemata DHB Consumer Council. This process identified the DHB has several gaps with regard to effective consumer engagement including clinical governance, quality and safety and decision making. The establishment of a Consumer Council would enable the effective design and delivery of high quality, safe and accessible health care services for the Waitemata community.

Four options were considered, including do nothing, for how the proposed Consumer Council could be aligned within the existing DHB management and governance structures. While a long-term aspiration is to establish a Consumer Council that would bring together community engagement, values and patient and whānau centred care, it is proposed that the Consumer Council would initially focus solely on the existing gap of clinical governance, quality and safety and decision making. This is the immediate need for the DHB and would provide a strong foundation for the Consumer Council to support patient and whānau centred care. The Council would be accountable to the Waitemata DHB Senior Management Team with reporting lines to the Board via the Hospital Advisory Committee and Clinical Governance Board.

The expected costs of establishing a Consumer Council include Council member fees, training, management support and supplies and other costs associated with supporting the Council. These costs have been estimated at $72k and will be included in the 2018/19 operational budget.

The implementation of the Consumer Council would include review of the Health Links contracts, which are due to expire in June 2018. This would ensure resources are effectively focused and that arrangements with the Health Links align with the proposed Consumer Council.

The Waitemata DHB Consumer Council would provide a strong voice for consumers on quality improvement and delivery of services that meet the needs of the people. Aligning strategically with Waitemata DHB priorities, the Consumer Council will enhance consumer engagement and patient experience across all services. This Consumer Council will also demonstrate a commitment by Waitemata DHB to become a patient and whānau centred organisation and to transform our culture to one where working in partnership with our community is business as usual.

2. Strategic Alignment

Community, whanau and patient centred model of care	Establishing a Consumer Council would be an effective way for Waitemata DHB to create a formal structure to seek and incorporate patient feedback and involve consumers in service planning, delivery, monitoring and evaluation of our quality and safety performance and improvement. It will also assist in moving the Waitemata DHB from a consultative organisation to a consumer empowering organisation with a sense of ownership in the community it serves.
Evidence informed decision making and practice	Government policy guidance, community feedback, existing risks and issues, and staff and other DHB's experience have informed the options analysis. The proposal to establish a Consumer Council is based on evidence based guidance prepared by the Health Quality and Safety Commission.
Operational and financial sustainability	The preferred option for establishing a Consumer Council utilises an existing steering group and structure to minimise the additional resources required to support the new Council.

3. Introduction/Background

Waitemata DHB has a long-standing commitment to consumer and community engagement. This includes the relationship with the Health Links who facilitate consumer and community involvement in DHB groups and processes, the development of an Engagement Strategy that outlines how the DHB will improve its engagement with patients, whānau and the wider community and the development of Waitemata Experience effort to co-design and deliver an excellent experience for patients, whānau and staff.

Historically there were three cross-organisational groups responsible for the delivery of the Waitemata experience. These were the Community Engagement Forum (focused on the community), the Patient and Whānau Centred Care Steering Group (focused on patients) and the Values Steering Group (focused on staff). The Patient and Whānau Centred Care Steering Group was disestablished in early 2015.

As part of the annual planning DHB priorities guidelines for 2016/17 and 2017/18 an expected focus for improving quality at Waitemata DHB is to 'commit to either establish or maintain a consumer council (or similar) to advise the DHB'[1]. Waitemata DHB's 2017/18 Annual Plan committed to establish a Community Council by December 2017. The expectation by the Ministry of Health to establish a Consumer Council creates an opportunity to revisit the current structure and to consider how best to establish a governance model which supports Waitemata DHB's commitment to engagement.

[1] https://nsfl.health.govt.nz/dhb-planning-package/201718-planning-package/annual-planning-priorities-guidance

Consumer Councils are an integral feature of consumer engagement in the health sector landscape in New Zealand. Consumer Councils are made up of a range of people, with diverse backgrounds and areas of interest. Most DHBs have established a Consumer Council as part of their governance structure or are in the process of set up and recruitment. A review of the initial twelve DHBs Consumer Councils highlighted the following key roles (refer Appendix 2 for further detail):

- enhancing the collection and use of feedback from a service user's perspective
- assisting to improve the organisation's information sharing responsibilities with service users
- contributing to the design or re-design of services and/or facilities by the DHB
- working in partnership with the DHB to improve the quality of the patient journey
- working to remove barriers for consumers whilst enhancing safe service provision
- representing the interests of consumers with plans, policies, publications and operational decisions
- raising issues that are being identified in the community
- providing a consumer perspective and evaluation of quality and safety of care.

The expectation to set up a Consumer Council is part of the new People Powered theme in the NZ Health Strategy which reflects the Government's priority of delivering 'better public services' and the opportunity to achieve this through taking more people-centred approaches to providing health services.

4. Risks/Issues

Waitemata DHB's long history of community and consumer engagement has enabled a broad range of engagement activities to be well established within the DHB from consumer representation on project groups, to advice on health literacy and facilitation of community forums. However there remain some issues which may be resolved by responding to the Ministry's planning expectation. These include:

- The role of consumer engagement in governance (executive management and Board level), including accountabilities and responsibilities. For example how do all of the consumer related groups contribute and link to the DHB's operational management and governance structure?
- Consumer participation/engagement gaps with clinical governance and decision making. Currently the DHB advocates for consumer engagement but there is no formal, structural support to ensure consumer engagement is business as usual.
- The expectations of the Health Links and their role linking with the DHB at the DHB's management, executive and governance level.
- Balancing the level of consumer and community engagement with the current funding and resources available to support these activities. For example the Health Links have indicated their preference is for additional funding to be made available to support the proposed consumer council.
- Reputational risk with community and with other DHBs – as an outlier compared to other DHBs who have consumer councils to support quality improvement activity, service redesign, evaluation, patient experience feedback analysis and quality and safety performance.

There is also the risk relating to the relationship with the Ministry of Health if Waitemata DHB does not meet the annual planning DHB priorities guidelines for 2017/18.

5. Approach/Methodology/Analysis/Justification

5.1 Investigation/Research/Evidence

Expectations of DHBs
The DHB objectives under the New Zealand Public Health and Disability Act include:

- "to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services.
- to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services".

The Health Quality and Safety Commission has provided guidance through its Partners in Care and Improving Leadership and Capability programmes[2]. This guidance is intended to support DHBs meet the expectations of the legislation, but more importantly to improve health and disability services.

In a recent publication by the Health Quality Safety Commission – Clinical Governance: Guidance for health and disability providers[3]– consumer engagement and participation is highlighted as one of four major components for effective clinical governance. In addition, Consumer Councils are mentioned as a key element of governance for consumers to contribute to discussions on improved quality, safety and decision making.

The recently revised National Reportable Events Policy indicates a shift towards consumers becoming more involved with adverse events, governance, investigations and recommendation outcomes.

The Ministry of Health's 2016/17 and 2017/18 planning priorities guidance requiring the establishment of a consumer council (or similar) to improve quality also sends a clear signal. DHB's are expected to implement more formalised structures for consumer engagement.

Current Waitemata DHB consumer and community engagement
Waitemata DHB developed an engagement strategy in 2015 to outline how Waitemata DHB could improve its engagement with patients, whānau and the wider community through its community engagement and patient experience work using existing resources. The strategy built on the existing patient experience programme of work and demonstrated how engagement supports the DHB's promise, purpose, priorities and values.

Progress against the strategy has been reported through the Board twice a year however, the establishment of the new Institute of Innovation and Improvement (I3) and the new Patient Experience Team has led to different ways of working within the DHB and the strategy is now due for review.

The key consumer related groups and their functions are included below to provide a summary of the current breadth of activity and its current status.

[2] Health Quality and Safety Commission's "Engaging With Consumers - A Guide for District Health Boards" published in 2015. http://www.hqsc.govt.nz/assets/Consumer-Engagement/Publications/DHB-guide/engaging-with-consumers-3-Jul-2015.pdf
[3] Health Quality Safety Commission – Clinical Governance: Guidance for health and disability providers <https://www.hqsc.govt.nz/publications-and-resources/publication/2851/>

Key consumer groups / teams	Key functions
Community Engagement Forum	• Provide support and advice to DHB community engagement and patient participation activities. • Provide support and advice in monitoring and evaluating engagement activities and a platform to share learnings. • Develop an oversight of all community engagement activities taking place within Waitemata DHB. • Co-ordinate community engagement activities to reduce duplication and ensure joined up engagement processes. • Develop approaches to improve communication and engagement with communities who are currently less engaged (Māori, Asian, Pacific, Youth, Refugees and Migrants, Disabled people). • Coordinate DHB processes with other sectors, contributing to inter-sectoral approaches to community engagement where appropriate. • Develop competencies and processes for community engagement. • Develop reporting mechanisms to monitor DHB progress against objectives for community engagement and patient participation. • Connect with other existing community networks and organisations to support communication and engagement with the community on a range of topics and issues.
Patient and Whanau Centred Care (PWCC) Steering Group – disestablished in early 2015	• To promote patient and whānau-centred care and the continuous improvement of experience for service users and their families and whānau. • The steering group was established to provide strategic advice and guidance during the development, implementation and evaluation of the PWCC programme. • The steering group was responsible for advising on risks, quality and timeliness of programme deliverables, and providing recommendations to ensure the successful delivery of the programme objectives.
Values programme	• To promote the staff values and standards of behaviours throughout the organisation. • Information from staff and patients were translated into a set of shared service standards and behaviours our staff and patients told Waitemata DHB they want to see. • The development of a set of shared standards and behaviours was just the beginning, the steering group is now responsible for innovative projects that will help deepen individually and collectively understanding of our values, standards and behaviours and how they influence better patient outcomes and enhance patient experience.
Community Engagement Manager	• Focused on population based engagement, eg consultation on primary birthing, community views and aspirations. Areas of work include: • Health Needs Assessments and building understanding of

Key consumer groups / teams	Key functions
	population health perspectives. • Plans, policies and strategies. • Building community capacity and networks to connect including consumer representatives. • Partnership with community organisations and demographic groups.
Patient Experience Team	Patient or health condition focused. Areas of work include: • Patient feedback, surveys and measurement. • Development of patient stories and videos. • Co-design processes, journey mapping and peer support • Volunteer programme. • Facility design, food services and wayfinding.
Health Links	• Provide advice and support to Waitemata DHB on community engagement activities including facilitating focus groups, forums and community outreach. • Support the DHB's Consumer Representative work by assisting with recruitment, mentoring, training and networking. • Facilitate health literacy consumer groups that review draft patient information such as brochures, patient letters, DVDs or web-based information.

Waitemata DHB Consumer Participation Gaps

Analysis of expectations, guidance and current Waitemata DHB consumer participation suggests the following gaps in consumer participation:

- Consumer engagement and participation is highlighted by the HQSC as one of four major components for effective clinical governance. Waitemata DHB has consumer representatives on some clinical governance groups but does not currently have a formalised mechanism for consistently involving consumers.
- With the exception of quality related projects with consumer representation there is minimal consumer involvement in discussions on improved quality, safety and decision making.
- Waitemata DHB does not currently have a formalised mechanism for involving consumers in adverse events and complaint governance.
- Waitemata DHB currently sits across the consultation and partnership area of the consumer participation continuum (refer table below). This can often lead to the community being consulted with, but with limited impact on the final decision/outcome. The ultimate goal is to enable consumers and the community to be in control of specific decisions about their health service.
- There is no governance model which links consumer and community engagement groups with the DHB's organisation management and governance structure.

Table 1: Continuum of participation[4]

	Information	Consultation	Partnership	Delegation	Control
Description	The organisation develops or adopts a policy, plan or program and provides information about this to the consumers and/or carers and the community.	The organisation identifies an issue and proposes a policy, plan or program which responds to the issue. It then provides information to consumers and/or carers and the community on that proposal and seeks views and comments with a view to maximising acceptance.	The organisation identifies an issue and presents a tentative policy, plan or program which responds to the issue. The organisation seeks active involvement and feedback from consumers and/or carers and the community which is incorporated into the plan.	The organisation identifies an issue, presents this to consumers and/or carers and the community for them to make decisions or propose actions to address the issue.	The organisation asks consumers and/or carers and the community to identify an issue and make all the key decisions on the development of solutions to address the issue. The organisation supports them to accomplish this.
Examples	**Giving:** Flyers, mail outs, factsheets, press releases, brochures, newsletters, public displays, websites, public meetings **Gathering:** Surveys, phone-ins, focus groups, in-depth interviews, suggestion boxes	Workshops Consumer representatives on management committees, advisory groups Public meetings/patient forums Online discussion groups Circulation of proposal for comment Conferences or seminars Evaluation surveys	Strategic alliances built utilising a combination of other methods (including those mentioned in Information and Consultation) for example: • workshops • consumer representatives on committees or advisory groups • round tables • patient forums • surveys • focus groups	Shifting some or all of decision making on particular issues to consumers. For example: spending on specific budget items, management of particular programs by consumers eg. Healthy Families Waitakere	Community appointed management committees

Continuum of Participation

Lower ⟷ **Higher**

[4] Queensland Health. *Consumer and Community Participation Toolkit*. Brisbane. Queensland Health, 2007

Success criteria for advisory groups

A recent review of the Auckland Council's Advisory Panels identified some key criteria for advisory panels to be effective. Their recommendations can be summarised for the DHB as:

- expert facilitation and support for the advisory panel;
- time to build with about a decade being required to reach maturity;
- elected member liaison and a formal relationship with the board;
- leadership from an executive leadership team member to ensure the panel is embedded in the organisation's work; and
- quality and commitment of council members, which reflects good selection criteria and selection process.

Consultation with Health Links

During late 2017, three workshops were held with members of the two Health Links to consider how a Consumer Council could work. These discussions focused on funding, scope and recruitment of members for the proposed Consumer Council. Their proposal based on these discussions is summarised below.

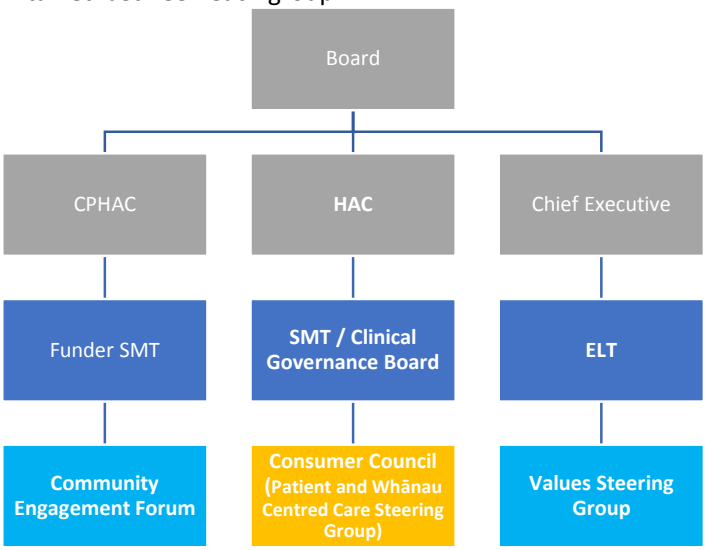
Scope	• There was agreement that the scope of the Consumer Council would ideally cover patient experience, quality, community engagement, values programme and governance. This would help to bring together different strands of work within the DHB and ensure that they are in alignment. • Council members would be able to add items to the agenda and identify their own issues. • The Consumer Council should have the authority to give advice and make recommendations to the Waitemata DHB Senior Management Team, Hospital Advisory Committee and Clinical Governance Board, as well as other services or divisions who seek the Consumer Council's advice and guidance. The organisation will be obligated to provide a response to these recommendations and advise on how it is being used to inform future planning/strategy/healthcare design. • The Consumer Council would not have executive powers or authority to implement actions and would not have delegated financial responsibility. In addition, the Council would not: o Provide clinical evaluation of health services o Discuss or review issues that are processed as formal complaints, for which an effective process exists o Be involved with Waitemata DHB contracting processes.
Membership and Recruitment	• There should be up to 12 consumer members and two staff on the Consumer Council, consumer members should include at least: o Health Link North Board – two members o Waitakere Health Link Board – two members o Māori – two members with strong connections to the local Māori community o Pacific – one member with strong connections to the local Pacific community o Asian – one member with strong connections to the local Asian community o Disability – one member with strong connections to the local disability community o Youth – one member with strong connections to local youth o Mental health – one member with experience of the mental health service

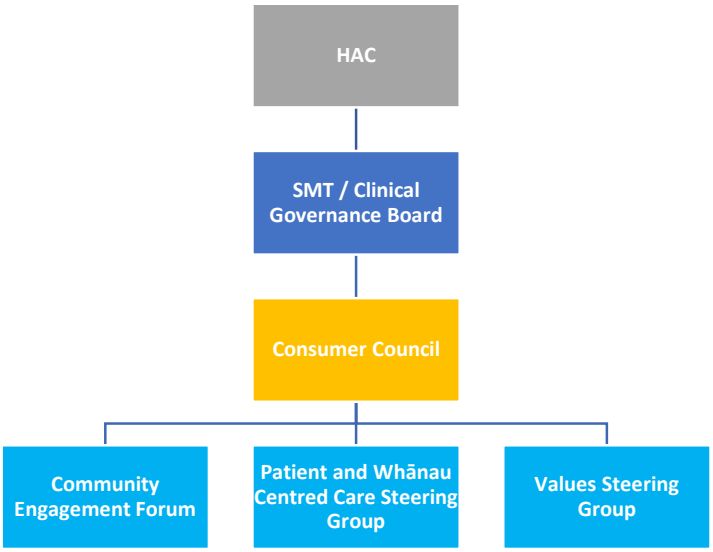
	• Members would be selected to provide a good cross-section of age groups, health experience and geographical locations of the local community. It was agreed that members of the Consumer Council should be lay people and should live or have strong connections in the Waitemata area. • Each year a third of the Consumer members' terms should end and a selection or election process would take place. • The chair should be elected by the Consumer Council members. • A selection panel for the inaugural Consumer Council should include a board member from each Health Link, Te Runanga o Ngati Whatua, the Community Engagement Manager and the Director of Patient Experience. • Waitemata DHB staff representation should include two rotating Senior Management Team members and representatives from Quality, Patient Experience, Community Engagement and the Values Programme to coincide with quarterly reports to the Council.
Link to organisation structure	• It is preferred that the Consumer Council operate at a DHB governance level that is accountable to the Waitemata DHB Senior Management Team and reports to the Hospital Advisory Committee and Clinical Governance Board.
Meetings	• The frequency of meetings is recommended to be every six weeks • Minutes from the Consumer Council should be tabled at Waitemata DHB Senior Management Team, Hospital Advisory Committee and Clinical Governance Board meetings. Opportunities to present consumer recommendations and advice should also be provided at these forums.
Link to other organisations	• The Consumer Council would work closely with the DHB's Quality Team, Patient Experience Team and Senior Management Team as a way of reaching all Waitemata DHB divisions and services
Funding	• The Health Link Boards agreed that they would like to retain their current independence and nominate representatives to join a new Consumer Council that would be established with new funding.
Support for the Council	• Administrative support for the Consumer Council would need to come out of existing resources to support the administrative functions including: preparation of agenda, consumer payments, taking of minutes, communication (including facilitating communication between Waitemata DHB and the Council) and other council logistical arrangements.

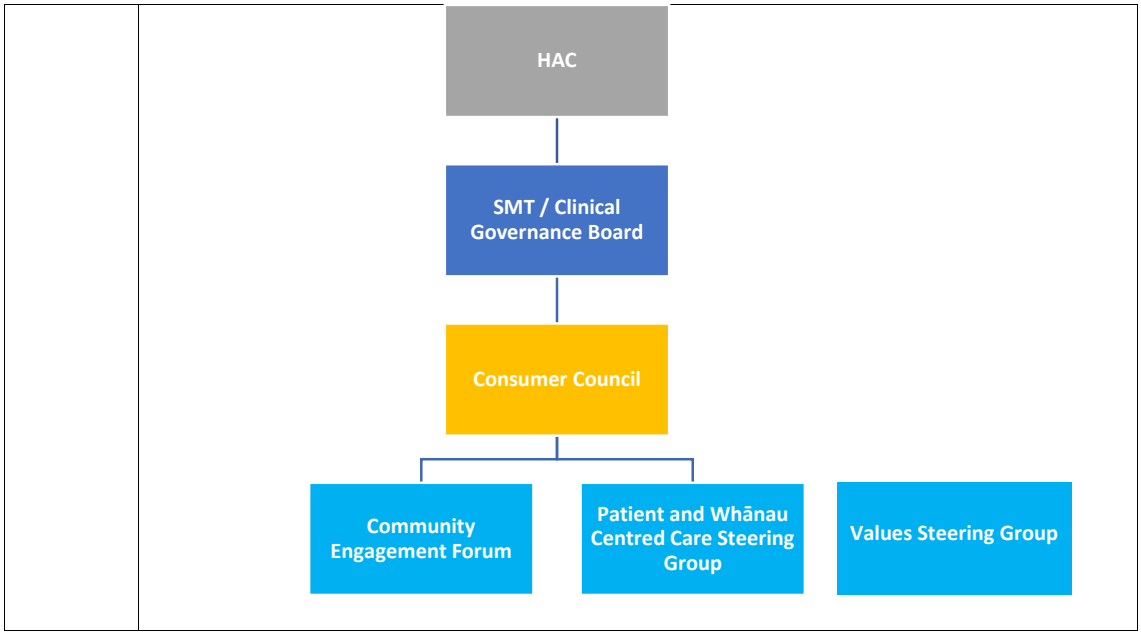
6. Options Analysis

The analysis and consultation with Health Links supported the establishment of a Consumer Council. Therefore the options considered focus on maintaining the status quo, and options to determine how the Consumer Council could be aligned within the existing DHB management and governance structures. The following options were identified:

Option 1	Do nothing. The risk of this approach is that the DHB will not meet the Ministry of Health and the community's expectations. Furthermore the gaps identified in consumer participation, particularly with regard to clinical governance, quality and safety, will not be resolved.
Option 2	Establish the Consumer Council by re-establishing and re-configuring the Patient and Whānau Centred Care Steering group with a focus on: • decision making about safety and quality • design and redesign of health services

	• analysis and evaluation of organisational safety and quality performance • ensuring the patient/community voice is heard/valued by the DHB • evaluation of patient feedback data • improving patient experience • recommending quality activities that relate to patient feedback data. Adjustments to the Community Engagement Forum and to the Values Steering Group may be needed to ensure that the functions are distinct and that strategic and operational links are maintained between each group. The benefits include: • clear accountability and linkage to the existing DHB management and governance structure • each Board committee has a management level group to provide consumer and community input into DHB decision making • improved participation of consumers at all levels in DHB decision making • improved approach to consumer input focused on quality and safety and clinical governance • the ability for senior management and governance to have clear mechanisms for receiving and requesting advice from consumers and the community • this structure would not require an additional steering group compared with the current arrangements. • The focus on clinical governance, quality and safety would respond to the DHB's immediate need and would provide a strong foundation for the Consumer Council to support patient and whānau centred care. The risks include: • duplication of effort, therefore the functions of each group need to be distinct • maintaining a consistent organisational approach to community and consumer engagement. Therefore it will be important that strategic and operational links are maintained between each group. 
Option 3	Establish the Consumer Council, based on the approach recommended by the Health Links to provide a governance structure across the three operational groups.

	The benefits include: • Clear accountability and linkage to the existing DHB management structure. • One governance group bringing together all consumer and community related activities across the funder and provider which will improve consistency and improve participation of consumers at all levels in DHB decision making. • The ability for senior management and governance to have clear mechanisms for receiving and requesting advice from consumers and the community. • Oversight of quality and safety, patient experience, community engagement and values across the whole DHB. The risks include: • The need for an operational structure, additional steering group, to advise patient and whānau centred care work and ensure the current gaps regarding clinical governance, quality and safety were resolved. • Managing the separate functions of funder and provider and their need for consumer and community participation in decision making. • Appropriate management support across these functions to ensure the opportunity provided by the Consumer Council is realised. 
Option 4	Establish the Consumer Council to provide a governance structure across the Community Engagement Forum and the Patient and Whānau Centred Care groups. The Values work would remain separate. There would be a need to set up both a Consumer Council and a Patient and Whanau Centred Care Steering Group. The benefits and risks of this approach would be similar to option 3, however the alignment with the Values work programme would be more challenging.



6.1 Recommended option

The preferred option is option two, establish the Consumer Council, by re-establishing and re-configuring the Patient and Whānau Centred Care Steering group, as this approach:

- enables the DHB to mitigate many of the consumer participation gaps, particularly those related to clinical governance, quality and safety.
- moves the DHB along the participation continuum once implemented
- aligns with the Ministry of Health's expectations regarding establishment of Consumer Councils.
- ensures the Consumer Council is an integral part of the DHB's management and governance structure.
- establishes a governance model of consumer involvement that could be expanded in the future to cover community engagement or values work
- recognises that it takes time to establish a fully functioning consumer council. By focusing on the DHB's immediate gaps this option provides the Consumer Council an opportunity to start where the need is and grow its scope once well established.

During the consultation process the Health Links signalled a preference for an overarching council across all DHB consumer and community engagement activities. The option recommended is a first step to fill existing gaps and needs within the DHB's consumer and community engagement towards achieving that aim. In the future, the DHB may be in a position to move towards greater alignment across the three strands of work through a combined governance group. All other aspects of the consultation outcomes with the Health Links are proposed to remain within the Consumer Council terms of reference.

The proposed terms of reference for the Consumer Council is included as Appendix 1.

Implementation of the preferred option will need to include review of the contractual arrangements with the Health Links to consider what alignment is needed alongside the establishment of the Consumer Council.

7. Linkages/Impact

7.1 Strategic Context

This proposal aligns with the following strategies plans or goals:

Level	Strategy/Plan/Goal
Local (Waitemata DHB)	• Alignment with the Board goals of improving patient experience and outcomes. • Ensuring our services are co-designed with our community and the needs of our community are represented as part of the overall organisational governance. • Waitemata DHB Engagement Strategy.
Regional	• Alignment with the established Consumer Councils of Counties Manukau and Northland DHBs and soon to be established Auckland DHB Patient and Whanau Centred Care Board.
National	• Ministry of Health – Annual planning DHB priorities guidelines for 2016/17 and 2017/18. • NZ Health Strategy Action 3 – Engage the consumer voice. • Health Quality and Safety Commission guidance for engaging with consumers.

7.2 Impact on reducing inequalities and Maori Health Gain.

Two Consumer Council members would be appointed to represent the Māori community and to help to ensure a strong focus on Māori health issues and perspectives, upholding the principles of the Treaty of Waitangi.

8. Costs/Resources/Funding

The following table outlines the costs associated with establishing and running a Consumer Council:

- Consumer reimbursement is based on a payment of $250 per consumer per meeting in line with current practice and policy.
- Management and administrative support for the committee is based on the experience of other DHBs and local government. Excellent support for the Consumer Council is required to champion the Council within the DHB, manage the workplan, day to day support for Council members, managing the election process, manage training and orientation, manage payment and reimbursement of council members, co-ordinate content for the meetings, follow-up actions and overall meeting management and administration. This role is not an administration role, rather it requires a level of management experience and skill in governance practices and meeting management.

Item	FTE	Annual Cost
Personnel Costs		
Consumer Reimbursement (Eight meetings annually – including travel/parking)	12 consumer members	$24,000
Consumer Reimbursement (orientation, mandatory training x 4 hours each – including travel/parking)	12 consumer members	$3,000

Item	FTE	Annual Cost
Allowance for 1-2 consumers to attend national consumer council events and activities	As required	$3,000
Management / Administration Support	0.6	$36,000
Administration Supplies – printing, catering, recruitment, other training costs		$6,000
Total Expenditure per annum		**$72,000**

9. Consultation/Engagement

9.1 Consultation already undertaken

Three workshops have taken place with the Health Links during 2017 to develop this proposal.

10. Communications/Marketing

10.1 Internal

Promotion of the Consumer Council through members of the Senior Management Team to encourage engagement on key issues and projects.

10.2 External

Promotion of the Consumer Council recruitment process to encourage nominations through a wide range of community networks as well as social and local media.

Promotion of the achievements of the Consumer Council through existing communication channels eg website, newsletters etc once established.

11. Implementation

11.1 Issues/considerations

Issue / consideration	Mitigation
• Ability to recruit consumers to the Consumer Council	• Develop Communications Plan to include communication through MoU Partners Te Runanga O Ngati Whatua, Health Links and other community networks. • Signalling of establishment of Consumer Council and planned recruitment process prior to recruitment. • Implementation timeline builds in sufficient time to attract suitable candidates.
• Senior Management Team support priorities and promotion of the Consumer Council throughout organisation	• The management support for the Council, SMT sponsor, Quality and Risk Manager and Director Patient Experience work with SMT to provide opportunities for promotion of the Consumer Council.

Issue / consideration	Mitigation
• Ability to source content for the Consumer Council meetings which enables members to add value to DHB decision making	• DHB commitment to actively involve Consumer Council in decision making (eg health plan development, model of care development, actions in response to incident and complaint themes etc). • Sufficient management support for the Council.
• Maintaining positive relationships between the DHB, health links and other community groups during implementation	• Maintain regular communication with the Health Links. • Clearly separate contractual discussions from general catch-ups or contribution to consumer / community engagement.
• Supporting consumer representatives to be able to function at a governance level	• An orientation programme for new Consumer Council members will be required to support them to be able to participate in DHB programmes of work. • Additional training and attendance at conferences from time to time will help to maintain skills and knowledge.

11.2 Timelines

Activities	Indicative Dates (2018)
Board Approval	11 July
Management planning	July
Communication to community regarding establishment of Consumer Council (if approved)	July
Recruitment of consumers begins (two month process)	August / September
Appointment of Consumer Council members	October
First meeting of Consumer Council	November
Post implementation review	Six months and twelve months after the first meeting

Establishing a Consumer Council is a learning process for the Council members and for the DHB. It is expected to take up to two years before the Council is stable and embedded in the DHB.

12. Conclusion

The Waitemata DHB Consumer Council would provide a strong and viable voice for consumers on quality improvement and delivery of services that meets the needs of the community. Aligning strategically with Waitemata DHB priorities, the Consumer Council will enhance consumer engagement and patient experience. This Consumer Council will also demonstrate a commitment by Waitemata DHB to become a patient and whānau centred organisation and to transform our culture to one where working in partnership with our community is business as usual.

Appendix 1

Purpose & Brief

Purpose

The Waitemata District Health Board (DHB) Consumer Council works collaboratively with the Waitemata DHB Senior Management Team, Hospital Advisory Committee and the Clinical Governance Board to develop effective partnerships in the design, planning and delivery of high quality, safe and accessible health care services for the Waitemata Community.

The focus of the Consumer Council is:

- decision making about safety and quality
- design and redesign of health services
- analysis and evaluation of organisational safety and quality performance
- ensuring the patient/community voice is heard/valued by the DHB
- evaluation of patient feedback data
- improving patient experience
- recommending quality activities that relate to patient feedback data.

The People Powered theme in the NZ Health Strategy reflects the Government's priority of delivering 'better public services' and the opportunity to achieve this through taking more people-centred approaches to providing health services. Through meaningful partnerships, the Waitemata DHB Consumer Council provides a strong and viable voice for the community and consumers on healthcare planning, quality improvement and delivery of services that meets the needs of the people. The Waitemata DHB Consumer Council will enhance consumer engagement and experience across all services. The Consumer Council is a commitment by Waitemata DHB to become a patient and whānau centred organisation and to transform our culture to one where working in partnership is business as usual.

The Waitemata DHB Consumer Council will develop an effective process to communicate their activity and meeting outcomes to the community. The Consumer Council also has a quality improvement role to advise and encourage best, better, brilliant practice and innovation.

Scope

All Waitemata DHB services and divisions.

Brief / Responsibilities

To represent the interests of consumers by objectively communicating their views.
Patient experience

- Overview and monitoring of patient experience strategy (ensure accountability for Patient Experience team meeting strategy objectives)
- Patient Experience Strategy quarterly update
- Report, identify, highlight patient experience/community feedback – identify priority areas for Patient Experience activity
- Understand and critically review feedback themes from Patient Experience surveys and improvement activities

Quality

- Understand and critically review complaint and adverse event themes and recommendations that impact on patient experience
- Advice on intent and language for a selection of complaint responses (excluding Heath & Disability Commission [HDC] responses)
- Feedback and monitoring of Quality Strategy (quarterly updates)

Governance

- Advice and support in ensuring the Waitemata DHB are engaging with consumers at all levels of governance.

Associated functions

- Recruitment and management of consumer council members with far-reaching community representation
- Training and mentoring of all committee members
- General advice to teams/services who present their work to the Council, seeking advice about direction and/or engagement

Exclusions

The council will not:

- Have access to personal identifiable information
- Provide clinical evaluation of health services
- Discuss or review issues that are processed as formal complaints, for which an effective process exists
- Be involved with WDHB contracting processes.

Accountability

The Waitemata DHB Consumer Council is accountable to the Waitemata DHB Senior Management Team and reports to the Hospital Advisory Committee and the Clinical Governance Board. The Consumer Council would also work closely with the DHB's Quality Team, Patient Experience Team and Senior Management Team as a way of reaching all WDHB divisions and services.

Structure

Membership / Composition

The Consumer Council should be lay people and should live or have strong connections in the Waitemata area. There are 12 consumer members and 2 staff on the Consumer Council, consumer members should include at least:

- Health Link North Board – two members
- Waitakere Health Link Board – two members
- Māori – two members with strong connections to the local Māori community
- Pacific – one member with strong connections to the local Pacific community
- Asian – one member with strong connections to the local Asian community
- Disability – one member with strong connections to the local disability community
- Youth – one member with strong connections to local youth
- Mental health – one member with experience of the mental health service

Members would be selected to provide a good cross-section of age groups, health experience and geographical locations of the local community.

Waitemata DHB staff representation would include two rotating Senior Management Team members and representatives from Quality and Patient Experience.

Appointment & Term of Office

Each year a third of the consumer members terms would end and a selection or election process will take place. A selection panel for the inaugural council would include a board member from each Health Link, Te Runanga o Ngati Whatua, the Quality and Risk Manager and the Director of Patient Experience.

Meetings

Chair	Consumer member who is elected by the Council every 12 months
Quorum	50% of consumer members plus one and two Senior Management Team representatives
Frequency	Six weekly meetings (at least seven meetings per annum) – two hours in length No meetings to be held in January or during school holidays. Meeting venue to alternate between North Shore & Waitakere Hospital sites.
Minutes & Agenda	Agenda be circulated within one week of schedule meeting Minutes to be sent out one week post meeting and made available on the WDHB Consumer Council webpage for public access once endorsed by Council members.
Reporting	Consumer Council minutes to be tabled at Senior Management Team, Clinical Governance Board and Hospital Advisory Committee meetings.

Meeting Fees	Consumer payment for attending meetings will be set at WDHB rate for consumer representatives.

MEMBER REQUIREMENTS

Members are to attend all meetings and are responsible for sending apologies to the WDHB Consumer Council Chair. It is expected that the agenda and all papers are read prior to the meeting.

Senior Management Team representative is to organise a Senior Management Team member replacement if unable to attend. Patient Experience and Quality representatives are to be in attendance at their scheduled quarterly updates. Senior Management Team members attend meetings to listen to the discussions, provide updates from the organisation and answer questions as required. In addition, their experience of attending the meetings will enable active promotion of the Consumer Council function.

DECISION MAKING / ESCALATION

The Council has the authority to give advice and make recommendations to the Hospital Advisory Committee, Waitemata DHB Senior Management Team and Clinical Governance Board, as well as other services or divisions who seek the Council's advice and guidance.

The Consumer Council does not have executive powers or authority to implement actions and does not have delegated financial responsibility.

DRAFT and CONFIDENTIAL

Appendix 2 - Overview of some current New Zealand Consumer Councils

DHB	No. of Consumer Members	Governance level		No. of meetings annually	Meeting time length	DHB staff representation (Board, Executive, Senior Management?)	How consumers are recruited?	Dedicated staff time to support Council
		Who Council reports to	Who reports to Consumer Council					
Counties Manukau	10 plus 4 spaces for reps from localities	Patient and Whanau Centred Care Board	- No direct reports	10	120 minutes	1 x Patient Advisor	Open advertisement Through community groups via DHB website	Not dedicated time- part of Patient advisor role.
Canterbury	16	CEO	- Disability Action Group - Maori Health Gain Advisory Committee - Senior Management Team	11 every month except Decembers	120 minutes	Consumer Council Coordinator 1 Executive director 1 DHB Staff	Advertise through the specific area that a replacement is needed eg: Youth health goes to youth groups via open advertisement through DHB recruitment site Targeted to specific community groups	0.6 FTE – Consumer Council Coordinator
Southern Community Health Council for the Southern health region (Southern DHB, WellSouth PHO and Alliance South)	Up to 12; 7 currently appointed with 2 pending and future appointments to be made to ensure continuity within the CHC; inaugural meeting 23 February	Southern DHB, WellSouth PHO and Alliance South. The Council has the authority to make recommendations to the Southern DHB Board, WellSouth PHN, Alliance South and the DHB's Provider Arm Executive.	TBC; Chair of Community Health Council currently sits on Clinical Council	10	<180 minutes	Ex officio members of the CHC include: Chief Executive Officer SDHB; Chief Executive Officer WellSouth PHN; Chair of Alliance South; Chair of Clinical Council; Executive Director of organisation development and performance Executive Director of patient services; Chief Medical Officer; Executive Director planning and funding	Open advertisement through websites and newspapers; advertisement called for people to have particular interest, understanding and knowledge in at least one of twelve areas and with consideration needing to be given to maintaining a demographic balance that generally reflects that of the population	TBC
Nelson Marlborough	7 (initially; not yet established; Council members to be	Nelson Marlborough Health Board	No reports to the Council, close relationship with Clinical	Up to 12 – meetings are held monthly	120 minutes	N/A: Standing reciprocal invitation will be extended to the Iwi Health Board,	Open advertisement in local media and DHB recruitment site; Email to local community groups	0.5 FTE Consumer Council Facilitator

DHB	No. of Consumer Members	Governance level		No. of meetings annually	Meeting time length	DHB staff representation (Board, Executive, Senior Management?)	How consumers are recruited?	Dedicated staff time to support Council
		Who Council reports to	Who reports to Consumer Council					
	selected by March 2017)		Governance Group and Iwi Health Board			and three local clinical governance committees (Nelson Marlborough Health and two PHOs)		
Hawke's Bay	15 plus Chair Currently 13 members. In the process of appointing 2 new members (Mental Health and Youth)	Hawke's Bay Health Consumer Council represents the sector therefore reports through to the CEO's of HBDHB and Health Hawke's Bay (PHO) and through the CEO's to the respective HBDHB and HHB Boards.	Sub committees exist (eg: Mental Health and Youth Committee) but don't report to Council. Reporting lines are currently being formalised	Monthly, excluding January, or more frequently at the request of the chair. Consumer Council sits alongside co-chairs of Clinical Council/Maori Relationship Board and attends monthly HBDHB Board meetings. Joint meetings with Clinical Council are held bi-annually to collaborate and strategise.	120 minutes	• Clinical Council representative • PHO (Health Hawke's Bay) representative • Consumer Engagement Manager • Director of Quality and People (exec) • Company Secretary (exec)	Appointed to reflect 14 areas of interest. Nominations are requested either via open advertisement or specific groups targeted depending on area of interest Consideration is given to maintaining a demographic balance that generally reflects that of the population. Members are appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following interview.	No dedicated staff member however support provided by Consumer Engagement Manager (relationships, links to projects, improvement initiatives and services, recruitment and orientation, support to the Chair) Executive Assistant, Director of Quality and People (minutes) Board Secretary (Agenda, papers, calendar invites)
Northland	13	Direct to CEO & Executive Leadership Team – at same		11 – monthly meetings except December	120 minutes	2 x executive members and 1 x minute taker	Consumer organisations and non-government organisations (NGOs) with a consumer advocacy role were identified through the family services directory and	Patient- and whānau-centred care project team

DHB	No. of Consumer Members	Governance level		No. of meetings annually	Meeting time length	DHB staff representation (Board, Executive, Senior Management?)	How consumers are recruited?	Dedicated staff time to support Council
		Who Council reports to	Who reports to Consumer Council					
		level as Clinical Governance Board					through local knowledge networks. Each organisation was sent a letter of introduction with a call for expressions of interest from suitable consumers.	
West Coast	10	Executive Management Team and Clinical Board through Quality and Patient Safety Manager reports	Quality & Patient Safety reports Programme reports	6	120 minutes	1 Executive representative 3 x Senior Management Team representatives	Membership will be decided by way of a call for expressions of interest, with membership recommendations made to the Chief Executive. Recommendations will be based on what prospective members bring by way of skills, perspective, and ability to enhance the work of the council, along with the collective mix of council attributes.	Quality and Patient Safety Manager & Administration Support Person
Mid Central	12	Board, CEO & Executive with direct links to Clinical Council		Meets quarterly – set up more as a reference group	120 minutes		Membership includes an independent chair appointed by the Board on the recommendation of the CEOs, MDHB and the Central PHO. Members to be appointed by the CEOs, MDHB & CPHO following consultation with Manawhenua Hauora. Membership to reflect diversity of ethnicity, gender, age, disability (including sensory, intellectual and physical), socio economic status, and demography.	

6.1 Financial Performance May 2018

Recommendation:

That the Board note the content of this report

Prepared by: Simon Watts (Deputy Chief Financial Officer)
Endorsed by: Robert Paine (Chief Financial Officer and Head of Corporate Services)

Glossary

IDF - Inter District Flow
NGO - Non Government Organisation
YTD - Year To Date

1. Executive Summary

The May 2018 YTD result for the DHB was a surplus of $199k, against a budgeted surplus of $100k, and therefore is $99k favourable to budget.

The May 2018 month result was a deficit of $1.568m which was $312k favourable to budget. The Provider made a deficit of $2.403m, against a budgeted deficit of $2.463m, and therefore was favourable to budget by $60k. The Governance and Funding Administration Arm made a surplus of $236k and the Funder made a surplus of $598k, both against a breakeven budget.

The Provider Arm YTD result primarily reflects unbudgeted expenditure in non-personnel costs, unrealised expenditure reduction initiatives, and an increase over budgeted growth in acute demand. Non-personnel expenditure consisted of outsourced services and labour (to cover budgeted vacancies), increased clinical supplies (volume demand and pricing) and utility costs. Within the Provider Arm, an actively managed Financial Sustainability Portfolio is being executed.

Capital expenditure for the eleven months ending May 2018 was $18.322m with a year-end forecast of $20m against a previously planned $21m, and a $30m approved budget.

The forecast cash position at year end is a balance of $28.5m.

The financial position as at 31 May 2018 indicates a net worth of $614.416m including $41.447m in cash.

2. Financial Performance - May 2018

The financial result for the DHB for the month ended May 2018 compared to the budget is summarised in the following table:

Waitemata DHB Consolidated Statement of Financial Performance

May 2018

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	141,758	140,360	1,397	1,547,862	1,543,074	4,789	1,683,292
Other	2,899	2,890	9	29,585	28,709	876	32,579
Total Revenue	144,657	143,250	1,407	1,577,447	1,571,783	5,664	1,715,872
EXPENDITURE							
Personnel							
- Medical	15,868	15,986	118	165,593	167,743	2,150	183,419
- Nursing	19,191	19,438	247	219,532	219,576	44	239,775
- Allied Health	9,572	10,437	865	103,430	107,052	3,622	117,043
- Support	1,545	1,619	74	17,460	18,009	549	19,785
- Management / Administration	6,347	6,806	460	69,797	70,791	994	77,360
	52,523	54,286	1,763	575,811	583,171	7,360	637,382
Other expenditure							
Outsourced Services	5,913	5,726	(187)	68,143	62,592	(5,551)	68,253
Clinical Supplies	10,770	10,496	(274)	112,658	106,117	(6,541)	115,849
Infrastructure & Non-Clinical Supplies	10,077	8,808	(1,269)	107,633	95,837	(11,796)	104,608
Funder Provider Payments	66,942	65,815	(1,127)	713,003	723,967	10,964	789,782
	93,703	90,845	(2,858)	1,001,437	988,513	(12,924)	1,078,491
Total Expenditure	146,226	145,131	(1,094)	1,577,248	1,571,684	(5,564)	1,715,872
NET RESULT	(1,568)	(1,881)	312	199	99	100	(0)

Comment on Major Variances for the month of May 2018

Revenue
Revenue was $1.407m favourable to budget due primarily to revenue from MoH and IDF.

Expenditure
Personnel ($1.763m favourable)
The favourable variance was driven by vacancies across all service areas.

Other Expenditure ($2.858m unfavourable)
The unfavourable variance was driven by unbudgeted expenses and unrealised expenditure reduction initiatives, as follows:

Outsourced Services ($187k unfavourable)
The unfavourable variance was due to unbudgeted outsourced radiology, gastroscopy and colonoscopy services. These procedures continue to be outsourced to meet MoH targets and population demand.

Clinical Supplies ($274k unfavourable)
The unfavourable variance was driven by unbudgeted costs for clinical supplies, inpatient pharmaceuticals and unbudgeted repairs and maintenance.

Infrastructure and Non-Clinical Supplies ($1.269m unfavourable)
The unfavourable variance was driven by unrealised expenditure reduction initiatives.

Funder Provider Payments ($1.127k unfavourable)
Funder Provider payments for May was $1.127m unfavourable to budget for the month and $10.96m favourable to budget for the YTD. Funder Provider payments as reported in the Consolidated Statement of Financial Performance table represents all Funder expenditure to third party providers and includes payments to NGO Providers as well as payments to other DHBs through Inter District Flow expenditure. Importantly, it does not include payments made to the Waitemata DHB Provider Arm which on inclusion reduces the YTD Funder expenditure position to $7.81m favourable to budget.

Commentary on key drivers of the favourable Funder position are summarised under the Funder Financial Performance section that follows later in the report.

3. Financial Performance - DHB Arms (YTD)

The financial performance for each of the DHB Arms for the month and the year is summarised in the following table. A detailed Statement of Financial Performance by DHB Arm is provided as Attachment 1.

Waitemata DHB Statement of Finacial Performance By DHB Arm

May 2018

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Provider Arm - Clinical Services	2,918	2,915	3	30,425	29,796	628	33,988
Provider Arm - Corporate & Support Services	73,151	72,753	398	803,402	798,578	4,824	870,892
Governance & Funding Admin Arm	1,047	1,184	(137)	12,744	13,025	(281)	14,209
Funder	137,769	137,097	671	1,511,715	1,508,073	3,642	796,782
Elimination	(70,228)	(70,699)	471	(780,840)	(777,690)	(3,150)	0
Consolidated	**144,657**	**143,250**	**1,407**	**1,577,447**	**1,571,783**	**5,664**	**1,715,872**
EXPENDITURE							
Provider Arm - Clinical Services	53,428	50,887	(2,540)	593,362	577,863	(15,499)	647,008
Provider Arm - Corporate & Support Services	25,045	27,245	2,200	259,393	256,829	(2,564)	264,872
Governance & Funding Administration	811	1,184	373	11,490	13,025	1,535	14,209
Funder	137,170	136,514	(656)	1,493,843	1,501,656	7,814	789,782
Elimination	(70,228)	(70,699)	(471)	(780,840)	(777,690)	3,150	
Consolidated	**146,226**	**145,131**	**(1,094)**	**1,577,247**	**1,571,683**	**(5,564)**	**1,715,872**
NET RESULT							
Provider Arm - Clinical Services	(50,510)	(47,973)	(2,538)	(562,938)	(548,067)	(14,871)	(613,020)
Provider Arm - Corporate & Support Services	48,107	45,508	2,598	544,010	541,749	2,261	606,020
Governance & Funding Admin Arm	236	0	236	1,254	0	1,254	0
Funder	598	583	15	17,873	6,417	11,456	7,000
Elimination	(0)	(0)	0	(0)	(0)	0	0
Consolidated	**(1,568)**	**(1,879)**	**312**	**199**	**100**	**99**	**0**

Comment on Major Variances YTD

Net Result - Consolidated
The overall DHB result for the YTD to May 2018 was a surplus of $199k which is $99k favourable to budget.

Provider Arm - Clinical Services
The Provider Clinical Services was $14.871m unfavourable YTD. The key drivers of the variance are summarised below;

Acute and Emergency Medicine ($3.194m unfavourable YTD)

The variance was driven by unbudgeted increased RMO costs due to over allocations, pricing variations and increased allowance costs. The strategies for reducing costs have focused on optimising the operational efficiency gains have been achieved from the TransforMED 'Home Warding' initiative through maximising leave consumption and opportunistic bed closures.

Specialty Medicine and HOPS ($5.193m unfavourable YTD)
The variance was driven by outsourced gastroscopy and colonoscopy procedures, and increased demand for high level respite care for complex needs patients and a change to the model of care in the Kingsley Mortimer Unit.

Surgical and Ambulatory Services ($8.816 unfavourable YTD)
The variance was driven by increased unbudgeted Registered Medical Officer expenditure due to unbudgeted over allocations and ongoing unbudgeted outsourcing expenditure associated with Radiology. Radiology procedures continue to be outsourced to meet MoH targets and population demand. Increasing implant and consumable costs, unbudgeted repairs and maintenance and minor purchases, other one-off costs such as Otorhinolaryngology outsourcing and unrealised saving initiatives have also had an unfavourable impact.

Elective Surgical Centre ($378k favourable YTD)
The variance was driven by lower than budgeted Orthopaedic and Gynaecology procedure volumes and case mix variances which is resulting in favourable package of care and clinical supplies costs.

Child, Women and Family Services ($464k favourable YTD)
The variance was driven by higher than anticipated vacancies across Allied Health and Management/Administration staffing groups. Partially offsetting this are unrealised cost reduction initiatives. The service continues to actively recruit but is being hindered by either regional and/or national workforce shortages across both Dental and Maternity services. Other costs pressures are evident in repairs and maintenance of clinical equipment, treatment disposables and patient meals driven by service demand as well as laundry and cleaning supplies.

Specialist Mental Health and Addiction Services ($1.492m favourable YTD)
The variance was driven by vacancies in nursing, partially offset by casual staff and overtime cover. There were also vacancies in medical which was partly offset by locum cover. To minimise vacancies, a retention and recruitment committee explore ways of attracting and retaining staff. We have had a trend of declining vacancies over the last year, and mental health has been successful in bringing down vacancy numbers, particularly in nursing in recent months.

Provider Arm - Corporate and Support Services
Corporate and Support Services were $2.260m favourable YTD. The variance was due to the wash-up of accruals partially off-set by unrealised budgeted financial sustainability initiatives across Corporate and Provider Support and unbudgeted inpatient pharmaceuticals and patient meal contract price increases in Hospital Operations.

Governance and Funding Administration Arm
The Governance and Funding Administration (GFA) represents the Waitemata DHB share of the Joint Planning Funding and Outcomes Arm and includes the Waitemata DHB share of the Northern Regional Alliance expenditure. The Governance and Funding Administration core net variance to budget for the month was $236k favourable and $1.254m favourable to budget YTD. The main factors contributing to the favourable result relate to Human Resources and includes lower than budgeted expenditure across both payroll and outsourced contractors. The year-end result forecast remains approximately $1.3m favourable to budget.

Funder

The Funder net result for May is $15k favourable to budget for the month and $11.456m favourable to budget YTD. This is derived from a favourable Funder YTD revenue position of $3.64m to budget and a favourable Funder YTD expenditure position of $7.81m to budget. This Funder result is for the totality of the Funder Services across all its divisions and is inclusive of Funder Provider Arm, Funder NGO and Funder IDF. Also of note is that a substantive component of the Funder net result is interrelated and compensatory in nature. For example, unbudgeted Funder revenue allocations to the Provider Arm have a favourable impact on the Provider Arm result and are accounted for within the Funder as additional Funder expenditure.

The Funder net result was a consequence of contributing factors across both revenue and expenditure and across all of its divisions. The most fundamental of these include adjustments relating to prior years. These adjustments are mostly one off in nature and currently account for most of the upside within the Funder's favourable YTD result. Other factors influencing the Funder result include the normal expenditure variations across Funder demand services, current year wash-up considerations within IDF services, additional revenue allocations within Provider Arm Services and changes relating to funded initiatives subsequent to budgets having been set.

The Funder year end net result is currently forecast to be approximately $9.3m favourable to budget. This is still very indicative and less favourable than the May YTD position. This is in expectation of the typical year end expenditure increment relating to demand services and IDF wash-up realisation.

4. Capital Expenditure

Capital expenditure for the eleven months ending May 2018 was $18.322m with a year-end forecast of $20m against a revised stretch target of $21m and $30.901m approved budget. Management has improved the scrutiny over capital expenditure with all strategic investment decisions now being made by the Portfolio Investment Committee, comprising of the ELT supported by the Portfolio Support Office.

Waitemata DHB Capital Expenditure Budget

May 2018

	FULL YEAR	MONTH			YEAR TO DATE		
($000's)	Budget	Actual	Budget	Variance	Actual	Budget	Variance
Land	0	0	0	0	0	0	0
Buildings & Plant	14,864	785	1,235	450	10,029	13,599	3,570
Clinical Equipment	3,869	99	276	177	5,994	3,492	(2,502)
Other Equipment	1,832	24	153	129	255	1,683	1,428
Information Technology	6,408	164	534	370	1,820	5,874	4,054
Motor Vehicles	160	0	10	10	224	150	(74)
Purchase of Software	3,768	0	314	314	0	3,454	3,454
Total Capital Expenditure	**30,901**	**1,072**	**2,522**	**1,450**	**18,322**	**28,252**	**9,930**

5. Financial Position/Cash Flow Position

The financial position as at May 2018 is given below. This indicates a net worth of $614.416m including $41.447m in cash. The detailed Statement of Financial Position for the DHB is provided as Attachment 2.

Waitemata DHB Statement of Financial Position

May 2018

	OPENING	MONTH			FULL YEAR
($000's)	30-Jun-18	Actual	Budget	Variance	Budget
Crown Equity	614,215	**614,416**	**615,687**	**(1,271)**	**615,588**
Represented by :					
Current Assets	85,857	109,930	90,117	19,813	90,853
Current Liabilities	218,353	249,031	221,351	(27,680)	221,674
Net Working Capital	(132,496)	(139,100)	(131,234)	(7,866)	(130,821)
Fixed Assets	784,389	782,738	797,341	(14,603)	796,912
Term Liabilities	37,678	29,222	50,420	21,198	50,503
Total Employment of Capital	614,215	**614,416**	**615,687**	**(1,271)**	**615,588**

Summary of the cash flow statement as at May 2018 is given below. The detailed Cash flow statement is provided as Attachment 3.

Waitemata DHB Statement of Cash Flows

May 2018

	MONTH			YEAR TO DATE		
($000's)	Actual	Budget	Variance	Actual	Budget	Variance
Opening cash	54,100	18,809	35,291	17,812	17,812	0
Operating	(10,726)	595	(11,321)	50,054	27,322	22,732
Investing	(1,927)	(2,522)	595	(26,420)	(28,252)	1,832
Financing	0	0	0	0	0	0
Closing cash	**41,447**	**16,882**	**24,565**	**41,447**	**16,882**	**24,564**

The Cash movements and daily cash balance is being monitored on a daily basis. The net operating cash flows are greater than budget due to elective revenue received in the month and supplier and payroll payments being less than anticipated in the budget. Capital expenditure is being incurred at a lower monthly rate than in 2016/17, with a number of major projects concluded.

The year end forecast cash position reflects the half yearly payment of Capital charge of $18.3m paid on 21 June to the MoH.

Attachment 1

Waitemata DHB Statement of Finacial Performance By DHB Service Group

Month - May 2018

	Direct Revenue			Direct Expenditure			Net Result		
($000's)	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
PROVIDER									
Acute & Emerg Medicine	271	313	(41)	11,049	10,523	(526)	(10,778)	(10,210)	(567)
Sub Specialty Med HOPS	891	828	63	7,777	7,157	(620)	(6,886)	(6,329)	(557)
Medical Services	1,162	1,141	22	18,826	17,680	(1,146)	(17,664)	(16,539)	(1,125)
Surgical Services	816	837	(21)	14,056	12,822	(1,234)	(13,240)	(11,985)	(1,255)
ESC	(0)	(0)	(0)	2,492	2,534	42	(2,492)	(2,534)	42
Child, Women & Family Services	492	453	39	7,372	7,375	2	(6,881)	(6,922)	41
Mental Health	448	484	(36)	10,681	10,476	(204)	(10,233)	(9,992)	(240)
Sub Total - Clinical Services	**2,918**	**2,915**	**3**	**53,428**	**50,887**	**(2,540)**	**(50,510)**	**(47,973)**	**(2,537)**
Director of Hospital Services	1,260	1,166	93	1,885	1,552	(333)	(625)	(386)	(240)
Elective & Outpatient S	8	14	(6)	385	362	(23)	(377)	(348)	(29)
Sub Total-Hospital Services	**1,267**	**1,180**	**87**	**2,270**	**1,914**	**(356)**	**(1,002)**	**(733)**	**(269)**
Hospital Operations	743	389	354	7,169	7,013	(156)	(6,426)	(6,624)	198
Facilities	29	5	24	3,128	2,791	(337)	(3,099)	(2,786)	(313)
Provider Management	69,552	69,641	(89)	5,198	5,788	590	64,354	63,853	501
Corporate	1,561	1,538	23	7,280	9,739	2,459	(5,719)	(8,201)	2,482
Sub Total - Corporate & Support Services	**73,151**	**72,753**	**398**	**25,045**	**27,245**	**2,200**	**48,107**	**45,508**	**2,598**
Total Provider	**76,069**	**75,668**	**401**	**78,472**	**78,132**	**(340)**	**(2,403)**	**(2,464)**	**61**
Governance & Funding Administration	**1,047**	**1,184**	**(137)**	**811**	**1,184**	**373**	**236**	**0**	**236**
FUNDER ARM									
Funder NGOs	42,319	41,406	913	42,000	40,822	(1,178)	318	584	(266)
Funder Inter District Flows	25,047	24,993	54	24,942	24,993	51	105	(0)	105
Funder Governance	919	1,166	(246)	919	1,166	246	0	0	0
Funder Own Provider	69,484	69,533	(49)	69,309	69,533	225	175	0	175
Elimination	(70,228)	(70,699)	471	(70,228)	(70,699)	(471)	(0)	0	(0)
Total Funder Arm	**67,541**	**66,399**	**1,142**	**66,942**	**65,815**	**(1,127)**	**598**	**584**	**15**
Consolidated	**144,657**	**143,251**	**1,407**	**146,226**	**145,131**	**(1,094)**	**(1,568)**	**(1,880)**	**312**

Waitemata DHB Statement of Finacial Performance By DHB Service Group

Year to Date- May 2018

	Direct Revenue			Direct Expenditure			Net Result		
($000's)	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
PROVIDER									
Acute & Emerg Medicine	3,370	3,341	29	124,504	121,281	(3,223)	(121,134)	(117,941)	(3,194)
Sub Specialty Med HOPS	7,749	8,168	(419)	85,485	80,711	(4,774)	(77,736)	(72,542)	(5,194)
Medical Services	11,119	11,509	(390)	209,990	201,992	(7,997)	(198,871)	(190,483)	(8,387)
Surgical Services	8,548	8,138	410	157,213	147,986	(9,226)	(148,664)	(139,848)	(8,816)
ESC	(0)	(0)	(0)	25,350	25,728	378	(25,350)	(25,728)	378
Child, Women & Family Services	4,988	4,963	25	81,854	82,293	438	(76,866)	(77,330)	464
Mental Health	5,769	5,186	583	118,956	119,865	908	(113,187)	(114,678)	1,492
Sub Total - Clinical Services	**30,425**	**29,796**	**628**	**593,362**	**577,863**	**(15,499)**	**(562,938)**	**(548,067)**	**(14,871)**
Director of Hospital Services	12,377	11,807	570	22,178	18,235	(3,944)	(9,801)	(6,427)	(3,374)
Elective & Outpatient S	175	154	21	4,317	4,047	(270)	(4,143)	(3,893)	(249)
Sub Total-Hospital Services	**12,552**	**11,961**	**591**	**26,496**	**22,282**	**(4,214)**	**(13,944)**	**(10,321)**	**(3,623)**
Hospital Operations	4,343	4,282	61	78,259	75,052	(3,208)	(73,916)	(70,770)	(3,147)
Facilities	408	280	128	34,078	31,109	(2,968)	(33,670)	(30,829)	(2,840)
Provider Management	768,740	765,904	2,836	12,880	19,389	6,509	755,860	746,514	9,345
Corporate	17,359	16,151	1,209	107,680	108,997	1,317	(90,320)	(92,846)	2,526
Sub Total - Corporate & Support Services	**803,402**	**798,578**	**4,824**	**259,393**	**256,829**	**(2,564)**	**544,010**	**541,749**	**2,261**
Total Provider	**833,827**	**828,374**	**5,452**	**852,755**	**834,692**	**(18,063)**	**(18,928)**	**(6,318)**	**(12,610)**
Governance & Funding Administration	**12,744**	**13,025**	**(281)**	**11,490**	**13,025**	**1,535**	**1,254**	**0**	**1,254**
FUNDER ARM									
Funder NGOs	457,092	455,461	1,632	435,848	449,044	13,196	21,244	6,417	14,827
Funder Inter District Flows	275,264	274,923	341	277,155	274,923	(2,232)	(1,891)	(0)	(1,891)
Funder Governance	12,647	12,821	(174)	12,647	12,821	174	(0)	0	(0)
Funder Own Provider	766,712	764,868	1,844	768,192	764,868	(3,324)	(1,480)	0	(1,480)
Elimination	(780,840)	(777,690)	(3,150)	(780,840)	(777,690)	3,150	(0)	0	(0)
Total Funder Arm	**730,876**	**730,383**	**492**	**713,003**	**723,967**	**10,964**	**17,873**	**6,417**	**11,456**
Consolidated	**1,577,447**	**1,571,783**	**5,664**	**1,577,248**	**1,571,684**	**(5,564)**	**199**	**99**	**100**

Attachment 2

Waitemata DHB Statement of Financial Position

31 May 2018

($000's)

	30/06/2017 Actual	31/05/2017 Actual	31/05/2017 Budget	30/06/2018 Budget
Crown Equity				
Crown Equity	379,721	379,721	379,721	379,721
Revaluation Reserve	273,512	273,512	273,512	273,512
Retained Earnings - Prior Years	(40,935)	(39,018)	(37,645)	(37,645)
Retained Earnings - 2017/18	1,917	201	99	
	614,215	**614,416**	**615,687**	**615,588**
Represented by :				
Current Assets				
Bank and Short Term Deposits	17,812	41,446	19,863	19,599
Debtors	55,291	59,433	57,500	58,000
Prepayments	5,201	1,342	5,201	5,201
Inventory	7,553	7,708	7,553	8,053
Assets Held for Resale				
	85,857	**109,930**	**90,117**	**90,853**
Current Liabilities				
Bank Overdraft				
Creditors	108,871	139,701	109,491	106,874
Provisions and Accruals	1,051	1,051	1,051	1,051
Staff Related Liabilities - Current	108,175	108,023	110,553	113,721
Term Debt - Current Portion	256	256	256	28
	218,353	**249,031**	**221,351**	**221,674**
Net Working Capital	**(132,496)**	**(139,100)**	**(131,234)**	**(130,821)**
Fixed Assets				
Land, Buildings and Plant (net)	641,592	630,414	638,182	637,890
Leasehold Building Works (net)	3,328	3,061	3,329	3,329
Equipment (net)	37,963	33,754	36,269	39,127
Information Technology (net)	140	204	5,862	6,382
Intangible Software (net)	252	137	3,546	3,846
Vehicles (net)	3,474	2,336	2,605	2,522
Work in Progress	55,991	68,231	57,974	54,242
	742,740	**738,137**	**747,767**	**747,338**
LT & Investments in Associates	41,649	44,601	49,574	49,574
	41,649	**44,601**	**49,574**	**49,574**
Term Liabilities				
Staff Related Liabilities- Term	36,988	28,854	37,334	37,334
Trust and Special Funds	348	261	12,744	12,827
Term Debt - External	342	107	342	342
	37,678	**29,222**	**50,420**	**50,503**
	614,215	**614,416**	**615,687**	**615,588**

Attachment 3

Waitemata DHB Statement of Cash Flows

31 May 2018

	MONTH			YEAR TO DATE		
	Actual	Budget	Variance	Actual	Budget	Variance
Cash flows from operating activities:						
Inflows						
Crown	139,420	139,252	168	1,528,689	1,530,993	(2,304)
Interest Received	115	235	(120)	1,740	2,576	(836)
Other Revenue	3,302	3,763	(461)	38,375	38,219	156
Outflows						
Staff	56,406	54,284	(2,122)	570,403	583,052	12,649
Suppliers	30,376	18,728	(11,648)	216,836	195,341	(21,495)
Other Providers	66,943	66,566	(377)	713,003	732,226	19,223
Capital Charge	0	3,077	3,077	18,358	33,847	15,489
GST (net)	(162)	0	162	150	0	(150)
Net cash from Operations	**(10,726)**	**595**	**(11,321)**	**50,054**	**27,322**	**22,732**
Cash flows from investing activities:						
Inflows						
Sale of Fixed Assets	0	0	0	0	0	0
Associates	0	0	0	0	0	0
Outflows						
Capital Expenditure	1,593	2,522	929	23,468	28,252	4,784
Investments	334	0	(334)	2,952	0	(2,952)
Net cash from Investing	**(1,927)**	**(2,522)**	**595**	**(26,420)**	**(28,252)**	**1,832**
Cash flows from financing activities:						
Inflows						
Equity Injections	0	0	0	0	0	0
New Debt	0	0	0	0	0	0
Deposits Recovered	0	0	0	0	0	0
Outflows			0			
Interest Paid	0	0	0	0	0	0
Funds to Deposit	0	0	0	0	0	0
Net cash from Financing	**0**	**0**	**0**	**0**	**0**	**0**
Net increase / (decrease)	**(12,653)**	**(1,927)**	**(10,726)**	**23,634**	**(930)**	**24,564**
Opening cash	54,100	18,809	35,291	17,812	17,812	0
Closing cash	**41,447**	**16,882**	**24,565**	**41,447**	**16,882**	**24,565**
Closing Cash Balance in HBL Sweep account	41,447			41,447		

Attachment 4

Waitemata DHB Statement of Accounts Receivable

May 2018

	As %	Total Outstanding	Current	1 - 30 D	31 - 60 D	61 - 90 D	91 Days +	Prior Month
ACC	0.9%	465,290.29	421,270.37	1,218.16	796.38	323.19	41,682.19	124,146.25
Accredited Employers	0.1%	12,726.93	1,455.47	0	1,303.94	0	9,967.52	12,312.98
Commercial	2.0%	303,987.79	250,202.06	74,495.39	3,784.88	(407.17)	(24,087.37)	279,844.71
Crown (excluding MoH)	12.8%	1,466,103.23	547,390.78	686,362.28	3,266.87	8,028.50	221,054.80	1,829,084.06
DHBS'	36.3%	3,148,111.28	1,613,275.16	297,837.19	83,228.73	151,522.09	1,002,248.11	5,200,239.38
MOH	25.2%	5,790,877.01	5,616,876.09	151,031.66	28,750.00	0	(5,780.74)	3,600,814.14
Non Residents	22.7%	3,380,899.74	114,986.62	539,471.50	219,988.22	291,747.23	2,214,706.17	3,247,484.95
Overseas Govt	0.0%	0	0	0	0	0	0	0
Patient	0.1%	17,805.87	875.28	7,213.65	0.00	6,858.27	2,858.67	17,005.17
Staff	0.0%	0	0	0	0	0	0	-382
WDHB Total	**100%**	**14,585,802.14**	**8,566,331.83**	**1,757,629.83**	**341,119.02**	**458,072.11**	**3,462,649.35**	**14,310,549.64**
			60%	12%	2%	3%	24%	
Total Less Non- residents		11,063,065	8,451,345	1,218,158	121,131	166,325	1,247,943	
			76%	11%	1%	2%	11%	
				Total 30+	1,535,399			
					14%			

7.1 Minutes of the Hospital Advisory Committee Meeting held on 09 May 2018

Recommendation:

That the minutes of the Hospital Advisory Committee meeting held on 09 May 2018 be received.

Minutes of the meeting of the Waitemata District Health Board

Hospital Advisory Committee

Wednesday 09 May2018

held at Waitemata District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 1.34 pm

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

James Le Fevre (Committee Chair)
Max Abbott
Kylie Clegg
Morris Pita
Allison Roe

ALSO PRESENT

Dale Bramley (Chief Executive Officer)
Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer)
Cath Cronin (Director of Hospital Services)
Fiona McCarthy (Director of Human Resources)
Jocelyn Peach (Director of Nursing and Midwifery)
Penny Andrew (Clinical Leader Quality)
Peta Molloy (Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES

WELCOME

The Committee Chair welcomed those present. He noted the meeting held at the DHB earlier in the day for the Mental Health Inquiry.

APOLOGIES

Apologies were received and accepted from Brian Neeson, Sandra Coney and Tamzin Brott.

DISCLOSURE OF INTERESTS

James Le Fevre noted that he was a member of the Northern Regional Clinical Practice Committee.

Morris Pita noted his disclosed interest for Healthcare Applications Limited and advised that he would step out of the meeting for any discussion related to Emergency Department updates.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee Meeting held on 28 March 2018 (agenda pages 5 to 12)

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the Minutes of the Hospital Advisory Committee meeting held on 28 March 2018 be approved.

Carried

Actions Arising (agenda page 13)

Noted.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Provider Arm Performance Report – February 2018 (agenda pages 14 to 72)

Cath Cronin (Director Hospital Services) spoke about the key updates in the executive summary, including a meeting held with Fonterra who would like to keep working with the DHB. In addition the winter and flu planning update was noted.

Matters covered in discussion and response to questions included:

- Noting that with regard to the financial update the DHB will breakeven, but the services will not.
- The Committee Chair noted that the demand for acute services is increasing over demand for elective and higher acute demands for both the Auckland and Waitemata DHBs, he queried whether this is being managed regionally. In response Cath Cronin noted that a piece of work had been undertaken some time ago in this area; a more in depth look can be progressed and include discussions with Auckland and Counties Manukau DHBs. Joanne Brown further advised that information is being prepared ahead of the 2018/19 forecast population, with some key areas identified for Waitemata DHB.
- Max Abbott queried the shift in Allied Health expenditure year to date and how that might impact on the remainder of the year. In response Cath Cronin advised that the shift includes phasing and recruitment to positions.
- It was noted that the flu vaccination rate target is 60% for the DHB, with a current rate of 36% achieved three weeks into the programme.

Human Resources (agenda page 30 to 33)

Fiona McCarthy (Director, Human Resources) summarised this section of the report. In response to a query from the Committee Chair, Fiona advised that the reported 40% rate of overtime for Adult and Forensic inpatient units is for unrelieved meal breaks.

This will be separated out and reported to the Committee along with actual worked overtime.

Acute and Emergency Medicine Division (agenda page 34 to 41)

Gerard de Jong (Division head Acute and Emergency Medicine), Alex Boersma, (General Manager, Acute and Emergency Medicine) and Lucy Adams (Associate Director of Nursing) summarised this section of the report.

Alex Boersma introduced the report, noting the reported highlight of the month 'chest pain clinical wait time under six weeks against a target of 80%,' and the 'Choosing Wisely Campaign in EDs.' In addition the scorecard was summarised.

Matters covered in discussion and response to questions included:

- In response to a question from the Board Chair about the turnover rate for the Acute and Emergency Medicine Division, it was noted that there had historically always been high turnover rate. Work has been undertaken to better understand the reasons for leaving and what can be done to retain staff.
- Max Abbott acknowledged the promising results of the 'Choosing Wisely – Urine Testing Process Improvement in Emergency Departments' campaign and queried whether this system was being applied in other areas; Alex Boersma said that there had been work in the area of Medicine to identify delays to patient treatment, including a close watch on the number of different tests people have. Clinicians are then engaged with when areas of improvement are identified. By way of example, Gerard de Jong noted the improvement seen in reducing the waiting time for MRIs.
- The Committee Chair asked a question about the 'to be seen time' for orthopaedics and queried how the ADU leadership works with surgical specialities and whether there are opportunities; in response Alex Boersma advised that a governance group in this area had been established, however, there had not been a meeting for some time and the group need to be reinvigorated.

Specialty Medicine and Health of Older Persons (agenda page 42 to 48)

Dr John Scott (Head of Division, Specialty Medicine and Health of Older People) and Brian Millen (General Manager, Specialty Medicine and Health of Older People Services) were present for this section of the report.

John Scott introduced the report and summarised the highlight of the month reported 'Type 2 Diabetes: supporting people and their families living with poorly controlled type 2 diabetes to be *leading partners* in their own care.' It is anticipated that more intensive support can be provided.

Brian Millen Summarised the key issue reported 'reducing inequalities'.

Matters covered in discussion and response to questions included:

- Morris Pita noted the example provided on the diabetes model of care (James, a 44 year old male) and acknowledged the patient centred view. From that example, he queried the flexibility of accessible services for patients. Brian Mullen said that clinics are held Monday to Friday from 8.30am to 12.30pm, alternative hours have been experimented with in the past with evenings and Saturdays

trialled and it was found that while there was initial engagement, long term most people did not attend.
- In addition it was noted that a family member attending a clinic appointment with a patient can be beneficial to provide support as well as understanding and communication with the clinician and team and optimises the interaction with a patient during the treatment process.
- In response to a query from Allison Roe about the use of technology and appointments, Brian Millen advised that a pilot is underway in Telehealth where videoconferencing for initial appointments is used.
- The Committee Chair inquired about the directorates that utilise patient focussed booking, in response Cath Cronin advised that gynaecology, orthopaedics, medicine and a few other areas are rolling this out.
- The Committee Chair queried when the colonoscopy procedures would be back to target, Brian Millen noted that since the time of submitting the report there has been some improvement to about 68 per cent, but there is still a waiting list. The target may be met in coming months, but reaching target is dependent on outsourcing. It was further noted that the Northland DHB Chief Medical Officer had been asked to lead a review process on how to improve colonoscopy production planning, with a number of reasons identified on why wait times exist in this area. Cath Cronin noted a piece of work underway in this area and that it can be reported to the Committee when available.

Child Women and Family (agenda page 49 to 58)

Dr Meia Schmidt-Uili (Head of Division Medical Child Women and Family), Stephanie Doe (General Manager Child Women and Family Services) and Emma Farmer (Head of Division Midwifery) were present for this item.

Stephanie Doe introduced the iTui App which was shown to the Committee. She noted that iTui was largely developed by Dr Maneesh Deva, Paediatrician) and allows vulnerable children to communicate via a drawing tool. The App is available to clinicians nationwide. The Board Chair noted that it would be beneficial for healthAlliance to view the App, demonstrating a beneficial tool developed by a clinician for their speciality.

Meia Schmidt-Uili summarised the key issue reported on 'oral health inequities.'

Matters covered in discussion and response to questions included:

- The Committee Chair thanked the service for the report. He noted the impact of diet of oral health and it was acknowledged that diet is a factor, along with oral hygiene and not enough water consumption in oral health outcomes. In obtaining the best outcome for improving oral health the pre-school action plan was provided as an example. The plan has two areas of focus, one being a water only policy in preschools; the same messages are also given to families. It was noted that a national advisory group recommended water only in schools and the removal of sugar sweetened drinks. The initiative resulted in over 50 per cent of schools providing water only. The guidelines were removed approximately six years ago, but there may be an opportunity to represent these.
- The Committee Chair also queried whether MedTech for GPs provided a prompt to check oral health. Stephanie Doe advised that there was a 'lift the lip'

campaign. She also noted that NCHIP (National Child Health Information Platform) will provide greater tools for prompting.

Specialist Mental Health and Addiction (agenda page 59 to 64)

Susanna Galea (Head of Department) and Pam Lightbown (General Manager) presented this section of the report.

Susanna Galea noted that the Service had the opportunity to meet with the Mental Health Inquiry panel earlier in the day. Later in the discussion, Susanna said that there were approximately 70 people in attendance including representatives from the CEO working group, NGO's working in mental health and addiction, leadership from Auckland DHB and Counties Manukau Health and primary care. Discussed with the panel was the challenges faced by Waitemata DHB in the mental health space. In addition an example of topics covered in the meeting included rapid population growth and subsequent workforce issues; what mental health and action services could look like ('blue sky' thinking); improving connected care; the 'Our Health in Mind' model and working together with primary care to bridge the gap between the DHB and primary care for better outcomes.

Matters covered in discussion and response to questions included:

- Morris Pita noted the update provided around children and adolescent psychiatry time and queried at what age children are exhibiting mental health issues; Susanna advised that it is from an early age and work is underway with schools and families to address any issues that may develop. She noted dialectical therapy where issues start to develop and help is provided for children/adolescents to deal with emotional turmoil and to know that it is ok to feel the way they do and that it is normal.
- Morris Pita also noted the reported comment that there are a number of vacancies for child and adolescent psychiatry; Pam Lightbrown advised that there are very few psychiatrists specialising in child and youth psychiatry. Susanna further noted that this is an international problem.
- The Committee Chair noted the services reported favourable finances and queried if this was because of staff vacancies; Pam Lightbrown advised that financial improvements are being made month-by-month. She noted that with regard to recruitment it was intended to look at succession planning and talent mapping.

Surgical and Ambulatory Services/Elective Surgical Centre (agenda page 65 to 72)

Dr Michael Rodgers (Chief of Surgery) and Debbie Eastwood (General Manager) presented this section of the report.

Michael Rodgers introduced the report. Matters covered in discussion and response to questions included:

- The Committee Chair noted the highlight of the month reported around Telehealth and queried whether it was integrated nationally or for Waitemata DHB specifically. Penny Andrew advised that it is regionally integrated and linked to the Ministry of Health. healthAlliance has undertaken an initial test of three Telehealth options with one now in the process of gaining agreement. There are 30 interim licences for the next 12 months and trialling underway in Corporate and other administration areas.

- The Committee Chair noted the scorecard presented and queried a solution for theatre utilisation; Cath Cronin advised that a solution will not be available until additional lists are booking, which will be in July 2018.

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the report be received.

Carried

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 73 to 79)

Dr Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer) and Dr Jocelyn Peach (Director of Nursing and Midwifery; Emergency Systems Planner) presented this item.

Medical Staff

Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer) summarised this section of the report. He acknowledged the work Dr Paul Muir who had completed his RACMA (Royal Australasian College of Medical Administration) fellowship at the end of 2017, noting that Dr Muir is now in an operations manager role for the DHB. The Committee Chair also acknowledged Dr Muir's work and asked that the Committee's congratulations be extended to him.

Nursing and Midwifery

Jocelyn Peach (Director of Nursing) summarised this section of the report, noting in particular the update provided on care capacity demand management.

Allied Health, Scientific and Technical Staff

Apologies from Tamzin Brott were received and the report was noted.

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the report be received.

Carried

4.2 Human Resources (agenda pages 80 to 87)

Fiona McCarthy (Director of Human Resources) summarised the report. The Health Excellence Awards being held on 10 May were noted.

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the report be received.

Carried

4.3 Quality Report (agenda pages 88 to 223)

Jacky Bush (Quality and Risk Manager), (Penny Andrew (Clinical Lead Quality) and David Price (Director of Patient Experience) were present for this item.

Jacky Bush introduced and summarised the report, noting in particular a scenario identified regarding intravenous (IV) leur insertion and maintenance; it was noted that this is a regional issue and that a comprehensive campaign is in place around the use of IV leurs.

Matters covered in discussion and response to questions included:

- Morris Pita noted the 'clean hands' message posted throughout the organisation and that it is encouraging to see the message received; he advised that he had recently he saw an administrative staff member return to their desk in reception and use sanitiser before sitting down. Penny Andrew noted that the DHB does have a committed and passionate infection control team. It was suggested that a message of encouragement and acknowledgement from the Board could be incorporated into patient safety week.
- Allison Roe queried the definition of a pressure injury; Jocelyn Peach advised that there is an international definition for pressure injuries and briefly outlined that.
- Allison Roe queried the use of vitamin C in hospitals, particularly its use in preventing infection. Andrew Brant noted a study approximately 3 years ago about vitamin C use and pneumonia; he also advised that a study was being undertaken in France around high dose vitamin C use for infection in intensive care units. When available, a copy of the study will be provided to Committee members.
- In addition to the discussion on vitamin C use, Andrew Brant advised that normal doses of both vitamin C and other vitamins are used in the inpatient areas and ICU when required, these are given on daily basis as a nutritional supplement when needed. Supplement need may be recommended if a patient requires a nutritional assessment.
- David Price summarised the patient and whanau centred care section of the report. In addition he noted that a Health Symposium was being held on 24 May – an invitation to the symposium will be extended to the Waitemata DHB Board as well as the Auckland DHB (and Waitemata DHB) members of the Community and Public Health Advisory Committee.
- Penny Andrew noted the national 'Patient Deterioration Programme,' with all DHBs introducing an early warning system. The DHB will introduce the system at North Shore Hospital and Waitakere Hospital by 1 December 2018; the delay is to ensure adequate resourcing and response teams are in place (noting that more resource is required for care overnight). In response to a query from the Committee Chair about what the Auckland DHB and Counties Manukau Health are doing in this area; Penny advised that Waitemata DHB will be modelling their system on Auckland DHB's. It was noted that all of the larger DHBs have either PARs or outreach teams.

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the report be received.

Carried

5. INFORMATION ITEMS

5.1 Winter Plan 2018 (agenda pages 224 to 247)

Cath Cronin (Director Hospital Services) presented this item noting that there is concern about a potential influenza outbreak.

The Committee Chair acknowledged the 2018 winter plan; he advised that clarity was important with respect to principles, clear statements that patient safety will not be compromised and timely access for patients to be seen will be maintained during the winter period.

In addition the Committee Chair queried the regional work being undertaken in this area; Cath Cronin said that there has been positive discussion on extending the process and creating a joined up plan.

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That the Committee notes the content and intent of the winter plan.

Carried

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda page 248)

Resolution (Moved Kylie Clegg/Seconded Max Abbott)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 28/03/18	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
4. Human Resources 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	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons,

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
	reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

Carried

The open session of the meeting concluded at 4.21pm.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 09 MAY 2018

_____COMMITTEE CHAIR

8.1 Government Expectations on Employment Relations in the State Sector

Recommendation:

That report be received.

Prepared by: Fiona McCarthy (Director, Human Resources)

1. Executive Summary

The Government Expectations (the Expectations) on Employment Relations in the State Sector were reintroduced on 30 April 2018.

The Expectations set out the priorities and approach the Government will be taking for employment relations in the state sector. The Expectations cover general work place relations, negotiation of employment agreements and policies on pay and conditions.

Waitemata DHB is well placed to respond to the expectations, already having many of the core principles in place as a result of national, regional and local negotiations and combined activities; and from significant focus on wellbeing over the last five years.

The Government Expectations on Employment Relations in the State Sector are outlined in the letter from Hon Dr David Clark, Minister of Health, dated 30 April 2018 (Appendix 1).

2. Strategic Alignment

Community, whanau and patient centred model of care	This report comments on broader socio-economic issues that have flow on impact to patient care alongside professional and organisational culture and wellbeing.
Emphasis and investment on both treatment and keeping people healthy	This report comments on investments in our workforce, who provide individual and population based healthcare services.
Intelligence and insight	The report provides information and insight on what Waitemata DHB is doing to respond to the Expectations.
Evidence informed decision making and practice	Responses outlined in this paper are based on current best practise/evidence.
Outward focus and flexible, service orientation	Responses outlined in this paper are designed to meet employee and organisational needs, ensuring appropriate focus on being employee centred and flexible.
Operational and financial sustainability	As appropriate, work programmes outlined in this paper have been considered from a sustainability perspective,

3. Background

The Government Expectations on Employment Relations in the State Sector outline the Government's priorities on workplace policy, relations and conditions for State Sector employees.

Key aspect of the Expectations and Waitemata DHB's response are as follows:

3.1 Workplace relations

Expectation	Waitemata DHB response
Relations are based on good faith, justice, human rights, good employer practice	The DHB's employee policies express the expectations of good faith and natural justice practise e.g. disciplinary practises. The DHB has a good employer policy, and practises meet the Human Rights Commission expectations on data, key good employer elements, policy and employee participation. The DHB provides paid leave to release union delegates to attend training, conferences and other activities.
Employees have a voice, especially through effective and productive relationships with unions	The DHB has in place a large number of joint consultation committee meetings. These meetings are active at Chief Executive Officer and division level and across all workforce groups. The DHB has over 300 trained health and safety representatives. The DHB has a staff health, safety and wellbeing committee that staff and unions attend. Staff and unions are active in areas where changes in structure or models of care are being discussed. Informal meetings between staff and unions senior staff occur almost daily. The DHB has a joint steering group to implement the care capacity demand management (CCDM) model which helps predict staffing needs vs acuity and demand.
Where a collective agreement exists, employees have a clear choice to join the relevant union	The DHBs offer of employment extends the relevant collective agreement to the prospective employee together with details on the union and how to contact them.
Pay equity claims	The DHB will contribute to pay equity claims made in the public health sector. There are currently pay equity claims for nursing, allied and clerical staff.

3.2 Workplace Policy

Expectation	Waitemata DHB response
Work to reduce the gender pay gaps and apply the gender pay principles	The current gender pay gap is 2% for Waitemata DHB. This is the largest gap in the Country.
Work to narrow the gap between the highest and lowest earners	The DHB considers this expectation when bargaining strategies are developed. A most common example is the addition of steps on salary scales and the removal of bottom steps.
Work toward best practise worker engagement and worker representation in health and safety	The DHB is waiting for the final draft of the employer participation agreement which has been agreed with Council of Trade Unions. This agreement will include engagement expectations that align with worker expectations as well as the principles of high performance, high engagement. The DHB has a staff health, safety and wellbeing committee with eight health and safety representatives and six unions organisers. The DHB has over 300 trained health and safety representatives who are active in health and safety activities in the DHB. The DHB recognises excellence in health and safety through the bimonthly health and safety Health Hero award.
Agencies consider policies on: - Family friendly practises - Flexitime - Wellbeing incentives - Professional development - Support to employee affected by family violence - Recognition of service - Minimum redundancy provisions - Recognition of cultural contributions - Leave in civil emergencies - Consistent application of the changes in the Government's legislative programme in workplace relations	The DHB has policies or practises that address all the aspects noted here. For example: 1. In summer we run the flexitime policy allowing staff to reduce their FTE, on agreement, for the summer period. 2. Service 15 years and above is recognised throughout the year. 3. Wellbeing clinics have commenced for Senior Medical Staff. 4. The DHB provides regular professional development for healthcare professionals and also has a professional development fund for staff who do not get an education allowance in their employment agreement. 5. The DHB has redundancy provisions in their employment agreements. 6. The DHB provides for paid domestic and special leave as well as parental leave for employees. 7. Where staff provide cultural contribution this is noted in the position descriptions and considered as part of salary bands and salary offers.

3.3 Workplace conditions

Expectation	Waitemata DHB response
Negotiations include rates of pay	All collective agreements include rates of pay for our staff.
Work towards removal of at risk ad performance pay	The DHB's remuneration policy prohibits at risk or performance pay.
Adjustments to pay support agencies organisational strategies and contribution to wider system goals and delivery of results; adjustment should recognise imperatives such as improved performance and recruitment and retention difficulties.	The DHB considers the wider workforce and economic drivers for pay as part of local, regional and national bargaining strategy development. The DHB consults with the national strategic employee relations team and Ministry of Health prior to progressing any regional or local negotiation.
Adjustment are fair and affordable and take into account total cost of all adjustments	Any adjustments proposed are assessed for sustainability before being suggested. DHBs' apply a sophisticated average and annual cost of settlement calculation to all negotiations that take into account total costs.
Agencies consider potential cross agency impacts from changes to employment agreements	All flow on impacts to other DHBs or the wider Government sector are considered and articulated as part of employment agreement strategies.
Agencies have the capacity to bargain effectively and efficiently; and avoid backdating agreements	The DHBs' have retained a national team of advocates and analysts to support and negotiate national employment agreements. Waitemata DHB has an Employee Relations Manager who undertakes regional and local negotiations, and an analyst who assists with local costings. Unless specifically agreed with the Ministry of Health, agreements are not backdated.

4. Conclusion

Waitemata DHB has largely achieved or is contributing towards achievement of the Government Expectations on Employment Relations in the State Sector. Areas of immediate focus will be pay equity, application of gender pay principles and ensuring employee relations work aligns to best practise and consistently and appropriately engages employees and unions.

Hon Dr David Clark

MP for Dunedin North
Minister of Health
Associate Minister of Finance

30 APR 2018

Mrs Kylie Clegg
Acting Chair
Waitemata District Health Board
Private Bag 93 503,
Takapuna
NORTH SHORE CITY, 0740

Dear Mrs Clegg

New Government's Expectations on Employment Relations in the State Sector – Application to District Health Boards (DHBs)

You may be aware that Cabinet has agreed to replace the previous Government's Expectations for Pay and Employment Conditions in the State Sector (the Expectations) issued in 2012 with new expectations.

The Expectations are a strong statement of Government policy that reflects the Government's employment relations priorities. They outline the Government's approach to employment and workplace relations generally, and in the negotiation of collective agreements, individual employment agreements, and policies on pay and conditions.

The Expectations will form the foundation of the Ministry of Health's (the Ministry's) consultation feedback to DHBs. It will also be the basis for advice when reporting to Government regarding your overarching employment relations strategic approach, and your strategies for specific industrial negotiations.

A copy of the new Government Expectations is attached.

Accordingly, I expect you and your board to take into account the attached Expectations when setting pay and conditions at your DHB. Under the principle as set out in your enduring letter of expectations, if your DHB intends to take action that could be seen to be at odds with the Expectations, I expect you to consult with the Director-General of Health. In some cases this will require the approval of Ministers. In all cases I will need to be informed.

If you have any questions regarding the Expectations or the consultation process, please contact Tony O'Rourke, Acting General Manager, Employment Relations on 021 563 611 or at Tony_O'Rourke@moh.govt.nz.

Yours sincerely

Hon Dr David Clark
Minister of Health

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Government Expectations on Employment Relations in the State Sector

STATE SERVICES COMMISSION
Te Komihana O Ngā Tari Kāwanatanga

PURPOSE

This statement of Government policy sets out the Government's expectations of State sector employers in relation to employment and workplace relations generally, and the negotiation of individual employment agreements, collective agreements and agency policies on pay and conditions.

INTRODUCTION

The Government has an ambitious workplace relations agenda and has signalled its intention to introduce legislative change. These Expectations guide State sector employers on how to apply Government policy under current legislative settings.

These Expectations may be reviewed in light of any legislative change or developments from possible tripartite discussions between Government, State sector employers and unions.

These expectations are designed to ensure that State sector employers have high standards in workplace relations, create safe and healthy places of work, and to foster consistency on employment matters in the State sector. Improved consistency in pay and conditions supports employment security through greater workforce mobility across the system and provides the opportunity to manage common pressures.

It is important that parties to employment negotiations recognise the Government's objective for fiscal sustainability. It is expected that employment relations outcomes uphold the Government's objective to maintain government expenditure according to agencies' strategic plans, within existing baselines and indicated operating allowances.

GOVERNMENT POLICY FOR EMPLOYMENT AND WORKPLACE RELATIONS

Government's overarching policy for employment and workplace relations is that:

- State sector employers recognise and give effect to the Object of the Employment Relations Act[1] (see footnote below) in their employment relations practice and policies; and
- all parties are treated fairly and with respect; and

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[1] 3 Object of this Act

The object of this Act is—

(a) to build productive employment relationships through the promotion of good faith in all aspects of the employment environment and of the employment relationship—
  (i) by recognising that employment relationships must be built not only on the implied mutual obligations of trust and confidence, but also on a legislative requirement for good faith behaviour; and
  (ii) by acknowledging and addressing the inherent inequality of power in employment relationships; and
  (iii) by promoting collective bargaining; and
  (iv) by protecting the integrity of individual choice; and
  (v) by promoting mediation as the primary problem-solving mechanism other than for enforcing employment standards; and
  (vi) by reducing the need for judicial intervention; and

(ab) to promote the effective enforcement of employment standards, in particular by conferring enforcement powers on Labour Inspectors, the Authority, and the court; and

(b) to promote observance in New Zealand of the principles underlying International Labour Organisation Convention 87 on Freedom of Association, and Convention 98 on the Right to Organise and Bargain Collectively.

- workplace relations are based on good faith, natural justice, human rights, good employer practice and requirements; and
- employees have a voice in their workplace, particularly through effective and productive relationships with unions; and
- where a collective agreement exists employees will have a clear choice to join the relevant union when being employed; and
- employers will address any pay equity claims through the process established by the Joint Working Group on Pay Equity Principles.

The Government's priorities particular to core Public Service departments are that:

- employers will work to close gender pay gaps and apply the Gender Pay Principles
- employers will work to narrow the gap between the highest and lowest earners in the organisation
- employers will work toward best practice worker engagement and worker representation in health and safety
- negotiations for collective agreements must include the rates of salary or wages payable to employees or transitional arrangements to reach this point
- employers will work toward removing at-risk pay and performance bonuses from pay policies and employment agreements.

Other State sector agencies may consider what opportunities exist to make progress on any of these issues when setting organisational strategies and priorities.

PAY AND EMPLOYMENT CONDITIONS

State sector agencies are expected to meet the following criteria when adjusting pay and employment conditions, whether through collective bargaining or individual negotiation processes:

1. Negotiations should be conducted in a manner consistent with the policies above.
2. Adjustments to pay and conditions should support agencies' organisational strategies and their contribution to wider system goals and delivery of results.
3. Adjustments must be fair, affordable within baselines and sustainable as signalled within agency and sector four-year plans or their equivalent.
4. Agencies must consider the potential cross-agency impacts from changes to employment agreements including opportunities to build greater consistency across agencies.
5. Adjustments should recognise imperatives such as improved organisational performance, and recruitment and retention difficulties.
6. The financial parameters for both bargaining and remuneration strategies must take into account the total cost of all adjustments to pay and conditions. This includes the cost of progression through pay scales and any performance-based pay increases.
7. The parties to negotiations should ensure they have the capability to bargain efficiently and effectively and avoid backdating any or all components of settlements.

In the context of a restrained fiscal environment and the commitments above to Pay Equity and closing Gender Pay Gaps, State sector agencies are encouraged to consider opportunities for broadly based benefits to employees. Agencies should consider the relevance to the agency and its workforce, the agency's current offerings and how any changes could support greater consistency and management of common pressures across the State sector. Illustrative examples of the sort of broadly based benefits that may be relevant include:

- Enhanced family friendly policies in areas such as domestic leave for carers and parental leave.
- Improved availability of flexitime, wellness incentives, unpaid special leave, professional development, capability building and portability for future workplaces.
- Support to employees affected by family violence (including special leave).
- Recognition of service to support mobility across the system.

- Providing minimum redundancy protections.
- Recognition of employees' cultural contribution in recruitment and job descriptions and associated pay.
- Clarified provisions covering leave at times of civil emergencies.
- Consistent application of changes as a result of the Government's legislative programme in workplace relations.

In order to support greater consistency in pay and conditions, approaches to some of these areas will need to be developed collaboratively across agencies.

APPLICATION

These Expectations apply to all State sector agencies except State Owned Enterprises and Mixed Ownership Model companies.

These Expectations replace the document Government's Expectations for Pay and Employment Conditions agreed by Cabinet in 2012.

Public Service departments must have a bargaining strategy that meets these Expectations approved by the Commissioner, and must not commence bargaining or commit to an outcome (including final Terms of Settlement) without this approval.

All State sector organisations except State Owned Enterprises and Mixed Ownership Model companies must have regard to these Expectations when setting bargaining and remuneration strategies, and determining other employment relations policies.

Outcomes of Remuneration Forums or other mechanisms that review pay rates should reflect these Expectations. Public Service departments must consult with the SSC before committing to an outcome.

Other agencies with a statutory requirement to consult with either the Commissioner or a monitoring department, must have bargaining and remuneration strategies that meet these Expectations as the basis for that consultation.

Where an agency wishes to pursue a course of action that the Commissioner or monitoring department considers is at odds with these Expectations, approval of the agency's responsible Minister, the Minister of State Services, the Minister of Finance and the Minister of Workplace Relations and Safety is required.

8.2 Equity Framework

Recommendation:

That the Board notes the development of the refreshed Equity Framework and the relationship to the Ministry of Health equity work programme.

Prepared by: Dr Karen Bartholomew (Director Health Outcomes, Waitemata DHB and Auckland DHB), Riki Nia Nia (General Manager Māori Health, Waitemata DHB and Auckland DHB) and Aroha Haggie (Manager Māori Health Gain, Waitemata DHB and Auckland DHB)
Endorsed by: Dr Dale Bramley (Chief Executive Officer and Lead Chief Executive Officer for Māori Health, metro Auckland DHBs)

Glossary

AAA - Abdominal Aortic Aneurysm
HPV - Human papilloma virus
IHI - Institute for Healthcare Improvement

1. Executive Summary

This paper has been produced at the request of the Chief Executive Officer. The paper provides an outline of a proposed enhanced focus at Waitemata DHB on equity and also seeks endorsement for a refreshed organisational equity framework.

2. Introduction

Health inequities are differences that are avoidable, unfair and unjust (widely cited definition in Whitehead (1992)[1] and adopted by the World Health Organisation[2]). This is in contrast to health disparities or inequalities which are difference in health status or outcome among groups of people. For example taking testicular cancer as a health outcome, there is a difference in the rate of testicular between men and women, which is an inequality but not an inequity. Inequities arise from a complex interplay of historical and current factors including:

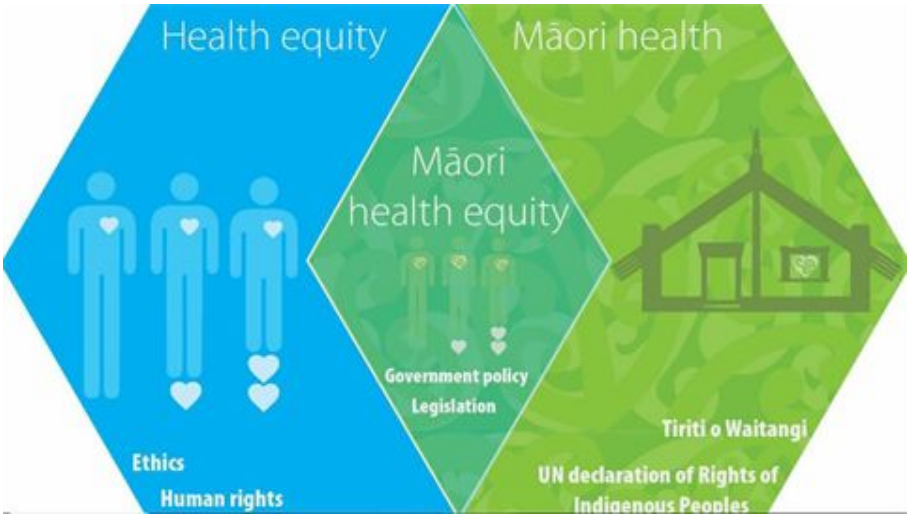
- Differences in the quality of care
- Differences in access to care
- Differences in the determinants of health, exposures, and opportunities (individual, whānau, neighbourhood, collective, intergenerational).[3]

There are a range of equity parameters including ethnicity, socioeconomic status, gender, age and rurality as well as for specific groups such as those with disabilities, mental health issues, the frail elderly and those with dementia or cognitive decline. The 'strongest' equity parameter is ethnicity, and there are differences by ethnicity even after differences by socioeconomic status are accounted for.

[1] Whitehead, M (1992). The concepts and principles of equity and health, Health Promotion International, Volume 6(3): 217–228.
[2] http://www.who.int/healthsystems/topics/equity/en/
[3] Camara Jones (2001), adapted by Reid and Robson (2006)
https://www.otago.ac.nz/wellington/otago067759.pdf

The objectives of the New Zealand Public Health and Disability Act (2000) state that it is a DHB responsibility to improve, promote, and protect the health of people and communities, improve health outcomes for Māori, to reduce with a view to eliminating health outcome inequities between various population groups and to foster community participation in health improvement. DHBs have a distinct Te Tiriti o Waitangi responsibility for Māori health improvement as well as a legislative responsibility to reduce health inequities. As such it is important that as part of the Equity work moving forward we do not perpetuate indigenous injustices that contravene the Treaty. The two areas of focus are related, and overlap substantially, although they are distinct. A conceptual Venn diagram below shows the relationship of Māori health and equity.

Figure 1. Venn diagram. Source Health, Quality and Safety Commission.



3. Equity frameworks

In New Zealand There are many strategies and frameworks currently for achieving Māori health improvement and health equity. He Korowai Oranga,[4] the national Māori Health Strategy, sets out four pathways to achieving Pae Ora (healthy futures or horizons):

- Whānau, hapu and iwi community development
- Māori participation
- Effective service delivery
- Working across sectors

A similar national strategy for Pacific: 'Ala Mo'ui (2014)[5] includes four areas of focus: local delivery of services, service responsiveness, support to be healthy in the community and consideration of the social determinants of health.

The Ministry of Health Equity of Health Care for Māori Framework (2014)[6] covers three dimensions: leadership, knowledge, and commitment across three levels: health system, health care

[4] He Korowai Oranga strategy refreshed 2014: https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga
[5] https://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018

organisations and health practitioners. The Health Equity Assessment Tool (2008)[7] covers drivers of inequities, an intervention framework (four components: structure, intermediary, health service and impact factors), and a ten question 'checklist' for policies and interventions to consider equity issues in planning and monitoring. The Whānau Ora Health Impact Assessment Tool (2007)[8] includes a short form policy scanning tool (the Health Lens) and a longer form Health Appraisal for more substantive policies and investments. Tumu Whakarae, national Māori General Managers network, have been champions for the elimination of Māori health inequities and have evolved a number of robust tools and enablers to help all DHBs both identify and eliminate inequities for Māori. This includes an online reporting tool to enable easy access to health system data and improvement intelligence. They have also developed the Te Ara Whakawaiora framework aimed at strengthening:

> Leadership (improving accountability), performance monitoring and accelerating performance with a view to eliminating inequities for Māori

More recently a framework developed out of the National Science Challenges for long term condition management has been suggested to have wider applicability for reducing health inequities. He Pikinga Waiora[9] includes four pillars based on kaupapa Māori and international theoretical underpinnings, and has rangitiratanga (self-determination) at its core:

- Cultural-centredness (assessed across three levels community voice, reflexivity, structural transformation and resources).
- Community engagement.
- Systems thinking (assessed across three levels systems perspectives, relationships and levels).
- Integrated knowledge transfer.

This model is designed for use by both planners and funder and by the community, and provides an assessment rating of each of the components to assist decision making.

Internationally there are also many frameworks for health equity. Equity frameworks may focus on specific types of organisation, activities, pathways, disease groups, health practitioners and clinical interactions. A recent World Health Organisation Equity Governance Framework[10] outlines the governance role in action on the social determinants of health as "strengthening the coherence of actions across sectors and stakeholders in a manner which increases resource flows to (a) redress current patterns and magnitude of health inequities; and (b) improve the distribution of determinants in opportunity to be healthy, as well as in risk and consequences of disease and premature mortality, across the population." The Institute for Healthcare Improvement (IHI) in the United States produced a health organisational model for equity in 2016[11] that includes five components for a healthcare organisational focus on steps to improve equity. There are also models of an Equity Triple Aim[12] which include: Implement health in all policies, strengthen community capacity and expand understanding of health equity (the New Zealand Triple Aim include equity as one of the core elements).

[6] https://www.health.govt.nz/publication/equity-health-care-maori-framework
[7] https://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf
[8] https://www.health.govt.nz/system/files/documents/publications/whanau-ora-hia-2007.pdf
[9] https://healthierlives.co.nz/research/making-health-interventions-work-for-maori-communities/
[10] http://www.euro.who.int/__data/assets/pdf_file/0020/235712/e96954.pdf
[11] http://www.ihi.org/resources/Pages/Publications/Framework-Improving-Health-Equity.aspx
[12] http://www.astho.org/Health-Equity/2016-Challenge/Ehlinger-Commentary-Article/

4. Waitemata DHB equity framework

At Waitemata DHB equity has been a focus for more than a decade. An Equity Framework for Planning and Funding was developed in 2009, alongside an Equity monitoring framework. Since that time the regional plans and local DHB Māori Health Plan, Pacific Health Action Plan and Asian Health Action Plan[13] have been developed to indicate strategic equity direction, areas of focus, specific activities and monitoring indicators. Indicators are reported by ethnicity to Board and Board sub-committees in various scorecards, including quality, access and outcome indicators.

With the Minister of Health's priority focus on equity it is timely to refresh Waitemata DHB's Equity Framework, particularly with the opportunity to align this with the Ministry of Health *Achieving Equity in Health Outcomes* work programme. Our Chief Executive Officer is the sector co-sponsor for this work programme alongside Alison Thom, Māori Leadership at the Ministry of Health. Work from this framework will be provided to the *Achieving Equity in Health Outcomes* work programme, so that both programmes can inform each other.

In consideration of an equity framework it is important to clarify the intended outcome. Waitemata DHB has an established outcomes framework, as well as the Nga Painga Hauora framework (developed with Sir Mason Durie), which articulate life expectancy and a reduction in the life expectancy gap as the key population outcome focus. We propose to confirm this outcome as the primary outcome. To achieve the aim continuing to reduce the life expectancy gap and accelerate Māori health the DHB has a role in both pursuing equity in **health care** and working with MOU and intersectoral partners to influence the **social determinants of health**.

Life expectancy is a high level summary measure which reflects the complete mortality experience in a population, from earliest infancy through to old age. Waitemata DHB has the highest life expectancy in New Zealand. Of particular note although Māori have lower life expectancy, in Waitemata DHB Māori life expectancy gain in the last decade has been double (2.8 years gained) that of European/Other (1.5 years gained). This means over the last decade health inequities in life expectancy have been decreasing in our district. In addition, Waitemata DHB has the lowest life expectancy gap in metro Auckland at 3.8 years (latest available data 2015-2017). Despite these positive findings, analyses demonstrate that around two-thirds of the Māori gap in Waitemata DHB can be attributed to avoidable causes of death. Cancers of the trachea, bronchus and lung as well as coronary disease and stroke are the leading avoidable conditions contributing to the life expectancy gap in the Māori population.

Health related quality of life is also increasing overall,[14] and is gaining acceptance as patient centric approach alongside life expectancy. Quality of life includes generic measures of wellbeing and function and disease-specific measures. The Waitemata DHB Patient Reported Outcomes Measures (PROMs) work programme is focused on implementing a range of quality of life measures. The OECD Better Life Index noted that with New Zealand's high life expectancy when asked "How is your health in general?" 88% of people reported to be in good health, much more than the OECD average of 69% and one of the highest scores across the OECD. Despite the subjective nature of this question, answers have been found to be a good predictor of people's future health care use.[15] In general quality of life tools have not been examined for their appropriateness or uptake by ethnicity, or as

[13] Based on the deep insights of the International Benchmarking report and Technical report: http://www.waitematadhb.govt.nz/dhb-planning/health-needs-assessments/international-benchmarking-of-asian-health-outcomes-for-waitemata-and-auckland-dhbs/
[14] https://www.gov.uk/government/publications/health-profile-for-england/chapter-1-life-expectancy-and-healthy-life-expectancy and https://www.ageing.ox.ac.uk/download/21
[15] http://www.oecdbetterlifeindex.org/countries/new-zealand/

tools to examine inequities. Waitemata DHB is working in partnership with academics to explore this issue further.

Although we propose that life expectancy remains the primary outcome we would also propose to create a series of secondary outcomes, created in partnership with iwi and MoU partners so that reflect their priorities. This work will occur through the year and will be brought back to the Board once concluded.

This paper proposes the early development of an equity framework for consideration. The organisational equity framework presented below been developed from the IHI model and localised to a New Zealand and Waitemata DHB context and aligned with the development of the Ministry of Health work programme.

Under the fifth element of the framework 'specific strategies' the **Māori Health Pipeline** will be a central mechanism for action. Within the pipeline further targeted programmes of work are being developed and implemented over the next few years with the specific aim to improve Māori health equity. The activities build on from recent initiatives such as the Abdominal Aortic Aneurysm (AAA) and Human Papilloma Virus (HPV) Self-Sampling screening research programmes, the equity research programmes in the Bowel Screening Pilot, the community cardiac rehab pilot and the work of the **Māori Alliance Leadership Team (MALT)** to increase Māori workforce.

Figure 2. Proposed Waitemata DHB Equity Framework

1. Health equity as a strategic priority - Governance and Senior Leadership	• Treaty of Waitangi is the foundation. • Prioritises Māori health equity. • Leadership starting at governance including creation of metro Auckland governance group. • Extension of Tikanga functions over all metro DHBs. • Committed leadership who champion the elimination of inequities at all levels.
2. Ongoing investment in partnership approach	• Iwi and MoU partnership is key. • Whānau ora commissioning agents and the progression of whanau ora. • Strengthening Māori and Pacific providers. • Intersectoral with focus on collective impact eg investing in social wellbeing pilots eg employment wrap around services in stroke (RESTORES) and mental health (Individual Placement Support prototype). • Alliances eg Healthy Auckland Together (HAT), led by Auckland Regional Public Health Service and Healthy Babies Healthy Futures. • Specific areas of focus for social determinants of health action for example housing, smokefree, alcohol. • Community, localities/places, organisations eg Healthy Families Waitakere. • Consideration of a new Māori funding entity that would partner with iwi and MoU.

3. Develop structures and processes to support equity work	• Dedicate budget to support equity work. • Establish resource to coordinate and manages a core of accelerated equity work (compilation of tools, training, specific strategy implementation, monitoring). • Deep understanding, intelligence, quality improvement.
4. Ensure that equity is a key component of quality in delivery of care	• Workforce development, provider capacity and capability building - achieving equity in Maori workforce - including work of the MALT. • Patient and whānau involvement in the co-design of services, interventions and pathways (eg the diabetes co-design approach). • Equity focus for patient experience. • Bias reduction processes/policies.
5. Deploy specific strategies	• Focus on access and quality in mainstream services, with the deployment of targeted equity focused services and investment cases for new services or innovations (with appropriate evaluation). • Targeted approaches based on those with most need. • Under the Māori Health Pipeline develop specific health gain and research programmes aimed at reducing life expectancy gap including a lung cancer screening research proposal, alternative models for pulmonary rehabilitation, structured use of data to improve access to screening and treatment in the breast and cervical screening programmes. • Use specific tools (eg HEAT, He Pikinga Waiora) as part of service development. • Review elements of the physical service environment. • Priorities Māori and Pacific workforce development and enhancement. • Professionalism and living wage for all low paid staff by the end of 2020.

Building Blocks and Enablers

Conscious move in language away from deficit focus	Systematic reporting or performance by ethnicity (ethnic-specific monitoring frameworks)	Deep understanding and intelligence of data, ongoing quality improvement	Timely access to high quality ethnicity data	A robust mechanism for the timely sharing of excellence	Robust research and evaluation, equal explanatory power
Cultural and equity competency	Funding arrangements	Patient and whānau centred	Provider capacity and capability development	Health literacy	Information technology

The building blocks include a focus on language – a conscious away from deficit and victim blaming language towards systems focused solutions based on deep understanding of problem definitions and data. This includes a common understanding of the definition of equity (and the difference between equity and inequalities/disparities). They also include the requirement of data to be based on high quality and timely ethnicity data. Waitemata DHB is a national leader and champion for high quality ethnicity data, having been an early adopter and national exemplar for implementation of the primary care Ethnicity Data Audit Toolkit (EDAT), and champion and driver of the refreshed national Ethnicity Data Protocols, which are now standards rather than guidelines. We have also been working hard to improve ethnicity data in our own HR systems, in order to accurately monitor Māori participation. Has a workstream tasked with identifying the issues and improving ethnicity data in HR systems and improving the data quality and monitoring of other areas such as employment coding. This work has included:

- A re-collect (using the correct census question and the correct recording classification processes) of ethnicity for staff recorded with 'not-stated' ethnicity (7% at Waitemata DHB), where we 'found' 5% of the respondents identified as Māori. Similar levels of misclassification were noted for Pacific and Asian. We also found that 15% of the respondents identified multiple ethnicities that were not previously recorded. Further work is underway on this issue, including a phone survey to update records and identifying longer term IT solutions.
- A current datamatch with the Ministry of Health to identify the potential level of misclassification in our broader staff ethnicity recording.
- A project to update ethnicity where iwi affiliation was recorded.
- A correction of data from paper HR forms and updated 'free text' fields.

Ethnic-specific monitoring of performance is one of the critical enablers outlined by Tumu Whakarae, including the continuation of the Māori Health Plans and the monitoring of activities in the plans. Ethnic-specific monitoring includes to governance and management, from the Chief Executive Officer report down (as implemented in this Board report).

Timely data and intelligence, alongside ongoing quality improvement, research and evaluation are also important building blocks in the framework. Equal explanatory power refers to the power of research to generate findings and to offer explanations that are specific to Māori patients and communities. Historically, research has predominantly involved a representative population sample (that is approximately 15% Māori), or even under sampled for Māori due to inappropriate and/or ineffective methods. In quantitative research, such as surveys, this approach may require oversampling Māori participants in order to achieve equal statistical power for Māori and therefore produce information to improve Māori health.

Mechanisms for sharing excellence includes the new governance and regional forums to promote what is working well. It is proposed that this will include the development of a Māori lecture series from recognised leaders and learning from other sectors. Tumu Whakarae include the use of the Health Excellence Webinars as a critical enabler.

Other building blocks include a range of elements already a focus of the DHB including cultural competency (with a renewed emphasis on shared understanding of equity and the use of an equity lens), consideration of funding arrangements, centralising patient and whānau experience of care, the ongoing development of Māori and Pacific provider capacity and capability, health literacy (service literacy as well as supporting patient understanding) and IT systems.

5. Critical questions

A key role of governance and leadership in addressing equity is the asking of critical questions, keeping a close eye on performance in the equity space and ensuring the critical strategic enablers are in place in accelerate the elimination of inequities, particularly for Māori . Several of the frameworks, including the HEAT tool and the Whānau Ora, have a range of equity questions to enable reflection, deep understanding of the problem and the drivers, and identification of appropriate solutions. The HEAT questions are outlined below.

Figure 3. HEAT Tool Equity Questions

HEAT enables health initiatives to be assessed for their current or future impact on health equity. The questions challenge users to think broadly about equity issues. The 10 questions are listed below and discussed in more depth in the next section.

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where/how will you intervene to tackle this issue?
5. How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

Some further questions to consider include:

- How did we get to here?
  - What decisions were made before this point
  - What values were those based on?
  - Who was at the table?
- Do we deeply understand the issue, especially its equity aspects (are we assured of this)?
- Who is benefiting? Who is missing out?
- If we designed this for the least well served, would it look different?
- Are we reaching who we should be (what should we expect)?
- Do we know what people impacted by our decisions think?
- Have we looked at all the relevant components of access?
- Are there evidence based strategies or an intervention logic to address known issues before we decide on innovation?

6. Conclusion

Waitemata DHB is refreshing the organisational equity framework, aligned to the Ministry of Health strategic work programme. This refresh is focused on accelerating Māori health gains and the elimination of unfair, unjust and preventable inequities. It will be informed by the existing strategies and frameworks, a range of national and international Māori health and equity strategies. Our preference will be to build on the work already done in this area and to strengthen our approach, leadership and the enablers for health equity in our system.

8.3 Car Parking Charges at Waitemata DHB

Recommendation:

That the Board:

a) **Receives the paper, noting that the Waitemata DHB Chair has recently received two letters regarding car parking charges at the DHB's hospital campuses.**
b) **Notes Management's comments regarding the issues raised.**
c) **Notes that once further investigations are complete these will be considered by the Audit and Finance committee with a final recommendation coming back to the Board.**

Prepared and Endorsed by: Robert Paine (Chief Financial Officer and Head of Corporate Services)

1. Executive Summary

In 2017 a revised schedule of public car parking charges was discussed at the Audit and Finance Committee, which then recommended to the Board that changes be implemented. The Board subsequently accepted the recommendations.

Two letters have been received recently by the Board Chair from the Waitakere Health Link Board and the Waitakere Grey Power Association.

The DHB manages parking issues by balancing the provision of new car parking facilities, and managing demand, whilst recognising the effects on the patient experience of having affordable and accessible parking for both patients and their visitors and also encouraging the public and staff to utilise public transport.

The DHB applies the compassion value strongly in the management of parking charges, and distributes a large number of free parking tickets to patients, whanau and visitors who may suffer financial hardship, or personal distress.

The changes to parking charges saw the reduction in the hourly rate by $1 (from $5 to $4), and almost 65% of all parkers pay $4 or less.

The changes also saw a reduction in the grace period for free parking, although the Waitemata DHB grace period remains longer than the other metro Auckland DHBs.

It is recommended that the Board notes the Next Steps Plan in this report and the Chair responds to the correspondence received following the deliberation of the Board.

2. Strategic Alignment

	**Operational and financial sustainability**	Car parking investment is reliant on revenue from car parking and does not form part of the current vote health allocation.

3. Background

The provision of car parking facilities to our staff and the public has not been seen as an input to health by successive governments. Accordingly, there is no funding from the Crown for car parking facilities, and DHBs are expected to fund car parking investment from their internally generated cash flow, or from external funding (private) sources. Large (greater than $10m) capital investments in parking facilities requires approval from the Ministers of Health and Finance, and even if Waitemata DHB had funds to invest its own funds in such an investment, it is most likely that such an investment would not be approved in Wellington.

Car parking charges for both staff and the public have been in place at Waitemata DHB's hospital campuses for a number of years. In 2010 the DHB spent $25m on constructing the multi-storey car park on the North Shore Hospital campus. Funding for the car park project was provided by way of a loan from the Crown that required interest and principal repayments. The loan was converted to Crown Equity in 2017 and the Waitemata DHB pays 6% Capital Charge per annum.

To date, Waitemata DHB has not utilised the private sector for parking facilities, since in such arrangements control of car parking charges is lost to the private operator, who are normally free to determine parking rates.

Waitemata has a growing population, and each year the number of users of parking facilities grows. This has led to congestion and shortages of available parking for both public and staff.

The Long Term Investment Plan includes provision for more parking on the North Shore Hospital campus.

4. DHB's response

The DHB has tried to manage the parking issue by balancing the provision of new car parking facilities, and managing demand, whilst recognising the effects on the patient experience of having affordable and accessible parking for both patients and their visitors, and also encouraging the public and staff to utilise public transport.

The public may apply for parking concessions if the charges cause undue hardship. Similarly the DHB may exercise its compassion policy when deciding to give relief to parking charges. Decision making regarding concession and hardship parking is held at the charge nurse level, who is best placed to identify patients, whanau and other visitors to whom the compassion policy might best apply. The availability of concessionary parking is not widely advertised, as it might bring undue pressure to charge nurses.

The DHB also provides extended free parking to certain groups of the public, such as Breast Screening, parents of patients in Special Care Baby Unit, renal dialysis patients, paediatrics ward, cancer and blood services, and patients who come to clinics to receive regular treatments. The DHB issues between 3,000 and 4,000 free tickets per month.

The DHB has a 20 minute grace period, under which anyone accessing the site for less than 20 minutes will not be charged.

This grace period is the longest within the Metro DHBs - at Auckland and Counties Manukau the period is 15 minutes, although at Auckland the public can access the site to pick up patients for any length of time without charge provided they do not leave their vehicle unattended. This is possible at Auckland DHB because the ticket barriers are at the entrance to the carparks, not at entrance to the campus.

The grace period at Waitemata DHB used to be 30 minutes, and the charge for a stay between 30 minutes to one hour was $5. In 2017 this arrangement was amended to reduce the grace period, but also reduce the charge for the first hour to $4 to align regionally with car parking charges.

Approximately 64% of all public visitors and patients are charged $4 or less for their visit.

The DHB actively encourages staff to utilise alternate methods of transport to come to work. We believe that a number of staff park in the residential streets surrounding North Shore Hospital, and note that Auckland Council is currently consulting to introduce paid parking in these areas. This is most likely to drive staff onto the hospital campus, where they would pay $3 per day for parking, but might therefore allow greater access by the public to these on street spaces at rates lower that they would cost if they parked on site.

The parking charges for the public increases reasonably rapidly after the first hour, to a maximum charge of $20.40 after four hours. Notices on the ticket machine at the entrance to the campus notify the public that if they are planning to make several visits on the same day, the $20.40 charge is the daily maximum amount payable.

Lower public rates would encourage the use of parking at the hospital by workers in the surrounding areas, especially from the Smales Farm business park.

The public rates are also set to encourage turnaround times, since we are seeing clinics being missed because patients cannot find parking spaces.

5. Correspondence

The introduction of the new charges in 2017 has been met with a number of comments from the public. Several complaints arise from visitors attending sick family members for long periods over several days, and in those cases refunds have been made under the hardship and compassion policies.

Two substantive letters have been received recently by the Chair from the Waitakere Health Link Board, and the Waitakere Grey Power Association (these are available in the Diligent Boardbooks resource centre for Board members reference).

The main points raised by Waitakere Health Link concerned Waitemata DHB's hourly rates being higher (other than the first hour) than Auckland DHB's rates, and the weekend rate at Downtown Auckland. They requested that the following:

- Grace free period be raised back to 30 minutes to allow families enough time to drop off and pick up patients.
- Set parking charges lower than other hospitals because Waitakere Hospital does not offer the same level of service as other hospitals.
- Weekend parking be reduced to half price.

- Parking Policy/Guidelines for parking 'relief' be easily accessible and public.

The letter from Grey Power focussed on the grace period, and also some relief for their members over 65 years old.

There have also been other suggestions regarding Gold Card holders, and increasing the granularity of the hourly time steps.

6. The way forward – Next Steps Plan

Waitemata DHB acknowledges the matters raised about car parking charges on its hospital sites, but we do not believe the charges are overly excessive. Our charges match Counties Manukau DHB exactly, although we have a longer grace period. Our charges are not significantly different to Auckland Hospital (maximum per day $19) or Greenlane Hospital (maximum daily rate $16), although we get to the top rate quicker than Auckland DHB. Our rates are more favourable that the Downtown car park week day rates.

We are currently investigating the following:

1. If the rates can be set out in 20 or 15 minute graduations (so tipping just over an hour mark does not incur a whole hour's additional charge).
2. Investigate the feasibility of moving parking barriers for the public to the entrance of the car park on the North Shore Hospital Site, and so enable a short stay pick up/drop off area that is not time bound.
3. Extending staff charges to ensure that at all locations where staff park in parks paid for by the DHB via rental.
4. If a differential parking charge can be made for staff, such that low income staff pay less than others.
5. Formalising and publishing the compassion guidelines

The DHB has the lowest staff parking charges in Auckland and do not believe that it would be prudent to consider increases to staff parking rates at this time. However, it is clear that the DHB subsidises staff parking.

The financial implications of any change to the car parking arrangements would need to be assessed, as reduced revenue would add to the DHB's deficit and reduce our ability to develop more car parking facilities. Note that if the 30 minute grace period was reinstated the revenue loss is estimated to be $600k.

It is proposed that the above issues are managed via the Audit and Finance Committee, with recommendations coming back to the Board for approval once the above investigations are complete.

In the meantime it is recommended that following the deliberation of the Board, the Chair responds to the correspondence received regarding car parking.

8.4 Health and Safety Marker Report

Recommendation:

That the report be received.

Prepared by: Fiona McCarthy (Director, Human Resources)

1. Purpose of report

The purpose of this report is to provide an update on progress towards meeting the expectations of the Health and Safety at Work Act 2015, which came into effect on 4 April 2016.

2. Executive Summary

The new Health and Safety at Work Act 2015 came into force on 4 April 2016. The new legislation and updated regulations is the result of work from the health and safety taskforce established in 2012 to evaluate whether the workplace and safety system in New Zealand was fit for purpose, and to recommend practical strategies for reducing the high rate of workplace fatalities and serious injuries by 2020. From taskforce recommendations made in 2013, WorkSafe NZ was established with one goal – to reduce workplace deaths and injuries by 25% by 2020.

The Waitemata DHB has been working on key aspects of the legislation specifically those related to:

- Contract and reactive maintenance triage and works management.
- Incident management.
- PCBUs, where we share accountability and procurement processes.

To monitor our compliance, nine dive audits have been completed in 2016-2018 and four are set for 2018/19. Audit actions are noted in the Appendix as applicable.

A summary of our compliance with the Health and Safety at Work Act is outlined below and details are outlined in Appendix 1.

Key	
High 	Complies substantially or fully with legislation
Good 	Some actions to be completed
Low 	Significant or some key actions to be completed

Topic	**Performance**	**Outstanding actions**
1. Policy		
2. Worker engagement, participation and representation		A proposed national worker participation agreement template is due to be circulated in June to DHBs.

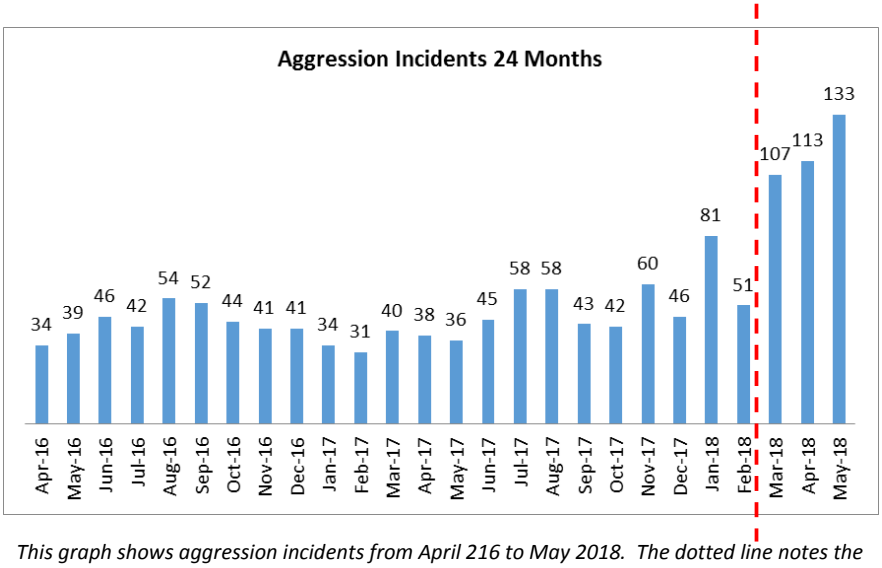
Topic	Performance	Outstanding actions
3. Notifiable events		
4. Health, Safety and Wellbeing Committee		
5. Orientation • Staff and Volunteers		
• Local orientation for staff and students		New systems for recording local orientation are in development.
• Contractor		Online induction for non-clinical contractors is now live. Mandatory pre-employment Health and Safety online orientation was rolled out in December 2017.
6. Risk Management		Funding for dedicated health and safety software will be raised during the year; planned implementation mid 2018/19.
7. Contractors (Facilities, healthAlliance and IT)		Underway (see section 7 and 10 of the appendix).
8. Hazardous substances		High use areas accounting for 80% of chemicals currently under audit - over 300 sites still to be completed. This is a three year piece of work.
9. Health of workers		Comprehensive health monitoring plan in development.
10. Equipment and Maintenance		Processes for reactive maintenance triage and works planning and completion is under review. Interim processes for health and safety works assessment are in place. Phase 1 resources now approved for recruitment.
11. Training		Health and safety training in place, key components are being reviewed.
12. Audits		Audit programme for 2017/18 underway (see section 12). Audits for hazardous substances underway (43% complete). Annual organisational wide Safe Way of Working audits scheduled for April 2018.
13. Reporting		A health and safety scorecard allowing access to regular divisional level reporting can be delivered following the implementation of dedicated Health and Safety software.

Topic	Performance	Outstanding actions
14. Resources		Discussion underway to convert existing contract resource to Full Time Equivalent (FTE) for additional Occupational Health Physician and work injury administration support. Discussion underway on possible resourcing for recent updates to the new Health and Safety at Work (Hazardous Substances) Regulations 2017.

Aggression Incidents: review and management

Aggression is a focus nationally across all DHBs. Aggression remains one of the DHB's highest health, safety and wellbeing priorities and every physical aggression incident is followed up by the Occupational Health and Safety Service (OH&SS). In following up the incident we seek to understand that the root cause is understood, whether there was intent to cause harm and engaging with the manager of the area to ensure all suitable controls are in place. During these reviews, we also identify if there were any contributing factors involved, such as location of duress alarms and inadequate responses, which are also rectified where possible.

The DHB has also focussed heavily on ensuring that all aggression incidents reported are visible across all our systems. Our focus on this has been successful and we are now reviewing additional aggression incidents per month (approximate 90). This increase does not constitute an increase in actual incidents occurring or incidents being reported, simply increased visibility of these incident reports. We can provide a breakdown of aggression incidents by staff profession but not gender.



This graph shows aggression incidents from April 216 to May 2018. The dotted line notes the timeframe where additional incident categories were identified for review as noted above.

For hospital based aggression incidents, Code Orange calls remain the primary response, activated either by phone or by wall mounted duress alarm button. In the event that a code orange is called, the Security Service, Duty Manager and on-call Orderly are notified via pager. Security Officers attend the scene very quickly, usually within two minutes, and receive a handover from the Charge Nurse Manager at the scene. The Duty Manager takes the role of overall scene controller and the orderly opens doors and moves equipment. We are unable to provide information on the number of police attendances as we do not keep our data centrally.

For May 2018, there were 59 code orange activations, 25 at Waitakere Hospital and 34 at North Shore Hospital. Of these code orange activations, 27 were activated by phone call and 32 by duress alarm button. All staff are trained on code orange activation and when inducted into an area, are also shown where all duress alarms are located.

Waitemata DHB has completed a large number of projects regarding aggression over the last two years, which includes the following:

- Development of aggression related policies covering:
  - Safety and Security in the Hospital Setting (hospital workers).
  - Safety and Security in the Community Setting (community workers).
  - Safety and Security in Satellite Facilities (workers in buildings outside of the main hospital campus).
- Development of Aggression Risk assessment and guidance documents:
  - General aggression guidance for managers and staff.
  - Aggression risk assessment tables for managers to complete and upload to the Hazard Register.
- Reception Area Aggression Risk Assessment (for managers to complete and upload to the Hazard Register, highlighting any controls required for reception areas).
- Development and implementation of online CALM training, focussed on calming and de-escalation (available to all staff).
- Establishment of an Emergency Department (ED) Safety Taskforce, to review all processes, systems, policies and training of the ED, including security responses.
- Provision of security related training to ED nurses.

3. Glossary

HSNO - Hazardous Substances and New Organisms Act 1996.

PCBU - person conducting a building or undertaking, and has a primary duty of care to ensure the health and safety of workers. The Waitemata DHB is the PCBU.

Officers - Includes Board Directors and the Senior Management team who make governance decisions that significantly affect the business. Officers have a duty of due diligence to ensure their business complies with its health and safety obligations. Officers may be found guilty of an offence under the Act, in addition to the PCBU.

Due Diligence - taking steps to acquire and keep up to date knowledge of health and safety matters. Gain an understanding of the business and hazards and risk associated with that business. Ensure PCBU has available and use appropriate resources and processes to manage risk. Ensure PCBU has appropriate processes for considering incidents, hazard and risks in a timely way. Ensure PCBU implements processes for complying with obligations under the Act, validates the provision and use of resources and processes to comply with obligations under the Act.

Workers - Workers have a duty to take reasonable care for their own safety and that their own actions do not adversely affect the safety of others. They need to comply with reasonable health and safety instructions from the PCBU and co-operate with health and safety policies and procedure.

Workers are people who work at the Waitemata DHB and include employees, contractors, sub-contractors or their employees, apprentices, trainees, persons gaining work experience, employees of a labour hire company and volunteers.

Other people - People who come to the workplace such as visitors or customers also have duties to comply with health and safety processes. Our patients and visitors are in this group.

Notifiable injury or illness - an injury or illness that requires immediate treatment (i.e. amputation, serious burn, serious head injury or burn), admission to hospital, serious infection and medical treatment within 48 hours of exposure. All notifiable injuries or illnesses are to be reported to WorkSafe NZ.

Notifiable incident - an incident that is an unplanned or uncontrolled incident in a workplace and that exposes a worker or other person to a serious risk to health and safety.

Notifiable incidents include events such as: a spillage or leak of a substance, explosion or fire, escape of gas or steam, falls, electric shocks, structural collapses, in rush of water, gas or mud, interruption of underground ventilation. All notifiable instances are to be reported to WorkSafe NZ.

Health and Safety Representative - a person elected to represent the workers in relation to health and safety matters. The representative has specific functions and roles under Schedule 2 of the Act.

Appendix 1

Progress implementing the Health and Safety at Work Act 2015

1. Policy

The Waitemata DHB policies have been reviewed and are aligned to the new legislation. Changes and updates to policy will occur over the next few years as new regulations, audits and experiential learnings lead to new processes. Significant policy changes will be endorsed by the Board.

2. Worker engagement, participation, and representation

What the Act says	A PCBU must: • Initiate election of health and safety representatives on request of workers. • Agree the work groups that are represented by a health and safety representative. • Consult about matters related to health and safety. • Provide information as requested with due consideration to the Privacy Act. • Allow a health and safety representative time to discharge their powers under the act. • New regulations on worker engagement, participation and representation were introduced in February 2016 and outline the functions, number, training, powers and participation expectations of health and safety representatives.
How do we comply?	We have 307 health and safety representatives throughout the business, most of whom have baseline health and safety representative training, as endorsed by WorkSafe NZ, as well as divisional health and safety committees in place to provide ways to participate in local issues. In addition, the annual update of hazards is reviewed by representatives, and representatives participate in the self-assessed departmental health and safety audit. Representatives also undertake Waitemata DHB wide health and safety activity such as flushing low use water outlets. Seven health and safety representatives sit on our health, safety and wellbeing committee. Transition training for representatives has been provided and foundation health and safety training is available online. Meeting with on-site contractors to establish health and safety representatives and discuss health and safety matters have commenced.

What is outstanding?	• The regional employee participation agreement between the Northern Region DHBs and unions has not yet been signed by the Unions. Discussions are progressing nationally with union parties. • On-going training needs (as part of the new Worker Engagement, Participation and Representation Regulations) have been assessed following the completion of a special project led by Margaret Kamphuis (Specialist Health and Safety Advisor). We are currently reviewing our training providers to meet these needs.
Consequences	There are fines for not having appropriate employee participation processes in place.

3. Notifiable events

What the Act says	A PCBU must: • Report on notifiable injury, illness and incidents as soon as possible after being made aware of them. • Secure a site if a notifiable event has occurred. • Keep a record of notifiable events.
How do we comply?	We have robust notifiable event reporting and recording processes in place.
What is outstanding?	There are no outstanding actions.
Consequences	There are fines for not notifying workplace injury or illness as soon as possible after being made aware of them.

4. Health, Safety and Wellbeing Committee

What the Act says	A PCBU must: • Put in place a health and safety committee if requested by a worker. • Establish a health and safety committee within two months of this request. • Consult about health and safety matters with the committee. • Allow time for members to attend and carry out functions as a member of the committee. • Provide information to the committee. • Within a reasonable time, adopt recommendations made by the committee. A PCBU can also establish a health and safety committee on its own initiative.
How do we comply?	The Waitemata DHB has two organisation-wide Health, Safety and Wellbeing Committees focussing on: 1. Executive governance and risk. 2. Operational and policy matters.
What is outstanding?	There are no outstanding actions.

Consequences	There are fines for not setting up a Health and Safety Committee if requested, and if a PCBU does not: • Allow time for members to attend committee meetings/consider matters raised at the committee. • If a PCBU does not implement recommendations from the committee.

5. Orientation

What the Act says	Orientation to a workplace is an important part of complying with the duty of care to ensure the provision and maintenance of a workplace that does not give rise to health and safety risks.
How do we comply?	A mandatory pre commencement orientation and 'safety first' video was made available to new staff from the end of December. Reporting on completion rates are included in the Scorecard in the Health and Safety Performance report from April. This online Health and Safety module is also utilised for all new Doctors and volunteers. A departmental health and safety induction checklist (form) is sent to recruiting managers. The current manual departmental health and safety induction form will be moved onto an electronic platform so we can start to record completed departmental inductions. Due date December 2018.
What is outstanding?	To put an Officer orientation programme in place however, in the meantime we have run Officer training for both the Senior Management Team and the Waitemata DHB Board. To check orientation processes for students. **New for July** • We are currently reviewing volunteer on-boarding processes including pre-employment health checks.
Consequences	There are fines and criminal punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

6. Risk Management

What the Act says	PCBUs have a duty of care to ensure the health and safety of another person is not put at risk from work carried out as part of the conduct of the business or undertaking. Risks must be eliminated or minimised so that a PCBU can, in so far is reasonably practicable: • Provide a workplace without risk. • Provide and maintain safe systems, plant and structures. • Ensure the safe handling, storage and use of plants, substances and structures. • Provide training or supervise to protect persons from risk. • Maintain accommodation so a worker is not exposed to risk.

How do we comply?	There is an online hazard management system where hazards are identified and controls recorded. This is complemented by a corporate risk register where service, division and organisation wide health and safety risks are also recorded, controlled and regularly reviewed. Hazards are reviewed between monthly and annually as well as after any related incidents, depending on the level of risk and risks are reviewed every 12 months by the divisional lead manager and Health and Safety Representatives. Waitemata2025 design and work impact meetings are occurring. Processes to monitor and maintain operational compliance are in place i.e. fire management plan, training, exercises, maintaining clear egress, etc. Entrance ways have non slip flooring and signage to indicate they may be slippery when wet. On wet days, additional signage is displayed to alert patients, staff, visitors, contractors to potential slips, trips and falls hazards. This expectation is spot audited. CCTVs are active in appropriate places in and around our sites. A reception and aggression hazard and security risk assessment tool has been developed for use in Community and inpatient settings. Asbestos surveys are ongoing for buildings constructed before 2000. An online Asbestos Register is ready to be populated and a volunteer resource will commence this month to load the information. A fixed term resource has been approved to oversee reactive maintenance triage and works management. Facilities staff have had existing Site Safe training which includes hazard identification. Refresher training has been completed for Trade staff. Remaining Facilities and Development staff booked to complete Hazard and Risk Management training beginning of November. The Safe Way of Working (SWoW) annual audit tool has been rolled out across the Waitemata DHB and completed by all areas, with validation audits now also completed annually. Final 2017 results have been compiled and were presented to the Executive Health, Safety and Wellbeing meeting on 30 October 2017. The 2018 Safe Way of Working annual audit goes live on 6 April 2018, for completion by all Waitemata DHB people managers. An additional eight risks have been added to the organisational wide health, safety and wellbeing risk register since December 2017. A total of 13 risks are now on the register (legislation, wellbeing, hazardous substances, use of sharps, aggression, community workers, working with machinery, electrical equipment, moving and handling, exposure to blood and body fluids, asbestos, psychosocial stressors, slips/trips and falls, fire safety).

	Evidence of audit, checks and compliance will be noted where controls prescribe this. Reporting on the register will be via the Executive Health, Safety and Wellbeing Committee, and where risks are elevated to the Corporate Risk Register - to the Risk and Compliance Committee, and the Audit and Finance Committee. 21 Draft Safety Maintenance Procedures (SMP) have been created and reviewed to manage Facilities hazards and risks. **New for July** • Electrical Safety Internal tagging and testing has commenced and we are initiating an engagement of a resource to undertake this work going forward. Draft Policy for Tagging and Testing is to be approved at the July 2018 Executive Health and Safety and Well Being committee for approval.
What is outstanding?	Recent audits have identified a number of Health and Safety Information Technology (IT) systems that are not providing the ability for robust, integrated and systematic analysis across the organisation. A Request for Information has been evaluated in February with a view to go to Request for Proposal in April/May 2018. In the interim: • A combination of the hazard register and the risk register is being used to store and make visible organisational, divisional and unit hazards (A new organisational risk register has been established as noted above). • A Microsoft Access database has been created to provide a greater ability to automate basic reporting of statistics and carry out limited data mining. • The new instance of the BEIMS system based on Auckland DHB implantation is being implemented to replace the current system version. Procurement confirmed and implementation by July 2018. A recent deep dive audit has identified a number of Facilities technology, systems and processes where improvements of current processes to better implement good practise is warranted. Actions have been identified and will be commented on in this report. Work to review and mitigate high residual risks is underway and due to be completed in 2018. Tranche 1 of critical resources for Facilities management works have been approved and recruitment is underway. • Working in Confined Spaces Potential confined spaces have been identified and management protocols developed. We are now accessing each confined space and putting in access protocols by December 2018.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

7. Contractors (Facilities, Health Alliance and Information Technology)

What the Act says	The PCBU, as well as ensuring the health and safety of its employees (workers), is also required to ensure the health and safety of other workers, as well as ensuring that plant and fixtures and fittings are fit for purpose and without risks to health and safety of any person. There are new asbestos regulations that require a change in how PCBU's currently manage and remove asbestos.
How do we comply?	**Selection of Construction Contractors**: The Waitemata DHB has moved to a process of selecting a panel of preferred contractors who can tender for Waitemata DHB construction and refurbishment work as it arises. Each main contractor has to first qualify to be a part of the panel by satisfactorily completing a contractor health and safety questionnaire which allows the organisation to demonstrate their performance against 12 health and safety criteria. Complete for incumbent contractors. Any new contractor must complete a requalification questionnaire. Maintenance contractors do not have a supplier panel arrangement in place as yet but contracts are in place and current for main contractors. All regular contractors have been required to submit prequalification documentation in response to an HS200 questionnaire. Only those that satisfy the prequalification requirements which are safety compliant focused can continue to work for the Waitemata DHB. **1. Supplier Contracts and RFP processes** Waitemata DHB contracts provide a standardised health and safety statement for minor or individual contracts. This clause is confirmed as satisfying the Act. The standard terms and conditions applicable to any procurement via an Oracle purchase order are being updated to include condition relevant to serviced included requirements to meet HSWA 2015. **Orientation:** The contractor induction documentation and process has been refreshed (a new document, revised presentation and updated requirements for all contractors). Online contractor inductions have been developed and are now operational. The online induction is required for all contractors, with medium to high risk contractors also needing to attend the Facilities and Development No contractor is now able to receive their security pass without either having completed the online induction (for low risk contractors) and/or the Facilities and Development induction (for medium to high risk contractors). **Site access:** All building contractors must report to Facilities before commencing their work and all healthAlliance staff (IT) will report to security. In addition: • New projects must be agreed and coordinated with Facilities prior to commencing.

	• A contractor carrying out an agreed task e.g. for call out that does not need to be reported to Facilities prior – they do need to report to the area supervisor prior to and post work. All healthAlliance staff and contractors are required to have healthAlliance issued photo identification on them at all times and for it to be visible. Usually if they are based on a particular site on a regular basis (i.e. not just visiting) then we will request a security access card with photo ID for that staff member from the site. **2. Facilities** Once inducted, contractors working for Facilities are issued with a Waitemata DHB ID card with a photo. Proof of identification (passport/ drivers licence) is required to obtain this ID. The duration of the ID card can be set to cover the estimated time of the project. Contractors carrying out very urgent works are exempt from the requirement to complete the formal induction course and photo ID but must be provided with an induction and safety briefing suitable for their task prior to starting work. **On the job:** Construction Toolbox meetings occur on a scheduled basis. There is active management and collaboration with architects and designers to meet design expectations and requirements. Work impact meetings to assess risk occur regularly and ensure contractor health and safety plans are implemented. All Project managers, including the Waitemata2025 team are Site Safe certified as they join the team. **Asbestos:** Asbestos management surveys are completed, and a register of these surveys is in place, with a register by building which notes hazard level. The type, location, condition and personal protective equipment expectations are identified in the survey so staff and contractors are alerted. Staff and contractors need to contact Facilities to seek information from the relevant survey. An online system is being implemented to provide easier access to the detailed information and is due to be complete by November. Corrective actions are being implemented to mitigate identified asbestos hazards. Asbestos management plans are being developed and implemented. This work is being led by the Waitemata DHB Asbestos Management Group in consultation with Auckland DHB Asbestos Management Group. **Incidents and Accidents:** Reporting of incidents and accidents follow the Waitemata DHB process. Contractors experiencing any accident or incident are required to notify the Waitemata DHB, investigate and report back any findings. **On site audits:** Regular external audits are conducted for construction site work. Project managers also undertake audits of their projects.

	Orientation: Induction material is in place. **On the job:** A pre start safety meeting process is in development for all build projects, as well as ensuring work impact meetings occur regularly during the project. Safety in design guidance is in development. Quarterly meetings with maintenance contractors are now in place with the first meeting held late last year. **Investigations** Facilities adopted an ICAM concept of investigation that will identify why things went wrong and what actions are required to ensure compliance and keep workers safe. Records gained through incident reviews, audits and investigations are saved as confirmation of active management by the Waitemata DHB in its role as the PCBU. **IT work review and sign off** For IT project work related to moves and new fit-outs, the desktop team work closely with the Waitemata DHB Project Manager who reviews and signs-off that the work is complete. **Building project health and safety management and sign off** A performance review is done mid-way through each major building project. Health and Safety design sign off and pre-occupation processes are complete. The building sign off process follows the relevant policy. **Post Implementation Reviews (PIRs)** PIRs are done for each facility build project and results provided to the contractor selection panel.
What is outstanding?	**Selection of contractors:** The Waitemata DHB is moving to the same preferred supplier process for maintenance contractors as noted above for large construction contractors. The Waitemata DHB will transition to this process over the next 12 months. The first step of this transition is underway i.e. Waitemata DHB maintenance team requires contractors to provide suitable prequalification material by a certain date. If not met the contractor will be removed from the approved contractor list. All regular and new contractors employed by Facilities and Maintenance are required to undertake pre-qualification. Any emergency contractors must provide relevant works planning details and meet work safe requirements. **healthAlliance processes:** The Waitemata DHB is working with healthAlliance on site orientation, works planning and safety and procurement processes. These processes will be agreed across the region. healthAlliance works affecting a facility will be approved by Facilities management before commencing. Where induction or works are not adequately planned or completed will be deferred until signoff/ approval

	has been achieved. **Building project health and safety management and sign off:** Waitemata DHB needs to put in place a complete implementation of project sign off documentation. Project sign off documentation for building commissioning is structured and comprehensive. **PCBU meetings** Facilities management are implementing a schedule for contractor engagement meetings expected to be initially held quarterly through the year.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

8. Hazardous substances

What the Act says	A PCBU has a primary duty of care to provide for staff use, handling and storage of substances. The Waitemata DHB is also required to comply with the Hazardous Substances and New Organisms Act 1996 (HSNO) and related regulations which requires the Waitemata DHB to prevent and manage adverse effects of hazardous substances and new organisms.
How do we comply?	The Waitemata DHB has focused on the 33 areas with high volume and/or exposure risk for the use of hazardous substances, constituting the highest risk areas, with 420 substances identified and added to the online register of substances available on StaffNet. A new and comprehensive HSNO policy has also been developed and published on the intranet, including new legislative updates relating to hazard classifications and tracked substances, with a strong focus on roles and responsibilities. The Intranet HSNO site now contains hot links to information covering: • Policy document. • Full HSNO database of all hazardous substances identified, including constituents, product state, United Nations number, Chemical Abstracts Service number, identified hazards, exposure limits, HSNO class and Personal Protective Equipment specific to each substance. • This database has recently been fully upgraded and allows each area to automatically create their own HSNO registers. • Master Material Safety Data Sheets repository. • Wastewater Disposal Guidelines. • Training resources, including introductory PowerPoint. • List of all Approved Handlers and their locations. • Emergency response requirements. • Specific spill kit contents list.

	• Managers' responsibilities. • Key contacts for staff. Approved handler training has been delivered for high risk areas. Work has also concluded with healthAlliance, to ensure that Material Safety Data Sheets are supplied for all new chemicals being procured. The North Shore Hospital has a dangerous goods store for holding hazardous substances to be used in the hospital and for storing waste prior to collection. The latest HSNO Legislation was released in November 2017 and we are currently reviewing it to understand all material changes required of us. Our existing HSNO Policy has been updated and republished. Of note, HSNO training will now be required under the new legislation, for all workers who use or handle hazardous substances. We are currently developing mandatory online training modules for these staff, with more specialised training for those staff that have a higher level of oversight and responsibility (competent persons). New for July A new trial process to utilise the orderlies for collection of HSNO from hospital areas and delivery of these substances to the Hazardous Goods Cabinets/Hazardous Goods Store has been approved and is currently in development. At present the waste removal work is being done via our Hazardous Substances and District Compliance Co-ordinators.
What is outstanding?	We have another estimated 420 areas to review but a comprehensive audit of the 33 high risk areas is underway. The tender for construction of the Dangerous Goods Store will form part of the Waitakere Hospital Development Program. Interim measures are noted below. In the interim a review of hazardous goods volumes and types has been completed and it has been determined that a temporary store for Waitakere Hospital is not required, so we are limiting the volumes that areas are able to order at any one time and hold in their own Dangerous Goods Cabinets. The only remaining issue is a lack of holding space for waste chemicals for disposal. At present materials are delivered via Waitakere to the North Shore Dangerous Goods Store, until we can activate an internal hazardous waste process utilising the dangerous goods cabinets at Waitakere Hospital (see new for July above).
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness. It is worth noting that hazardous substances are covered under three sets of national legislation, as well as local bylaws (Health and Safety at Work Act 2015, Hazardous Substances and New Organisms (HSNO) Act 1996, Resource Management Act 1991 and Auckland Council's 'Water Supply and Wastewater Bylaw'), under all of which fines can be payable.

9. Health of workers

What the Act says	A PCBU must ensure that the health of workers and conditions of the workplace are monitored for the purpose of preventing injury or illness. The PCBU must, as far as reasonably practicable, maintain accommodation so that the worker is not exposed to risks to health and safety.
How do we comply?	Pre-employment screening in place, however a number of staff still commence work pending their results. A pilot has been completed with the Specialist Mental Health and Addictions Services, and pending discussions on future options to implement across the Waitemata DHB, the pilot will continue and staff and managers asked to complete health screening prior to employment. We undertake occupational health monitoring via our Occupational Physician health clinics and have now extended this to monitoring exposure to noisy areas (facilities), hazardous substances, laser care, and other risk areas. Monitoring for exposure for radiation (Radiology, Cardiac Catheter Lab) occurs externally. We provide free influenza and other vaccinations for staff. We provide and maintain workplace heating, ventilation and cooling. Areas with friable asbestos are sealed and require additional security clearance to gain access. Containers for sharps, hazardous materials and substances are provided on each site. Staff are provided with Personal Protective Equipment (PPE) to wear. PPE requirements are outlined in various policies as well as the hazardous substances register, Infection prevention and control, use of lasers, etc. Infection prevention and control processes are in place to manage any disease exposure and outbreaks. Slips, trips and falls posters have also been developed and distributed to the Health and Safety representatives for display within their areas. OH&SS are also displaying these posters in 'common' areas, where Health and Safety Representatives are generally not allocated. Regular communication on hazards is issued. Staff have access to EAP works, the Employee Assistance Programme for up to three free sessions on work or personal matters. Wellbeing, resilience and mindfulness training is available as part of the organisation development team offerings as well as on request. The staff influenza campaign is underway, with static clinics having been completed and the in-team vaccinators, over 100 nurses, continuing to vaccinate until around the end of August 2018. Planning for patient

	responses, e.g. isolation of suspected flu cases, proactive vaccination of vulnerable cohorts is also underway. The latest HSNO Legislation was released in November 2017 and we are currently reviewing it to understand all material changes required of us. Of note is the expectation that we undertake specific area and hazardous substances task analysis and put in place appropriate processes to manage any possible exposure that may impact staff health. We are also developing mandatory online training modules for these staff, with more specialised training for those staff that have a higher level of oversight and responsibility (also called competent persons (was approved handler)).
What is outstanding?	Health monitoring programmes should be in place across all relevant risk areas. An audit on use of personal protective equipment will be planned as part of the health monitoring programme to validate the application of various policies and risk controls – due June 2019.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

10. Equipment and Maintenance

What the Act says	A PCBU must provide and maintain a work environment that is without risk to health and safety.
How do we comply?	Equipment that is broken is escalated for capital replacement as relevant. A register of capital assets is in place and being added to, to ensure that equipment is budgeted for replacement according to the life span of that equipment. All hospital bio-medical equipment is maintained by the Bio-Engineering team. An escalation process for urgent health and safety works has been agreed by the Chief Financial Officer, Chief Medical Officer and Director Human Resources. Work on updating the helipad, loading dock and five key pedestrian crossings is progressing, with final costings being sourced. The Waitemata DHB is currently collaborating with regular meetings between Waitemata DHB, Counties Manukau Health, Northland DHB and Auckland DHB on contractor management, asbestos management, aggression risk management and other legislative compliance work. Task planning and sign off process for maintenance work, ensuring competent review and management oversight will be shared. Support for Job Safety Analysis and safety planning is underway with training, monitoring and guidance for staff. Management of Job Safety Analysis is being provided by contracted resource prior to recruitment of permanent staff focused on health and safety and work management.

What is outstanding?	**Maintenance work review and sign off:** The Waitemata DHB needs to resource reactive maintenance triage and works planning and a fixed term resource has been engaged while a permanent resource is in recruitment. Trades staff have completed training in risk identification prior to undertaking maintenance works. An interim fast track process to approve maintenance triggered for health and safety reasons is in place but this needs to systematise. The BEIMS system is due for update in July2018. The security alert systems for community workers working group have completed their Request for Proposal and a pilot is underway. The completed pilot report is due in the next two months.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

11. Training

What the Act says	A PCBU must provide any information, training, instruction and supervision necessary to protect all persons from risks to health and safety arising from work carried out by the Waitemata DHB.
How do we comply?	A compulsory online Health and Safety Orientation is provided to staff pre-commencement. Health and Safety representatives are provided with two days of training (Four half day modules) by the Occupational Health and Safety Service covering an introduction to health and safety management, hazard and emergency management, accidents and occupational rehabilitation, safe working procedure, health and wellbeing and the new legislation. All staff are required to complete the mandatory annual health and safety update online. Training is provided on departmental specific instances such as moving and handling in patient areas, crisis intervention in areas where aggressive clients may be experienced, calming and restraint in mental health services, laser care in theatre, handling sharps by infection prevention and control. As already noted, approved handler training is in place for hazardous substances. Training is provided on how to access our incident management, risk register and hazard register systems. Training for notifiable events is complete. Emergency Response Training occurs regularly. • Fire Response and Evacuation Training occurs for all new staff and annually online and face to face in key areas.

	• Fire Evacuation drills occurs across all Waitemata DHB areas six monthly which means each week there are activities in order to cover all areas. • Warden Training occurs on all sites annually for all wardens and deputy wardens. This is for all areas so requires multiple sessions annually. • Duty Nurse Manager training occurs for all new duty nurse staff three times a year. • Incident Management Team training occurs quarterly. • Key staff are required to attend Health CIMS2 training – which is available monthly and is done as a regional programme with the other DHBs. This is open to all health settings including PHO's Accident and Medical centres and Residential Aged Care key staff. • The Waitemata DHB runs particular Health CIMS4 training with a provider twice a year for key areas that have identified a need. Training in the due diligence responsibilities as Officers for the Senior Management team was completed on 7 July 2017 and for Board members on 27 September 2017. Training for risk assessment complete for Facilities and Development staff. New online training to manage difficult communications was launched in mid-February and is now available for all staff. The CALM communication the module teaches good communication and de-escalation skills. Also in development is an online module called **"Introduction to Staff Safety and Security at WDHB"** for all staff to complete as part of Orientation. The module will deliver the foundational requirements to the Staff Safety policy training in the following areas: • S.T.E.P. Matrix for risk assessment • Know-how to call for assistance and respond to calls for help • Security alerts and incident reports • Security and safety tools Additional modules for community workers include Risk management, preparedness and safety planning. The DHB has also piloted a newly developed programme which will support staff to cope emotionally with challenging work related situations.
What is outstanding?	Development of e-learning for hazardous substances and noxious organisms is in development. **New for July** Waitemata DHB will be attending pilot training with Auckland DHB on managing aggressive or potentially aggressive people (MAPA) on 4 – 5 July.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

12. Audits

What the Act says	An Officer of a PCBU must verify the provision and use of resources and processes put in place by the Waitemata DHB.
How do we comply?	Since early 2015 we have completed a number of readiness audits to assess compliance with the new health and safety legislation and to assess new or different resources needed. Regular external audits of contractor sites are in place. A governance audit on the Board charter is completed biannually. An audit programme for 2016/17 has been completed with Internal audit and includes deep dive audits on essential service maintenance, investigation processes and feedback loops, contractor management, community safety, governance assurance, efficacy of works to improve our three top accident types, and environmental controls. The 2017 Safe Way of Working audit has been completed; divisional results have been validated and distributed. Audits complete for 2017/18 include: 1. Health and safety governance. 2. Companion audits for the 2016/17 deep dive audits for community workers and construction/contractors. These audits are planned to look at contemporary Waitemata DHB practise against industry expectations, as well as understanding what is working well, what we still need to develop and any work we should do regionally in these areas. 3. A follow up audit on the essential services maintenance deep dive audit to check that all critical or immediate steps have reduced overall residual risk. For 2018/19 audit topics are as follows: 1. Safety culture 2. Emergency response 3. Control measures for high accident types 4. Safety and security **New for July** • The organisational wide Safe Way of Working (SWoW) self-assessment audit was undertaken by all areas in June and July 2018. Responses are currently being reviewed and action plan requirements being sent back to all managers automatically by the system. Compliance levels will be reported in the next update. • We have commenced a review of external third party maintenance and electrical safety contracts to ensure all preventative checks comply with regulations.
What is outstanding?	There are no outstanding actions. Audit findings and actions are reflected in other sections of the report.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

13. Reporting

What the Act says	An Officer of a PCBU must ensure they acquire and keep up to date on health and safety matters.
How do we comply?	Monthly reports on health and safety matters are provided to the Board meeting, Audit and Finance Committee meeting and the organisational Health, Safety and Wellbeing committee. A new Board Health and Safety Reporting format has been developed and in place since November 2017 and additional information continues to be identified for inclusion, e.g. the recently added work-related injury claims cost data. The Waitemata DHB has commenced commentary on trend drivers in Board reporting to give Board members a view on what impacts our health, safety and wellbeing performance. Board reports now also comment on health and safety impacts on stakeholders including contractors, patients and visitors. A health and safety annual report is on the agenda for the first H&S Board workshop, currently being scheduled. Comprehensive health, safety and performance statistics will be attached as appendices.
What is outstanding?	A divisional real time reporting scorecard will be developed alongside the new health and safety IT system. As part of the outcome of the governance audit, an annual assessment of the DHBs risk profile has been suggested. The first annual review will occur in August/September 2018 and measure status as at 30 June 2018.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

14. Resources

What the Act says	An Officer of a PCBU must verify the provision and use of resources and processes put in place by the Waitemata DHB.
How do we comply?	A resource review was completed in 2016. Recommended actions were tabled to the Board in August 2016. On review of the report we have implemented the following new resource: • 0.4 training FTE to an existing Health and Safety adviser role. • Hazardous substances co-coordinator (1 FTE). • Health monitoring nurse specialist (1FTE fixed term for two years). • Health and Safety advisor (1FTE) so we can spread training across the advisory team and allow advisors to have service portfolios for in service outreach, advice, training and assistance. • Health and Safety Manager has been employed by Facilities and

	Development (1FTE). • Investigator/auditor (1FTE). An additional Duty Nurse resource has been in place for four months and extended for up to an additional 12 months. Facilities and Development roles are either currently being approved or in progress. The list of the roles are as follows: • Works Manager x1 • Works Planner x1 • Project Manager for Facilities and Maintenance small projects – 0.8FTE x1 • BEIMS Administrator Position 0.25FTE x1 • Carpenters x2 • Fitters x2 • Plumber x1 • Engineers x2 • Painter x1
What is outstanding?	Discussion underway to convert existing contract resource to FTE for additional Occupational Health Physician and work injury administration support and Duty Nurse role. Discussion underway on possible resourcing for recent updates to the new Health and Safety at Work (Hazardous Substances) Regulations 2017. Given number of incidents to review has increased with addition of security incident category from an average of 150 per month to 340 per month, additional resourcing for incident follow up is being discussed with ELT.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

8.5 Engagement Strategy Update

Recommendation:

That the report be received.

Prepared by: Carol Hayward (Community Engagement Manager), David Price (Patient Experience Director), Jarrard O'Brien (Associate Director Institute of Innovation and Improvement), G. Raj Singh (Project Manager Asian, Refugee and Migrant Health Gain), Leanne Kirton (Project Manager, Primary Care), Wiki Shepherd-Sinclair (Manager, Health Link North), Tracy McIntyre (Co-ordinator, Waitakere Health Link), Dr Carol Barker (Public Health Physician)
Endorsed by: Dr Karen Bartholomew (Director of Health Outcomes), Wendy Bennett (Manager of Planning and Health Intelligence) and Dr Debbie Holdsworth (Director of Funding)

Glossary

HNA - Health Needs Assessment
NGO - Non Governmental Organisation
PBU - Primary Birthing Unit
PERSy - Patient Experience Reporting System
SLM - System Level Measures

1. Executive Summary

The Waitemata DHB Engagement Strategy was endorsed by the Board in December 2015, a corresponding three year action plan was received by the Board in September 2016. This report provides an overview of completed actions and current priorities within the engagement cycle:

2. Strategic Alignment

Community, whanau and patient centred model of care	This paper provides a number of updates on how patients, whānau and community have been involved in improving patient experience and in designing services and activities being carried out by the DHB. It also covers strategies and processes to better support their ongoing involvement.
Intelligence and insight	This paper identifies how intelligence and insight gained from the community will inform decisions and activities being undertaken or considered by the DHB.

3. Introduction/Background

The Waitemata DHB Engagement Strategy was endorsed by the Board in December 2015 and a corresponding three year action plan was received by the Board in September 2016 which reflects the NZ Health Strategy's expectations within the People Powered theme.

This paper provides an update on achieved actions and priorities for the coming months using the Engagement Cycle's five stages where patients and the wider community can and should be engaged in DHB decisions.

4. Progress/Achievements/Activity

Overarching activities
The Engagement Strategy and Action Plan is due for a review and refresh which will be considered during 2018/19, once the decision has been made on whether or not to progress with a Consumer Council (elsewhere on agenda).

Stage 1: Analyse and plan: identify needs and aspirations

Completed actions:

South Kaipara Health Needs Assessment
Community and stakeholder engagement took place in the South Kaipara with support from Health Link North to inform the development of a Health Needs Assessment (HNA) to inform decisions on the future of Alison McKenzie House. The HNA was done to inform facilities planning for Helensville Health Campus. Initially the focus was on facilities planning for Alison McKenzie House, Commercial Rd, Helensville, which is in need of repair. However, this has now been extended to a whole of Helensville Health Campus Facilities Planning Project.

Key findings were:

1. Health Service Needs: Mental illness and addictions were seen as the most important health issue in South Kaipara. The opportunity to develop more local services was raised, including; addiction services, youth services and talking therapies. Access to timely GP appointments was an important issue with some community members waiting up to two weeks to see their GP. Primary care afterhours, accident and emergency and radiology were reported as the most difficult services to access, hospital outpatient appointments could be difficult to attend because of the distance needed to travel.

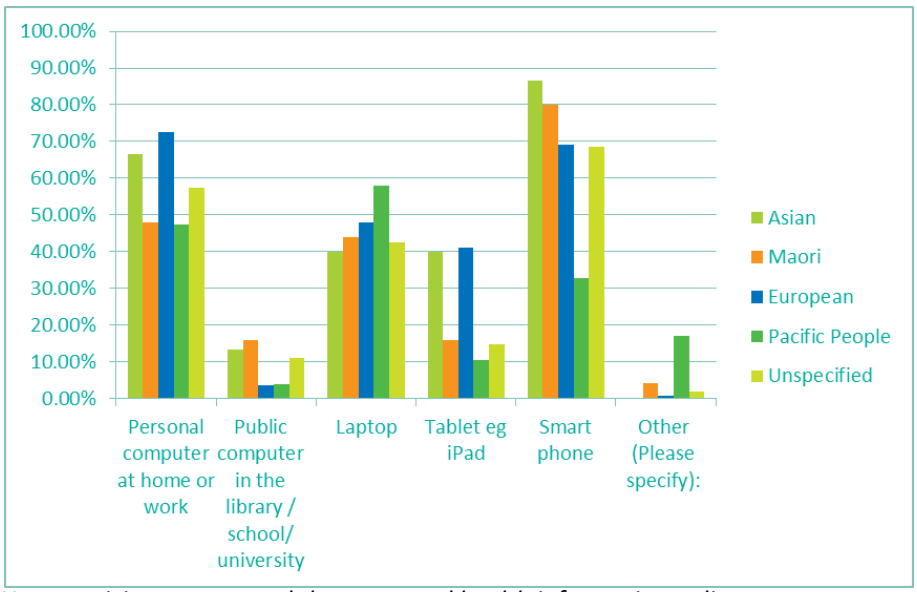
2. Populations Needing Tailored Support: There were calls for tailored support and services for specific groups in South Kaipara including older people, youth and Māori. For example, more residential and home based support for older people, a youth clinic and a more holistic approach for whānau health.
3. Social Determinants of Health and Healthy Lifestyles: Poverty, poor housing and transport were identified as some of the most important health issues for people living in South Kaipara. Supporting healthy lifestyles was seen as one of the most important steps towards becoming a healthy community.
4. New Ways of Working: There were calls for better communication and integration across health services and across health and social services including a 'one stop shop' for health and social services. Mobile nursing services, clinics in community settings, technology, health navigators and more information on how to access local services were suggested as ways of supporting community health.

Health information online

As part of the Health Navigator review and to inform health literacy activities, Auckland and Waitemata DHBs have been considering the best way of providing high quality online information on common health conditions and healthy lifestyles for patients and their families. A survey was circulated through the DHB's online community panel and through community events that asked where people looked for health information, how they accessed that information and what helped them to feel that the information was reliable

A total of 304 responses were received with a response bias towards people already online. Common feedback from participants were that they currently use Google to find health information but would like New Zealand information they could trust and a website that was easy to navigate, provided holistic or alternative options as well as the medical perspective, included good visuals and multimedia content, was endorsed by health professionals and was easy to find with regular communications on key areas of interest

Providing information in accessible formats and in different languages was also requested.



How participants reported they accessed health information online

NGO open days

- Health Link North facilitated an Aging Well expo with NGO services and community groups on Friday 20 April at the Totara Park retirement village in Warkworth. Services focused on providing up to date information as well as how best to access support. Two guest speakers provided information on research into nutrition and caring for an aging population. Tai chi and exercises to strengthen and maintain balance were also demonstrated (pictured) and people took part willingly. The Mahurangi Ramblers 5 piece band kept participants on their toes with popular renditions, while the Jade River Ukes strummed and sang along in harmony. Comprehensive Care sponsored an "all day lunch" which was ably prepared and presented by the Warkworth Rotary group. Service providers agreed it was a great networking opportunity, while members of the public commented it was good to see this sort of event taking place in the community

- Waitakere Health Link facilitated a NGO open day at Waitakere Hospital on 13 March. 21 NGOs attended who found it a useful way of connecting both with other NGOs and with hospital staff. A group of students also attended who enjoyed the opportunity to interact with people and understand more about community based support.

Current priorities:

- The planning team will be presenting information about the NZ health and disability system and health services in partnership with The Asian Network Incorporated at the ANZ Migrant Expo (16 June) with over 10,000 new migrants expected to attend
- Oral Health and Healthy Eating surveys are being conducted to investigate Chinese, Filipino, Middle Eastern and Indian parents' and caregivers' knowledge, attitudes and behaviours towards their child's healthy eating and oral health. The findings will inform decision making of culturally appropriate provision of oral health services and development of tailored oral health and healthy eating information.

Stage 2: Analyse and plan: develop priorities, strategies and plans

Health Literacy Symposium: Patient Experience Director David Price in a question and answer session on: "The power of patient stories"

Completed actions:

- A Health Literacy Symposium was held at the North Shore Hospital on 24 May. The event attracted over 150 attendees from the DHB, NGOs, primary care and the community, both in person and via video link. The focus of the symposium was to create a greater awareness of health literacy with an emphasis on what we can do to create better patient experiences. Topics covered cultural intelligence, community voices, health literacy in practice, reducing barriers, changing conversations and an interactive workshop to enhance clinical conversations. Feedback from attendees was very positive and it is likely that a similar event will take place during 2018-2019
- Two workshops have been held with consumers and midwives and primary birthing experts to inform the development of a concept design for a primary birthing unit (PBU) at Waitakere Hospital. The workshops considered what facilities should be provided at the PBU and how to make it a welcoming, culturally accessible and safe space
- Proposed Patient experience of care measures for the 2018/19 System Level Measures (SLMs) have been developed regionally with input from patient experience and participation teams. Consultation has taken place with the Health Links to inform this work
- A new guidebook has been developed by the Health Links for consumer representatives who support a wide range of the DHB's projects and programmes of work. The guidebook covers how to become a consumer representative, potential challenges and helpful tips, meeting procedures and background about the health and disability sector. This guidebook has been reviewed by current consumer representatives and is in the process of being finalised. This will be a valuable tool to assist new consumer council members in their orientation. Guidance has also been developed to help staff administer the steps involved in managing payments for consumer representatives.

Current priorities:

- 'Keep it simple' workshops for DHB staff have been scheduled to take place in June and October to provide good practice guidance and insights from consumers to help support the development of patient-friendly information.
- In partnership with Auckland DHB – development of a Health Literacy Policy. The Health Literacy Policy will:
    - define Health Literacy in the context of delivering services.
    - support staff to engage with patients to enable them to access, understand appraise and apply health related information to make effective decisions about their healthcare.
    - ensure all health literacy principles are implemented in service design, planning, implementation and evaluation.

Stage 3: Design pathways: improve services

Completed actions:

- Following a review of feedback from mothers accessing maternity services a maternity workstream group was created to improve services. One of the many issues identified by mothers was that they would like partners or a support person to be able to stay overnight. Four different bed/chairs have been trialled on maternity wards by mothers and their support people. This trial unanimously identified one particular bed/chair design which was endorsed for funding by the Well Foundation to be supplied to maternity wards.
- Kōrero Mai (Talk to Me) aims to co-design a patient/family/whānau-led escalation system for patients whose condition is deteriorating. Kōrero Mai is one of four work streams that form part of a Five Year National Adult Patient Deterioration Programme commissioned by the Health Quality and Safety Commission. A pilot for this programme of work was completed on two medical wards at Waitakere Hospital in May. The Waitakere Hospital pilot was very positive with some suggests to enhance communication about the programme to ensure patients and

their whānau are more aware of the process of escalating their care. Another pilot will be conducted in June at North Shore Hospital before rolling it out across all wards at both sites

- Sleep packs have been rolled out across Waitemata DHB to all inpatient wards to enhance patient sleep. Feedback about poor patient sleep is consistently reported. The sleep packs were designed and development with the support of volunteers and patient feedback. The sleep packs contain eye masks, ear plugs and information about sleep. These packs also support nursing staff to have conversations with patients about sleep and empower patients to make decisions about when and how they are woken up for their observations.

Current priorities:

- Work is underway to establish a GP transparency co-design group that will inform how clinical quality indicators will be published as part of the practice profile information available on the Healthpoint platform. This will utilise data from a small group of practices to identify how the clinical quality information should best be displayed. This pilot will be evaluated to inform recommendations for the future publication of clinical quality indicators. Social listening phase 2 programme to be rolled out across the Healthpoint website, enabling patients to comment publicly about their GP and community pharmacy experiences. Patients will rate the service and anonymously provide feedback. GP practices and pharmacies will also be able to respond to the feedback.
- Co-designing signs with the support of consumers for our Emergency Departments to make them more welcoming and friendly and assist patients in navigating their way through the triage process. Current consumer feedback reports that the word 'triage' is not well understood.
- Waitemata DHB is proud to support the #hellomynameis campaign which will take place on 23 July. This aims to help improve the patient experience by encouraging staff, regardless of their role to always introduce themselves and their colleagues to the people they support. The campaign was developed by Dr Kate Granger, a young consultant from Yorkshire who found herself a patient after being diagnosed with terminal cancer. During her time in hospital Kate noticed that many staff looking after her did not introduce themselves before delivering her care. Kate started the social media in 2013 urging staff to 'treat patients as people not conditions'.

"Introductions are about making a human connection between one human being who is suffering and vulnerable, and another human being who wishes to help. They begin therapeutic relationships and can instantly build trust in difficult circumstances."

Stage 4: Specify, design and contract services

Completed actions:

- A consumer reference group was established for the Waitemata 2025 and facilities programme of work. This was set up to support consumer representatives who are currently working within the team to understand the programme of work. The reference group has developed an outline framework of how and when to engage with the community and consumers to inform the development of new facilities. This group is currently on hold while projects and programmes of work are being confirmed.

Stage 5: Deliver and improve: monitor services

Completed actions:

- Release and roll-out of the Patient Experience Reporting System (PERSy) tool to collate data and help staff and patients monitor and evaluate services. PERSy is now being used to run the Friends and Family Test, a range of patient-reported outcome surveys (among many other patient surveys) and also the DHB-wide staff survey
- HQSC National inpatient survey is completed quarterly via 400 surveys sent out to a randomised group of patients that were discharged between a specific two week period. See the Chief Executive report to the Board for score information.

Current priorities:

- The next step for PERSy is to develop the system to allow us to triangulate patient experience, patient-reported outcome, and clinical outcomes measures in order to use these predictively. The system will also be linked to Concerto so that PROMs data can be linked to, and viewed within a patient's clinical record
- Service-level experience measures will be developed alongside the PROMs programme to allow for service-level triangulation of data and work will be undertaken to test patients' willingness to provide identifiable experience feedback to allow us to triangulate experience and outcomes data at an individual level
- The Health Quality and Safety Commission have introduced a Patient Experience Survey for Primary care. The survey is currently being rolled out nationally. Locally, only three PHOs are meeting the 50% target for participating practices, but this should improve as rollout continues.

5. Conclusion

This report has been developed to inform the committee of progress towards achieving the Waitemata DHB Engagement Strategy.

8.6 Statement of Performance Expectations (SPE) Performance Report: Quarter Three 2017/18

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Planning and Health Intelligence Manager, Auckland and Waitemata DHBs)
Endorsed by: Karen Bartholomew (Acting Director Health Outcomes, Auckland and Waitemata DHBs)
Noted by: Senior Management Team

Glossary

CPHAC	-	Community and Public Health Advisory Committee
HAC	-	Hospital Advisory Committee
SIR	-	Surgical intervention rate
SLM	-	System level measure
SPE	-	Statement of Performance Expectations
WIES	-	Weighted Inlier Equivalent Separation
YTD	-	Year-to-date

1. Introduction

The Board requested regular reporting of the indicators in the Statement of Performance Expectations (SPE), a key component of the Annual Plan (Module 3). SPE measures represent the outputs/activities we deliver to meet our goals and objectives in the Annual Plan and provide a reasonable representation of the vast scope of business-as-usual services we provide. Performance measures help to assess the quantity, quality, coverage and timeliness of service delivery. Actual performance against these measures is reported in our Annual Report and audited by Audit NZ.

The measures in this report have been updated to reflect those in the 2017/18 Annual Plan. This report excludes: 1) variance reported in other scorecards/reports to Board and Board Committees; 2) indicators for which data is available only annually; and 3) indicators that measure volumes without a specified target.

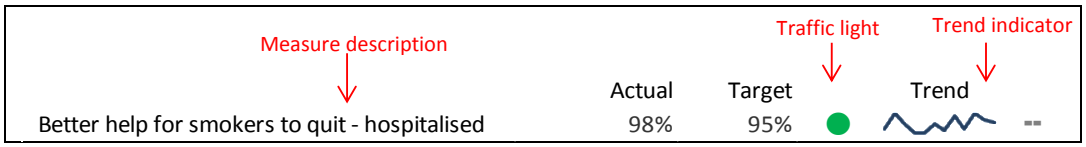
Waitemata DHB's overall performance is very good, with the majority of SPE indicators being met for quarter three. Of particular note is the achievement of four of the seven Health Targets set by the Ministry of Health, and six of the eight Health Quality and Safety Commission indicators.

Areas to improve include: breast and cervical cancer screening, Mental Health waiting times (<3 weeks in 0-19 year-olds), bowel screening (correctly completed kits returned) and the PHO enrolment rate in Māori.

How to Interpret the Scorecards

Traffic lights

For each measure, the traffic light indicates whether the actual performance is on target or not for the reporting period (or previous reporting period if data are not available as indicated by the ***grey bold italic*** font).



The colour of the traffic lights aligns with the Annual Plan:

Traffic light	Criteria: Relative variance actual vs. target		Interpretation
●	On target or better		Achieved
●	95-99.9% achieved	0.1–5% away from target	Substantially achieved but off target
●	90-94.9%*achieved	5.1–10% away from target AND improvement from last month	Not achieved, but progress made
●	<94.9% achieved	5.1–10% away from target, AND no improvement, OR >10% away from target	Not achieved or off track

Exception: Cardiac arrest calls is Green if number ≤1, Blue if =2, Amber if =3 and Red if ≥4

Trend indicators

A trend line and a trend indicator are reported against each measure. Trend lines represent the actual data available for the latest 12 months period. All trend lines use auto-adjusted scales. The vertical scale is adjusted to the data minimum-maximum range being represented. The small data range may result in small variations appearing to be large.

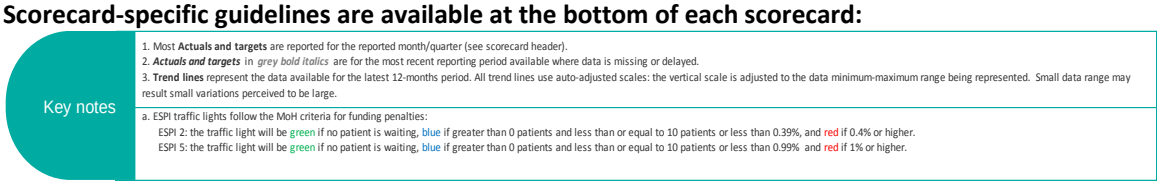
Note that YTD measures (such as WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

The trend indicator criteria and interpretation rules:

Trend indicator	Rules	Interpretation
▲	**Current > Previous** quarter (or reporting period) **performance**	Improvement
▼	**Current < Previous** quarter (or reporting period) **performance**	Decline
--	**Current = Previous** quarter (or reporting period) **performance**	Maintained

By default, the performance criteria is the actual:target ratio. However, in some exceptions (e.g., when target is 0 and when performance can be negative (e.g., net result) the performance reflects the actual.

Scorecard-specific guidelines are available at the bottom of each scorecard:



SPE scorecards: Quarter three 2017/18

Metro Auckland DHBs Performance Scorecard - Health Targets and key indicators

Quarter 3
2017/18

	Auckland DHB			Waitemata DHB			Counties Manukau DHB		
Health Targets	Actual	Target	Trend	Actual	Target	Trend	Actual	Target	Trend
Shorter stays in EDs	90%	95%		96%	95%		90%	95%	
Improved access to elective surgery	94%	100%		110%	100%		99%	100%	
Faster cancer treatment - within 62 days	91%	90%		93%	90%		95%	90%	
Increased immunisation at age 8 months (total)	94%	95%		92%	95%		93%	95%	
Better help for smokers - Primary Care	89%	90%		88%	90%		90%	90%	
Better help for smokers - Maternity	98%	90%		93%	90%		92%	90%	
Raising healthy kids	100%	95%		99%	95%		100%	95%	
Key indicators	Actual	Target	Trend	Actual	Target	Trend	Actual	Target	Trend
PHO-enrolled smokers with cessation support	29%	27%		32%	35%		25%	26%	
a. Breast screening coverage	*63%*	*70%*		*66%*	*70%*		*70%*	*70%*	
a. Cervical screening coverage	*67%*	*80%*		*74%*	*80%*		*73%*	*80%*	
b. CVD risk >20% on dual therapy (dispensed)	*42%*	*43%*		*41%*	*42%*		*49%*	*48%*	
b. CVD on triple therapy (dispensed)	*51%*	*53%*		*52%*	*54%*		*57%*	*59%*	
Preschoolers enrolled in DHB oral health services	89%	95%		94%	95%		82%	95%	
a. ED presentation rate per 1,000 population	*187.4*	*<202.91*		*233.8*	*<218.97*		*198.1*	*<212.27*	
a. Surgical intervention rate (SIR) - major joints	*18.5*	*21.0*		*27.6*	*21.0*		*23.6*	*21.0*	
a. SIR - cataracts	*42.2*	*27.0*		*45.9*	*27.0*		*36.6*	*27.0*	
a. SIR - cardiac surgery	*5.0*	*6.5*		*5.7*	*6.5*		*5.7*	*6.5*	
a. SIR - percutaneous coronary revascularisation	*12.5*	*12.5*		*16.1*	*12.5*		*12.3*	*12.5*	
a. SIR - coronary angiography	*30.7*	*34.7*		*42.3*	*34.7*		*28.4*	*34.7*	
Urgent diagnostic colonoscopy in 14 days	98%	90%		96%	90%		98%	90%	
HQSC inpatient survey aggregate score	8.3	8.5		8.1	8.5		7.9	8.5	
b. Opportunities for hand hygiene taken	*86%*	*80%*		*88%*	*80%*		*85%*	*80%*	
b. Hip/knee operations given prophylactic antibiotic	*98%*	*100%*		*97%*	*100%*		*95%*	*100%*	
a. 0-19 Mental Health waiting within 3 weeks	*71%*	*80%*		*71%*	*80%*		*72%*	*80%*	
a. 0-19 Mental Health waiting within 8 weeks	*89%*	*95%*		*95%*	*95%*		*95%*	*95%*	
a. 0-19 Addictions waiting within 3 weeks	*96%*	*80%*		*91%*	*80%*		*96%*	*80%*	
a. 0-19 Addictions waiting within 8 weeks	*100%*	*95%*		*99%*	*95%*		*99%*	*95%*	
a. HBSS clients with clinical interRAI in last 24 mth	*91%*	*95%*		*72%*	*85%*		*74%*	*75%*	

Waitemata DHB Performance Scorecard - Statement of Performance Expectations

Quarter 2
2017/18

Output Class 1: Prevention Services

Health promotion	Actual	Target	Trend
Clients engaged with Green Prescriptions (YTD)	2,854	3,690	
Increased immunisation at age 8 months (Māori)	84%	95%	
Population-based screening			
Bowel screening - correctly completed kits returned	*53%*	*60%*	
Bowel screening - referred for colonoscopy within 45 days	*96%*	*95%*	
B4 School Checks completed (YTD)	68%	68%	
Auckland Regional Public Health Service			
Tobacco retailer compliance checks conducted (YTD)	316	150	
TB treatments with a recorded start date	92%	95%	
Assessments related to Drinking Water Standards	57	57	

Output Class 2: Early Detection and Management

Primary health care	Actual	Target	Trend
a. Primary Care enrolment rate (Māori)	*81%*	*90%*	
POAC referrals (YTD)	10,873	8,108	
a,c. Eligible patients with HbA1c ≤64 mmol/mol in last 15 mo	*61%*	*70%*	
CVD risk assessed w/in 5 years (Māori)	86%	90%	
a ASH rate per 100,000 for 0-4 year olds - skin infections	*589*	*760*	

Output Class 3: Intensive Assessment and Treatment

Acute services	Actual	Target	Trend
a. Eligible stroke patients thrombolysed	*10.9%*	*8.0%*	
ACS patients with coronary angiography in 3 days	74%	70%	
Elective (inpatient/outpatient)			
Non-urgent diagnostic colonoscopy in 42 days	66%	70%	
Patients waiting >4 months for FSA (ESPI 2)	*Compliant*		
CTs completed within 6 weeks	86%	95%	
MRIs completed within 6 weeks	69%	90%	
Quality and patient safety (HQSC)			
a. Staph bacteraemia rate per 1,000 inpatient bed days	*0.09*	*<0.12*	
a. Older falls risk patients with an individualised care plan	*95%*	*90%*	
a. #NOF from falls per 100,000 admissions (rolling 12 m)	*4*	*<8*	
b. Hip/knee procedures given right antibiotic in right dose	*97%*	*95%*	
b. Surgical site infections per 100 hip and knee operations	*0.3*	*<0.8*	
Mental health			
a. Mental health service access (age 0-19 years)	*3.8%*	*3.5%*	
a. Mental health service access (age 20-64 years)	*3.5%*	*3.4%*	
a. Mental health service access (age 65+ years)	*2.0%*	*2.0%*	

Output Class 4: Rehabilitation and Support Services

Palliative care	Actual	Target	Trend
Hospice patient deaths that occur at home	37%	↑	
Referrals that wait >48 hours for a hospice bed	6%	↓	
Palliative Pathway Activations (PPAs): patients identified	24	75	
PPAs - conversations with Providers	32	75	
Residential care			
ARC residents LTCF interRAI w/in 230 days of previous	83%	80%	

Key notes

1. Most **Actuals** and **Targets** are reported for the quarter in the scorecard header
2. **Actuals** and **Targets** in grey bold italics are the most recent available data where current data are missing or delayed
3. **Trend lines** display the available data for the 4 most recent time points; the scale is auto-adjusted, small variations may appear large
4. Some indicators are regularly reported on in the Manawa Ora scorecard, as Māori vs. non-Māori

a. Q2 2017/18 data b. Q1 2016/17 data c. Aligns with MACGF indicator; differs from MoH indicator

Health Targets

Scorecard Variance Report

Indicator	On target	Variance commentary
1. Shorter stays in EDs	✓	In CEO report, HAC Provider Arm Performance report, and Manawa Ora report (Māori specific)
2. Improved access to elective surgery	✓	In CEO report
3. Faster cancer treatment – within 62 days	✓	In CEO report, HAC Provider Arm Performance report, and Manawa Ora report (Māori specific)
4. Increased immunisation at age eight months	✓	In CEO, CPHAC and SLM reports
5. Better help for smokers – Primary Care	✓	In CEO and CPHAC reports
6. Better help for smokers – Maternity	✓	In CEO report
7. Raising healthy kids	✓	In CEO and CPHAC reports and Manawa Ora report (Māori specific)

Key Indicators

Scorecard Variance Report

Indicator	On target	Variance commentary
Output class 1: prevention services		
8. PHO-enrolled smokers with cessation support	✗	In SLM report
9. Breast screening coverage	✗	In CEO report, SLM report (Māori specific) and Manawa Ora report (Māori specific)
10. Cervical screening	✗	In CEO and CPHAC reports and Manawa Ora report (Māori specific)
Output class 2: early detection and management		
11. CVD risk >20% on dual therapy (dispensed)	✓	In SLM report
12. CVD on triple therapy (dispensed)	✓	In SLM report and Manawa Ora report (Māori specific)
13. Pre-schoolers enrolled in DHB oral health services	✓	
Output class 3: intensive assessment and treatment		
14. ED presentation rate per 1,000 population	✗	In SLM report
15. Surgical intervention rate (SIR) – major joints	✓	In CEO report
16. SIR – cataracts	✓	In CEO report
17. SIR – cardiac surgery	✗	*The service provider for Waitemata DHB is Auckland DHB, which continues to be challenged with high volumes of transplant and acute complex work; this is negatively impacting on their ability to undertake elective surgery. A recruitment strategy is underway to increase capacity in the coming months. The service continues to clinically monitor patients closely, and despite the current challenges, overall the cardiac surgery waitlist number has remained within the MoH targets.*
18. SIR – percutaneous coronary revascularisation (angioplasty)	✓	In CEO report
19. SIR – coronary angiography	✓	In CEO report
20. Urgent diagnostic colonoscopy in 14 days	✓	In CEO report and HAC Provider Arm Performance report
21. HQSC inpatient survey aggregate score	✓	

Indicator	On target	Variance commentary
22. Opportunities for hand hygiene taken	✓	In CEO report, HAC Provider Arm Performance report and HAC Quality report
23. Hip and knee operations given prophylactic antibiotic	✓	In CEO and HAC Quality reports
24. 0-19 Mental Health waiting within three weeks	✗	In HAC Provider Arm Performance report
25. 0-19 Mental Health waiting within eight weeks	✓	
26. 0-19 Addictions waiting within three weeks	✓	In HAC Provider Arm Performance report
27. 0-19 Addictions waiting within eight weeks	✓	
Output class 4: rehabilitation and support services		
28. HBSS clients with clinical interRAI in the last 24 months	✗	In CPHAC report

Output Class 1: Prevention Services

Scorecard Variance Report

Indicator	On target	Variance commentary
Health promotion		
29. Clients engaged with Green Prescriptions (YTD)	✗	*Harbour Sport has a new contract that started in July 2017, their initial focus was to establish new services in West Auckland and they are now focusing on increasing referrals*
30. Increased immunisation at age 8 months (Māori)	✗	In SLM report
Population-based screening		
31. Bowel screening – correctly completed kits returned	✗	In CEO report
32. Bowel screening – referred for colonoscopy within 45 days	✓	
33. B4 School Checks completed (YTD)	✓	
Auckland Regional Public Health Service		
34. Tobacco retailer compliance checks conducted (YTD)	✓	
35. TB treatments with a recorded start date	✓	
36. Assessments related to Drinking Water Standards	✓	

Output Class 2: Early Detection and Management

Scorecard Variance Report

Indicator	On target	Variance commentary
Primary health care		
37. Primary Care enrolment rate (Māori)	✗	In CPHAC and Manawa Ora reports
38. Primary Options for Acute Care referrals (YTD)	✓	In Manawa Ora report (Māori specific)
39. Eligible patients with HbA1c ≤64 mmol/mol in the last 15 months	✗	In CPHAC report and Manawa Ora report (Māori specific)
40. CVD risk assessed within 5 years (Māori)	✓	In SLM report
41. ASH rate per 100,000 for 0-4 year olds – skin infections	✓	

Output Class 3: Intensive Assessment and Treatment

Scorecard Variance Report

Indicator	On target	Variance commentary
Acute services		
42. Eligible stroke patients thrombolysed	✓	
43. ACS patients with coronary angiography in three days	✓	In HAC Provider Arm Performance report
Elective (inpatient/outpatient)		
44. Non-urgent diagnostic colonoscopy in 42 days	✗	In CEO report and HAC Provider Arm Performance report
45. Waiting >4 months for FSA (ESPI 2)	✓	
46. CTs completed within 6 weeks	✗	In HAC Provider Arm Performance report
47. MRIs completed within 6 weeks	✗	
Quality and patient safety (HQSC)		
48. Staph bacteraemia rate per 1,000 inpatient bed days	✓	In HAC Quality report and HAC Provider Arm Performance report
49. Older falls risk patients with an individualised care plan	✓	In CEO and HAC Quality reports
50. Fractured NOF from falls per 100,000 admissions (rolling 12 months)	✓	In HAC Quality report and Manawa Ora report (Māori specific)
51. Hip and knee procedures given right antibiotic in right dose	✓	In HAC Quality report
52. Surgical site infections per 100 hip and knee operations	✓	In CEO report, HAC Quality report and Manawa Ora report (Māori specific)
Mental health		
53. Mental Health service access (age 0-19 years)	✓	In HAC Provider Arm Performance report and Manawa Ora report (Māori specific)
54. Mental Health service access (age 20-64 years)	✓	In HAC Provider Arm Performance report and Manawa Ora report (Māori specific)
55. Mental Health services access (age 65+ years)	✓	

Output Class 4: Rehabilitation and Support Services

Scorecard Variance Report

Indicator	On target	Variance commentary
Palliative care		
56. Hospice patient deaths that occur at home	✓	
57. Referrals that wait >48 hours for a hospice bed	✓	
58. Palliative Pathway Activations (PPAs): patients identified	✗	*The new Regional Palliative Care Outcomes Initiative was launched in November 2017. In Q2, a new system-based approach was established to enable the six hospices across the Metro Auckland region to work in collaboration with Age-Related Residential Care and Primary Care stakeholders to better support patients with a life-limiting illness and their families/whanau. The hospices have continued to progress with the development of the new service, but it is likely to take longer to achieve the target levels*

Indicator	On target	Variance commentary
Palliative care		
59. PPAs – conversations with patients	✖	*The new Regional Palliative Care Outcomes Initiative was launched in November 2017. In Q2, a new system-based approach was established to enable the six hospices across the Metro Auckland region to work in collaboration with Age-Related Residential Care and Primary Care stakeholders to better support patients with a life-limiting illness and their families/whanau. The hospices have continued to progress with the development of the new service, but it is likely to take longer to achieve the target levels*
Residential care		
60. ARC residents LTCF interRAI within 230 days of previous	✓	In CPHAC report

8.7 System Level Measures – Quarter 3 Report

Recommendation:

That the Board note the Quarter three progress and results for the second System Level Measures Improvement Plan and the 2018/19 planning approach.

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager – Auckland and Waitemata DHBs) and Leesa Russell (Project Manager Auckland Metro System Level Measures)
Endorsed by: Karen Bartholomew (Acting Director Health Outcomes – Auckland and Waitemata DHBs) and Tim Wood (Funding and Development Manager Primary Care – Auckland and Waitemata DHBs)

Glossary

ACP	-	Advance Care Plan
ALT	-	Alliance Leadership Team
ARPHS	-	Auckland Regional Public Health Service
ASH	-	Ambulatory sensitive hospitalisations
CVD	-	Cardiovascular disease
ED	-	Emergency Department
HT	-	Health Target
HQSC	-	Health Quality and Safety Commission
PES	-	Patient Experience survey
PHC	-	Primary health care
PHO	-	Primary Health Organisation
POAC	-	Primary Options for Acute Care
SLM	-	System level measure
WCTO	-	Well Child/Tamariki Ora

1. Strategic Alignment

Community, whānau and patient centred model of care	Our commitment to improvement against the System Level Measures (SLMs) demonstrates our dedication to our communities, patients and families to work to continually improve the quality of care we deliver and enhance the experience of our patients in their interactions with health care providers.
Emphasis and investment on both treatment and keeping people healthy	System Level Measures focus us to make improvements across the whole system. Activities focused on both treatment and keeping people healthy are identified within the 2017/18 System Level Measures Improvement Plan.
Intelligence and insight	The SLM programme of work is focused on using evidence-based solutions to effect change across the system and monitoring for that change to help us understand how our activities contribute to our overarching goals.
Evidence informed decision making and practice	
Operational and financial sustainability	Taking a whole of system approach also focuses us on how we work together to achieve not only better outcomes for our patients and communities, but also how we achieve that sustainably, effectively and efficiently.

2. Introduction

The New Zealand Health Strategy outlines the high-level direction for New Zealand's health system to 2026 to ensure that all New Zealanders live well, stay well, get well. One of the five themes in the Strategy is value and high performance. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health (MoH) worked with the sector to develop a suite of System Level Measures to provide a system-wide view of performance. Building on the work outlined in the 2016/17 System Level Measures Improvement Plan, in 2017/18, improvement milestones and contributory measures for each of the system level measures (SLMs) have been prioritised, in recognition of the significant amount of activity needed to make meaningful change for each measure.

The Counties Manukau Health and Auckland Waitemata Alliances are firmly committed to including additional contributory measures that are well aligned with SLM milestones over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded. This plan reflects a strong commitment to the acceleration of Māori health gain and the elimination of inequity for Māori.

The steering group has continued to meet in 2017/18, in order to further develop key actions (particularly at a local level), monitor data, and guide the ongoing development of the SLMs. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two Alliance Leadership Teams (ALTs) and provides oversight of the overall process. A PHO Implementation Group has been meeting throughout 2017/18 to support and enable implementation of SLM improvement activities.

The ALTs are strongly committed to improving performance where it matters most over the medium to longer term. The 2018/19 planning is well under way and builds on the approach, consolidating and refining the activities to substantially strengthen the equity focus. Planning for 2018/19 is in line with recently released Ministry of Health planning advice.

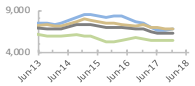
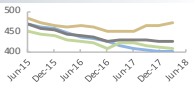
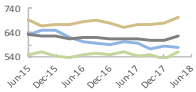
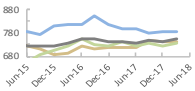
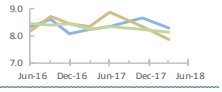
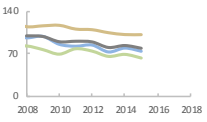
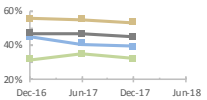
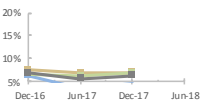
This paper reports on the current second improvement plan (2017/18). Note that measures 5 and 6 are developmental for 2017/18 and therefore the focus has been on base lining data, data quality improvement, and identifying key health sector partners and appropriate activities for the 2018/19 planning cycle.

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree households at six weeks
6. Youth are healthy, safe and supported.

For each SLM, there is an improvement milestone to be achieved in 2017/18. The milestone must be a number that improves performance from the district baseline, reduces variation to achieve equity, or for the developmental SLMs improves data quality. For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

This report includes the latest available data for each DHB for both the SLMs and their contributory measures. It also outlines progress against the improvement activities identified in for each SLM in the SLM Improvement Plan.

System Level Measure Reporting
Scorecard

		DHB / Region	Target	Performance: Actual	Data Period	Trend
1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds						
Measure:	Rate per 100,000 domiciled 0-4 year-olds.	Auckland	7,278 (max.)	**6,792**	12-monthly to Dec-17	
		Counties Manukau	6,754	**6,835**		
Target 2017/18:	5% reduction in rate by June 2018	Waitemata	5,409	**5,426**		
		Metro Auckland	6,420	**6,314**		
2. Acute Hospital Bed Days						
Measure:	Age-standardised rate per 1,000 domiciled population.	Auckland	425 (max.)	**400**	12-monthly to Mar-18	
		Counties Manukau	451	**470**		
Target 2017/18:	2% reduction for total population by June 2018	Waitemata	414	**409**		
		Metro Auckland	429	**426**		
Target 2017/18:	3% reduction for Māori population by June 2018	Auckland	578 (max.)	**577**	12-monthly to Mar-18	
		Counties Manukau	670	**706**		
		Waitemata	538	**562**		
		Metro Auckland	605	**626**		
Target 2017/18:	3% reduction for Pacific population by June 2018	Auckland	826 (max.)	**788**	12-monthly to Mar-18	
		Counties Manukau	689	**744**		
		Waitemata	709	**733**		
		Metro Auckland	730	**752**		
3. Patient Experience of Care						
Measure:	DHB Adult Inpatient Experience Survey: Aggregated Domain Score	Auckland	8.5 (min.)	**8.3**	Quarterly to Mar-18	
		Counties Manukau	8.5	**7.9**		
Target 2017/18:	Aggregated domain score of 8.5(/10)	Waitemata	8.5	**8.1**		
Measure:	Practices participating in Patient Experience Survey.	Alliance Health Plus	50% (min.)	91%	Total to Feb-18	
		Auckland PHO	50%	100%		
		Comprehensive Care	50%	73%		
Target 2017/18:	50% of each PHO's practices	EastHealth	50%	68%		
		National Hauora Coalition	50%	80%		
		Procare	50%	59%		
		Total Healthcare	50%	100%		
		Metro Auckland	50%	**72%**		
4. Amenable Mortality						
Measure:	Age-standardised rate per 100,000 domiciled 0-74 year-olds.	Auckland	71.4 (max.)	**74.0**	12-monthly to Dec-15	
		Counties Manukau	102.3	**101.2**		
Target 2017/18:	2% reduction (on single year baseline) by June 2018	Waitemata	64.3	**62.9**		
		Metro Auckland	78.6	**78.9**		
5. Youth Health						
Measure:	Chlamydia testing coverage for 15-24 year-olds.	Auckland	80% (max.)	**39%**	Quarterly to Dec-17	
		Counties Manukau	80%	**53%**		
Target 2017/18:	80% of pregnant women aged 15-24 years are screened for chlamydia	Waitemata	80%	**32%**		
		Metro Auckland	80%	**45%**		
6. Babies Living in Smokefree Households						
Measure:	Percentage of babies for whom smoke-free household status is not recorded by 6 weeks.	Auckland	10% (min.)	**5%**	6-monthly to Dec-17	
		Counties Manukau	10%	**7%**		
Target 2017/18:	Reduce to less than 10% by June 2018	Waitemata	10%	**7%**		
		Metro Auckland	10%	**6%**		

Legend

- Target met / on track
- Improvement needed
- Significant improvement needed

- Metro Auckland Region
- Auckland DHB
- Counties Manukau DHB
- Waitemata DHB

Overall Progress Report
Overarching activities for Q3: • Implementation is on-going. • Q3 reporting approved by the Ministry • A business as usual approach continues to be discussed • Static and dynamic reporting is embedded, with dynamic reporting being released regularly. Regular releases are enabled by participation in the Proof of Concept for Citrix Sharefile, which allows safe and secure sharing of confidential information via email • Training for PHOs in use of StatPlanet is complete • PHO Implementation meeting is business as usual and has been the starting point for planning for 2018/19 • Throughout the quarter we have held workshops to consult on broad planning themes, in lieu of concrete advice. This has involved consumers via HealthLinks, Māori and Pacific providers and Mana Whenua, and key stakeholders.

Ambulatory Sensitive Hospitalisations 0-4 year olds

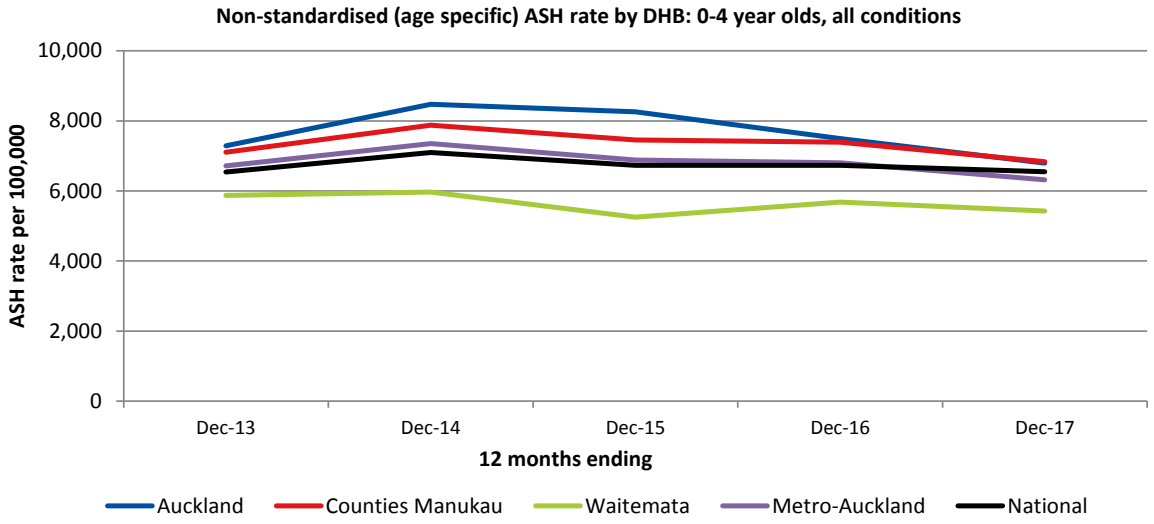
Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prevention or therapeutic interventions deliverable in a primary care setting.

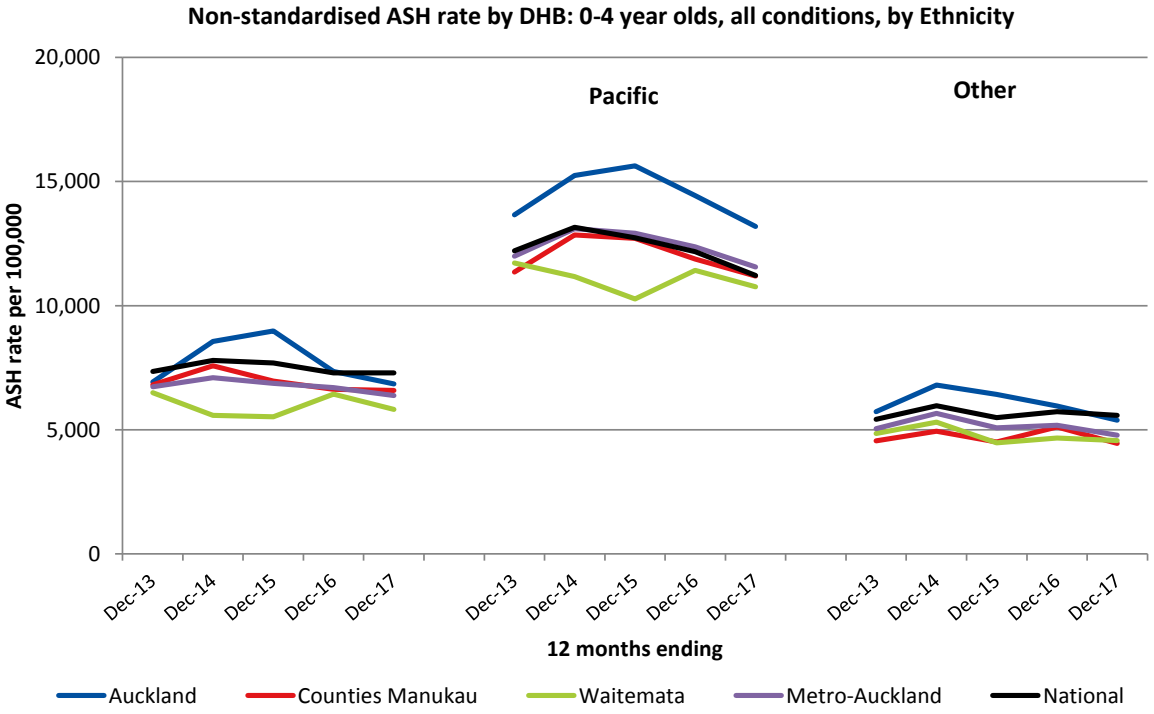
In New Zealand children, ASH accounts for approximately 30% of all acute and arranged medical and surgical discharges in that age group each year. However, determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure.

It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers.

ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This measure can also highlight variation between different population groups that will assist with DHB planning to reduce disparities.

In 2017/18, the overall improvement milestone is to achieve a reduction in ASH rates for 0-4 year olds of 5% by June 2018. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported alongside interrogation of approach to ensure that interventions reduce not worsen inequity. Metro Auckland's rate is 6,314 per 100,000 for the 12 months to December 2017 (latest results). This is more than a 5% reduction (target) on the results to September 2016 (baseline) of 6,758 per 100,000 population.



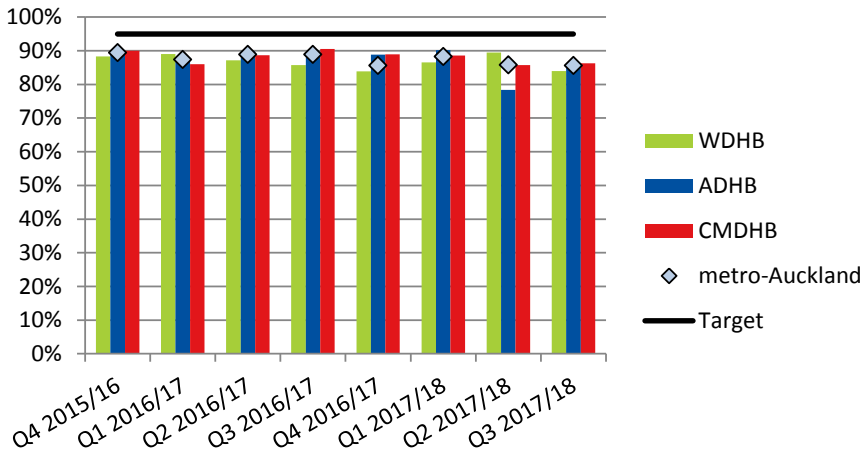


Contributory Measures

1. Māori babies fully immunised by eight months of age

The goal for 2017/18 is to achieve the national target of 95% coverage per quarter. To achieve this goal, the current whole-of-pathway focus of the immunisation programme would continue. For Quarter 3 2017/18, none of the metro-Auckland DHBs met the target overall, though results for Auckland DHB have improved on very low Q2 rates and Waitemata rates have declined 2% from last quarter.

Immunisation rates - 8 months: Maori by DHB

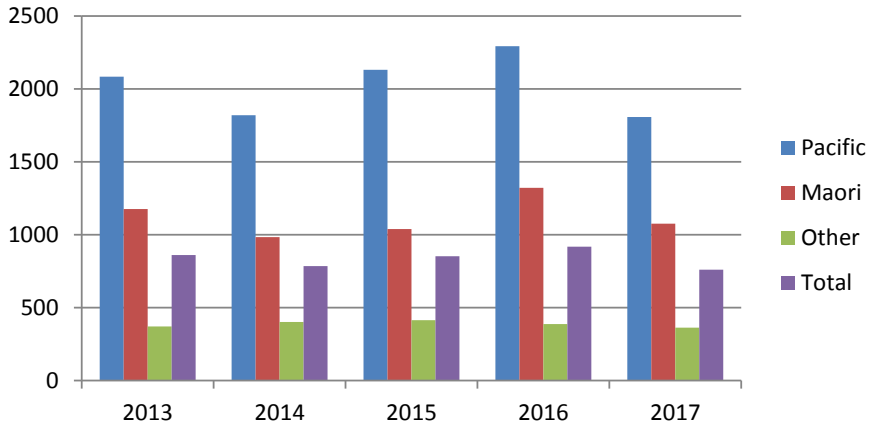


Improvement Activities	Progress Report
• Current immunisation programme (primary care coordinators, general practice systems, outreach immunisation service, Māori and Pacific providers, secondary care). • Continue to develop specific activity to improve Māori coverage (including ways to improve timeliness of immunisation), with leadership from Māori health gain teams and Māori leaders within primary care. • Develop links between immunisation outreach services and Māori Tamariki Ora providers to improve immunisation coverage for their enrolled children. • Investigate the possibility of Well Child Tamariki Ora nurses providing immunisation. • Utilise Whānau Ora services for immunisation of hard to reach children. • Promote immunisation in antenatal classes. • Investigate whether significant numbers of Māori babies are not engaged with general practice, with a view to include improvement activities to connect Māori whānau into the current newborn enrolment work.	All DHBs and PHOs continued with business as usual activities throughout the quarter. Closing the equity gap and targeting high risk children are priorities for DHBs, and scoping activities have begun for in-hospital immunisation monitoring and documentation. There is activity in each of the named improvement activities, although Well Child/Tamariki Ora (WCTO) immunisers and Whanau Ora service utilisation has not yet been addressed. The PHO implementation meeting scheduled was held on 27 February focused on the contribution of PHOs to this measure. A set of strategies developed to identify and engage high risk children. This work will be focused on opportunistic vaccination in various settings. NIR inform of issues weekly related to Māori babies and provide overdue lists for follow up by immunisation coordinators - good partnerships have developed. This also picks up messaging errors from Medtech to NIR.

2. Skin infections

The goal is a reduction in hospitalisation rates by 5% by June 2018, from a baseline of 907 per 100,000 0-4 population as at September 2016. To achieve this goal, there are a number of targeted activities around promotion of key prevention messages, in various community settings. The latest data is for the 12 months to December 2017 and shows a result of 761 per 100,000 0-4 population, around a 19% reduction on baseline. However, results are much higher for Māori and Pacific populations and also typically fluctuate between quarters.

Metro-Auckland age specific skin infection rates 0-4 year olds to December



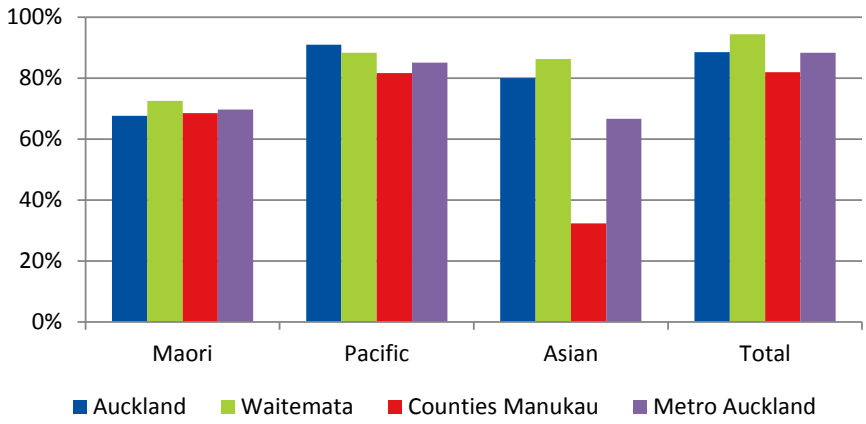
Improvement Activities	Progress Report
• Improve distribution of resources to primary care, urgent care, Well Child Tamariki Ora services, and early childhood education centres. • Deliver an educational package 'skin infection combined key messages' to primary care, urgent care, WCTO services, and early childhood education centres. Use forums such as the Pacific Community Child Health Network (managed by TAHA, the Well Pacific Mother and Infant Service) to reach community groups. • Use DHB nurse educators and other health promotion resources in a coordinated way, so that health promotion messages reach early childhood education centres and other organisations that connect with families of young children. Currently Counties Manukau DHB and Auckland DHB have nurse educators; Waitemata DHB does not • Link in to early childhood education centre health promotion activities delivered Auckland Regional Public Health Service. • Consider further development of primary care skin clinics. (Working group suggest this is an analysis or discussions document activity about reinstatement of primary care skin clinics). • Consider new approaches for providing access to care, e.g. community outreach, pharmacies, parish nurses. • Consider the opportunities for community pharmacy to provide more education on the best use of topical and oral products. • Consider targeted outcomes for Pacific and Māori children.	The clinical network has a working group who are implementing education resources to PHOs which will enable key messages to family. They have been focused on clarification of key messages and implementation in community settings for Pacific children. Regionally shared PHO CME has been filmed and will shortly be available on Ko Awatea Learn.

3. Oral Health

The goal is 95% enrolment with oral health services amongst preschool children. The recently finalised Oral Health Strategy is the basis of the improvement, with SLMs aligning and supporting this work.

As at March 2018, the metro-Auckland result shows that around 88% of 0-4 year olds are enrolled with the Auckland Regional Dental Service. This is much lower for Māori at 70%. Counties Manukau have the lowest rate of enrolment overall at 81%, Waitemata the highest at 97%.

Percentage of preschool children enrolled in DHB funded oral health services as at March 2018 (rolling 12 months)



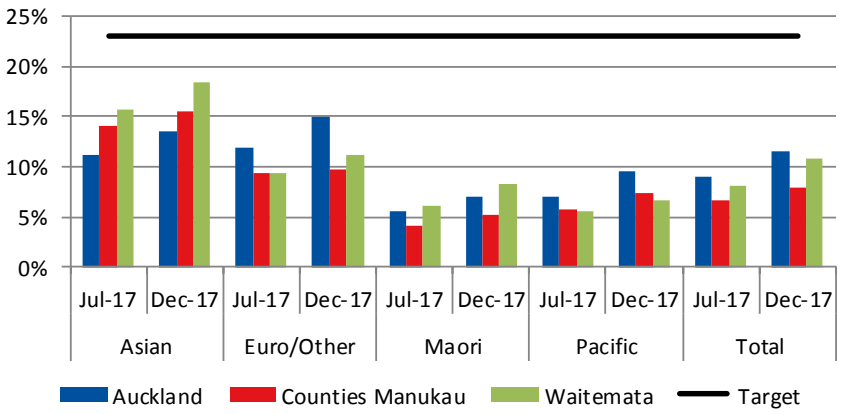
Improvement Activities	Progress Report
From the 2017 Pre-school Oral Health Strategy: • Oral health promotion at national, community and individual level. Focus on Pacific churches and parenting groups. • Messaging to align with Raising Healthy Kids National Health Target. • Increase awareness of free dental services. • Upskill primary care, Well Child Tamariki Ora and secondary care providers in lift-the-lip assessments, knowledge of dental services and referral processes. • Engage with the newborn enrolment project, which is: implementing systems to refer newborns for enrolment with the National Immunisation Register, general practice, oral health providers, Well Child Tamariki Ora providers and newborn hearing screening services. • Increased number of extended hours and Saturday dental clinics in appropriate locations. • Consider a targeted intervention for Pacific and Māori children to address inequity.	The Oral Health strategy has been finalised and is now moving toward implementation. Primary care continue to support increased Auckland Regional Dental Service (ARDS) referrals and train the trainer for lift the lip assessments was attended by all PHOs. Many of the activities in this measure are the agreed responsibility of ARDS under the Pre-School Oral Health Strategy. An ongoing relationship with ARDS has been facilitated to support implementation as far as possible. Regional lift the lip CME has been filmed and will be available on Ko Awatea Learn for Primary Care use.

4. Respiratory Conditions Potentially Preventable by Immunisations

The goal is to increase flu vaccination coverage by 10% (from a baseline of 13% at December 2016) for children who are for children who are eligible for funded vaccine. To achieve this goal, there is a focus on provision of information throughout the influenza season and improved key messages around flu vaccine for eligible children. This measure is across the calendar year in line with the flu season May to December. So the cohort is established at 1 March and vaccination rates are measured for these children at 31 May, 31 July and 30 September, with the final measure as at 31 December. Below shows rates at the first and last time points across the 2017 year flu season (ie. as at 31 July 2017 and at 31 December 2017). Rates were highest overall for Auckland DHB at both time points and lowest for Counties. However, Waitemata DHB showed the most improvement between time points (3%). Māori and Pacific rates are lowest.

The 2018 cohort was established as at 1 March 2018 and flu immunisation rates for these children will be measured initially at 31 May.

Flu vaccination rates between July to Dec 2017 for children hospitalised with a respiratory condition



Improvement Activities	Progress Report
• Develop the current activity to identify and vaccinate all children aged 0–4 who are eligible for free influenza vaccine. • Build on current activity to support both influenza and pertussis vaccine offer to all pregnant women, e.g. vaccinator at antenatal clinics, promotion campaigns, lead maternity carers education opportunities. • Undertake activities in primary and secondary care: *Secondary care* ○ Develop a documented, consistent system for providing lists of hospitalised children to PHOs and monitoring through the Influenza season (when the vaccine is available) ○ Make it mandatory to fill in the sections on discharge letters on eligibility for special immunisations ○ Promote vaccinations to patients and their families and proactively refer patients back to GPs for vaccinations.	Centralised (regional) processes for the flu vaccination eligibility notification are now embedded, in line with early and more consistent supply of eligibility information to primary care. An education programme was agreed for later in the year, with key messages at conferences and on web based platforms to decrease barriers to access. Conversations about the feasibility of offering influenza vaccination to all children 0-4 years have been postponed until the key actions in this SLM Plan have been undertaken. PHOs have received their lists of eligible children early in this quarter via Sharefile, which has enabled the safe sharing of NHI level information. The PHO implementation group will monitor uptake throughout the season. An antenatal vaccine coverage indicator was developed for pertussis and influenza vaccine during pregnancy. A centralised (regional) process has been developed and monitoring points agreed.

Improvement Activities	Progress Report
Primary care ○ Immunisation coordinators in PHOs provide education to general practice staff on special immunisations while visiting practices. ○ The Immunisation Advisory Centre will provide education and support to general practice, to improve understanding of who is eligible for special immunisations and to enhance processes for identification and recall, through continuing medical and nursing education sessions. • Develop systems for measuring the impact of these activities, e.g. on readmissions for respiratory illness. • Consider the feasibility of offering Influenza vaccination to all children aged 0-4 years. • Pregnancy related immunisations: develop data definitions and agreed consistent process steps and monitoring points.	

Acute Hospital Bed Days Per Capita

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between the community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

Certain conditions are more likely to result in unplanned hospitalisation alongside other contributory factors such as the referral process to ED (self, provider variation, ambulance etc.). The social determinants of health are a key driver of acute demand.

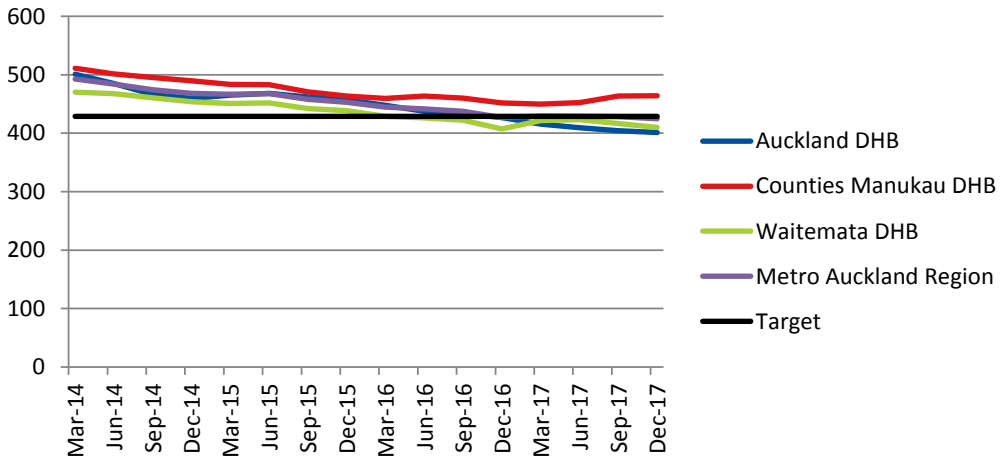
The Auckland Metro age standardised acute bed day rate per thousand population was calculated to be 437.7 as at September 2016 with a target set to reduce the rate by:

- 2% for the total population – 428.9 standardised acute bed days/1000 by June 2018
- 3% for the Māori population – 604.6 standardised acute bed days/1000 by June 2018
- 3% for the Pacific population – 729.6 standardised acute bed days/1000 by June 2018

It must be noted that any new beds opening will require accounting for, as supply side changes will impact this indicator in a stepwise fashion.

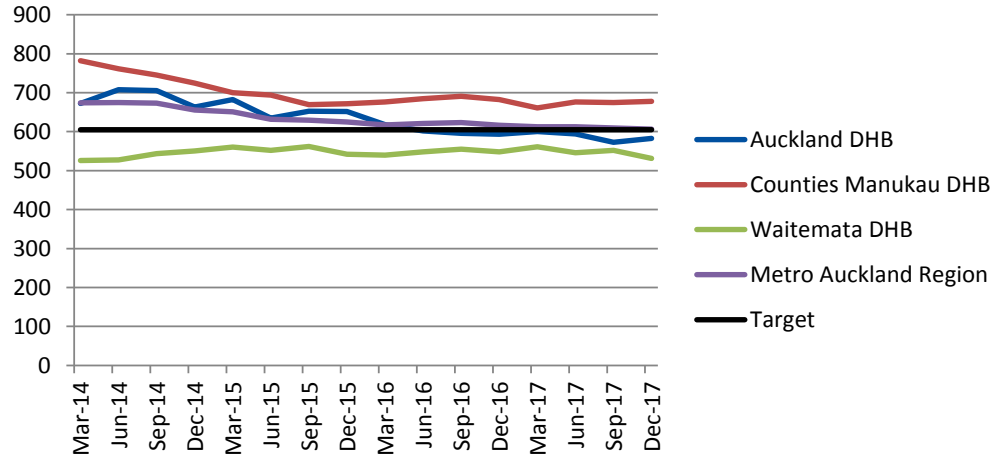
While overall standardised rates for Auckland and Waitemata DHBs have been generally declining each year, Counties Manukau DHB's rates remain above target. The metro-Auckland overall rate to December 2017 (latest available) remains slightly better than the June 2018 target at 424.5 standardised acute bed days/1000 (target is 428.9).

Standardised Acute Bed Days per 1,000 Total Population: 12 months ending

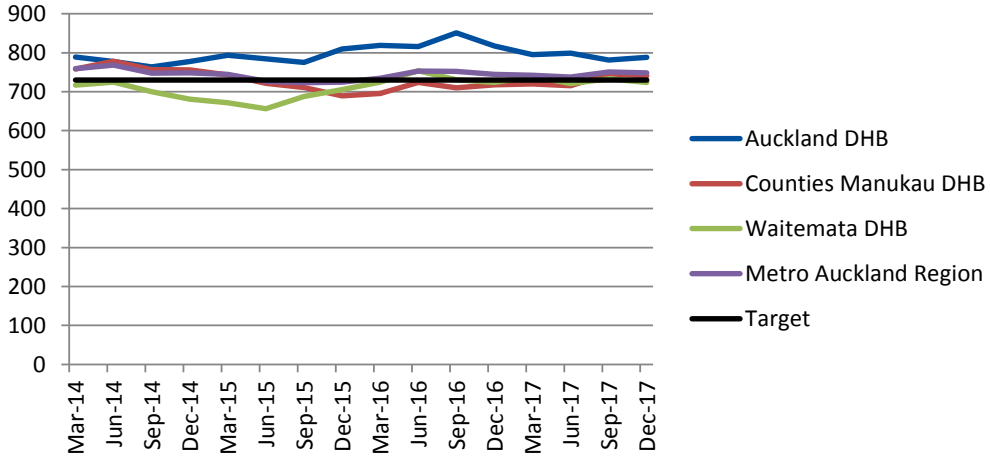


However, rates are much higher and more static for Māori and particularly Pacific populations. While both Auckland and Waitemata have rates better than target, Counties Manukau is some way from achieving for Māori. For Pacific, only Waitemata DHB is meeting the target, with Auckland well away from target.

Standardised Acute Bed Days per 1,000 Maori Population: 12 months ending



Standardised Acute Bed Days per 1,000 Pacific Population: 12 months ending



Contributory Measures

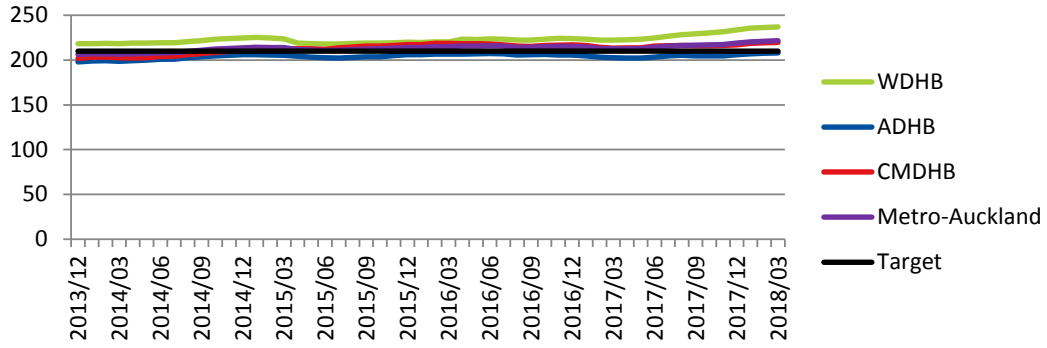
1. ED Presentation Rates.

Overall reduction in ED presentations may result in less admissions and bed day use. There is complexity involved in this measure as the likelihood of admissions may depend on the acuity of the patient and the availability of beds. Other measures such as Primary Options for Acute Care (POAC) utilisation rates are also being monitored.

Once the methodology for calculating this measure was finalised and approved a baseline was established of 214.3 ED attendances per 1000 population (standardised), for the 12 months to 30 September 2016. The 2017/18 SLM Improvement Plan set a target of reduction of 2% by June 2018. Data to March 2018 shows ED presentation rates are higher and continue to rise for the Waitemata DHB population. Only Auckland DHB has sustained performance below the target.

Note that these rates are aged standardised to allow comparison between the metro-Auckland DHBs.

Age standardised ED presentation rates per 1,000 population - rolling 12 months



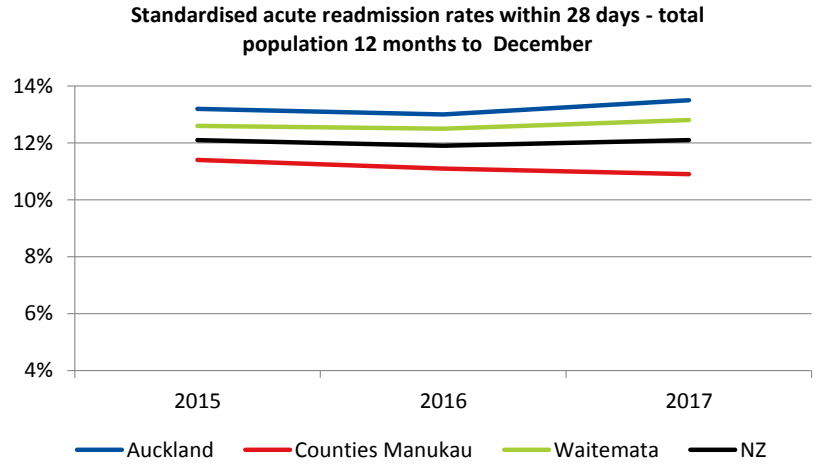
These rates are per 1,000 of the population and age standardised to the New Zealand population 2013 and presented as a moving 12 month rolling figure. Note that the data will be refreshed retrospectively for each reporting period, so previously reported figures may change.

Improvement Activities	Progress Report
Primary Options in Acute Care (POAC) activities: • Determine baseline utilisation of POAC across the region, including an ethnicity-level and a practice-level analysis. • Identify gaps and areas for potential improvement. • Convene expert group to determine and agree consistent interventions. • Monitor POAC utilisation, intervention rate and impact. • Develop and implement an education programme to promote appropriate use of POAC. • Explore current barriers to general practices using POAC. • Develop practice-level reports showing POAC usage relative to peers. • Pilot new and innovative ways to encourage patients to use primary care services appropriately, e.g. social media campaigns, vouchers for after-hours care.	Initial POAC data analysis was undertaken in quarter 2. An increase in visibility and CME/CNE resulted in a marked increase in utilisation, which has now normalised and returned to usual rate. We are now working towards more targeted utilisation for high risk populations to further reduce presentations. Development of an education programme is underway and we aim to embed routine practice level POAC utilisation reporting next financial year. Individual PHOs are additionally incorporating this and other SLM focused education into their annual CME/CNE calendars and peer group sessions.

2. Acute readmission rates at 28 days

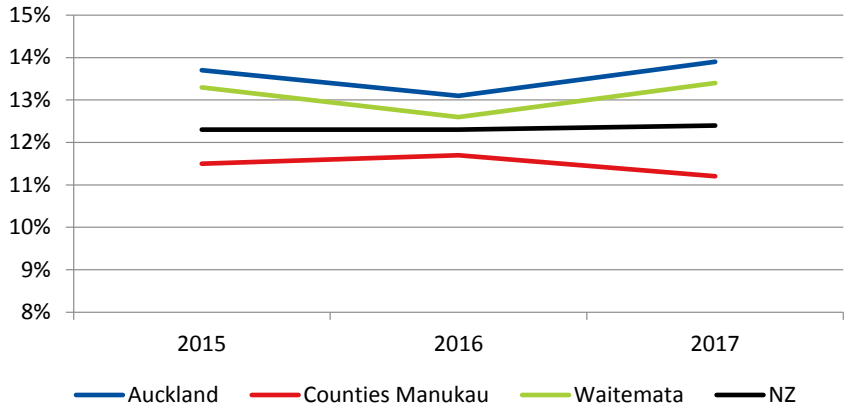
Avoidance of readmission to hospital following a recent discharge from hospital. Readmissions included here are only those that contribute to the acute bed days milestone, so may differ from readmission rates presented elsewhere.

The Ministry of Health changed the methodology last year for calculating acute readmission rates at 28 days significantly. The latest Ministry results (to December 2017) show Auckland DHB has a result of 13.5%, Counties Manukau 10.9% and Waitemata DHB 12.8%. There has been little movement across the three data points, though Counties Manukau shows a small but steady decline. Auckland and Waitemata rates are amongst the highest in the country. Only Counties Manukau is below the New Zealand rate.

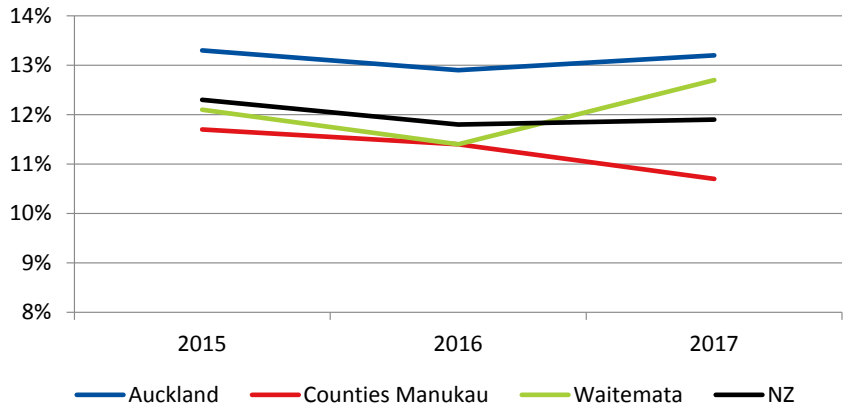


For Māori, readmission rates for Auckland are highest and climbing and lowest and declining for Counties Manukau. Waitemata rates have also risen between this and last reporting period. There is a consistent decline across the data points for Pacific for Counties Manukau, and a sharp increase for Waitemata between this and last reporting period, with Auckland relatively static.

Standardised acute readmission rates within 28 days - Maori
12 months to December



Standardised acute readmission rates within 28 days - Pacific
12 months to December



Improvement Activities	Progress Report
• Determine baseline readmission rates by ethnicity, by PHO and across the region. • Explore the potential of risk stratification to identify patients at highest risk of readmission. • Review discharge planning processes across the hospital systems. • At the point of discharge and in primary care, target patients discharged with CHF, COPD and the frail elderly. • Encourage active follow up of patients discharged from hospital with a relatively high risk of readmission, in particular for those with CHF, COPD and the frail and elderly. • Ensure that patients discharged from hospital with a relatively high risk of readmission have a patient centred care plan and, ensure Advance Care Plans (ACP) are in place, with a focus on initiating the ACP in primary care settings.	• Auckland DHB working group is creating linkages between the DHBs and their ongoing projects in this area. • Counties Manukau Health has several working groups newly created to address the condition-based issues. • Auckland DHB has 'Using the Hospital Wisely' programme and a specific consideration of chronic obstructive pulmonary disease (COPD). • Waitemata DHB has the TransforMED programme which has a bed day reduction focus, and a frail and elderly emphasis. • The three programmes above are linking up with the Auckland DHB working group and sharing ideas and successes. • Risk stratification is ongoing at Counties Manukau Health. • The Acute Hospital Bed Days working group continue to monitor these data and have considered practice level analysis to gain further insights.

Patient Experience of Care

'Person centred care' or how people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

Measures

1. DHB Adult Inpatient Survey

The nationally applied DHB Adult Inpatient Survey has been conducted quarterly since 2014 and for 2016/17 the SLM milestone for patient experience focused on the Adult Inpatient Experience Survey. This survey captures four measured domains - communications, partnership, coordination, physical and emotional needs. The 2016/17 target was to achieve an aggregate score of 8.0/10 across all four domains measured, this was increased to 8.5/10 for 2017/18.

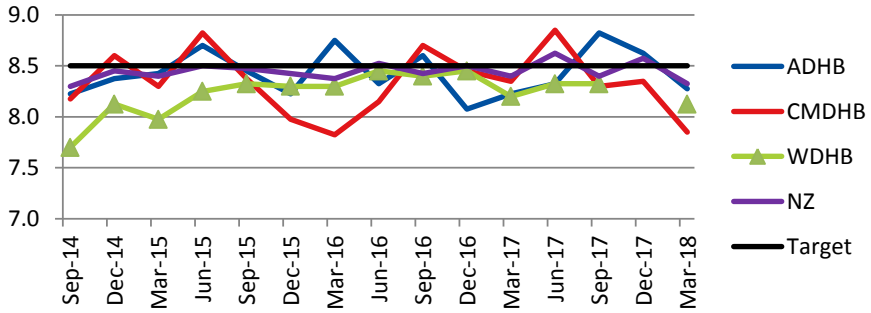
Interventions are aimed at improving patient experience scores in the four domains along with promoting the survey to improve participation and using the results to improve quality. Individual DHBs need to improve survey participation, particularly with respect to equity and foster greater regional collaboration. This may include working with Māori, Pacific and Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

Despite little variation over the time period observed generally, there has been some decline in scores since the last reported period, particularly for Counties Manukau. The national response rate

for the latest time period is 26%, compared to 35% for Waitemata, 29% for Auckland, but only 22% for Counties Manukau. Response rates for surveys invited via post are still better than those invited via email and SMS. Nationally, respondents were reasonably representative of all ages and genders, however, under-representation continued for people in the 15–24, 25–44 and 85+ age groups and for people in Māori, Pacific and Asian ethnic groups.

DHB Adult Inpatient Experience Survey: Aggregated Domain Score (/10)



Note: no Waitemata DHB data available for December 2017

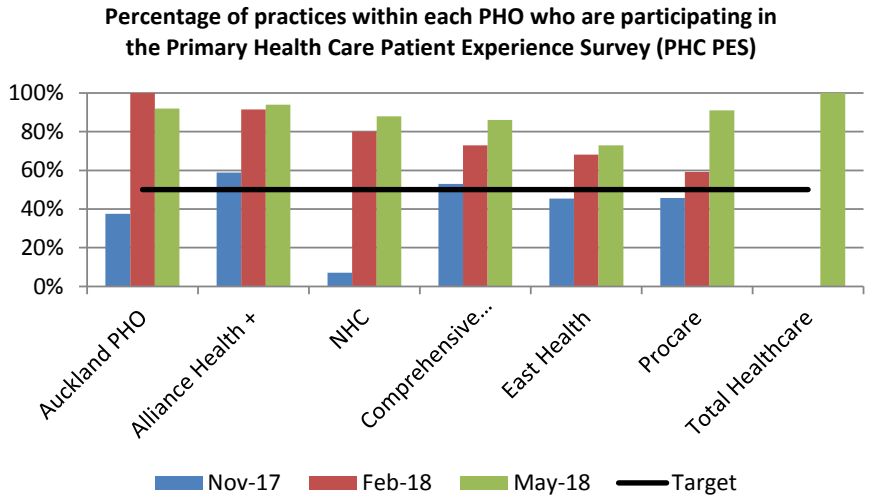
Improvement Activities	Progress Report
• Individual DHB focus areas via annual planning will be worked on at a local level. For 2017/18 there will be a particular focus on enhancing connections through improved communication and addressing equity gaps, via specific programmes and initiatives, which will be locally delivered. • A regional DHB group for patient experience of care meets monthly via teleconference and quarterly face-to-face. The SLM Improvement Plan will become core business for this group. • Develop long-term strategies in response to specific equity challenges (Pacific and Māori specialist team engagement), and broaden communication and conversations for patients to improve their experience and journey of care. • Share individual DHB learning and harness opportunities to replicate successes across Metro Auckland.	This work in ongoing in DHBs. Regular joining-up occurs, with lessons learnt contributing to initiatives in primary care. Key stakeholders meet regularly to share learnings. Waitemata DHB did not return survey results in December 2017 (see below). Unfortunately when the data extract for the National Survey was requested, the data range was mistakenly uploaded for discharges from the 3rd October – 12th November. This led to only 144 (instead of the usual sample size of 400) patients being invited to participate in the survey who were discharged between the 30 October and 12 November 2017 timeframe. Only 33 responses were received for the fortnight that was being targeted, which is much lower than our average response rate of 130. Due to the anomaly in the Patient Experience Data upload, the results for Waitemata District Health Board were not reported due to inconsistent methodology and results were not comparable to other quarters. Results for March 2018 were returned.

2. The Primary Health Care Patient Experience Survey (PHC PES)

Rollout of the Primary Health Care Patient Experience Survey (PHC PES) across Auckland is largely complete. In Auckland six PHOs with a total of 143 practices participated in the November Primary Health Care Patient Experience survey week. The second survey was conducted in February 2018.

According to the Health Quality and Safety Commission (HQSC), this will be implemented in all practices, and has been critically dependent on establishment of the National Enrolment System (NES), which has now been implemented in every PHO. The 2017/18 target is to ensure 50% of each PHO's practices (approximately 166 practices) are participating in the PHC PES by June 2018.

Between the November 2017 and the May 2018 surveys, there has been a huge increase in the percentage of practices participating. As at May 2018, all PHOs have exceeded the 50% target. The delay for Total Healthcare has been due to the late linking to NES, which was out of their control, as this was implemented in steps and they were in the final group.



Improvement Activities	Progress Report
• Ensure socialisation of resources and support for practice-related activities, such as, PHOs follow HQSC/Ministry of Health 'Getting Started' resource pack and advice. • PHOs advise Cemplicity of PHO name and contact for survey, and IT key contact to enable log on via email address. • Practices are supplied with and follow getting started guide and resources. • Practices provide PHO with details to appear on survey invitation email, text message and online survey. • Marketing of the survey week (one week every quarter), process and survey intent across practices is enabled. • Practices check email addresses of all patients 15 years and over and save preferences. • Follow up by PHO and practices to view real-time patient experiences and appropriately respond to request for contact or any indicated follow up required. • Once survey is closed, practices and PHOs will review the final results of the survey.	PHOs are rolling out the survey to practices in tranches with a view to full participation by the end of the financial year. The PHO Implementation meeting identified survey participation as a concern. Although overall survey participation is good, participation for Māori and Pacific is very low, and there are concerns the survey is not fit for purpose. The Ministry have advised there will be some activity in 2018/19 to address these issues.

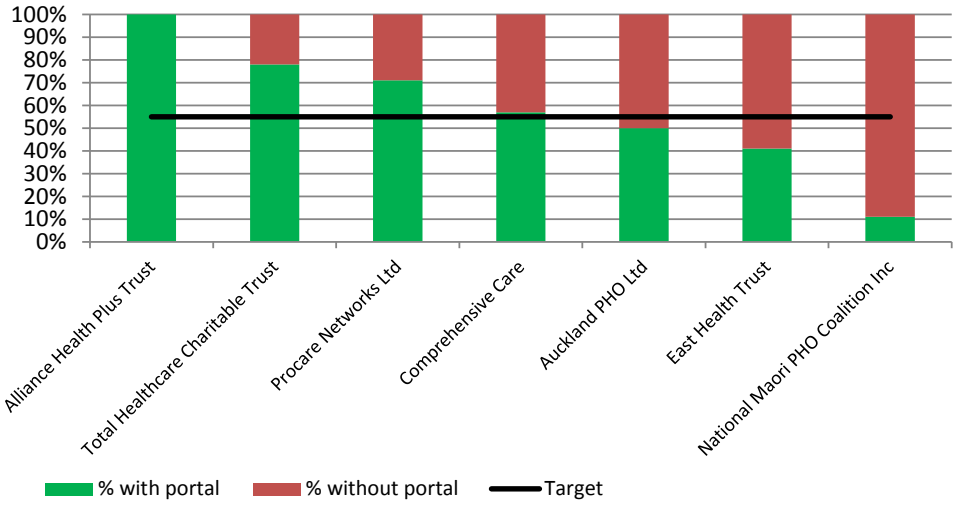
Contributory Measures

1. E-Portals.

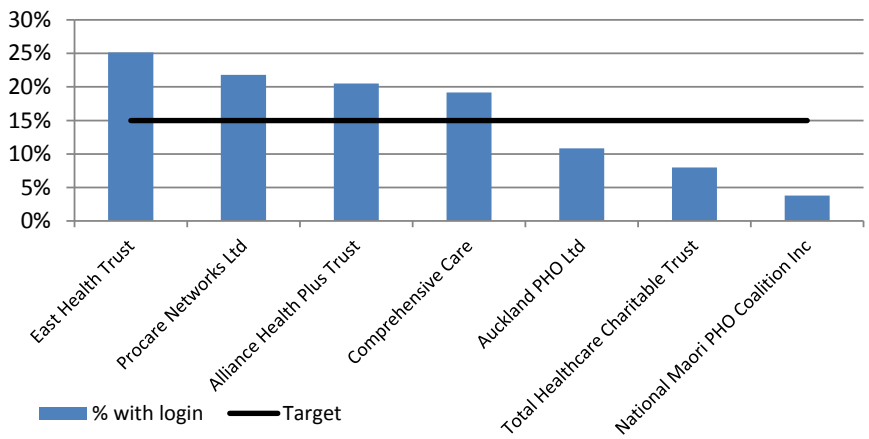
E-portals are a single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records. More general practices are offering patient portals and there is scope within primary health care for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).

For 2017/18 the target is that 55% of each PHO's practices are registered with a portal and 15% of each PHO's population have access to a portal. The latest (March 2018) results show that three PHOs have still to meet the 55% target for having portals in place however they all show progress towards the target. Three PHOs have yet to meet the 15% target of enrolled patients registered to use portals.

Percentage of practices with/without patient portal - by PHO: as at March 2018



Percentage of enrolled patients with e-portal login - by PHO: as at March 2018



Improvement Activities	Progress Report
• E-portal ambassadors and provider options will continue to be socialised amongst clinicians and consumers via PHOs and practices. • PHO teams will provide support to practices to implement e-Portal enrolment systems. • Portal options are explored by practices and adopted in a staged approach relative to level of clinician confidence and consumer request. These will include: ○ access to clinical data – diagnoses, notes, allergies, immunisations, lab results ○ access to communications – messaging to doctor or nurse, repeat prescription requesting appointments, self-scheduling; ○ access to education – condition specific information, websites with merit, self-management activities ○ PHOs will access resource materials and actively use these to support e-Portal implementation in practices and e-Portal uptake by patients.	Update of e-portals is now increasing and PHOs are generally using a tranche approach to engage groups of practices per quarter. For those outstanding practices, plans are in place for many to on-board over the forthcoming year. We note that portal offerings with varied language options would be desirable for some practices i.e. Chinese language options. Some smaller practices have considerations to be made of the added value to patients and the cost implication of portals within their current operating model. Those PHOs without e-portals have a plan to implement.

Amenable Mortality

Amenable mortality is defined as premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before 75 years of age.

For 2017/18 the decision was made to continue with the two contributory measures that have the greatest evidence-based impact on amenable mortality – cardiovascular disease (CVD) management and smoking cessation.

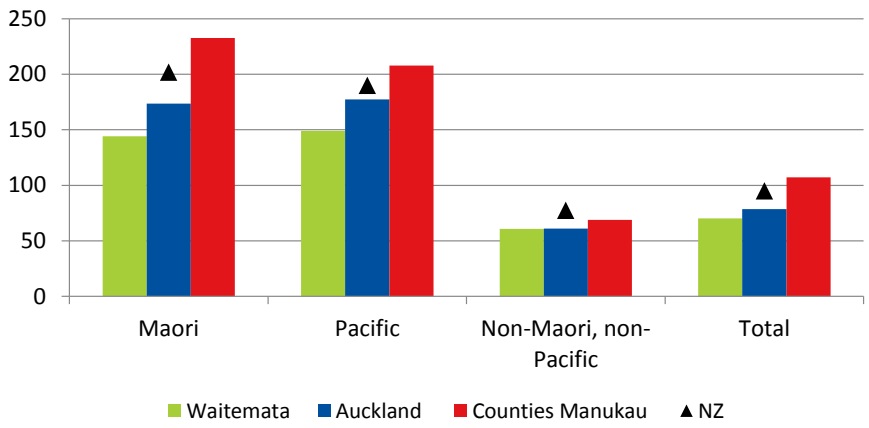
Amenable mortality rate per 100,000 population (age standardised), 0–74 year olds, using New Zealand estimated resident population as at June 30 was used as baseline.

	Baseline		Current	
DHB	**2013**	**2009-2013**	**2015**	**2011-2015**
Auckland	72.9	87.5	74.0	78.5
Counties Manukau	104.4	113.0	101.2	107.1
Waitemata	65.6	74.6	62.9	70.2
Metro Auckland	80.2	89.4	78.9	84.3

The goal is to achieve a 6% reduction for each DHB (on 2013 baseline) by June 2020, noting that changes in rates would generally only be seen over an extended timeframe of at least 3-5 years.

The current level of inequity in amenable mortality indicates the scope for health gain.

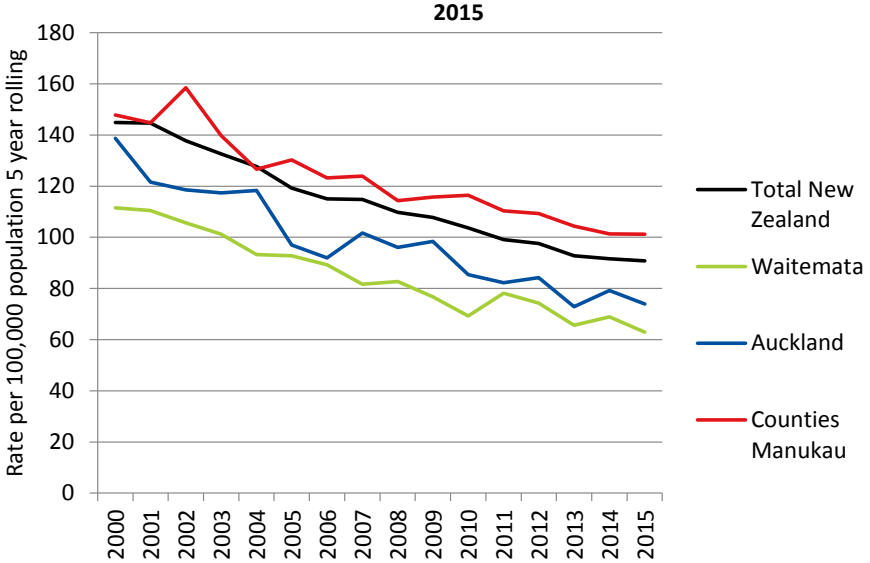
Standardised Amenable mortality (rates per 100,000) by ethnicity: 2011-2015

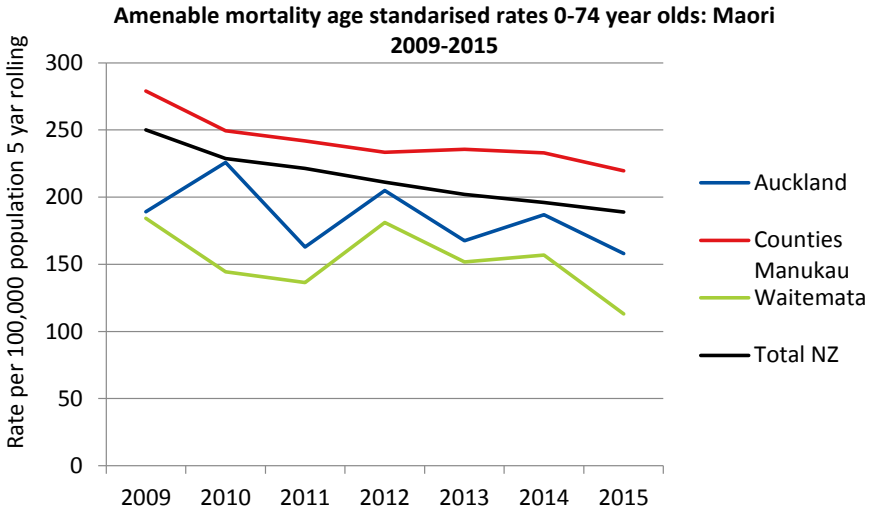


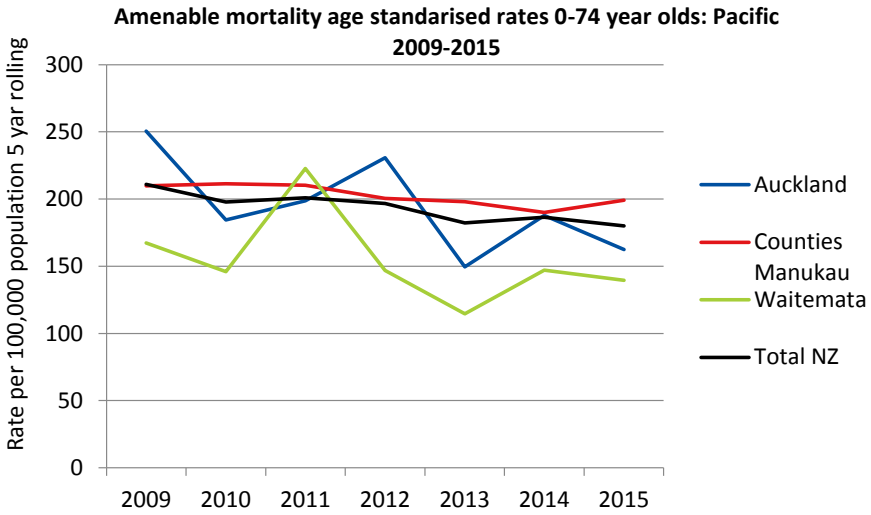
Based on five year trends, all three Metro Auckland DHBs show consistently declining rates as per graph below, despite an increase between 2013 and 2014 for Auckland and Waitemata DHBs. Comparing current (2015) rates with baseline (2013) rates, there is a 2% decline in rates for metro-Auckland, or 6% when comparing the 5 year rates. Given that there will always be some annual fluctuation and that the target extends to 2020, we should be on track to meet the 6% reduction by 2020.

While rates for Māori are also declining, the sharp, consistent decline seen for overall rates is not evident. This is even more so for Pacific rates, however smaller numbers will mean greater year on year variation.

Amenable mortality age standardised rates 0-74 year olds 2000-2015



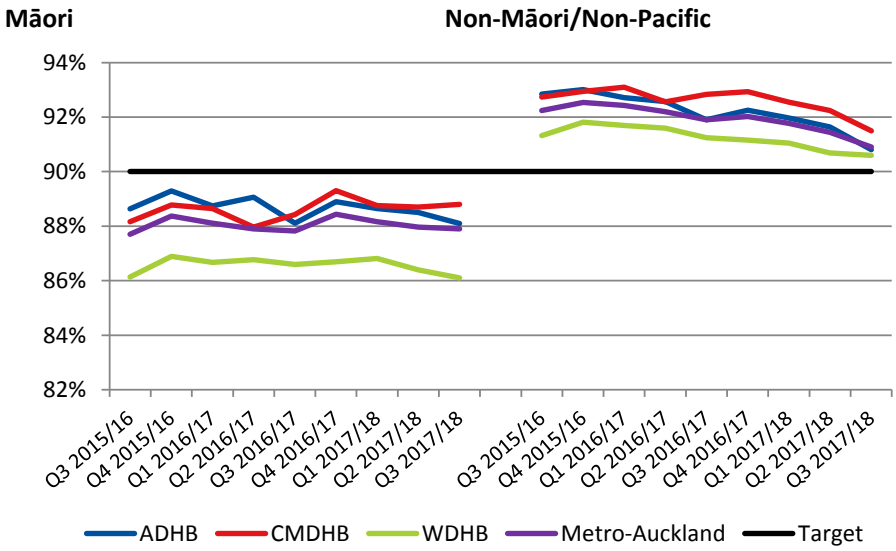




Contributory Measures

1. CVD Risk Assessment – to increase coverage of Māori to 90%

As at March 2018 (latest available data), Māori screening rates were slightly below the target with Counties Manukau DHB screening 88.8% of the eligible population, while Auckland DHB had screened 88.1% and Waitemata DHB 86.1%. For metro-Auckland, these results show a very slight decline from the preceding quarter's results.



Improvement Activities	Progress Report
• Follow up phone calls (evenings) for practice generated CVD RA recall letters to Māori. • Pilot of phlebotomy services in the practices or point-of-care testing when Māori males visit opportunistically.	These activities were discussed in the PHO implementation meeting in February, with a focus on increasing access to practices for young Māori males and facilitating the five year anniversary of CVD RA, which represents a workload bubble. Changes to the CVD consensus statement were also discussed, with implementation plan in early stages. Several practices are piloting use of the cobas machine to opportunistically test Māori males on presentation to clinics, with an informal evaluation to follow in early 2018. This work will continue to be supported via a MACGF working group to address the new Cardiovascular Assessment and Management Guidelines.

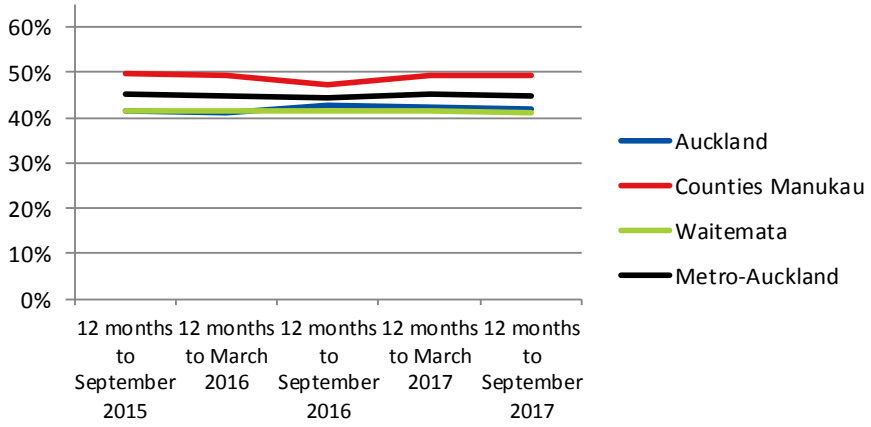
2. CVD Management - to increase triple therapy by 5% (relative) for those with a prior CVD event and dual therapy for those with a CVD RA of ≥ 20%

Baseline for 2017/18 was set on performance as at the twelve months ended September 2016.

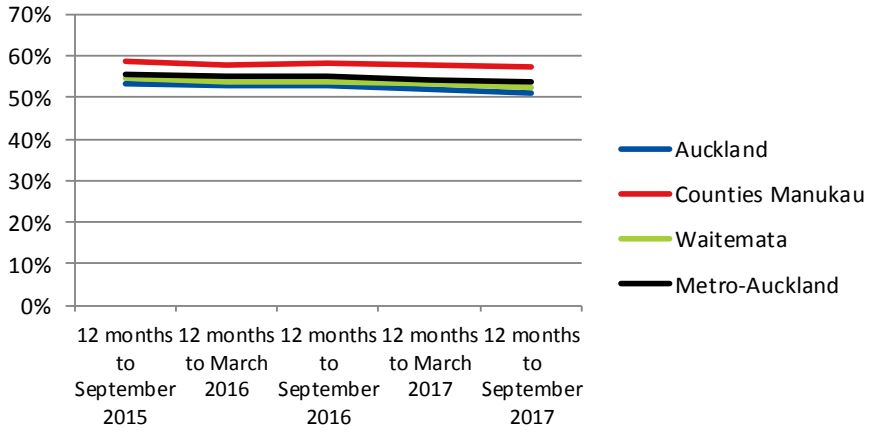
For triple therapy baseline results, Counties Manukau Health recorded 58.1%, Auckland DHB 52.7% and Waitemata 53.8%. Latest available data (for the 12 months ended September 2017) shows a small deterioration in results for all DHBs – 51.3% for Auckland, 57.4% for Counties Manukau and 52.4% for Waitemata, with a metro-Auckland rate of 53.8%. Rates are lowest for Asian at 46.6% across the metro-Auckland region, followed by Other ethnicities at 52.4%. Updated data is due out in July, for the year ending March 2018.

For the 12 months ended September 2016, dual therapy pharmaceuticals dispensed to those with a CVD risk assessment score greater than 20% were 41.6% for Auckland DHB, 49.1% for Counties Manukau and 41.4% for Waitemata DHB. Little change in rates for any of the DHBs can be seen in the twelve months ended September 2017, with results recorded as 41.7% for Auckland DHB, 49.2% for Counties Manukau and 41.2% for Waitemata DHB, or 44.9% for the metro-Auckland region. Across metro-Auckland, rates are lowest for Other ethnicities at 40.3%, followed by Asian at 42.7%.

Percentage of enrolled patients with a CVD risk assessment score ≥20% dispensed dual therapy pharmaceuticals - Total Population



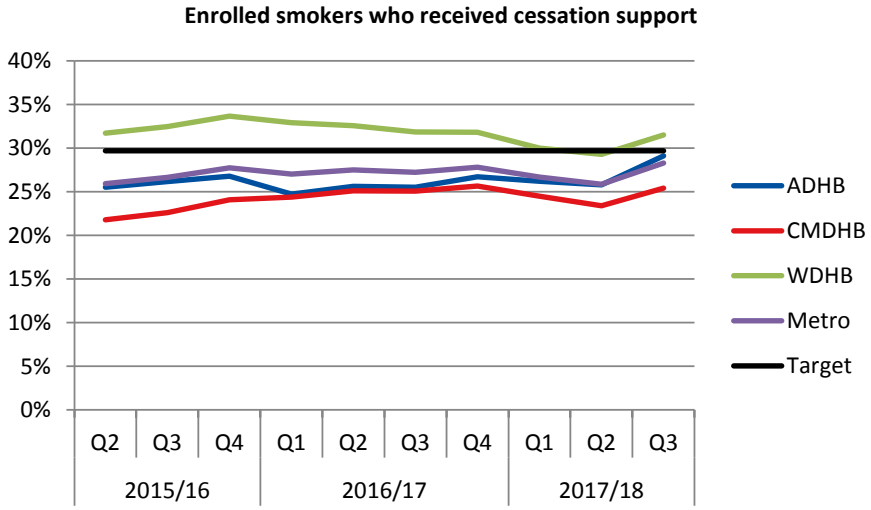
Percentage of enrolled patients with a prior CVD event dispensed triple therapy pharmaceuticals - Total Population



Improvement Activities	Progress Report
• Identification of patients at a NHI level who have had a CVD event and are not dispensed triple therapy. Feedback and comparison of these results to GPs via PHOs. • Total population and specific interventions for Māori, Pacific and Asian peoples to improve uptake and adherence to dual and triple therapy • Post-event medication counselling and other rehabilitation services in hospital. • Ongoing medication counselling by community pharmacists. • Consider an activity focussed on ensuring access to prescription subsidy cards and reducing prescription co-payments. • Establish a single process to report CVD indicators from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions.	There are regionally agreed definitions and standardised format of reporting for CVD dispensed medications available from the Northern Region Cardiac Network. Some PHOs have given approval to share the aggregated dispensing reports for regional reporting. All PHOs have agreed to identify patients who are not on optimal therapy and feedback these results to GPs. Regional CME detailing the new CVD Assessment and Management Guidelines, released in this quarter, will be available shortly. Filming has already taken place.

3. Increase rate of cessation support provided to enrolled smokers by 10%

The Auckland Metro DHBs have achieved the 'brief advice 'better help for smokers to quit' health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. For 2017/18 the target is an increase in cessation support by 10% disaggregated by ethnicity. Baseline data, for the quarter ended September 2016 showed rates of cessation support provided to smokers enrolled in PHOs was 24.7% for Auckland DHB, 24.4% for Counties Manukau Health and 32.9% for Waitemata DHB – with a metro-Auckland result of 27%. Latest results (for the quarter ended March 2018) show some improvement on baseline rates for Auckland DHB which recorded a result of 29.1% and Counties Manukau increasing to 25.4%. However, Waitemata recorded a small decrease to 31.5%. Overall metro-Auckland rate was slightly better at 28.3%. The Ministry of Health is not currently able to provide ethnic specific results for this indicator. PHOs have agreed to provide the data locally but initial data sets are not of sufficient quality to include currently.



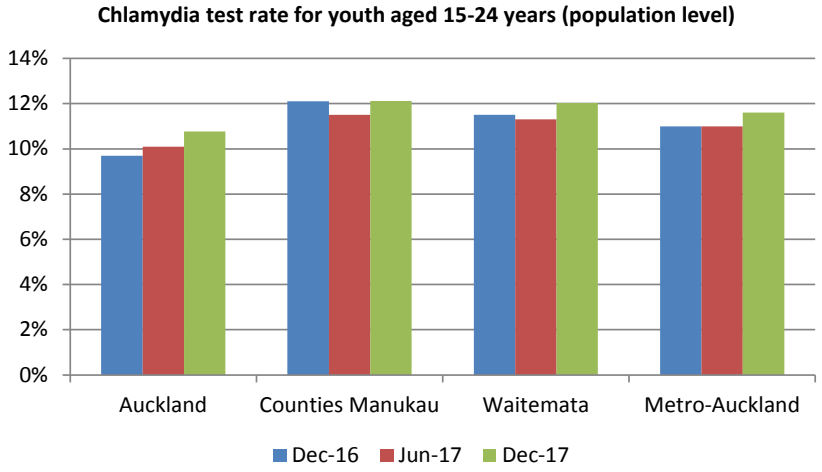
Improvement Activities	Progress Report
• Analyse reasons for historical low referrals to smoking cessation providers. • Improve referral pathways to smoking cessation providers. • Improve feedback to referrers from smoking cessation providers. • Access aggregated data for Auckland population. • Establish a single process to report smoking from PHO practice management systems. This dataset includes collection of ethnicity data to level 2 supporting equity interventions • Benchmark 'access to smoking cessation' READ codes across PHOs: i.e. the number of patients with codes 1, 2 and 3: 1. ZPSC10 – referral to smoking cessation support 2. ZPSC20 – prescribed smoking cessation medication 3. ZPSC30 provided smoking cessation behavioural support.	Regionally agreed definitions have been developed which have been approved by the data custodian group. These have also been approved by the SLM steering group, with source requests delivered to organisations in late September and the second data upload was held in January 2018. There have been some delays to the third upload, pending a trial of HealthSafe. Initial data sets are not of sufficient quality to include currently and therefore Ministry of Health quarterly reported data is presented here. This activity has been completed, although the final data upload will provide the best data for reporting.

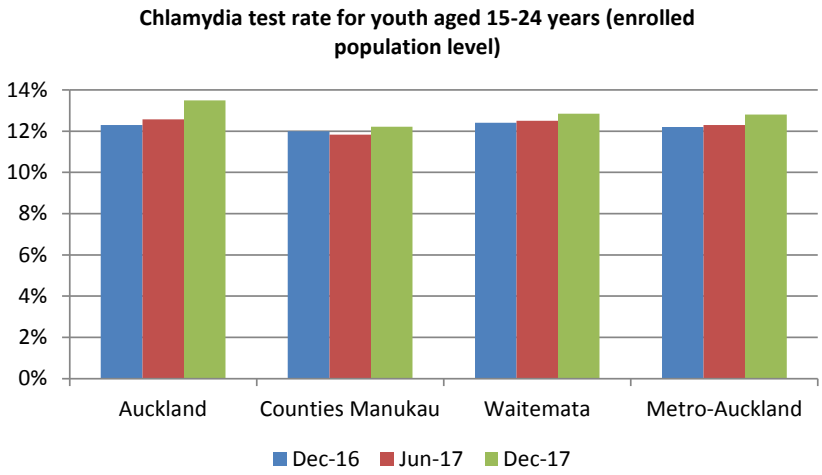
Youth Access to and Utilisation of Youth-appropriate Health Services

The Youth Domains are 5 separate areas of youth health which combine to support a positive youth experience of health care. This domain is developmental for 2017/18 therefore the focus has been on base lining data, data quality improvement, and identifying key health sector partners and appropriate activities for the 2018/19 planning cycle.

The focus this year is on Sexual and Reproductive Health. The overarching milestone is 80% of pregnant woman aged 15-24 years are screened for chlamydia during pregnancy.

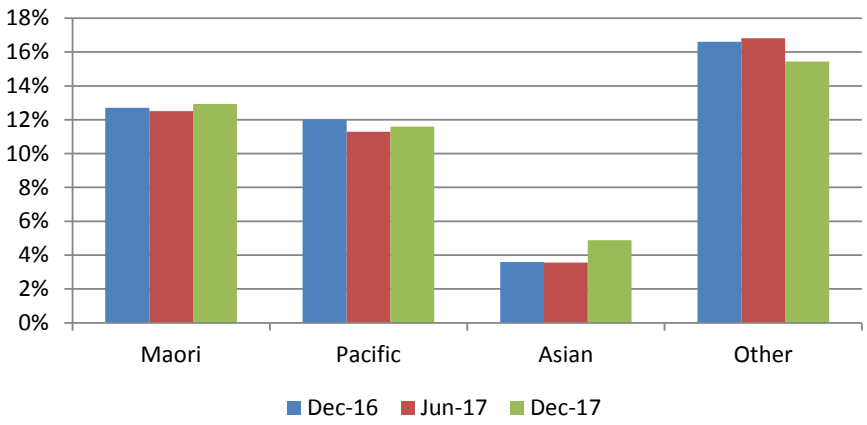
There is work on-going in the contributory measures to set up other domains in preparation for next year.





Note: a small number of enrolees within a practice outside of the Auckland region have not been included

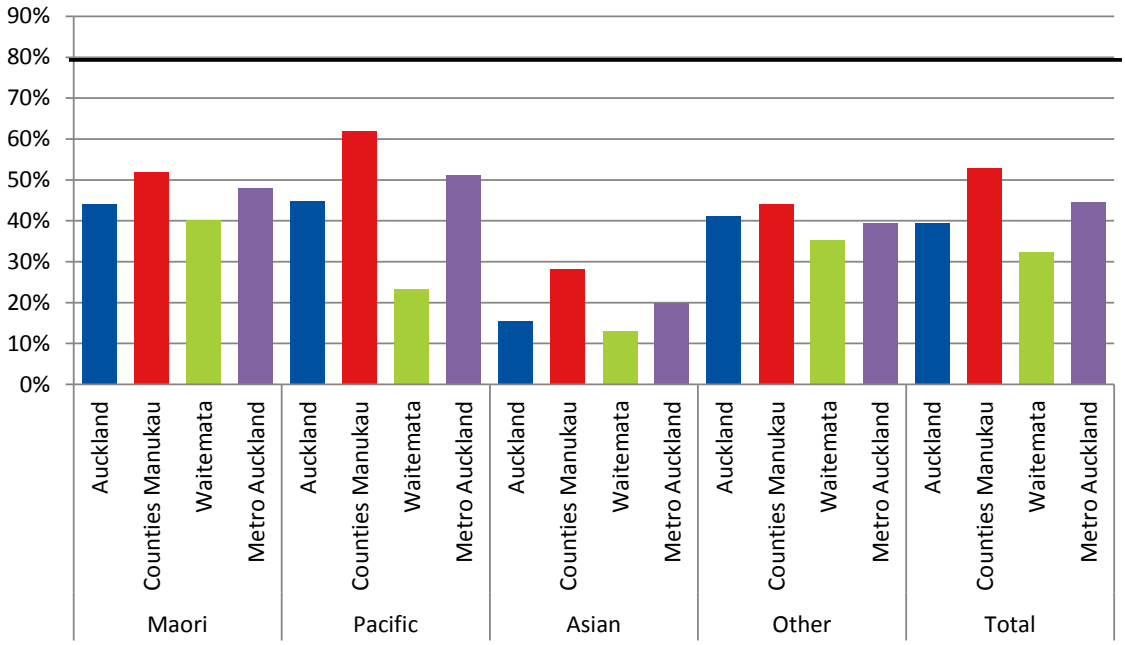
Chlamydia test rate for youth aged 15-24 years by ethnicity (population level) - metro-Auckland DHBs



All Pregnant Women are Screened for Chlamydia

The target for this year is 80% of pregnant women aged 15-24 years are screened for chlamydia during pregnancy. Overall rates are relatively static between this and last reporting periods. However, rates for Pacific and Asian are falling, while rates for other ethnicities have increased – note small numbers in some cases.

Chlamydia testing coverage for women giving birth in Q4 2017 (15-24 years) by ethnicity



Improvement Activities	Progress Report
• Workforce development activities for lead maternity carers. • Data analysis looking for missed opportunities, e.g. primary care visits during pregnancy. • Data analysis looking for the potential to report back screening rates to lead maternity carers.	• Development of a prospective data definition is underway to enable a pregnancy alert to be provided to PHOs so that chlamydia testing can be carried out in a timely way. Completion is anticipated by July 2018.

Contributory Measures

1. Development of Future Sexual and Reproductive Health Contributory Measures

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
• Analysis of SLM data by age, ethnicity, and PHO. • Identify gaps and potential areas for improvement. • Review the literature to identify options for improving access to chlamydia testing for Māori and Pacific youth including school-based services, pharmacy, community laboratories, primary care, outpatients, justice systems, and other opportunistic settings.	• Indicator definitions for the SLM has been completed, as has analysis. • There is ongoing work to identify gaps and promote improvement, particularly in primary care and student and youth health services. • A registrar has been identified to undertake the literature review and will be supervised by Dr Farrant, Chair of the Youth Network.

2. Chlamydia Burden of Disease

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
• Establish regular reporting of chlamydia prevalence by age, ethnicity and locality.	• This data definition is in progress and has been approved by the Data custodians in September. The SLM Steering Group approved this data request in September, and the user request form was submitted in late September.

3. Healthcare Utilisation by 15-24 year olds

The target for this year is to complete the analysis detailed in the activities.

Improvement Activities	Progress Report
• Explore the availability of data across services potentially accessed by youth and the feasibility of data linkage to explore systems-wide youth health service utilisation and identify gaps • Baseline primary health care enrolment and utilisation.	• Baseline enrolment established, further activities have not been progressed.

4. **Development of Baseline Data for Youth Domains:**
    a. **Alcohol and Other Drugs**
    b. **Access to Preventative Services**
    c. **Mental Health and Well-being**
    d. **Youth experience of the health system**

The target for this year is to establish a baseline in these domains.

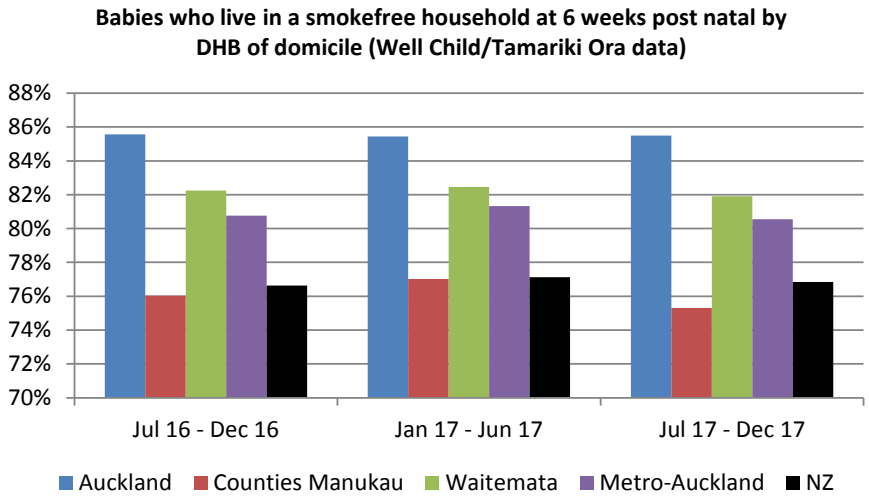
Improvement Activities	Progress Report
• Analysis of SLM data by age, ethnicity, and PHO. • Identify gaps and potential area for improvement.	• Baseline data are now available for the SLMs in these domains. • Data is of variable quality.

Proportion of Babies Living in Smokefree Homes at six weeks postnatal

The original Well Child Tamariki Ora (WCTO) dataset from the Ministry of Health showed the data for this measure was of poor quality, with a high proportion of 'unknown', missing or 'not asked' data.

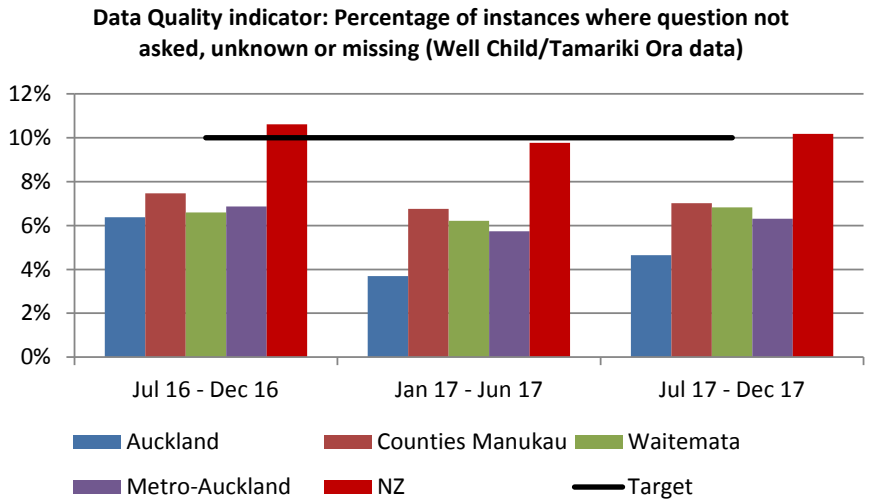
A later dataset has recently been released which shows less significant data quality issues.

This more recent data shows little shift in results over time. In the six months to December 2017, around 81% of metro-Auckland babies lived in a smokefree household at 6 weeks post-partum – of those asked at their first core contact check (within 56 days of birth) with their Well Child provider.



About 6% of WCTO enrolled babies in Metro Auckland did not have smokefree household data recorded within this same time period. WCTO activities in the 2017/18 plan focused on improving data quality. As data quality improves, the proportion of babies living in smokefree households is likely to decline initially. Therefore, measuring the impact of activities on the SLM will be challenging in the short term. Not all babies are captured in the WCTO data – probably about 20% of births over the time period July 2016 – December 2017 are missing. These may not be enrolled with a Well Child provider, may not have had a first core contact check or may have had their first core contact check outside of the 56 day timeframe.

The milestone target for this measure is to reduce missing smokefree household data to <10% by June 2018. This has already been achieved – when using the later dataset to assess performance.



Contributory Measures

1. Maternal Smokefree Services

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
• Improve regional data collection so that timely maternal smoking prevalence data is available, brief advice and quit support can be monitored, and referral to SSS for women who are pregnant and are current smokers can be monitored • Analyse reasons for historical low referrals to smoking cessation providers, particularly for Māori women • Promote regional pathway for first trimester visit (includes smoking cessation referral) with a focus on Māori women • Facilitate early enrolment of pregnant women with lead maternity carers • Provide lead maternity carers and GP training on smoking cessation • Provide feedback to lead maternity carers on their referral rates • Provide pregnancy SSS incentives programme • Arrange for SSS providers to attend pregnancy and parenting classes in the community (particularly those for Māori and Pacific) • Explore innovative ways of engaging pregnant smokers to quit, with a focus on Māori women, e.g. through use of a Sudden Unexpected Death in Infancy App.	• The smoking cessation health pathway has been reviewed and is awaiting clinical editor approval • Smoking cessation incentives programmes are beginning start quarter 3 at Auckland/Waitemata DHB and ongoing at Counties Manukau Health. All three programmes have a whānau incentives component to support whānau members to quit • CME sessions have now been filmed and are available regionally. • LMC online training has been developed and was launched on May 31 and is available regionally through Ko Awatea.

2. Household Smoking Cessation

The target for this year is to establish a baseline in this measure.

Improvement Activities	Progress Report
• WCTO Data Quality Improvement: Review and align data collection processes for SLM measure across WCTO providers and provide SOPs for data collectors • Provide WCTO providers feedback on missing smokefree data rates • Scope processes to identify household members of pregnant women and newborns who are current smokers, including data collection processes • Explore opportunities to offer smoking cessation support to whānau of newborn inpatients and outpatients, and paediatric ED attendances • Explore additional ways of offering smoking cessation support to whānau of young children, e.g. pharmacy initiatives, Well Child providers • Support the work undertaken in the Amenable Mortality SLM.	• The Ministry have convened a working group who have decided on data definitions and are in the process of rolling out improvements in the national data collection. These will be finalised through Well Child contracting shortly • We anticipate some further data in June 2018

10. Resolution to Exclude the Public

Resolution:

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Minutes of Meeting of the Board - Public Excluded (30/05/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Recommendations from the Audit and Finance Committee – Public Excluded (20/06/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
3. Minutes of the Audit and Finance Committee – Public Excluded (09/05/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be

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		in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4. Minutes of the Hospital Advisory Committee – Public Excluded (20/06/18)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
6. 2018/19 Annual Plan Financial 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
7. Review of Provisions and Accounting Treatments	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
8. Business Case – Substance Misuse Prevention 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 (2) (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. [Official Information Act 1982 S.9 (2) (i)]

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	[NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; or ii) would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information. [Official Information Act 1982 S.9 (2) (b)]
9. Deed of Settlement	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
10. Draft 2018/19 Annual Plan	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
11. Infrastructure as a 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 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the

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		greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
12. After Hours and Overnight Services	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
13. Mental Health NGO Sustainability	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
14. Facility development – Mission Homeground	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
15. Facilities update		**Commercial Activities** The disclosure of information would not be in the public interest because of the

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]