BOARD MEETING

Wednesday 26 February 2020

10.00am

AGENDA

Items to be considered in public meeting

VENUE

Waitematā 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
26 February 2020

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Tce, Takapuna  
Time: 10.00am

WDHB BOARD MEMBERS
Judy McGregor - Chair  
Max Abbott  
Edward Benson-Cooper  
John Bottomley  
Chris Carter  
Kylie Clegg - Deputy Chair  
Sandra Coney  
Warren Flaunty  
Allison Roe  
Renata Watene  
Arena Williams

WDHB MANAGEMENT
Dale Bramley - Chief Executive Officer  
Robert Paine - Chief Financial Officer and Head of Corporate Services  
Andrew Brant - Deputy Chief Executive Officer  
Dr Jonathan Christiansen - Chief Medical Officer  
Debbie Holdsworth – Interim Director Hospital Services  
Tim Wood- Interim Director Funding  
Jocelyn Peach - Director of Nursing and Midwifery  
Tamzin Brott - Director of Allied Health  
Fiona McCarthy - Director Human Resources  
Peta Molloy - Board Secretary

APOLOGIES:

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

10.00am 1. AGENDA ORDER AND TIMING

2. BOARD & COMMITTEE MINUTES
10.05am 2.1 Minutes of the Meeting of the Board (18/12/19)
   Actions arising from previous meetings
   2.2 Minutes of the Special Meeting of the Board (19/02/20)
   2.3 Minutes of the Hospital Advisory Committee Meeting (05/02/20)

10.10am 3. CHAIR’S REPORT

4. EXECUTIVE REPORTS
10.20am 4.1 Chief Executive’s Report
10.30am 4.2 Health and Safety Performance Report
10.40am 4.3 Communications Report

5. DECISION ITEMS
10.50am 5.1 Director Appointment to the healthAlliance NZ Limited Board

6. PERFORMANCE REPORT
10.55am 6.1 Financial Performance Report

7. INFORMATION PAPERS
11.05am 7.1 Reducing Harms from Hazardous Alcohol Use in our Communities
11.20am 7.2 System Level Measures Quarter Two Report

11.30am 8. RESOLUTION TO EXCLUDE THE PUBLIC
**Waitematā District Health Board**

**Board Member Attendance Schedule 2020**

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<th>NAME</th>
<th>Feb</th>
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✓ Present

* Apologies given

* Attended part of the meeting only

# Absent on Board business

^ Leave of Absence
# REGISTER OF INTERESTS

<table>
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<tr>
<th>Board/Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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| **Judy McGregor**  
(Chair) | Chair – Health Workforce Advisory Board  
Associate Dean Post Graduate - Faculty of Culture and Society, AUT  
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 | 11/09/19 |
| **Kylie Clegg**  
(Deputy Chair) | Trustee – Well Foundation  
Director - Auckland Transport  
Director - Sport New Zealand  
Director - High Performance Sport New Zealand Limited  
Trustee and Beneficiary - M&K Investments Trust (includes shareholdings in a number of listed companies, but less than 1% of shares of these companies, includes shareholdings in MC Capital Limited, HSCP1 Limited, MC Securities Limited, HSCP2 Limited, Next Minute Holdings Limited).  
Orion Health has commercial contracts with Waitematā District Health Board and healthAlliance. | 05/02/20 |
| **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)  
Edward has three (different) family members who hold the following positions:  
Family member - FRANZCR. Specialist at Mercy Radiology. Chairman for Intra Limited. Director of Mercy Radiology Group. Director of Mercy Breast Clinic  
Family member - Radiology registrar in Auckland Radiology Regional Training Scheme  
Family member - FANZCA FCICM. Intensive Care specialist at the Department of Critical Care Medicine and Anaesthetist at Mercy Hospital | 25/03/19 |
| **John Bottomley** | Consultant Interventional Radiologist – Waitematā District Health Board | 17/12/19 |
| **Chris Carter** | Chairperson – Henderson-Massey Local Board, Auckland Council  
Trustee – Lazarus Trust | 18/12/19 |
| **Sandra Coney** | Member – Waitakere Ranges Local Board, Auckland Council  
Patron – Women’s Health Action Trust | 18/12/19 |
| **Warren Flaunty** | Chair – Trust Community Foundation  
Trustee (Vice President) – Waitakere Licensing Trust  
Shareholder – EBOS Group  
Shareholder – Green Cross Health  
Director – Life Pharmacy Northwest  
Chair – Three Harbours Health Foundation  
Trustee – Hospice West Auckland (past role) | 05/02/20 |
| **Allison Roe** | Chairperson – Matakana Coast Trail Trust  
Member – Rodney Local Board, Auckland Council  
Member – Wilson Home Committee of Management (past role) | 22/08/18 |
| **Renata Watene** | Owner – Occhiali Optometrist | 17/12/19 |
## REGISTER OF INTERESTS

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<td>Board Member – OCANZ Strategic Indigenous Task Force Council Member – NZAO</td>
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<td>Arena Williams</td>
<td>Director – Kōwhiri Elections Services Limited Trustee – Jacqueline Allan Family Trust Beneficiary – Ngāi Tahu and Whai Rawa Savings Limited Beneficiary – Te Aitanga-a-Mahaki Family member is an Associate of Meredith Connell Admitted Barrister and Solicitor of the High Court of New Zealand Member – Te Rūnanga o Wairaka (Unitec)</td>
<td>18/12/19</td>
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Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member’s knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out responsibilities, then he or she may not be “interested in the transaction”. The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a majority of other members of the Board permit the member to do so. If this occurs, the minutes of the meeting must record the permission given and the majority’s reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board’s integrity.

IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

Ensure the nature of the interest is disclosed, not just the existence of the interest.

Note: This sheet provides summary information only.
2.1 Confirmation of Minutes of the Board meeting held on 18 December 2019

Recommendation:

That the Minutes of the Board meeting held on 18 December 2019 be approved.
DRAFT Minutes of the meeting of the Waitematā District Health Board

Wednesday, 18 December 2019

held at the Boardroom, Level 1, 15 Shea Tce, Takapuna, commencing at 9.45am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Judy McGregor (Board Chair)
Max Abbott
Edward Benson-Cooper
John Bottomley
Chris Carter
Kylie Clegg (Deputy Chair)
Sandra Coney
Warren Flaunty
Allison Roe
Renata Watene
Arena Williams

ALSO PRESENT:

Dale Bramley (Chief Executive Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Andrew Brant (Deputy Chief Executive Officer)
Jonathan Christiansen (Chief Medical Officer)
Debbie Holdsworth (Interim Director Hospital Services)
Tim Wood (Interim Director Funding)
Jocelyn Peach (Director of Nursing and Midwifery)
Tamzin Brott (Director of Allied Health)
Fiona McCarthy (Director Human Resources)
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:

Cheryl Hamilton (Auckland Womens Health Council)
Mihi Blair (Hāpai Te Hauora)
Rebecca Ruwhiu-Collins (Hāpai Te Hauora)
Candace Bagnall (Cancer Society Auckland)
Richard Portch (Auckland Regional Public Health)

KARAKIA

Arena Williams led the Karakia.

WELCOME:

The new Board were welcomed prior to the meeting with a Mihi Whakatau.

The Board Chair formally welcomed the new members of the Board.
APOLOGIES:

There were no apologies received.

DISCLOSURE OF INTERESTS

Kylie Clegg noted that she had emailed the Board Secretary to advise registered interest related to Counties Manukau DHB and to Genesis Energy can now be removed.

Chris Carter, John Bottomley, Renata Watene and Arena Williams gave a copy of the registers interests to the Board Secretary.

During the meeting, Sandra Coney advised the Board Secretary that her registered interests related to Portage Licencing Trust and the West Auckland Trusts Services (WATS) can now be removed.

There were no interests declared that might involve a conflict of interest with an item on the open agenda.

1 AGENDA ORDER AND TIMING

For the open meeting, items were taken in same order as listed in the agenda.

2 BOARD AND COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Board Meeting held on 13 November 2019 (agenda pages 8-18)

Resolution (Moved Warren Flaunty/Seconded Allison Roe)
That the Minutes of the Board meeting held on 13 November 2019 be approved.

Carried

Actions arising from previous meetings (agenda page 19)
Noted.

2.2 Draft Minutes of the Hospital Advisory Committee Meeting held on 04 December 2019 (agenda pages 20-27)

Edward Benson-Cooper requested that the draft Hospital Advisory Committee minutes for the 04th December meeting be updated to note his attendance.

Resolution (Moved Sandra Coney/Seconded Edward Benson-Cooper)
That the draft minutes of the Hospital Advisory Committee meeting held on 04 December 2019 be received.

Carried
3 CHAIR’S REPORT (agenda pages 28-30)

The Board Chair introduced the report. She suggested and it was agreed that the Board explore an opportunity for younger people who may be interested in standing for or participating in the future on a DHB Board to have a seat at the table to observe DHB Board governance.

In summarising the report, the Board Chair:

- thanked Warren Flaunty for his participation in/attendance at various DHB events in the District over the past year.
- noted the two-day national DHB Chair induction recently held.
- advised the Minister of Health had now signed-off the Waitematā DHB’s Annual Plan. Warren Flaunty acknowledged the work undertaken by Wendy Bennett and her team to prepare the Annual Plan.
- wished the Chief Executive and all staff a very Merry Christmas from the Board.

Sandra Coney noted the work of staff who had gone to Samoa to assist with the Measles outbreak; this work would be formally acknowledged.

4 EXECUTIVE REPORTS

4.1 Chief Executive’s Report (agenda pages 31-51)

The Chief Executive introduced the report. Two video clips were shown of the DHB’s Christmas decorations across the many sites.

Additional matters raised and response to questions included:

- Noting the recent CE Lecture series with guest speaker Heather Simpson.
- Noting the recent Mason Clinic Land purchase; a site visit for new Board members will be arranged.
- The Kaumatua who lead the new Board’s Mihi Whakatau prior to the commencement had noted two significant events they were involved with, the Chief Executive advised these were the Measles epidemic in Samoa, where sadly there has been a big loss of life. The help of those that had gone to assist was acknowledged. The other significant event was the Whakaari/White Island volcanic eruption; the DHB is assisting where possible with acutes (neck of femur and hands) from Counties Manukau being transferred to the DHB. Staff voluntary rosters have also gone out. It was noted that support will be required for some time. In response to a question, it was advised that the Ministry of Health has been closely involved in the response to this event and in this circumstance the Counties Manukau DHB is coordinating the burns units nationally. The immediate support received from Australia for its citizens was acknowledged.
- Noting the priority targets reported.
- Noting the work of the i3 interns. The results of their work is shown during a workshop at the completion of their internship; the Board will be invited to attend at the next opportunity.

The report was received.
4.2 **Health and Safety Performance Report** (agenda pages 52-64)

Michael Field (Group Manager, Occupational Health and Safety Service) and Fiona McCarthy (Director, Human Resources) presented this item.

Fiona McCarthy summarised the report. Matters covered in discussion and response to questions included:

- The reported ‘top five incidents by Nature of Incident October 2019’ (page 54 of the agenda) includes ‘unsafe shift pattern and hours of working’.
- A lot of work has been done in the area of reducing incidents of aggression. It was noted that there has been training for staff in high risk areas, which has been successful. There is a wide range of aggression from verbal right up to physical aggression. Occupational health and safety follows up on all incidents with additional control methods now in place. In addition, a variety of training has been introduced with the CALM course including methods for de-escalation and how to manage more aggressive incidents.
- Wellbeing initiatives introduced are being measured, such as the use of body cameras for security staff. When change is not seen after the introduction of Wellbeing initiatives, a follow up audit can be undertaken to determine next steps for improvement.
- In response to a question, it was noted that incidents reported into RiskPro do not include bullying. Staff who may want to report a matter of bullying are advised to do this via an alternative pathway due to staff reporting lines.
- Staff fatigue is not a top 5 incident by ‘Nature of Incident’ (page 54 of the agenda).
- Reporting levels for near misses is low, there is a focus on ensuring staff report actual incidents. With the roll-out of a new programme (Assura), near misses will be easier to record. When an investigation is undertaken for an actual incident, near misses not recorded are looked at.

The Chair thanked Fiona and Michael for their work over the past year.

4.3 **Communications Report** (agenda pages 65-74)

Matthew Rogers (Director Communications) was in attendance for this item. He noted the report presented and summarised the volume of work managed by the Communications team for the new Board members.

Matthew noted a Christmas Day story that has been pitched, where two of the DHB’s staff come in to spend the day with patients and their families and whanau on Christmas Day. TV1 will be attending to film the visit.

In response to an action point raised at the last meeting about understanding who was accessing the DHB’s website and can it be improved, Matthew noted that:

- The Consumer Council had given feedback and raised issues around navigation and functionality of the site.
- The current site was launched in 2015 with 22,000 visits per year; this has increased to 66,000 visits as at November 2019.
• Of the traffic to the site, 70 per cent is via google, with 54 per cent male.
• The biggest age group visiting the site is between 25-34 years of age.
• On average people spend two minutes and access up to two pages per visit.
• The data available is quantitative and not user experience.
• 51 percent of visitors access the website via an Apple device, with 15 percent via a Samsung. Very few people access the site via a desktop computer.
• The current site needs to be updated to host videos and display adequate on mobile devices. Updating the site has been discussed with i3 and the DHB will need to work with healthAlliance to progress website development.
• The greatest number of visits to the site are by New Zealand people at 98 percent, the other large groups are from Australia and the United Kingdom.
• A proposal for a new website will be developed and presented to the Board.

The Chair thanked Matthew and the Communications team for their work over the past year.

5 DECISION ITEMS

5.1 Waitematā DHB Board – Interim Committee Membership (agenda pages 75-76)

The Board Chair introduced the report and discussed membership, the following was agreed:

Hospital Advisory Committee
Chair: Sandra Coney
Deputy Chair: Edward Benson-Cooper
Committee Members: all Waitematā DHB Board members, with the exception of the Deputy Chair (Kylie Clegg) are members of the Committee
Ex officio: Judy McGregor

Audit and Finance Committee
Independent Committee Chair: Norman Wong (Professor of Accounting and Finance, Head of the Department of Accounting and Finance, University of Auckland)
Deputy Chair: Kylie Clegg
Committee Members: Judy McGregor, Kylie Clegg, Warren Flaunty, Max Abbott, Edward Benson-Cooper and Arena Williams

Community and Public Health Advisory Committee (combined meeting arrangements with Auckland DHB)
Chair: Kylie Clegg
Deputy Chair: to be agreed with ADHB
Waitematā DHB Committee Members: Chris Carter, John Bottomley, Arena Williams, Allison Roe, Sandra Coney, Warren Flaunty and Max Abbott
Ex officio: Judy McGregor

Disability Support Advisory Committee (combined meeting arrangements with Auckland and Counties Manukau DHBs)
Chair: Independent Chair be appointed to replace co-Chair arrangements.
Deputy Chair: to be agreed with Auckland and Counties Manukau DHBs.

Waitematā DHB Committee Members: Allison Roe, John Bottomley, Renata Watene
Ex officio: Judy McGregor

**Iwi-DHB Partnership Board** (combined meeting with Auckland and Northland DHBs and Iwi partners)

- Independent Chair: Gwen Teopia-Palmer
- Waitematā DHB member: Judy McGregor
- Waitematā DHB attendees: Renata Watene and Arena Williams

**Other Appointments**

- **Well Foundation**: Kylie Clegg and Chris Carter
- **Three Harbours Trust**: Warren Flaunty (Chair) and Edward Benson-Cooper
- **Wilson Home Trust**: all Waitematā DHB Board members

The ongoing arrangements for the combined Community and Public Health Advisory Committees meeting will be discussed with the Auckland DHB Chair and Chief Executive.

Attendees for the proposed Iwi-DHB Partnership Board will be further discussed at its next meeting.

The agreed list of interim Committee membership will be sent to all Board members; a full review of Committees and their terms of reference would take place in the New Year.

**Resolution** (Moved Edward Benson-Cooper/Seconded Max Abbott)

That the Board approve the appointment of Board members as members and Chairs of Committees, Trusts and Foundations as follows:

**Hospital Advisory Committee**

- Chair: Sandra Coney
- Deputy Chair: Edward Benson-Cooper
- Committee Members: all Waitematā DHB Board members, with the exception of the Deputy Chair (Kylie Clegg) are members of the Committee
- Ex officio: Judy McGregor

**Audit and Finance Committee**

- Independent Committee Chair: Norman Wong (Professor of Accounting and Finance, Head of the Department of Accounting and Finance, University of Auckland)
- Deputy Chair: Kylie Clegg
Committee Members: Judy McGregor, Kylie Clegg, Warren Flaunty, Max Abbott, Edward Benson-Cooper and Arena Williams

Community and Public Health Advisory Committee (combined meeting arrangements with Auckland DHB)
   Chair: Kylie Clegg
   Deputy Chair: to be agreed with ADHB
   Waitematā DHB Committee Members: Chris Carter, John Bottomley, Arena Williams, Allison Roe, Sandra Coney, Warren Flaunty and Max Abbott
   Ex officio: Judy McGregor

Disability Support Advisory Committee (combined meeting arrangements with Auckland and Counties Manukau DHBs)
   Chair: Independent Chair be appointed to replace co-Chair arrangements.
   Deputy Chair: to be agreed with Auckland and Counties Manukau DHBs.
   Waitematā DHB Committee Members: Allison Roe, John Bottomley, Renata Watene
   Ex officio: Judy McGregor

Iwi-DHB Partnership Board (combined meeting with Auckland and Northland DHBs and Iwi partners)
   Independent Chair: Gwen Tepania-Palmer
   Waitematā DHB member: Judy McGregor
   Waitematā DHB attendees: Renata Watene and Arena Williams

Other Appointments
   Well Foundation: Kylie Clegg and Chris Carter
   Three Harbours Trust: Warren Flaunty (Chair) and Edward Benson-Cooper
   Wilson Home Trust: all Waitematā DHB Board members

Carried

5.2 Establishment of Executive Committee of the Board (agenda pages 77-78)
   The Board Chair introduced the report. The following Board members confirmed availability during the holiday period: Judy McGregor, Kylie Clegg, Sandra Coney, Warren Flaunty, Max Abbott and Allison Roe. Kylie advised that she would be overseas between 8th and 22nd January 2020 and not available to participate in an Executive Committee of the Board meeting during that period.

Resolution (Moved Kylie Clegg/Seconded Sandra Coney)
   a) That the Board approves the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/New Year Board recess.
b) That membership of the Committee is to comprise Judy McGregor, Kylie Clegg, Sandra Coney, Warren Flaunty, Max Abbott and Allison Roe, with a quorum of [4] members (the Chair or Deputy Chair needs to be one of the [4] members).

c) That the Executive Committee be given delegated authority to make decisions, on the Board’s behalf, relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from a Committee or the Chief Executive (same arrangements as last year).

d) That all decisions made by the Executive Committee be reported back to the Board at its meeting on 26 February 2020.

e) That the Executive Committee be dissolved as at 25 February 2020.

Carried

5.3 Adoption of Waitematā DHB Governance Manual (including review of Code of Conduct and Standing Orders) by the new Board December 2019 (agenda pages 79-202)

The Board Chair introduced the report, noting that endorsement of the Waitematā DHB Governance Manual is sought from the new Board who took office on 9th December 2019.

Resolution (Moved Warren Flaunty/Seconded Kylie Clegg)

That the Board:

a) Approve the Code of Conduct as shown as Chapter 7 in the attached proposed Governance Manual.

b) Approve the Standing Orders as shown as Appendix 2 to the attached Governance Manual.

c) Adopt the Waitematā DHB Governance Manual.

d) Note that the State Services Commission, in its review of Crown Entity and State Sector legislation, is preparing a Code of Professional Conduct for Crown Entity Board members. When approved this will be incorporated into the Waitematā DHB Governance Manual.

Carried

6 PERFORMANCE REPORT

6.1 Financial Performance Report – October 2019 (agenda pages 203-216)

Robert Paine (Chief Financial Officer and Head of Corporate Services) summarised this report, noting in particular the work underway on the remediated payroll system.

Resolution (Moved Max Abbott/Seconded Allison Roe)

That the Board receives the report.

Carried
7 PERFORMANCE REPORT

7.1 Vaping Update (agenda pages 217-228)

Tom Robinson (Public Health Physician), Karen Bartholomew (Director Health Outcomes), Dr William Rainger (Auckland Regional Public Health) and Mihi Blair (Hāpai Te Hauora) were present for this item.

The Chief Executive congratulated Dr William Rainger’s recent appointment to lead the Auckland Regional Public Health Service.

The Board Chair introduced the discussion paper, noting it is an initial conversation on areas where the Board can collaborate further (with schools and the like) regarding the use of vaping as the DHB waits for legislation to be introduced that might assist in guiding vaping use.

Karen Bartholomew introduced those in attendance for this item to the Board. The Board Chair acknowledged those in attendance.

Tom Robinson summarised the paper.

Matters covered in discussion and responses to questions included:

- Noting the number of vaping outlets now in the community.
- The Ministry of Health and Public Health England summarised vaping as 90-95% less harmful than smoking tobacco.
- Noting the verbal comments by Hāpai Te Hauora (see also page 224 of the agenda).
- Noting the Radio NZ *Smoke and Mirrors* investigation, and in particular the story on ‘Youth addition worry as high-nicotine vape JUUL to hit NZ’ (July 2019).
- That clinical outcome harms are emergent. Time is needed for them to become evident and data is accumulated over many years.
- Noting that Australia has banned nicotine in vape. Hāpai Te Hauora noted the use of vape flavours in assisting, in particular, Māori women to stop smoking tobacco.
- Currently in New Zealand, vaping groups are self-regulating.
- Hāpai Te Hauora has a process in place to educate people who want to utilise vaping to stop smoking.
- DHB staff regularly provide briefings with staff/smoking services on programmes to quit smoking. It was reiterated that harm associated with vaping and long term harms are unknown at this time.
- It is the Government’s intent to restrict vaping to three flavours, however, Hāpai Te Hauora said it would not be supportive of this. People like to select their own vaping flavour when deciding to vape and stop tobacco smoking.
- Noting that multiple flavours could be an attraction for youth to start vaping. Evidence of youth vaping uptake is observational at this time, with the primary issue still smoking.
- Noting the Board’s concern that youth vaping could be a gateway to tobacco smoking. Youth vaping is a concern for many secondary schools.
- Noting concern that people who may not have been inclined to smoke tobacco could be drawn to vaping due to current popularity.
- Nicotine based vape cannot be sold to anyone under the age of 18.
- Support for ‘vape free’ cars; noting in particular safety for drivers due to the smoke emitted from vaping and healthy air for tamariki.
- Hāpai Te Hauora advised that its stop smoking programme is a transition to vaping to quit smoking and then transition to quit vaping. A key campaign message is to prevent youth from smoking.

It was requested that a further paper be prepared for the Board which provides:
- direction on how the Board can support moving forward on the prevention of vaping, particularly for youth, how the DHB can influence and/or support the moving of legalisation in this area and what can the DHB do to support secondary schools to prevent smoking/vaping. To form the paper, it is suggested the DHB consult with interested agencies, including school principals in the district.

The Chair thanked the group for the report.

7.2 Suicide Overview (agenda pages 229-243)

Sarah Gray (Public Health Physician), Susanna Galea-Singer (Director, Specialist Mental Health and Addiction Services), Derek Wright (Advisor, Mental Health and Addictions Services) and Manu Fotu (Programme Manager, Mental Health Funder) were present for this item.

Sarah Gray introduced the paper, summarising the key messages. Matters covered in discussion and response to questions included:
- A lot is known about risk factors, however, predicting a person who may attempt suicide can be difficult. Peoples’ reactions to circumstances are all unique and individual in response.
- Manu Fotu (Programme Manager, Mental Health Funder) assists in coordinating training requirements for staff. Mr Fotu is advised of each suicide in the district, which identifies clusters and the like.
- A plan is being developed and will be presented to the Board in 2020.
- Manu advised that the Ministry of Health had recently led a suicide prevention hui, which also provided an opportunity to meet new correctors for suicide prevention and those working in this area nationally. There is confidence in working together with the development and implementation of plans.
- Noting a policy introduced by the Ministry of Education some time ago related to bullying in schools, recalling that there was a number of teenage suicides due to grappling with sexuality. In addition, Susanna Galea-Singer advised that there has been some work done in much higher risk situations, including at a regional level as well. There is also regional work to develop a model of care to reduce risk of suicide/self-harm in the transgender community.
- Noting the appointment of Carla na Nagara as Director, Suicide Prevention Office (SPO). The SPO is planning a road show in 2020, in addition it would be valuable for there to be a wider forum in the district, such as a CEO lecture.
- The implementation of phoning clients within seven days of discharge has had a positive impact on client wellbeing.
- Noting social factors and subsequent impact (as noted pages 236/237 of the agenda).
- There is strong support for the DHB’s staff if an incident occurs, including time spent with individual staff members, briefing and counselling support, cultural support. The support continues to be followed up when required.
• Noting the talk given by Mike King to staff, which was well attendance and had an impact.

Following the discussion, it was requested that the next paper to the Board on this matter include the role of governance in helping to support the Service.

The Chair thanked the group for the report.

GENERAL BUSINESS

On behalf of the Board, Kylie Clegg thanked the Board Chair, Chief Executive and all staff for their work over the past year. She acknowledged the Board Chair’s work for Waitematā DHB as well as her work regionally and nationally.

The Board Chair noted a recent review and increase of Board fees, which will be implemented from 9th December 2019.

Max Abbott noted the work of the two information papers presented at the meeting (items 7.1 and 7.2) and queried the extent of discussion and sharing of resources with other DHBs; in response Karen Bartholomew said that the papers were prepared by the Funder’s Health Outcomes unit and that there is a lot of preparatory work/dialogue with other DHBs.

A wider discussion will be held on the dissemination of good ideas and topics of interest for the community, such as the two information papers (items 7.1 and 7.2). In addition, it was requested that the Regional Governance Group work underway related to obesity and reducing harms from alcohol use be presented to the Board in the New Year.

8 RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 244-247)

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

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:

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
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<th>Ground(s) under Clause 32 for passing this resolution</th>
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<tbody>
<tr>
<td>Minutes of Meeting of the Board - Public Excluded (13/11/19)</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.</td>
<td>Confirmation of Minutes As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&amp;D Act.</td>
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Waitematā District Health Board, Meeting of the Board 26/02/20
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| 2. Minutes of the Audit and Finance Committee – Public Excluded (04/12/19) | 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. | 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 Hospital Advisory Committee – Public Excluded (04/12/19) | 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. | 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. |
| 4. KARE Project | 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
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[Official Information Act 1982 S.9 (2) (j)] |

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</table>
| 5. Evergreen agreements for community pharmacy and aged residential care 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. | Commercial Activities  
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[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)] |
| 6. Sewer stack replacement – North Shore Hospital | 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  
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[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)] |
| 7. Submission about STV to the Justice Committee | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. | Conduct of Public Affairs  
The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment.  
[Official Information Act 1982] |
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| 8. | Strategic Capital Programme Group - Procurement Update and Approvals | 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  
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Negotiations  
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| 9. | Strategic Capital Programme 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  
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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)] |
| 10. | Legislative Compliance | 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)] | Conduct of Public Affairs  
The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment. [Official Information Act 1982 S.9 (2) (g)(ii)] |
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<td>11.</td>
<td>Legal Services Report</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] Legal Professional Privilege The withholding of the information is necessary to maintain legal professional privilege. [Official Information Act 1982 S.9 (2) (h)] 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)]</td>
</tr>
<tr>
<td>12.</td>
<td>Update on Recent Issues in Informed Consent</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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</tr>
</tbody>
</table>

**Carried**

The following item was considered during the public excluded session of the meeting whilst regional approval was sought for the draft submission. The Board agreed that the matter be brought into the open meeting.

**Submission about Single Transferable Voting (STV) to the Justice Committee**

**Resolution** (Moved Warren Flaunty/Seconded Chris Carter)
That the Board approve of the draft submission to the Justice Committee on the Inquiry into the 2019 Local Elections on behalf of the Northern Region Governance Group.

Carried

The open meeting concluded at 12.38pm.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD - BOARD MEETING HELD ON 18 DECEMBER 2019

______________________________ BOARD CHAIR
## Actions Arising and Carried Forward from Previous Board Meetings as at 20 February 2020

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/07/19</td>
<td>4.2</td>
<td>Health and Safety Update</td>
<td>Michael Field</td>
<td>The review has commenced and a further update will be provided when available.</td>
<td></td>
</tr>
<tr>
<td>21/08/19</td>
<td>4.2</td>
<td>Health and Safety Update</td>
<td>Michael Field</td>
<td>In progress.</td>
<td></td>
</tr>
<tr>
<td>18/12/19</td>
<td>7.1</td>
<td>Vaping Update</td>
<td>Karen Bartholomew</td>
<td>Noted for action.</td>
<td></td>
</tr>
<tr>
<td>18/12/19</td>
<td>7.2</td>
<td>Suicide Overview</td>
<td>Manu Foto/ Derek Wright</td>
<td>Noted for action.</td>
<td></td>
</tr>
</tbody>
</table>
2.2 Confirmation of Minutes of the Special Board meeting held on 19 February 2020

Recommendation:

That the Minutes of the Special Meeting of the Board held on 19 February 2020 be approved.
DRAFT Minutes of the Special Meeting of the Waitematā District Health Board

Wednesday, 19 February 2020

held at the Boardroom, Level 1, 15 Shea Tce, Takapuna, commencing at 9.45am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Judy McGregor (Board Chair)
Max Abbott
John Bottomley
Chris Carter
Kylie Clegg (Deputy Chair)
Sandra Coney
Warren Flaunty
Arena Williams

ALSO PRESENT:

Dale Bramley - Chief Executive Officer
Peta Molloy - Board Secretary

Karakia

Arena Williams led the karakia.

PUBLIC AND MEDIA REPRESENTATIVES:

There were no public or media representatives present.

WELCOME:

The Board Deputy Chair welcomed everyone to the meeting.

APOLOGIES:

Apologies were received and accepted from Allison Roe, Edward Benson-Cooper and Renata Watene.

DISCLOSURE OF INTERESTS

There were no additions or amendments to the Interests Register.

1 Resolution to Exclude the Public

Resolution: (Moved Arena Williams / Seconded Warren Flaunty)

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 item, for the reasons and grounds set out below:
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<td>Governance – Board Committee</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Conduct of Public Affairs: The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment. [Official Information Act 1982 5.9 (2) (g) (ii)] 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 5.9 (2) (ba)]</td>
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</table>

Carried

The meeting in open session concluded at 9.48am.


______________________________ CHAIR
2.3 Minutes of the Hospital Advisory Committee meeting held on 05 February 2020

Recommendation:

That the Minutes of the Hospital Advisory Committee meeting held on 05 February 2020 be received.
Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday, 05 February 2020

held at Waitematā District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 1.30pm.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT
Sandra Coney (Committee Chair)
Judy McGregor (from 1.43pm)
Max Abbott
Edward Benson-Cooper
John Bottomley
Warren Flaunty
Allison Roe
Renata Watene
Arena Williams

ALSO PRESENT
Dale Bramley (Chief Executive Officer) (from 2.45pm)
Andrew Brant (Deputy Chief Executive Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Jonathan Christiansen (Chief Medical Officer)
Jocelyn Peach (Director of Nursing and Midwifery) (until 3.00pm)
Fiona McCarthy (Director Human Resources)
Deanne Manuel (Committee Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT
No public and media representatives were present during the meeting.

WELCOME
The Committee Chair welcomed those present

APOLOGIES
Apologies were received and accepted from Chris Carter, Debbie Holdsworth and Lorraine Bailey and for late arrival from Judy McGregor and Dale Bramley.

DISCLOSURE OF INTERESTS

Warren Flaunty advised that he had been appointed Chair of the Trust Community Foundation and requested that his registered interest related to shareholding of Genesis Energy be removed.
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 04 December 2020** (agenda pages 6-13)

**Resolution** (Moved Warren Flaunty /Seconded Sandra Coney)

That the Minutes of the Hospital Advisory Committee meeting held on 04 December 2019 be approved.

**Carried**

**Actions Arising** (agenda page 14)

No issues were raised.

3. **PROVIDER ARM PERFORMANCE REPORT**

3.1 **Provider Arm Performance Report – November 2019** (agenda pages 15-81)

**Executive Summary/Overview**

Jonathan Christensen (Chief Medical Officer) summarised this section of the report, highlighting the following:

- The ongoing disruption in service due to continued industrial actions by MITs and Sonographers leading to the deferment of Echo tests resulting in longer waiting times for patients. However, there continues to be a focus on mitigating clinical and patient risk.
- There is a region-wide shortage of specialists in ORL which contributes to lower electives.
- Following the Whakaari White Island incident, Waitematā DHB accommodated a number of acute surgery patients from Counties Manukau DHB.
- The Annual Plan 2019/20 has been signed by the Minister and the ‘Strategic Initiatives’ table will be updated in the next agenda.

In response to a question, it was noted that the matters highlighted by Jonathan could impact ‘revenue’ of the DHB as a provider of service.

This section of the report was received.

**Human Resources**

Fiona McCarthy (Director Human Resources) was present for this report.

This section of the report was received.
Acute and Emergency Medicine Division

Gerard de Jong (Division Head, Acute and Emergency Medicine), Alex Boersma (General Manager, Acute and Emergency Medicine) and Melody Rose Mitchell (Associate Director of Nursing) were present for this section of the report.

Alex Boersma introduced the report highlighting ECHO performance below target due to industrial action. There was also a breach with respect to pressure injuries; the division is constantly monitoring practices align with pressure injury prevention strategies.

This section of the report was received.

Specialty Medicine and Health of Older People Division

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

Brian introduced the report highlighting the kidney transplant liaison service. The service provides support to potential donors to improve kidney transplant access to. There are a number of Māori on the waiting list and the extension of funding for this service will help contribute to equity outcomes.

In response to a query on Clinical Supplies expenditure, it was noted that requisitions and approvals have now been centralised to enhance cost control and efficient use of equipment.

This section of the report was received.

Child, Women and Family Services

Stephanie Doe (General Manager), Marianne Cameron (Head of Division – Nursing) and Diana Ackermann (Clinical Director) were present for this section of the paper.

Stephanie Doe introduced the report and highlighted the growing number of nurse practitioners at Waitematā DHB uplifting the clinical team’s skills. Other matters covered in the discussion and responses to questions included:

- While the service has seen an increase in demand for maternity services the number of births has not increased. Increased demand is a result of various factors including the change of birth type (normal delivery to caesarean), increased obesity and diabetes in pregnancy as well as change in clinical practice. These factors are being reviewed along with the review of staffing to increase FTE, review of the model of care as well as development of future workforce.
- There is a nationwide gap of midwives, but the DHB continues to attract new graduates as well as retain existing midwives.
- In response to a question, it was clarified that caesarean (CS) rates are not electives and are a result of several drivers. It was also noted that once a patient has had CS it can result in future caesareans. A review is on-going and a ‘deep dive’ on this matter was requested by the Committee.
Stephanie also summarised the Oral Health services. Matters covered in the discussion and responses to questions included:

- The Qlik dashboard is in place and is now able to capture those children with missed appointments. The service is prioritising those children who have not been seen for some time.
- The Committee requested that the next report show more detail, including the number of children who have been ‘in arrears’ for an extended period and those who have recently missed appointments. Information on types of treatments the children are undergoing will also be included.
- The ‘Standardised pathway’ for Oral Health will also be included in the next report as a focus of the Committee.
- In response to a question, it was clarified that the service accepts walk-in patients who are in pain.

This section of the report was received.

**Specialist Mental Health and Addiction Services**

Pam Lightbrown (General Manager), Derek Wright (Interim Lead), Murray Patton (Consultant Psychiatrist) and Alex Craig (Associate Director of Nursing) were present for this item.

Derek Wright highlighted the Mason Clinic expansion, the placement of long-stay clients to funded community beds and increased ED presentations of people with mental health issues. Matters covered in the discussion and responses to questions included:

- Regarding post discharge community care for adults, it was noted that transitioning the patients will reduce the deferment of services to those in need. The assistance of NGOs is also recognised, but they have also reached capacity.
- The ‘self-harm and agitation’ bundle was developed to help ED staff identify patients that require mental health services.
- In response to a question, it was clarified that the current focus and approach is preventative care and holistic care, using more of primary care to address the gap in the current model of care.
- There are government funded NGOs as a complementary service and/or in coordination with the DHBs, however, they are also facing challenges in terms of the capability of workforce.

**Surgical and Ambulatory Services**

John Cullen (Interim Chief of Surgery) was present for this item.

John highlighted the impact of the increased acute elective volumes on service delivery. The division has implemented the ‘agreed cancellation’ process which has lessened the number of cancellations. John also acknowledged the work of Sam Titchener (General Manager) on improvements made on the system which reduced clinical risks for ‘long-waiting’ patients

Other matters covered in the discussion and response to questions included:
- There is a specific structure and process adopted to respond to incidents such as the eruption of Whākaari White Island. Efforts are coordinated between the DHBs.
- Waitematā DHB’s surgical volumes were impacted by the White Island eruption, but it is not clear yet how the Novel Coronavirus [COVID-19] will impact our surgical services. There are regional and local teams managing this and the expectation is that the impact will be lesser.

Dr Dale Bramley (Chief Executive) joined the meeting at 2.45pm.

This section of the report was received.

**Diagnostic Services**

Brad Healey (General Manager and Head of Division) presented this section of the report. He highlighted the CT and MR performance versus target has been affected by industrial actions. The service is reviewing is production planning.

This section of the report was received.

**Clinical Support Services**

Brad Healey presented this section of the report noting that a current focus for the division is food services. The contractor has indicated commitment in working with the DHB to improve the service with an update to be presented to the Board at its next meeting.

This section of the report was received.

**Asian Health Services**

Grace Ryu (Operations Manager) was present for this section of the report. As this is the first profile highlight of the service, she was welcomed by the Committee members.

Grade introduced the report noting that following the Novel Coronavirus outbreak, the team has assisted in the development of information materials and public guidelines to keep people safe.

This section of the report was received.

**Resolution** (Moved Sandra Coney /Seconded Max Abbott)

**That the report be received.**

**Carried**

3.00pm - Jocelyn Peach retired from the meeting

**3.2 Provider Arm Performance Summary Report – December 2019** (agenda pages 82-93)
The report was noted by the committee and no issues were raised.

**Resolution** (Moved Sandra Coney /Seconded Max Abbott)

*That the report be received.*

*Carried*

4. **CORPORATE REPORTS**

4.1 **Clinical Leaders’ Report** (agenda pages 94-105)

Jonathan Christiansen (Chief Medical Officer) and Sharon Russell (Associate Director) were present for this item.

**Medical Staff**

Jonathan Christiansen highlighted the completion of the Health and Disability services certification audit of Waitematā DHB. The auditors noted the continued prioritisation of quality improvements with some minor corrective actions. The report will be published in the next couple of months. He also acknowledged the efforts of the staff for this achievement.

This section of the report was received.

**Allied Health, Scientific and Technical Professions**

Sharon Russell summarised the report in particular the implementation of the new team structure for Allied Health Services. The structure was developed in consultation with staff and is expected to align teams with clinical workload and patient pathways. She also noted the graduate trainee programme, which supports the transition from student to professionals, now has 47 graduates.

This section of the report was received.

**Nursing and Midwifery and Emergency Planning Systems**

This section of the report was received.

**Resolution** (Moved Sandra Coney/ Second Warren Flaunty)

*That the report be received.*

*Carried*

4.2 **Quality Report** (agenda pages 102-187)

Jacky Bush (Quality and Risk Manager) and Penny Andrew (Director, i3 and Clinical Lead) were present for this section of the report.

**Quality Update**
Jacky Bush summarised the Quality section of the report noting the significant improvements on markers including the reduction of falls and falls with major harm, decrease in unstageable pressure injuries, reduction in ESBL, robust infection control and reduction of the turn-around time for complaints response to 12 days. She acknowledged the efforts by the clinical teams for the improvements achieved.

In response to a question and following the Novel Coronavirus outbreak, it was noted that Waitematā DHB is one of the DHBs with the highest compliance rate and this is being constantly monitored.

This section of the report was received.

**i3 update**

Penny Andrew presented the ‘Surgical Implant Tracking System,’ which will enable easier tracing of implants and linking to patient and theatre information; this is currently being done manually. User feedback has been positive. In response to a query, Penny confirmed that the system will be shared with other DHBs as well as with the MoH.

This section of the report was received.

**Patient and Whānau Centered Care**

This section of the report was received.

**Resolution (Moved Sandra Coney/ Second Warren Flaunty)**

_That the report be received._

_Carried_

5. **INFORMATION ITEMS**

There were no information items in the agenda.

6. **RESOLUTION TO EXCLUDE THE PUBLIC** (agenda page 203)

**Resolution (Moved Edward Benson-Cooper/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:_

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confirmation of Public Excluded Minutes – Hospital</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the</td>
<td>Confirmation of Minutes As per resolution(s) to exclude the public from the open section of the minutes of the above</td>
</tr>
</tbody>
</table>
### General subject of items to be considered

<table>
<thead>
<tr>
<th></th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advisory Committee Meeting of 04/12/19</strong></td>
<td>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&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>meeting, in terms of the NZPH&amp;D Act.</td>
</tr>
<tr>
<td><strong>2. Quality Report</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]</td>
</tr>
<tr>
<td><strong>3. Human Resources Report</strong></td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>Privacy The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 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)]</td>
</tr>
</tbody>
</table>

**Carried**

The open session of the meeting concluded at 3.25 p.m.

**SIGNED AS A CORRECT RECORD OF THE WAIEMATĀ DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 05 FEBRUARY 2020.**

______________________________
CHAIR
3.1 Chair’s Report – February 2020

Recommendation:

That the report be noted.

Prepared by: Judy McGregor (Board Chair)

Coronavirus

Huge thanks to those staff involved in the teams that have been working both behind the scenes and front of house in preparation for coronavirus. I would ask Dr Dale Bramley, as lead CEO for the Northern Region Emergency Planning, to pass on the Board’s thanks to all staff who have been engaged in preparations and information sharing, and particularly those who have volunteered time and expertise. Thank you.

Ministerial Letter of Expectations and the DHB Balanced Scorecard

The new 2020/21 Letter of Expectations is expected any time from the Minister of Health. We’re working on the updated letter for 2019/20 with its priorities of monitoring improved performance, fiscal responsibility, improved child wellbeing, improving mental health, prevention, planned care, cancer and CCDM implementation for nursing and midwifery.

In relation to performance monitoring, the Ministry is developing a DHB balanced scorecard which will be a key component of the regular set of DHB performance reports the Ministry provides to the Minister and shares with DHB Chairs and Chief Executives. The scorecard is intended to bring together financial, service delivery, quality and safety, and workforce information on a quarterly basis. This is accompanied by a one page quarterly performance heat map and the scorecard and the heat map will replace the previous dashboard systems.

DHB Board Chairs and Governance Development

The Chair’s at their February meeting in Wellington unanimously decided that they wanted greater involvement with the Ministry of Health in developing their own fit-for-purpose governance development programme that was health sector specific. This followed comments about the need to have equity as a governance consideration from the outset of any planning and general acknowledgement that this will need new thinking. There was also discussion from new Chairs about how they understood what their boards needed or wanted in terms of governance training and development. The need for real-situation scenario-based examples underpinning governance development was also agreed to by the Chairs. A sub-group of Dr Karen Poutasi (Waikato); Sir Michael Cullen (Lakes and BOP); Cassandra Crowley, (Taranaki) and Waitematā DHB was established and we’re underway.

Other messages from the meeting via the Director-General of Health Dr Ashley Bloomfield related largely to financial sustainability and performance. Challenged about the time consuming capital bids process and the need for earlier indications that might save DHBs time and money, his response was that DHBs had to “keep planning.” Cost drivers such as increased FTE costs, elective targets, and the need for timely implementation of CCDM were other aspects Boards should be monitoring.
Select Committee Annual Review

Waitematā along with Auckland and Counties Manukau appeared before the Health Select Committee for its annual review on Wednesday 13 February, 2020 at Parliament Buildings. Dr Dale Bramley opened with an overview of LTIP then the Chairs spoke of current challenges such as financial sustainability, the funding model and IDF flows, indexing of capital provision to deficit management, population growth in the north and south corridors, obesity, poverty, rural/urban divide, Greenlane etc. The urgent need to build a mental health workforce to address the unmet needs of people suffering mental distress and illness was also referenced. Questions related to the Holidays Act were answered by Robert Paine and measles by Dr Karen Bartholomew. Maggie Barry, North Shore MP and former Seniors Minister, asked a question relating to the low visibility of older people in Waitematā DHB’s strategic documents. Follow up material has been sent to her. The Annual Review involves a huge amount of compilation of data by Peta Molloy and various iterations of editing. Reviewing the compiling and reporting process would be worthwhile to see if the process can be streamlined to save staff time annually.

Outreach

I’ve recently met with Hospice West Auckland to support its strategy for community palliative care and inpatient beds in the future. Mark Gosche and I completed the Seat at the Table concept for mentoring young potential Board members and the budget request has been sent to the Ministry. Mark, Margie Apa and Associate Professor Tai Sopoaga and I also met re the possible extension of Health Science Academies in metro-Auckland and nationwide and this will be discussed by the Health Workforce Advisory Board. I also met with an enterprising young South Auckland GP, Dr Canaan Aumua, who has developed the Mitara bot, answering measles questions as a social media response to vaccine hesitancy.
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:

**Te reo Māori in high demand:** It is fantastic to see more than 100 staff have signed up for the next intake of te reo Māori classes at North Shore and Waitakere Hospitals. Staff who attend weekly classes for the next 18 months will gain a national Level 3 qualification at the end of it. Course participants will have the confidence to converse in te reo at an intermediate level and develop cultural competencies that will assist in delivering healthcare within our diverse communities. The first intake of people started their te reo classes in February last year and will graduate in August. We are proud to be partnering with Te Whare Wānanga o Awanuiārangi on this programme.

**Advisory group of rangatira announced:** Our Chief Advisor Tikanga, Dame Naida Glavish, has been selected as a member of the Māori Advisory Panel to the Chief Ombudsman. The external advisory panel, which was announced by Chief Ombudsman Peter Boshier in December, is the first of its kind for the office. The group consists of seven tangata whenua representatives and will support the Chief Ombudsman’s role by being more responsive to Māori and ensuring fairness for all. The panel will help guide engagement on matters that have the most positive and enduring impact on Māori communities.

Dame Naida Glavish is a member of the panel made up of prominent experts and rangatahi leaders.
New faces and board changes at Well Foundation: I would like to extend a warm welcome to Tim Edmonds who took up the role of Well Foundation CEO in November. Tim previously worked as the Research and Innovation Director at Cure Kids and was GM of Cure Kids Fiji. Anna Rennie is also a new arrival on the Well Foundation team where she has been hired as the Director of Fundraising and Communications. Anna has extensive fundraising experience after working at Starship Foundation, KidsCan and Melanoma NZ. Craig Donaldson has stepped down as Chair of the Well Foundation, with David Downs moving into the role. Craig will remain on the board until the end of 2020. Mark Jeffries and Sussan Turner have also stepped down as Trustees. The board recently agreed to a 90-day plan to advance the foundation’s strategic and operational priorities. A key priority is to agree future fundraising projects and further diversify sources of fundraising income to complement Well Foundation’s previous success in engaging philanthropic trusts, commercial businesses and major donors. The foundation is currently fundraising for two big projects. The Special Care Baby Unit at Waitakere Hospital is just $694,276 away from its $5 million target and another $654,451 is needed to raise the $2 million required for the new Diagnostic Breast Services area at North Shore Hospital.

Fond farewell: I would like to extend our gratitude and heartfelt thanks to Chaplain Uesifili Unasa whose last day at North Shore Hospital was on 31 December. Uesifili joined us two years ago from the Remuera Methodist Parish. As one of the hospital chaplains at our North Shore Hospital Spiritual Centre, Ahurewa, he worked closely with our health care professionals to provide emotional and spiritual support for patients and their families. He also encouraged multi-faith worship to reflect the changing cultural landscape of Auckland. Uesifili would often visit patients on the wards or in other areas of the hospital on request. We wish him all the very best in his new appointment at the Waitakere Methodist Parish.
SMOs recognised: Two of our Senior Medical Officers have been recognised at the Distinguished Clinical Teacher Awards. Nav Sidhu from Anaesthesiology and Wendy Burgess from Obstetrics and Gynaecology were honoured for their outstanding contributions to teaching and guiding the next generation of healthcare professionals. Nav and Wendy were presented with awards for educators who’ve made a positive impact on students and their education in 2019 during an event at the University of Auckland’s School of Medicine. We are extremely fortunate to have clinicians like them who are committed to developing and supervising our student placement. Their guidance, leadership and mentoring is invaluable to our next generation of healthcare professionals. Congratulations to them both.

First baby of the new decade: North Shore Hospital’s maternity ward welcomed the first baby of the new decade with the arrival of little Ziona Zhu at 12.04am on 1 January. Ziona is the fourth child of parents Jason and Mira Zhu who called her a “special gift”. Her story appeared on page three of the NZ Herald and online: [https://bit.ly/38L2J8m](https://bit.ly/38L2J8m)

Celebrating Chinese New Year: The start of the Lunar New Year was marked by our Asian Health Service team with staff and colleagues over a shared lunch. People gathered in their offices to celebrate while enjoying the delicious food. This year, 2020, is the Year of the Rat. The rat is associated with wealth, optimism and likeability in Chinese culture.
International Year of the Nurse and the Midwife: 2020 has been chosen by the World Health Organization as the International Year of the Nurse and Midwife, coinciding with the 200th anniversary of the birth of Florence Nightingale, one of the founders of modern nursing. We will celebrate this initiative by profiling some of our fantastic nurses and midwives and the work they do within Waitematā DHB.

Manaaki Wahine funding approved: I am very pleased to announce that our application to the Proceeds of Crime Fund has been approved, pending ministerial sign-off. This vital funding of $1.7 million, over three years, will provide a 15-bed residential treatment service for women who are homeless or rough sleeping. The service is already up and running and will include a comprehensive residential programme and therapeutic arm from 1 July. The aim is to ultimately support women into their own permanent accommodation. Pathways to employment and training/engagement in meaningful activities will also be explored once women are established in their own homes. We expect 180 women will access the service over three years.

DHB capital announcement: It was very pleasing to see Waitematā DHB listed among those set to benefit from the government’s recently announced $12 billion infrastructure package that includes a $300 million boost for the health sector. Approximately $11.6 million has been allocated to the upgrade of our Central Sterile Services Department (CSSD) at North Shore Hospital. The planned refurbish and upgrade will fully utilise the current CSSD footprint to create one centralised department that allows for maximum efficiency while providing safe and timely service-delivery for our patients. The new CSSD will help us meet growing demand for our services as our population continues to expand. The upgrade is needed before the new hospital building on our North Shore campus is completed, so the timing could not have been better. Much of the design work associated with this project is complete and the business case is now moving through the sign-off process. The business case will be presented to the Board for consideration in the coming months. We plan to open the upgraded facility in 2022.

Occupational therapy recognition: Congratulations to Cathryn Wong, Ashleigh Donavan and Jenny Bos who have been recognised at the Occupational Therapy awards. The awards recognise Waitematā DHB occupational therapists who have demonstrated exceptional practice over the year. Cathryn won the Mental Health and Addictions category for her work providing education to families and whānau and for her ongoing focus on occupation and participation. Child Health and Rehab winner, Ashleigh, was acknowledged for going above and beyond when providing best care and interventions for patients and their whānau. Jenny also won the Medicine and Health of Older people/SAS award for proving there is not a clinical conundrum she can’t solve while sharing her knowledge across the teams.
**New Zealand Primary Healthcare Awards finalists:** The innovative work being conducted within Waitematā DHB has been recognised in the inaugural New Zealand Primary Healthcare Awards. Auckland and Waitematā DHBs have been named finalists in the ACC Patient Safety Award category for Safety in Practice Team. This is New Zealand’s only team to focus entirely on patient safety in the community. It is a multidisciplinary team working for Auckland and Waitematā DHBs to design, develop and deliver the safety in practice programme to primary care providers across the region. The programme helps health professionals to create system-level changes that improve their processes and reduce admissions. We have also been named a finalist in the Southern Cross Health Insurance Primary and Secondary Integration Award category. E-consult, developed by our Institute of Innovation and Improvement (i3), is an electronic consultation programme based on an alliance model between primary and secondary care. The project builds bridges among healthcare providers and addresses the protracted wait times that cause undue suffering for patients. The awards celebrate individuals and teams who have made a positive change to, and impact on, healthcare services. Winners will be announced at a gala night on 29 February in Auckland. Good luck, Team Waitematā!

**New Mason Clinic building update:** Construction of the E Tū Tanekaha building is well underway and the facility is on track to open later this year. Work-to-date includes installation of the piles; boxing of foundation and retaining walls; waterproofing foundations; pouring of ground beams and installation of in-ground services.

*E Tū Tanekaha will be a new 15-bed medium secure unit*
Outpatient Department refurbishment: The three-stage refurbishment of the lower ground floor of North Shore Hospital is nearing completion. In phase one, the Radiology Department waiting room was upgraded and followed by a renovation of the entire Phlebotomy Department. We are now in the final phase of the project with the upgrade of the Outpatients Department. The department now has new chairs, vinyl and paint. Work to improve the look and feel of these spaces will enhance patient experience and create a more pleasant working environment for staff.

Up to 400 people a day will pass through the newly-refurbished Outpatient Department

Creating a culture of appreciation
Another 21 people 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 are included as Appendix One.

2. Upcoming events

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

- 29 February – Rare Disease Day
- 8 March – International Women’s Day
- 12 March – World Kidney Day
- 20 March – World Oral Health Day
- 21 March – International Day for the Elimination of Racial Discrimination
- Ongoing work on the demolition of Taharoto building as part of preparation works for our new hospital building
- CEO Lecture Series to recommence
4. 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

Better Outcomes ✓

*Progress: On track*

National Inpatient Survey

<table>
<thead>
<tr>
<th>HQSC weighted results</th>
<th>Communication</th>
<th>Partnership</th>
<th>Co-ordination</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5 WDHB</td>
<td>8.6 WDHB</td>
<td>8.5 WDHB</td>
<td>8.7 WDHB</td>
<td></td>
</tr>
<tr>
<td>8.4 National Average</td>
<td>8.6 National Average</td>
<td>8.4 National Average</td>
<td>8.6 National Average</td>
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</tbody>
</table>

Table 1: National Survey Quarter One (July - August 2019)

Quarter 3 (Q3) results include patients discharged between 29 July and 11 August 2019. The response rate for Q3, 2019, was 32% (the highest response rate of all DHBs). All surveys were distributed via email. The national response rate for this quarter was 22%. Waitematā DHB results continue to improve, with our best results ever recorded for the domains of Partnership, Co-ordination and Needs. The communication domain decreased by 0.2 from the previous quarter but is above the national average.

Graph 1: Waitematā DHB run chart for all domains, 2014-19
Friends and Family Test
In December 2019, we achieved our highest-ever Net Promoter Score (NPS) of 81. The previous high score of 80 was first achieved in June 2018. In December we received feedback from 924 people (down from 1096 people the previous month). The NPS continues to consistently perform well and score above the DHB target of 65.

Friends & Family Test Overall Results
The net promoter scores in December have met target for all Friends and Family Test questions. All measures are up on the previous month, performing well above the target. The highest performers are, once again, ‘welcoming and friendly’ and ‘care and respect’ - achieving scores of 93 and 91 respectively. Our lowest performer this month was ‘did we see you promptly,’ which scored 79.
**Waitematā DHB - Patient Experience Report (December 2019)**

**Graph 3:** Waitematā DHB Net Promoter Score over time

**Total Responses and NPS to Friends and Family Test by ethnicity**

<table>
<thead>
<tr>
<th>December 2019</th>
<th>NZ European</th>
<th>Māori</th>
<th>Overall Asian</th>
<th>Overall Pacific</th>
<th>Other/European</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>616</td>
<td>73</td>
<td>87</td>
<td>56</td>
<td>213</td>
</tr>
<tr>
<td>NPS</td>
<td>81</td>
<td>86</td>
<td>77</td>
<td>80</td>
<td>81</td>
</tr>
</tbody>
</table>

Table 3: NPS by ethnicity

In December, all ethnicities met the Waitematā DHB NPS target and score 65 and above.

<table>
<thead>
<tr>
<th>December 2019</th>
<th>NZ European</th>
<th>Māori</th>
<th>Overall Asian</th>
<th>Overall Pacific</th>
<th>Other/European</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did we see you promptly?</td>
<td>78</td>
<td>85</td>
<td>84</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>Did we listen and explain?</td>
<td>85</td>
<td>89</td>
<td>82</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>Did we show care and respect?</td>
<td>91</td>
<td>95</td>
<td>87</td>
<td>88</td>
<td>90</td>
</tr>
<tr>
<td>Did we meet you expectations?</td>
<td>82</td>
<td>84</td>
<td>83</td>
<td>88</td>
<td>85</td>
</tr>
<tr>
<td>Were we welcoming and friendly?</td>
<td>93</td>
<td>93</td>
<td>91</td>
<td>86</td>
<td>91</td>
</tr>
</tbody>
</table>

**4. Future Focus**

Soft wristbands with barcodes are now being used for patients across almost all areas at Waitakere Hospital with great feedback. This gets us a step closer to closing the loop in verifying patient identity at the bedside for taking blood samples and the administration of medications.

Learnings from the Patient Experience Reporting System (PERSy project) have been shared with a demonstration at Counties Manukau DHB.

Older Adults, paediatrics and renal services are about to go-live with digital postage. The team is working on the proposal from the preferred vendor in the Outpatient Flow Tools project and will be reporting on this soon.

The new WiFi TWA network is now up-and-running in all clinical areas across North Shore Hospital. The TWA is a new WiFi network for clinical applications/systems to use, rather than the Hospital Hotspot for patients/visitors or the existing staff WiFi network SWA. Plans for which devices and systems will use TWA are still being finalised.
The team is working with the Ministry of Health and the region on plans for being ‘FaxFree’ later this year. We are also working on developing the Robotic Process Automation platform.

**Achieving the priority targets – December 2019**

- Planned Care interventions – 105% (target 100%)
- Shorter waits in ED – 96% (target 95%)
- Faster cancer treatment – 93% (target 90%)
- Increased immunisation – 93% (target 95%)
- Raising healthy kids – 100% (target 95%)
- Māori percentage of overall workforce – 7.2% (target 7.4%)

**Health Quality and Safety markers**

**Falls**
The monthly audits of falls risk assessments for the Health Quality and Safety Commission data continue. Overall, Acute & Emergency Medicine completed 97% of falls risk assessments, Specialist Medicine & Health of Older People completed 100% and S&A completed 100% on admission. Of those, Acute & Emergency Medicine completed 91%, Specialist Medicine & Health of Older People completed 68%* and S&A completed 81% within eight hours of admission (against a target of 90%).

*Issue with information systems not recognising that AT & R ward patients are “Admitted” following transfer/discharge from an acute ward; I believe this is being looked at.

**Hand Hygiene**
Waitematā DHB’s Hand Hygiene Compliance Audit result for December 2019 is 89%; this exceeds national target of 80% compliance and the DHB is consistently above the national average of 85%.

**Healthcare-Associated Infections**
The CLAB insertion bundle was used in ICU on 100% of occasions in December 2019. The insertion bundle compliance exceeds the national target of 90%.

**Māori Health**

**Model of Care Review – He Kamakā Waiora**
The investigation phase of the Model of Care Review of He Kamakā Waiora Services has now been completed. The review team has submitted the final draft of findings report and recommendations. It will be shared with key internal stakeholders in the first instance before being finalised for implementation.

**Māori Health Service Improvement Projects**
As well as the report into the Model of Care Review of He Kāmaka Waiora services, there are a number of other key improvement projects underway.

- **Automating referrals to the service**
  We are working with IT teams at Waitematā and Auckland DHBs to implement automated referrals to the service. At Wāitematā DHB, a practical solution using current online systems is already in place. The proposed system has been developed and will be tested over the next three months. The system will use the current clinical portal and will enable wards to make electronic referrals to He Kāmaka Waiora service across its six key service pathways:
Waitematā District Health Board, Meeting of the Board 26/02/20

a. Cultural expertise e.g. karakia
b. Bereavement support e.g. support for whānau
c. Emergency whānau accommodation
d. Mediation – support for staff to work with whānau
e. Health literacy – support for patients and whānau
f. Advocacy - support for patients and whānau

This approach will also enable better performance reporting of the service in the future and make its daily activities more transparent. In the past, referrals have been done over the phone or via email. Reporting on service utilisation has been done manually in the past. This innovation has been shared with the IT team at ADHB to help aid developments and progress of this project there.

• **Automating booking to whānau accommodation**
  He Kāmaka Waiora is responsible for running whānau accommodation at North Shore Hospital which has four rooms, three single family rooms (two adults and one child) and one large family room (up to 10 people). In the past, bookings for accommodation have been done over the phone or via email. An investigation is currently underway to check the feasibility of the implementation of RMS Cloud Software for property management. This is the same software used by Ronald McDonald House. It will enable automated referrals by the wards, performance reporting and better coordination of several property management functions such as cleaning. Initial assessments have been favourable. A business case for the implementation of the software for all whānau accommodation being managed by He Kāmaka Waiora is currently being worked on.

**Pacific Health**

**Division Priorities for 2019/20**
2. Workforce pipeline: health science academies, building maintaining and sustaining outcomes.
3. Supporting high-needs Pacific families in inpatient settings.
4. Leadership support and advisory.

**The Synergy Evaluation of Health Science Academies**
This evaluation reported on the implementation and outcomes of the HSA programme (administered by Counties Manukau DHB and subcontracts Auckland DHB and Waitemata DHB to deliver to schools in the region) from a systemic perspective. It aimed to describe the delivery in schools; understand the benefits and experiences of key stakeholders involved; identify ideas for improvements to the programme, including considerations for future roll out of the programme. The reports and recommendations have contributed to a more strategic direction. As a regional team we have agreed to re-set and re-brand for 2020. An official launch is planned for April.

**Review of Pacific Health Services Tautai Fakataha**
Pacific Health space: ADHB have recently offered space on level 4 of Auckland City Hospital to bring all Pacific Health services into one space with potential to serve WDHB from Auckland. This significantly alleviates the challenges of having Pacific Health services spread across the four main hospitals across the two DHBs.
Passing away of Matua Mahe Uliuli Ha'unga
Waitematā DHB has extended condolences to the family, friends and colleagues of Maha'uli'uli Ha'unga, a much-respected matua (elder) with the Pacific Health team. Matua Mahe was the first matua to be endorsed by Pacific Health for our hospital services and worked across Waitematā and Auckland DHBs. He was a key figure at multiple Waitematā DHB openings and events that were supported by the Pacific team and also worked on the Planet FM Radio station - communicating Tongan news to the community.

Pacific Health Strategy
This has been submitted to Waitematā DHB CEO for feedback and due to be presented to Waitematā DHB Board layer in the year.
APPENDIX ONE – CEO RECOGNITION

Nominated by Kelle Smith.
“Jess always has a smile on her face and is a pleasure to see on the ward. We recently had a very ill patient whom she cared for beautifully. This patient voiced such appreciation of how she was treated; she felt that she was ‘the only person that mattered to Jess’. Jess cared for her so marvellously that the patient reported that she forgot about her anxiety for a brief period, which felt like Christmas to her. It would be lovely to have Jess acknowledged for her outstanding care of patients, which is always seen demonstrated.”

Miriam Laidlaw - Instructional Designer, Learning & Development, Corporate.
Tabitha Parker - Instructional Designer, Learning & Development, Corporate.
Nominated by Stephen Anderton.
“Our Instructional Designers, Miriam and Tabitha are recognised for their exceptional contribution in creating our eLearning landscape on Ko Awatea LEARN. Their extraordinary work touches every single one of us at Waitematā DHB, and is a true expression of what it looks like to be ‘better, best, brilliant!’.”

Julie Anaru-Johnson - Administration Clerk, Booking & Scheduling, Surgical & Ambulatory.
Nominated by Shruthi Adunuthula.
"Julie is always proactive and always keen to offer the best service to our patients."

Annette Lane - Occupational Therapist, North Therapies, Allied Health.
Nominated by Simone Skelton.
"Annette has done a fantastic job covering the Duty Occupational Therapy role during a recent period of short staffing. Although we know this part of the role is not her first love, she has done a stellar job to continue working her caseload and maintained an upbeat and enthusiastic attitude whilst supporting the team and her colleagues. Your work and efforts over the past few months have been greatly appreciated."

Marieke Dijk - Occupational Therapist, Community West Therapies, Allied Health.
Nominated by Simone Skelton.
"Marieke has also done a fantastic job covering the Duty Occupational Therapy role during a recent period of short staffing. Although this role is busy and demanding, Marieke has done a wonderful job to balance her caseload and the demands of the role whilst still being able to support her Community West Occupational Therapy colleagues. We very much appreciate your work and efforts over the past few months covering the Duty OT role."

Prescilla Menezes - Registered Nurse, Kahikatea Unit, Mason Clinic, Mental Health & Addiction Service.
Sen George - Enrolled Nurse, Kahikatea Unit, Mason Clinic, Mental Health & Addiction Service.
Nominated by Maris Lal.
"Both Prescilla and Sen are highly trained and competent members from general nursing, and in the past year have entered into Mental Health Services and shown how valuable their skills are. They have taken on-board working with service users with mental health issues along with dedicating time and effort to up-skill and train our Psychiatric nurses around holistic care and the importance of physical health while monitoring mental health needs."

Josilina Silimaka - EA to GM Pacific Health, Pacific Support Services, Corporate.
Nominated by Tuliana Guthrie.
"Josilina is an efficient and hard-working member of our team. No task is too small nor too big for her. She strives for 'better, best, brilliant'. Josilina is selfless, kind and acts with humility. She embodies our values of 'everyone matters' and 'with compassion'.

Abel Smith - Clinical Nurse Director, Pacific Support Services, Corporate. Nominated by Tuliana Guthrie.
Abel is a courageous leader for all those people he serves – patients, families, colleagues. Through all his work he shows compassion and that 'everyone matters'.

Hannah Gray - Registered Nurse, Kahikatea Unit, Mason Clinic, Mental Health & Addition Service
Nominated by Maris Lal.

"Hannah is a bright and bubbly personality. She adds a touch of evidence-based care and ensures to help service users meet goals and potential. Hannah has also taken the initiative to help educate psychiatric assistance on how to complete mandatory trainings, work collaboratively with nurses and service users. Hannah is highly trained and works with passion. She is a valued member of the team at Kahikatea and her efforts are highly appreciated."

David Grayson - SMO & Clinical Leader, ORL & Audiology Services, Surgical & Ambulatory.
Nominated by Eleanor Gates.

"David stepped in to becoming our specialist support for Waitematā’s Tongue-Tie Assessment Clinics at short notice. He has encouraged evidence-based learning on this topic and supported our small team in pulling together a symposium (2018) and a Health Excellence entry (2019). He continues to support analysis of the research our practices are based on. His flexibility in seeing 'the extra baby' who needs his level of skill for mothers to continue breastfeeding comfortably, is wonderful. He is truly a delight to work with!"

Georgina Tucker - Immunisation Programme Manager, Funding - Child, Youth & Women, Corporate
Nominated by Ruth Bijl.

"Georgina Tucker has headed up bringing the National Immunisation Register (NIR) in-house. The register is a key tool supporting a population wide view of children’s immunisation status. As part of establishing Uri Ririki – Child Health Connection Centre, the Waitematā and Auckland Boards’ approved bringing the NIR in-house. Georgina’s systematic approach and skill in pulling a new team together has delivered the transition without impacting immunisation coverage. She has worked with PHO colleagues and others to identify and address multiple challenges."

Stephen Milburn - MHA Administrator, He Puna Waiora, Mental Health & Addition Service.
Nominated by Mimoza Trenceva.

"I have had the pleasure of working with Stephen and he is dedicated to his role and he always goes extra mile in his support for the clinicians while at the same time manages different styles."

Neil Harrop - Orderly, Theatre, ESC, Elective Surgery Centre.
Nominated by Tracy Purdy.

"Neil displays the WDHB value 'everyone matters'. He is always obliging, courteous and runs the extra mile in his role to ensure the department runs well. He undertakes his role willingly always wearing a smile. Neil has the ability to see what requires to be done and is happy to assist wherever possible. He is an asset to the department."

Suzanne Peeperkorn - Associate Clinical Charge Nurse / Nurse Educator, Emergency Care Centre NSH/ Learning & Development NSH, Acute & Emergency Medicine / Corporate.
Nominated by Dr Clare Fisher.

"We recently had a patient in extremis in Resus and Suzanne went the extra mile to be compassionate and recognise what the patient was worried about and did something about it. Thank you for caring."

Rhys Soppit - Registered Nurse, Theatre, ESC, Elective Surgery Centre.
Nominated by Wings Chang.

"Rhys always upholds Waitematā DHB value of 'better, best, brilliant' in his daily practice. He supports the junior nursing staff, covers extra shifts and is always very helpful. He runs the extra mile without being asked."

Mary Fuiono - Health Care Assistant, Karekare Ward, Acute & Emergency Medicine.
Nominated by Lindsay Nenova.

"Mary is a shining star to Waitakere ADU. She always has a smile, always happy to assist to the point that she overheard me telling a patient to wait in the chair for me whilst I locate a walking frame when ta-dah! There was Mary cleaning and delivering an unused walking frame to the patient. This
is just one of the many ways that Mary makes working in a very busy area so much easier. Thank you Mary.


"Ann-Kristin was exceptional with a dying man and his family, showing the DHB value of compassion. She was confident which was reassuring to the family and she was a great advocate for the gentleman’s needs."

**Eunice Ng** - House Officer, Urology, Surgical & Ambulatory. Nominated by Xu Cui.

"Eunice is an absolute pleasure to have as part of urology team for three month ward round. She is always keen to step up to new challenges and has an excellent work ethic and great communication skills, which is truly beneficial for, and noticed by the team. Thank you for all of your hard work and dedication to keep everything running so well."

**Pip Tangohau** - Team Leader, Clinical Support Services, Hospital Operations. Nominated by Wendy Jessup & Julia Gundy.

"Pip has supported the inpatient and rehab teams towards solutions and advocated for assistance from other services. She is always positive and proactive and is an absolute professional."
4.2 Health and Safety Performance Report

Recommendation:

a) That the Board endorses three areas for health, safety and wellbeing site visits
b) That the Board receives the report.

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 Performance Report is to provide quarterly reporting of health, safety and wellbeing performance including compliance, indicators, issues and risks to the Waitematā DHB.

2. Strategic Alignment

<table>
<thead>
<tr>
<th>Community, whanau and patient centred model of care</th>
<th>This report comments on issues and risks that impact on staff health and safety and therefore, patient care and organisational culture.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis and investment on both treatment and keeping people healthy</td>
<td>This report comments on organisational health and safety information via incident reports, health monitoring and identified hazards.</td>
</tr>
<tr>
<td>Intelligence and insight</td>
<td>This report provides information and insight into staff workplace incidents and what Waitematā DHB is doing to respond to these and other workplace risks.</td>
</tr>
<tr>
<td>Evidence informed decision making and practice</td>
<td>The leading and lagging indicator dashboard is based on current best practice indicators and targets. Risk controls are regularly audited to align to an evidence base.</td>
</tr>
<tr>
<td>Outward focus and flexible, service orientation</td>
<td>Health, safety and wellbeing risks and programmes are focused on staff, 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.</td>
</tr>
<tr>
<td>Operational and financial sustainability</td>
<td>As appropriate, programmes of work will outline how Services will ensure operational sustainability, how measures of success are set and value and return on investment is monitored.</td>
</tr>
</tbody>
</table>

3. Proposed Board Health, Safety and Wellbeing Site Visits

In order to ensure that members of the Board are able to gain a more detailed understanding of how health and safety is practiced/implemented at Waitematā DHB, the following three health and safety site visits are proposed for 2020:
• Safety and Security
  o Overview of Security Services at the Waitematā DHB
  o Demonstration of safety education

• Contractor Management
  o Discussion with ECIB Programme Director
  o Construction site visit

Hazardous Substances
  o Hazardous Substances Store, North Shore Hospital
  o Clinical area

When endorsed, we will work with the Board Secretary to schedule these visits at times that suit Board members.

4. Executive Summary

Construction near miss/incident escalation pathway

The DHB is working on a construction near miss/escalation communication pathway. The pathway has been drafted for consideration and we’ll give a verbal update at the meeting.

Learning exchange with Canterbury DHB

Canterbury and Waitematā DHBs are arranging to meet in March to exchange health and safety learnings in governance and health and safety management systems, including construction and facilities development. This is a positive and exciting move which will increase excellence in health and safety management across DHBs. We already work closely with Auckland, Northland and Counties Manukau DHBs.

December 2019 reporting period update

For the December reporting period Waitematā DHB has met the majority of leading and lagging indicators.

The lost time injury frequency rate (LTIFR) remains challenging (17 against a target of 10); however, the LTIFR relating to hazards has dropped to 12.

Although the LTIFR remains challenging, the Lost Time Incidents (LTIs) requiring less than seven days off work remains strong. This shows that many of the actions we have undertaken to reduce the consequence of incidents are delivering positive results.
Overall, reported incidents have reduced with a downwards trend since July 2018. In relation to top accident types:

1. Slips, trips and falls decreased this month to a total of twelve, down from sixteen in November. Of these 12 incidents, only three related to workplace hazards, with the remaining nine being unavoidable (tripping over own feet etc.).

2. Moving and Handling of patient incidents has dropped with five recorded in December. The Moving and Handling team reviews and follows up on all incidents, including auditing moving and handling equipment in the areas injuries were sustained. In addition, new online manual handling training is being finalised, to ensure the widest access for staff, especially those that do not handle patients, but are involved in lifting/moving equipment, such as orderlies and cleaners.

3. Physical Aggression incidents have dropped to 43 in December. As previously reported, a number of actions are in place to manage the likelihood of aggression incidents occurring and/or to reduce the severity of consequence when incidents occur. These actions include the establishment of two new aggression related committees, one for the general hospitals and one for Mental Health and Addiction Services. In December, 41 of all physical aggression incidents were caused by people who had no intention to cause harm, only two were deemed intentional.
5. Performance Dashboard

- **Number of Incidents by Division December 2019**
  - Acute & Emergency Medicine: 117
  - Obstetric & Neonatal: 0
  - Mental Health: 25
  - Primary Care: 2
  - Emergency Department: 4
  - Non-Medical Services: 0
  - Mental Health Services: 37
  - Medical Imaging: 1
  - Surgical & Anesthetics: 87
  - Pharmacy Services: 39
  - Other: 46

- **Top Five Incidents by “Nature of Incident” December 2019**
  - Physical Assault (Malicious): 18%
  - Unsafe Shift Patterns & Hours of Work: 11%
  - Damage or Failure of Internal Structure, Tool, Equipment, or Machinery: 10%
  - Medical Error/Mistake: 7%
  - Safety Concerns: 3%

- **Injury Outcomes of Aggression Incidents December 2019**
  - Psychological Effect: 38%
  - Cuts, Abrasions, or Bruises: 3%
  - Musculoskeletal Injury: 3%
  - Stress or Anxiety: 2%
  - Repetitive Strain Injury: 1%

- **Moving and Handling Incidents**
  - Jan 15, Feb 14, Mar 22, Apr 20, May 32, Jun 16, Jul 13, Aug 12, Sep 9, Oct 8, Nov 16, Dec 13

- **Physical Aggression Incidents**
  - Jan 19959, Feb 80, Mar 461, Apr 272, May 143, Jun 234, Jul 2020, Aug 3619, Sep 51, Oct 9, Nov 50, Dec 36

- **Slips Trips Falls Incidents**
  - Jan 19, Feb 14, Mar 12, Apr 10, May 9, Jun 8, Jul 17, Aug 16, Sep 9, Oct 15, Nov 10

- **Physical Aggression Incidents by Division December 2019**
  - Acute & Emergency Medicine: 10
  - Obstetric & Neonatal: 0
  - Mental Health: 3
  - Primary Care: 2
  - Emergency Department: 0
  - Non-Medical Services: 2
  - Mental Health Services: 9
  - Medical Imaging: 17
  - Surgical & Anesthetics: 9
  - Pharmacy Services: 2
6. Occupational Health Activity

Outlined below is a summary of occupational health activity undertaken in the DHB.
7. Work related injury Claim Data for December 2019

Outlined below is our injury claims data for December. Work injury claims data is for all work injuries currently managed by the Waitematā DHB, including injuries that occurred in previous years, up to and including injuries for December 2019. High accident events account for approximately 65% of the claims, as below:

### INJURY CLAIM DATA

<table>
<thead>
<tr>
<th>Lost days</th>
<th>Treatment cost</th>
<th>Weekly compensation costs (80% of salary)</th>
<th>Staff cover cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lost days for month</td>
<td>$ total for month</td>
<td>$ total for month</td>
<td>$total cover cost for month</td>
<td>Total $ cost for month</td>
</tr>
<tr>
<td>342</td>
<td>$38,810.18</td>
<td>$74,569.98</td>
<td>$93,212.48</td>
<td>$206,592.64</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Accident Injury type</th>
<th>Lost days this month</th>
<th>% of cost this month</th>
<th>Cost this month</th>
<th>Year to date trend for injury claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and handling</td>
<td>101</td>
<td>27%</td>
<td>$56,252.70</td>
<td>↓</td>
</tr>
<tr>
<td>Slips Trips Falls</td>
<td>88</td>
<td>29%</td>
<td>$60,397.46</td>
<td>↓</td>
</tr>
<tr>
<td>Aggression</td>
<td>29</td>
<td>13%</td>
<td>$26,049.24</td>
<td>↓</td>
</tr>
</tbody>
</table>

*Actions taken to mitigate high accident types are noted in the Executive Summary.*

1 December 2019 – 31 December 2019

<table>
<thead>
<tr>
<th>Total injury claims lodged</th>
<th>38</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury claims (work related hazards) lodged</td>
<td>28</td>
</tr>
<tr>
<td>Lost time injury claims lodged</td>
<td>11</td>
</tr>
<tr>
<td>Lost time injury claims (Work related hazards) lodged</td>
<td>8</td>
</tr>
</tbody>
</table>
Overview

Of the 11 lost time claims lodged in December 2019:

- 5 had 7 days or less of lost time and have returned to full duties.
- 2 had over 7 days of lost time and have returned to full duties.
- 1 staff member had over 7 days lost time and has returned to alternative duties.
- 3 other staff members remain fully unfit.

The following table has been included to provide information on the total cost of aggression related injury claims only (13 month rolling table).
Although there are the expected peaks and troughs, the overall trend is favourable. It should be noted that these costs are those expensed by Waitematā DHB during the reported periods, and do not reflect incidents that occurred within that same reported period. This is because there is a lag between an incident occurring and costs being expensed and because injuries can span multiple report periods, sometimes over multiple years, depending on the severity and time required to return to work (RTW).

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression Related Claims Costs</td>
<td>$52,417.28</td>
<td>$51,673.25</td>
<td>$47,379.09</td>
<td>$41,123.09</td>
<td>$38,153.51</td>
<td>$27,252.42</td>
<td>$17,786.37</td>
<td>$17,785.10</td>
<td>$24,380.99</td>
<td>$35,688.11</td>
<td>$26,049.24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Stakeholder feedback

8.1 Facilities and Development (F&D) – Health and Safety Management Systems November 2019

HIGHLIGHTS

Permit to Work – Approval to Proceed process
A pilot scheme allowing the main contractor to organise and manage all permits has been started on the Taharoto/Pupuke project. Oversight is carried out by the appointed Waitematā DHB project manager with evidence of this interaction recorded for future record and audit purposes.

RISKS

Contractor Asbestos Awareness
A recent event resulted in a contractor opening a section of a buildings fabric. An incident investigation was completed and it was confirmed no asbestos was present. The Facilities and Development Directorate’s approved list of contractors will be completed soon and communications will be sent to all contractors reiterating the health and safety requirements of their service agreements and the specific information captured in the induction/orientation process.

QualityHub – Contractor Health and Safety Questionnaire/Pre-qualification
All Facilities Management contractors that have not completed the Contractor Health and Safety Questionnaire have been contacted and advised to complete the survey. Reviews will be undertaken of all submissions and a final list of approved contractors will be circulated to all Facilities and Development Directorate staff.

Waitematā District Health Board, Meeting of the Board 26/2/20
HEALTH AND SAFETY STATISTICS - NOVEMBER 2019

<table>
<thead>
<tr>
<th>Incidents &amp; accidents</th>
<th>F&amp;D</th>
<th>FM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost time Injuries</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Serious harm accidents</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accidents requiring medical attention</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accidents requiring first aid</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Near Miss Incidents</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This month</td>
<td>1*</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mthly average</td>
<td></td>
<td></td>
<td>2.5</td>
</tr>
<tr>
<td>YTD</td>
<td></td>
<td></td>
<td>31</td>
</tr>
</tbody>
</table>

| Safety Inspections completed           |     |    |       |
| this month                             |     |    |       |
| Projects                               | 100%|    |       |
| Facilities operations                  | 75% **|  |       |

| H&S / Toolbox Meetings                 |     |    |       |
| this month                             |     |    |       |
| Projects                               | 100%|    |       |
| Facilities operations                  | 100%|    |       |

| Contractor Site Inductions             |     |    |       |
| This month                             | 20  |    |       |
| YTD                                    |     |    | 581   |

* 1 x minor near miss event that resulted in contractors accidentally using water from a neighbouring supply. Issue resolved immediately and future controls implemented.

**Current workload and resource constraints have been provided as the explanation as to why Facilities Management did not achieve all of its internal safety inspections for November. It is expected that with new positions due to be filled in early-2020 all the required internal self-inspections will be achieved going forward.

9. Health and Safety Risks

The table below outlines our key health and safety risk categories, commentary on the current projects related to that risk, and whether those projects impact the likelihood or consequence/outcomes of that risk. Traffic lights indicate progress of each project.

<table>
<thead>
<tr>
<th>Key</th>
<th>Progress Indicator</th>
<th>Risk Measure Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Major delays</td>
<td>L</td>
</tr>
<tr>
<td>Amber</td>
<td>Minor delays</td>
<td>C</td>
</tr>
<tr>
<td>Green</td>
<td>On track</td>
<td></td>
</tr>
</tbody>
</table>

Waitematā District Health Board, Meeting of the Board 26/2/20
### Biological Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>Update</th>
<th>Start Date</th>
<th>Est. Date to Complete</th>
<th>Progress Indicator</th>
<th>Risk Measure Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle stick injuries</td>
<td>Audit findings and recommendations were discussed at the October Executive Health, Safety and Wellbeing meeting and approval provided to move to safety cannulas. New: As approval has been received, a project is being set up to review the use of cannulas across both hospital sites, to firstly reduce their usage where unnecessary (Phase 1) and then to move to safety cannulas (Phase 2). First phase: due May 2020 Second phase: due date to be set</td>
<td>Oct 2019</td>
<td>Dec 2018</td>
<td>May 2020</td>
<td>L</td>
</tr>
<tr>
<td></td>
<td>A ‘sharps safety week’ has been scheduled for December 2019, in-line with the international sharps awareness month. Complete: 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Splashes</td>
<td>Incorporated within all BBFE related projects, including Personal Protective Equipment (PPE).</td>
<td></td>
<td></td>
<td></td>
<td>L/C</td>
</tr>
</tbody>
</table>

### Substances hazardous to health

<table>
<thead>
<tr>
<th>Risk</th>
<th>Update</th>
<th>Start Date</th>
<th>Est. Date to Complete</th>
<th>Progress Indicator</th>
<th>Risk Measure Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asbestos Register</td>
<td>Refurbishment surveys are carried out prior to invasive works. Current projects underway are: Taharoto building demolition Various other refurbishment surveys have also been completed for smaller projects managed by Facilities, in line with Safe Systems Of Work (SSOW) process. No concerns to date.</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>Mould</td>
<td>OH&amp;S continue to review all air testing reports relating to mould and provide advice to the relevant Service managers and Facilities. No concerns to date.</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td></td>
<td>L/C</td>
</tr>
<tr>
<td>Chemicals</td>
<td>Hazardous Substances and New Organisms (HSNO) Audits: Review of new Act has been completed and audits of 33 high risk areas (67 physical locations) have recommenced. Audits completed: 58%</td>
<td>Sept 2016</td>
<td>Dec 2020</td>
<td></td>
<td>L</td>
</tr>
</tbody>
</table>
### Hazardous Goods Store for Waitakere Hospital: Case

| Status | Complete: 20% | Dec 2016 | Sept 2020 | L |

### Ergonomics

| Moving and 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. There are no concerns to date. | Ongoing | Ongoing | L/C |

| Posture | There is online self-assessment guidance available for all staff to access. Workstation assessments are ongoing, as staff requests them. | Ongoing | Ongoing | L |

### Physical

| Machinery | A schedule has been set up for Facilities Maintenance staff to check/review and service all machinery. There are no concerns to date. | Ongoing | Ongoing | L |

| Equipment | Clinical Engineering hold a master file of all clinical equipment across WDHB and this equipment is serviced on a recurring schedule. There are no concerns to date. | Ongoing | Ongoing | L |

| Electrical safety | A project to identify all electrical equipment has been completed, with all external contract maintenance providers having been contacted and the standards that equipment is serviced to have been reviewed for compliance. Clinical Engineering holds all records, including service maintenance schedules. Clinical Engineering following up with all non-compliant suppliers. | Ongoing | Ongoing | L/C |

| Uneven surfaces | On-going actions: Communications continue to be developed and released regarding Slips, Trips and Falls hazards, focussed heavily on staff rushing to complete tasks. Each incident of this type is followed up by OH&SS, with any corrective actions tracked to completion. There are no concerns to date. | Ongoing | Ongoing | L/C |
## Roading

| Helipad: The pedestrian crossing to service the helipad, including appropriate lighting, has been scheduled for completion in 2019. Construction works on the raised crossing are now complete. Final piece of work to repaint crossings with red non slip paint is scheduled for 3 months’ time. Planning complete: 100% Physical works complete: 100% |
|---|---|---|---|
| Feb 2017 | December 2019 | L |

## Buildings

| Loading Dock: The scope has changed and changes to enclose the loading dock itself are no longer required, as brakes have been added to all trolleys. Waste bin location, roading area relating to the dock, truck movement, directions and road markings are still in scope and to be considered as part of the project and funding request. To be presented to ELT November for review & consideration. Planning complete: 85% |
|---|---|---|---|
| Feb 2017 | Mar 2020 | L |

## Emergency Management

### Fire

Fire evacuation drills are conducted regularly by the Fire Safety Officer and fire safety equipment, such as sprinklers and smoke alarms, are regularly audited for compliance, overseen by Facilities.

An Emergency Management Committee has now been formed.

- Ongoing

### Civil emergency

WDHB conduct desk-top emergency drills on an ongoing basis. Emergency response team personnel have been identified and trained. This includes contact points with Civil Defence.

An Emergency Management Committee has now been formed.

An audit on emergency preparedness is planned for 2020.

- Ongoing
**Bomb threats**

WDHB conduct desk-top emergency drills on an ongoing basis. Emergency response team personnel have been identified and trained. This includes evacuation and contact points with Emergency Services (Police and Fire).

An Emergency Management Committee has now been formed.

Drills are completed annually.

**Firearms**

WDHB conduct desk-top emergency drills on an ongoing basis. Emergency response team personnel have been identified and trained. This includes evacuation and contact points with the NZ Police.

An Emergency Management Committee has now been formed.

Drills are completed annually.

**Psychological Aggression**

The new Managing Aggression and Potential Aggression (MAPA) training has started being implemented across Waitemata DHB, managed by Learning and Development. MAPA Foundation has been delivered to a large number of staff across ED and the first MAPA Advanced workshops have taken place for our Security Service and Code Orange response teams.

Stage 1 Complete: 90% (due Dec 2019)

New: Two additional aggression committees have been set up to manage/oversee all related activities. Given the significant difference between the general hospital and mental health settings/environment and their associated hazards, one committee has been set up for each of these areas.

Additional Security Door Access, North Shore Hospital: New access way and design approved by internal stakeholders (OH&SS, ED and Security).

Design stage: 100%

Installation complete: 100%

<table>
<thead>
<tr>
<th>Psychological Aggression</th>
<th>Feb 2018</th>
<th>Dec 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>October 2019</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Oct 2016</td>
<td>Dec 2019</td>
</tr>
</tbody>
</table>

**Notes:**

- **L/C:** Latest completion date
- **C:** Current date

---

Waitematā District Health Board, Meeting of the Board 26/2/20
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Status</th>
<th>Due Dates</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying and harassment</td>
<td>Toolkit on Speaking up about bullying and harassment on StaffNet. HR Learn session held July 2019.</td>
<td>Ongoing</td>
<td></td>
<td>L/C</td>
</tr>
<tr>
<td>Lone workers</td>
<td>Following on from the previous work completed, a new project has commenced to review all organisational policies and procedures covering lone worker emergency response plans. This is to ensure that response plans are available within all areas with lone workers and that they are complete and communicated to staff. Complete: 100%</td>
<td>Jun 2018</td>
<td>Dec 2019</td>
<td>C</td>
</tr>
<tr>
<td>Stress/Distress/Fatigue</td>
<td>Employee Assistance Program (EAP) services in place and both staff usage and feedback is very positive. No issues to date.</td>
<td>Ongoing</td>
<td></td>
<td>L/C</td>
</tr>
<tr>
<td>Safe staffing</td>
<td><strong>RMO rosters:</strong> House Officers rosters developed, consulted and implemented: 100% Registrar rosters: rosters developed and consulted: 100% Consultation complete but not yet implemented. Rosters will be implemented once recruitment for specific rosters is complete- this is occurring with all urgency. Complete: 75% <strong>Nursing Care Capacity Demand Management (CCDM) and NZNO MECA Accord recruitment:</strong> CCDM: Services completing CCDM FTE reviews: 3</td>
<td>Dec 2018</td>
<td>Dec 2020</td>
<td>L</td>
</tr>
</tbody>
</table>

Waitematā District Health Board, Meeting of the Board 26/2/20
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:

- Coronavirus regional communications
- Holidays Act compliance
- Metro Auckland sonographers’ strike
- Communications planning with Mental Health Service
- Announcement of Christmas decoration competition winners
- Wilson Home upcoming events
- Retinal screening programme
- Waitakere Hospital site communications
- Regional dental newsletter
- New website planning with Consumer Council
- New hospital building project newsletter
- Flu season communications planning
- Internal executive information cascade planning
- Te reo language classes for staff
- Blessing of additional Mason Clinic land
- Māori Senior Medical Officers’ profile
- International Year of Nurse and Midwife promotion
- Māori recruitment specialist appointment
- Parliamentary Select Committee questions
- Planning for 2020 CEO Lecture Series
- Staff parking changes – further updates
- Career profiles for Recruitment Team
- Compassion campaign
- Ongoing implementation of Board decision re incorporation of macron
- Identification, scheduling and production of social media content and issues management
- Ongoing publication of messages via the Medinz primary care communications platform
- Health Heroes awards 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 home page and Waitematā Weekly
- Ongoing management of Official Information Act process
- 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
- Event photography and video
- Drafting of correspondence from the corporate office
- CEO Board Report
- Review of copy for DHB website
- Management of organisation-wide screensaver 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

**Waitematā DHB website – Google Analytics Statistics**

**Waitematā DHB website**

<table>
<thead>
<tr>
<th>Number of visits</th>
<th>December 2018</th>
<th>December 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total visits to this site</td>
<td>48,882</td>
<td>58,104 (+18.6%)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>21,787</td>
<td>25,520</td>
</tr>
<tr>
<td>Australia</td>
<td>645</td>
<td>786</td>
</tr>
<tr>
<td>USA</td>
<td>858</td>
<td>578</td>
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<tr>
<td>United Kingdom</td>
<td>195</td>
<td>221</td>
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</table>

<table>
<thead>
<tr>
<th>Top areas</th>
<th>December 2018</th>
<th>December 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitematā DHB staff page</td>
<td>27,879</td>
<td>34,271</td>
</tr>
<tr>
<td>Home page</td>
<td>9,640</td>
<td>10,596</td>
</tr>
<tr>
<td>North Shore Hospital</td>
<td>33,66</td>
<td>3,173</td>
</tr>
<tr>
<td>Waitakere Hospital</td>
<td>2,238</td>
<td>2,513</td>
</tr>
<tr>
<td>Contact us</td>
<td>1,969</td>
<td>2,170</td>
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<table>
<thead>
<tr>
<th>Traffic sources</th>
<th>December 2018</th>
<th>December 2019</th>
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</thead>
<tbody>
<tr>
<td>Search traffic</td>
<td>73%</td>
<td>73%</td>
</tr>
<tr>
<td>Direct traffic</td>
<td>24%</td>
<td>25%</td>
</tr>
<tr>
<td>Referral traffic</td>
<td>3%</td>
<td>2%</td>
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</table>
**Social media**

**Facebook**

Waitematā DHB Facebook page likes have increased by 83% since December 2018, with 10,699* current likes (5,847 likes – December 2018).

Total audience reach between 1 December, 2019 and 31 December, 2019 was 260,714 views.

Top three posts between 1 December, 2019 and 31 December, 2019:
1. People’s Choice Award 2019 (Audience reach: 66,295, including 29,698 engagements)

Waitematā District Health Board added 47 new photos to the album People’s Choice Award 2019.
Published by Ruth Dryfhout on 17 December 2019.

The time has come for the People’s Choice Award!
It’s your chance to vote for your favourite decorations in the DHB.
How to vote? 👇... See more

| 66,295  | 29,698  |
| People reached | Engagements |
2. Whaea Louise tribute (Audience reach: 18,261, including 5,018 engagements)

Waitematā DHB sends its deepest condolences to the family, friends and whānau of Whaea Louisiana Elia, a much loved kaumātua with our Māori Health Services - He Karakia Waiora. Whaea Louise had a long history with the health sector as a social worker and counsellor before taking on a Kaumātua role and in particular supporting Māori patients and their whānau – offering advice and comfort during their time in our hospitals. She also played an active role promoting the learning and use of Te Reo Māori by DHB staff and was a familiar face at the opening of many new Waitematā DHB facilities, joining other kaumātua to welcome guests and lead the proceedings. Her wisdom, friendship and kindness will be greatly missed. May she rest in eternal peace.
3. North Shore Hospital decoration judging (Audience reach: 11,452, including 4,243 engagements)

Day two of the Christmas decoration judging didn't disappoint!
Thank you to the staff, their families (and some patients) of North Shore Hospital for putting in a fantastic effort with this year's decorations - and we're only halfway! Another round of visits to come. 🌲🌟🎄

The exceptional displays and creativity are incredible!... See more

*As at 12 February 2020.
Twitter
Waitematā DHB Twitter followers have grown by 11.8% since December 2018, with 2,643* current followers* (2,364 followers as at December, 2018).

Total audience reach between 1 December, 2019 and 30 December, 2019 was 23,000.

Top tweet between 1 December, 2019 and 31 December, 2019:

1. Free measles event – (1615 reach)

SHARE this post with your West Auckland friends and whanau. 🙏

6-11 month year olds can get their FREE measles vaccine on Saturday 7 December at Waitakere Union Health Centre.

*As at 12 February 2020.
OIAs received

A total of 32 new Official Information Act requests were received between 3 December 2019 and 12 February 2020:

- N. Jones (NZ Herald) - Correspondence between ARDS and schools regarding the sale of sugary food and drink.
- B. McCoskrie (Family First) - Number of children under 18 years who have sought treatment/advice regarding gender identity.
- M. Mecham – Details of information provided to RNZ under OIA on informed consent.
- P. Pennington (RNZ) - Information regarding National Asset Management Plan (NAMP).
- M. Hubmann - Funding and referral details regarding phalloplasty operations for transgender patients.
- Name withheld to protect privacy - Complaint about nurse in relation to daughter's treatment.
- A. Andrews (FYI website) - Estimated floor space in square metres of all hospitals.
- S. Goss (Pain Management Centre) - Reports and data from Te Tumu Waiora pilot study.
- Mohammed A M (FYI website) - Total number of PGY 1 House Officers positions advertised solely for NZREX graduates (2014-20).
- K. Johnston (NZ Herald) - The number of sexual harassment allegations received for the past five years.
- S. Mackay (Auckland University) - DHB budget for population nutrition promotion over the last three years (2017/18, 2018/19, 2019/20).
- K. McCallum (Mediaworks) - Total hip replacements and total knee replacements referral info from 1 July, 2018 - 30 June, 2019.
- H. Martin (Stuff) - Number of people employed by DHB who contracted measles between 1 March and 31 December, 2019.
- S. Ockhuysen (Stuff) - The cost of Electroconvulsive Therapy (ECT) for the last five years.
- M. Badilla (BCI NZ Ltd) - Name of contractors awarded various Waitematā DHB building projects.
- S. Ockhuysen (Stuff) - Number of calls to the mental health crisis team over the past five years.
- L. Taylor (Tamaki Legal) - Information regarding disability support services in relation to current Waitangi Tribunal health inquiry.
- R. Wood - Documentation regarding the recruitment and selection of successful candidate for the position of General Manager - Surgical and Ambulatory.
- D. Lennon - Capital and infrastructure expenditure over the last 10 years.
- W. Shrimpton (Newshub) - Information regarding addiction services, detox, rehab and wait lists.
- J. Graham (NZ Taxpayers’ Union) - Copies of information provided to the MoH in relation to elective surgery access for 2019/20.
- M. Montgomery (FYI Website) - Asbestos management plans for all occupied workplaces with asbestos.
- R. Hill (RNZ) - Number of people referred for gender reassignment therapy.
- N. Akoorie (NZME) - Number of mental health patients who have left a secure facility.
- S. Mullin - Number of complaints received regarding a healthcare provider.
- D. Kittner - Number of people taking antidepressants and the length of time they have been prescribed.
### Media Clippings – 3 December 2019 – 12 February 2020

<table>
<thead>
<tr>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
</tr>
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#### Positive clippings

<table>
<thead>
<tr>
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<th>Newspaper</th>
<th>Clipping</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>33</td>
<td>Dominion Post</td>
<td>End of the world fizzes, so it’s time for cricket</td>
<td>0</td>
</tr>
<tr>
<td>82</td>
<td></td>
<td>Reaction in lift is ‘racist’</td>
<td>0</td>
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#### Neutral clippings

<table>
<thead>
<tr>
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<tr>
<td>20</td>
<td>Franklin County News</td>
<td>Patient rights breached</td>
<td>-</td>
</tr>
<tr>
<td>76</td>
<td></td>
<td>$3.3b for roads and rail</td>
<td>+</td>
</tr>
<tr>
<td>80</td>
<td></td>
<td>Intensive care expansion</td>
<td>+</td>
</tr>
</tbody>
</table>

#### Negative clippings

<table>
<thead>
<tr>
<th>Page no.</th>
<th>Newspaper</th>
<th>Clipping</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>24</td>
<td>Nor West News</td>
<td>Patient rights breached</td>
<td>-</td>
</tr>
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</table>

<table>
<thead>
<tr>
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<th>Newspaper</th>
<th>Clipping</th>
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<td>North Harbour News</td>
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<td>78</td>
<td></td>
<td>$3.3b for roads, rail</td>
<td>+</td>
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</table>

<table>
<thead>
<tr>
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<th>Newspaper</th>
<th>Clipping</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>North Shore Times</td>
<td>Patient rights breached</td>
<td>-</td>
</tr>
<tr>
<td>53</td>
<td></td>
<td>Patients at risk of ‘record’ wait times - union</td>
<td>-</td>
</tr>
<tr>
<td>72</td>
<td></td>
<td>$3.3b for roads, rail</td>
<td>+</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Page no.</th>
<th>Newspaper</th>
<th>Clipping</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>11</td>
<td>NZ Doctor</td>
<td>An integrated approach to meet patients’ mental health and psychosocial needs in primary care</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>HWNZ goes down in storm of criticism – but was it just too radical for its time?</td>
<td>0</td>
</tr>
<tr>
<td>57</td>
<td></td>
<td>Primary Healthcare Awards</td>
<td>+</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Page no.</th>
<th>Newspaper</th>
<th>Clipping</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NZ Herald / Weekend Herald</td>
<td>147 gunshot victims in violent surge</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Early bowel-cancer checks urged</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Apology for kids with rotten teeth</td>
<td>-</td>
</tr>
<tr>
<td>18</td>
<td></td>
<td>Consent to die</td>
<td>-</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>Drop cancer’s screening age: Nats</td>
<td>0</td>
</tr>
</tbody>
</table>
Time to build strength with China beyond trade

Anti-vaxxers on agenda

Road rage: Dad left in hospital

‘Special gift’ Ziona first bub of the decade

Medic kicked unconscious

‘Major risk’: Rundown wards need $14b fix-up

Sick hospitals risk patients and staff

Industrial action

DHB nurse suspended

Dog-lover needs surgery after roaming mutt bites off finger

‘I trusted the system’

Whistleblowers are needed

Mother who harmed children has sentence cut

Man suffers fractured skull in road rage incident

Female paramedic attacked

Shot in arm for pharmacy – MMR jabs arrive

Nurses sent to help Samoa

Patient rights breached

Bedridden to ultramarathon runner

Sonographers’ ‘drastic’ strike action

$3.3b for roads and rail

‘I was screaming and in tears’

‘But if I stop, I’m euthanising her’

Woman rescued from Kawau Island water tank

Film-inspired plea to victims

Woman rescued from Kawau Island water tank

Patient rights breached

Smash survival a ‘miracle’
5.1 Director Appointment to the healthAlliance NZ Limited Board

Recommendation:

That the Board:

a) Note the shareholders have, or are proportioning to, appoint a new director to healthAlliance NZ Limited, in place of Mr Meng Cheong.

b) Resolve that Dr Michael Roberts be appointed as a Class A director of healthAlliance NZ Limited and the company be notified accordingly.

c) Delegate authority to the Board Chair to execute all documentation necessary to formalise this director appointment.

Please see the attached paper submitted by healthAlliance for consideration by the Board. Dr Andrew Brant, the Waitematā DHB representative on the healthAlliance Board, has endorsed the proposed director appointment.
Decision Paper
Director Appointment to the healthAlliance N.Z. Limited Board
January 2020

Recommendation
It is recommended that the Board:

Note
• The shareholders have, or are proportioning to, appoint a new director to healthAlliance NZ Limited, in place of Mr Meng Cheong;

Resolve
• Dr Michael Roberts be appointed as a Class A director of healthAlliance NZ Limited and the company be notified accordingly; and

Delegate
• Authority to the Northern Region DHB Chairs to execute all documentation necessary to formalise this director appointment.

Prepared by: George Smith, hA Head of Corporate Services
Simon Jones, hA CFO

Reviewed by: Clayton Wakefield, hA Board Chair

1. Purpose
To seek DHB Board approval and a shareholders resolution to appoint Dr Michael Roberts (NDHB CMO) as a Class A director of healthAlliance N.Z. Limited (hA).

Dr Michael Roberts is the NDHB nominated replacement for Mr Meng Cheong (NDHB CFO) who has resigned from the hA Board by virtue of his resignation from NDHB.

2. Background
The hA Constitution and Shareholders Agreement provides that all shareholders appoint directors.

Auckland, Counties Manukau, Northland, and Waitemata DHBs (the Northern Region DHBs) each hold one quarter of the Class A shares. The hA Constitution provides, inter alia, that Class A shareholders may appoint up to four Class A directors. Custom and practice has been for each Northern Region DHB to appoint one Class A director.
3. **NDHB Class A Director Nomination**

NDHB has nominated Dr Michael Roberts (CMO) as their Class A director. Dr Michael Roberts has been the Chief Medical Officer for Northland District Health Board for 8 years. He holds fellowships of the Royal College of Surgeons of England, and the Australasian College of Emergency Medicine.

4. **hA Board Composition**

The hA Board composition following approval of these recommendations, is set out below:

<table>
<thead>
<tr>
<th>hA Board of Directors (following endorsement of this proposal)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class A shareholder directors</strong></td>
</tr>
<tr>
<td>• Rosalie Percival (ADHB CFO)</td>
</tr>
<tr>
<td>• Catherine Abel-Pattinson (CMH Director)</td>
</tr>
<tr>
<td>• Dr Andrew Brant (WDHB Deputy CEO)</td>
</tr>
<tr>
<td>• Dr Michael Roberts (NDHB CMO) — proposed director</td>
</tr>
<tr>
<td><strong>Independent directors</strong></td>
</tr>
<tr>
<td>• Clayton Wakefield (Chair)</td>
</tr>
<tr>
<td>• Roger Jones</td>
</tr>
<tr>
<td>• Russell Jones</td>
</tr>
</tbody>
</table>

5. **Next steps:**

The next steps are:

1. DHB Boards to approve and resolve the appointment of Dr Michael Roberts and delegate authority to execute documentation to DHB Chairs — *Jan/Feb DHB Board cycle*
2. DHB Chairs to sign the relevant documentation — *Jan/Feb DHB Board Cycle*
3. hA Corporate Services to update the Companies Office — *within 10 days of the final DHB Board approval.*
Appendix 1

NOTICE OF APPOINTMENT OF DIRECTOR

TO: HealthAlliance N.Z. Limited (Company)
585 Great South Road
Penrose
Auckland

Notice is hereby given by the Class A Shareholders pursuant to the Company’s constitution that the following person be appointed as a Class A director with effect from 28 February 2020:

1. Dr Michael Roberts

DATED _________ 2020

SIGNED on behalf of WAITEMATA DISTRICT HEALTH BOARD by:

____________________
Signature of authorised signatory

____________________
Name of authorised signatory

Note: The same resolution will be sought from each of the Class A Shareholders.
6.1 Financial Report for January 2020

Recommendation:

That the report be received.

Prepared by: David Dodds (Financial Planning Manager) and Cliff La Grange (Deputy Chief Financial Officer - Funder)
Endorsed by: Robert Paine (Chief Financial Officer and Head of Corporate Services)

Glossary

ACC - Accident Compensation Commission
ADU - Acute Diagnostics Unit
AIR - Advanced Interventional Radiology
DHB - District Health Board
ED - Emergency Department
FPIM - Financial and Procurement Information Management System
FTE - Full Time Equivalents
IDF - Inter District Flow
MECA - Multi-Employer Collective Contract
MHSOA - Mental Health Services Older Adults
MoH - Ministry of Health
MRI - Magnetic Resonance Imaging
NGO - Non-Government Organisation
NZNO - New Zealand Nurses Organisation
ORL - Otorhinolaryngology
PBFF - Population Based Funding Formula
PHO - Primary Health Organisation
RMO - Resident Medical Officer
SLA - Service Level Agreement
WDHB - Waitematā District Health Board

Background

The report summarises the financial performance of the Waitematā District Health Board for the period ended January 2020. The report covers all operating units of the Waitematā DHB, being the Funder Arm, Provider Arm and Governance.

1. Executive Summary

The Waitematā DHB result for the month of January 2020 was a deficit of $6.38m against a budgeted deficit of $6.39m, and therefore slightly favourable to budget by $0.01m.

The Waitematā DHB result YTD January 2020 was a deficit of $14.01m against a budgeted deficit of $14.28m, and therefore slightly favourable to budget by $0.27m.

The Waitematā DHB has submitted a break even budget for 2019/20.
Based on performance to date, the DHB is forecasting a break even position for the year, although this forecast is at risk due to a potential increase in annual leave costs, in the order of $10m associated with compliance to the Holiday Pay Act, that may now be realised in FY2020. While challenging to deliver, Management is committed to do so without reducing services or patient care, nor increasing clinical risk. No clinical vacancies are being held for financial purposes.

The DHB is behind its budgeted savings target by $11.2m year to date. This shortfall is being offset by a favourable result in the Funder Arm (refer commentary in section 3), and various adhoc savings in the Provider Arm, notably in Specialist Mental Health and Addiction Services (SMHAS) and Diagnostics services (refer divisional commentary in section 4). The budgeted savings variance is due to timing with the majority of tactical initiatives in execution, and the operational initiatives still in planning. The majority of the savings are expected to come from operational initiatives.

The savings programme is a priority for the Management team, with regular reporting to the Audit and Finance Committee and weekly updates to ELT. Savings obligations have been phased evenly in the budget. The financial savings target at the start of the year totalled $27.6m, reduced to $19.8m as at January 2020 (primarily due to capital charge adjustments). Year to date saving identified are $4.1m. It is anticipated the monthly shortfall to budget will close as initiatives are implemented. The largest improvements in performance, both operationally and financially (as measured by a reduction in real terms of unit outputs), will come from service reviews, which have already commenced for Orthopaedics and General Surgery. These reviews are clinically led, with a focus of improving the delivery of efficient and effective healthcare, as well as setting the direction for these services as we plan for the expansion of inpatient beds and theatre capacity.

### 1.1 Highlights

**Year to date operating deficit of $14.01m, favourable by $0.27m against a budgeted deficit of $14.28m.**

**Funder $11.10m favourable year to date - key financial performance factors:**

- The favourable impact resulting from the review and reassessment of accruals relating to prior period contractual liabilities as well as to current year new initiatives budgets not yet contracted
- The adverse impact resulting from reduced Hospital Medicines funding receivable from PHARMAC
- The favourable impact of out of cycle pharmaceutical funding – Waitematā DHB share of $20M
- The favourable impact due to the increase in drugs rebates receivable from PHARMAC as advised in their latest DHB expenditure forecasts
- Favourable variances in demand based utilisation services within Community Pharmacy, General Practice, Age Related Residential Care, and PHO Capitation

**Governance $1.01m favourable year to date - key financial performance factors:**

- HR Employee: underspend within Planning and Funding from positions not yet recruited to

**Provider $11.8m unfavourable year to date - key financial performance factors**

- Delays in the realisation of savings under the financial sustainability programme ($11.2m)
- Under delivery of electives programme resulting in lower revenue from the MOH ($1.7m)

The shortfall in elective surgical delivery has a direct impact on waiting lists, and as an outcome there are a large number of Orthopaedic patients (over 300) that are deemed to be non-compliant (have been waiting over 4 months for surgery). This, coupled with the risk of the MoH potentially withholding the normal ‘additional’ elective funding paid, has generated
urgent and focused plans to mitigate and address the situation. This is the absolute priority for the division. Plans and progress will be advised monthly to the Audit and Finance Committee.

- Additional nursing hours in Neonates & Maternity ($0.7m), and Acute Medicine primarily in ED and ADU ($0.9m), as a result of high patient demands

The financial impacts noted above were partially offset by savings due to:

- Additional ACC revenue, $1.2m
- Release of residual provisions for MECA settlements, $1.0m.

1.2 Financial Indicators

Table 1: Financial Indicators for January 2020

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Forecast</th>
<th>Budget</th>
<th>Variance</th>
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</thead>
<tbody>
<tr>
<td>Funder Arm</td>
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<td>0.0</td>
<td>0.4</td>
<td>11.1</td>
<td>0.0</td>
<td>11.1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>Provider Arm</td>
<td>-7.0</td>
<td>-6.4</td>
<td>-0.6</td>
<td>-26.1</td>
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<td>-11.8</td>
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<td>0.2</td>
<td>1.0</td>
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<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>DHB Result: Surplus / (Deficit)</td>
<td>-6.4</td>
<td>-6.4</td>
<td>0.0</td>
<td>-14.01</td>
<td>-14.28</td>
<td>0.27</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Position</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Forecast</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown Equity (net worth)</td>
<td>489.6</td>
<td>605.3</td>
<td>-115.7</td>
<td>489.6</td>
<td>605.3</td>
<td>-115.7</td>
<td>639.8</td>
<td>639.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>3.1</td>
<td>5.7</td>
<td>2.6</td>
<td>34.0</td>
<td>48.0</td>
<td>14.0</td>
<td>81.4</td>
<td>81.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Cash Flow Balance</td>
<td>39.8</td>
<td>16.4</td>
<td>23.4</td>
<td>39.8</td>
<td>16.4</td>
<td>23.4</td>
<td>22.2</td>
<td>34.6</td>
<td>-12.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Activity</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Forecast</th>
<th>Budget</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Attendances</td>
<td>9,543</td>
<td>9,494</td>
<td>-49</td>
<td>67,927</td>
<td>66,482</td>
<td>-1,445</td>
<td>115,299</td>
<td>113,299</td>
<td>-2,000</td>
</tr>
<tr>
<td>Acute Volumes (WIES)</td>
<td>5,541</td>
<td>5,702</td>
<td>161</td>
<td>39,523</td>
<td>39,544</td>
<td>21</td>
<td>67,317</td>
<td>67,317</td>
<td>0</td>
</tr>
<tr>
<td>Elective Volumes (WIES)</td>
<td>1,132</td>
<td>1,406</td>
<td>-274</td>
<td>10,137</td>
<td>10,714</td>
<td>-574</td>
<td>---</td>
<td>18,348</td>
<td>---</td>
</tr>
</tbody>
</table>

Please refer to section 7.0 for clinical activity commentary (including a breakdown of the shortfall in elective volumes in January).
2. Waitematā DHB Consolidated Financial Performance

2.1 Financial Result

Table 2: Waitematā DHB Consolidated Financial Result for the month ended January 2020

<table>
<thead>
<tr>
<th>$ 000's</th>
<th>Month</th>
<th>YTD</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>REVENUE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>160,149</td>
<td>157,736</td>
<td>2,413</td>
</tr>
<tr>
<td>Other</td>
<td>2,452</td>
<td>2,005</td>
<td>446</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>162,601</td>
<td>159,742</td>
<td>2,859</td>
</tr>
</tbody>
</table>

| EXPENDITURE |       |       |          |        |        |          |
| Personnel  | 64,018 | 65,019 | 1,001 | 422,770 | 422,661 | -109 |
| Outsourced Personnel | 2,083 | 1,401 | -683 | 14,382 | 10,322 | -4,059 |
| Outsourced Services | 5,305 | 5,451 | 147 | 38,982 | 39,828 | 846 |
| Clinical Supplies | 10,921 | 10,863 | -58 | 75,494 | 78,139 | 2,645 |
| Infrastructure & Non-Clinical Supplies | 10,531 | 7,717 | -2,813 | 66,080 | 52,749 | -13,331 |
| Funder Provider Payments | 76,118 | 75,675 | -443 | 514,294 | 529,728 | 15,434 |
| Total Expense | 168,975 | 166,127 | -2,848 | 1,132,001 | 1,133,427 | 1,426 |

DHB Result: Surplus / (Deficit) | -6,374 | -6,385 | 11 | -14,011 | -14,278 | 267 | 0

2.2 Financial Performance January 2020

Revenue: $2.859m favourable to budget

The favourable variance in revenue includes:
- Funder NGO 934k (refer section 3 for commentary)
- Bowel Screening 463k one off adjustment to align with the new contract rates this month
- Non acute rehabilitation ACC revenue 428k attributed to over 1000 bed days (the highest numbers in 18 months) in addition to a high number and complexity of elective treatment injury cases in the month
- SMHAS direct funding for acute secure care 211k for ID patients

Expenditure: $2.848m unfavourable to budget

The unfavourable variance in expenditure includes:
- Personnel costs in the prior month (December) were higher than plan due in part to additional acute cases from Counties Manukau associated with the White Island incident. In January, personnel costs have reduced with leave taken adjacent to four stat days in the financial month.
- Outsourced personnel costs are unfavourable due to the reliance of medical locum and agency nursing to cover vacancies ($343k), and management agency in corporate services ($261k).
- Supplies costs are on budget, compared with a favourable year to date variance attributed to the prior month one-off receipt of Pharmac rebates.
- Infrastructure costs include a shortfall on financial savings obligations ($11.2m), details of which are provided to Audit & Finance in a monthly report.
Refer to section 3.0 for commentary on Funder Arm financial performance. Refer to section 4.0 for commentary on Provider Arm financial performance.

3. **Funder Arm Financial Performance: January 2020**

The Funder consolidated core result variance is $365k favourable for the month and $11.10m favourable for the year to date. This is the net position across all four of the Funder divisions. The four Funder divisions are: Funder NGO, Funder Own Provider, Funder IDF and Funder Governance.

The Funder NGO division is the main focus of Funder performance and refers to contracted health services delivered by third party providers. These consist mostly of community services providers with approximately 80% of the services being demand based. They are mostly delivered by means of national agreements with little or no opportunity for DHBs to directly influence either the number of service providers or the number of patient/client presentations.

The Funder’s $11.10m favourable position for the year to date consists of a favourable Funder NGO variance of $12.71m, a favourable Funder Own Provider variance of $47k, an adverse Funder IDF variance of $1.65m and a nil variance within Funder Governance.

The table below summarises the key components of the Funder core result in terms of revenue and expenditure and across the four Funder divisions.

**Funder Arm Financial Performance**

<table>
<thead>
<tr>
<th>FUNDER ARM FINANCIAL PERFORMANCE</th>
<th>Month Jan-20</th>
<th>YTD Jan-20</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>REVENUE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funder NGO</td>
<td>49,129</td>
<td>48,194</td>
<td>935</td>
</tr>
<tr>
<td>Funder Own Provider</td>
<td>76,088</td>
<td>75,930</td>
<td>158</td>
</tr>
<tr>
<td>Funder IDF</td>
<td>27,404</td>
<td>27,481</td>
<td>(77)</td>
</tr>
<tr>
<td>Funder Governance</td>
<td>1,345</td>
<td>1,342</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total Funder Revenue</strong></td>
<td>153,966</td>
<td>152,947</td>
<td>1,018</td>
</tr>
<tr>
<td>EXPENDITURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funder NGO</td>
<td>48,449</td>
<td>48,194</td>
<td>(255)</td>
</tr>
<tr>
<td>Funder Own Provider</td>
<td>76,137</td>
<td>75,930</td>
<td>(207)</td>
</tr>
<tr>
<td>Funder IDF Outflows</td>
<td>27,669</td>
<td>27,481</td>
<td>(188)</td>
</tr>
<tr>
<td>Funder Governance</td>
<td>1,345</td>
<td>1,342</td>
<td>(3)</td>
</tr>
<tr>
<td><strong>Total Funder Expenditure</strong></td>
<td>153,600</td>
<td>152,947</td>
<td>(653)</td>
</tr>
<tr>
<td>CORE RESULT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funder NGO</td>
<td>679</td>
<td>679</td>
<td>0</td>
</tr>
<tr>
<td>Funder Own Provider</td>
<td>(49)</td>
<td>(49)</td>
<td>0</td>
</tr>
<tr>
<td>Funder IDF</td>
<td>(265)</td>
<td>(265)</td>
<td>(1,654)</td>
</tr>
<tr>
<td>Funder Governance</td>
<td>(0)</td>
<td>(0)</td>
<td>0</td>
</tr>
<tr>
<td><strong>FUNDER RESULT Surplus/(Deficit)</strong></td>
<td>365</td>
<td>365</td>
<td>11,101</td>
</tr>
</tbody>
</table>

**FUNDER TOTAL REVENUE**

Waitematā District Health Board, Meeting of the Board 26/02/20
The Funder consolidated revenue variance is $1.02m favourable for the month and $7.17m adverse for the year to date. Most of this variance is the net consequence of changes to and within Ministry funded initiatives introduced after budgets had been set and have equivalent expenditure variances that offset. The key variance drivers are summarised by division in the commentary below.

**The Funder NGO Revenue**
Funder NGO revenue variance was $935k favourable for the month and $946k adverse for the year to date. A significant component of the adverse year to date variance results from PHARMAC reducing their forecast national revenue allocation to DHBs for Hospital Medicines. The adverse impact for WDHB was $380k for the month and $2.66m for the year to date. PHARMAC also advised an increase in the Hospital Medicines component of their DHB Drug Rebate allocation resulting in an adverse impact of $106k for the month and $745k for the year to date. Waitematā DHB received share of the additional pharmaceutical revenue of $20m, which resulted in a favourable impact of $1.33m for the month and year to date. The other significant revenue factor relates to the Ministry In-Between Travel wash-up for 2018-19 (as advised to us in December) which resulted in a favourable impact of $1.34m for the year to date. Other year to date adverse variances of $209k are from funded initiatives, the most significant being pay equity, which have an equivalent expenditure variance, and has a nil impact on the core result.

**Funder Own Provider Revenue**
The Funder Own Provider revenue variance was $158k favourable for the month and $2.83m adverse for the year to date. The most significant driver of this variance is the under delivery of the Provider Arm component of the Planned Care Initiative for the July to December period. This resulted in an adverse impact of $2.03m for the year to date. Another factor is an adjustment made for the Hospital Medicines component of Drug Rebates as advised by PHARMAC in their latest DHB forecasts which resulted in a favourable impact of $106k for the month and $745k year to date. A prior month adverse adjustment of $2.07m resulting from a change in accounting for the Wilson Centre is a key driver in the year to date variance. Other year to date favourable variances of $531k are from funded initiatives, the most significant being PSA Clerical MECA Settlement/MERAS Settlement and Forensic Mental Health for Prison in reach services, which have an equivalent expenditure variance, and has a nil impact on the core result.

**Funder IDF Revenue**
The Funder IDF revenue variance was $77k adverse for the month and $3.43m adverse for the year to date. The most significant driver of this variance is the IDF component of the Planned Care Initiative under delivery for the half year to December 2019 which resulted in an adverse variance of $2.91m for the year to date. A post budget service change for Auckland Regional Dental Services resulted in an adverse year to date variance of $717k. PHO Capitation wash up has a favourable year to date variance of $331k, offset by an adverse year to date variance of $139k for budgeted PHO growth which has not been accounted.

**Funder Governance Revenue**
No variances of note for the month and year to date.

**FUNDER TOTAL EXPENDITURE**
The Funder consolidated expenditure variance was $653k adverse for the month and $18.27m favourable for the year to date. The consolidated year to date expenditure variance consists of a $13.65m favourable variance in Funder NGO expenditure, a $2.88m favourable variance in Funder Own Provider expenditure, a $1.78m favourable variance in Funder IDF outflow expenditure and a $44k adverse variance in Funder Governance expenditure.
It is typical for variance drivers within Funder to have equivalent offsets between Funder divisions and/or between Funder revenue and Funder expenditure. Within Funder expenditure it is also typical for monthly expenditure to vary between months and for associated variances to mostly offset between months and/or between services. This is usually related to variations in utilisation and claiming patterns across Funder demand services. The key variance drivers are summarised by division in the commentary below.

**Funder NGO Expenditure**
The Funder NGO expenditure variance was $255k adverse for the month and $13.65m favourable for the year to date with this being the net position across all Funder NGO community services. A substantive component of the year to date favourable variances is a result of an ongoing process of review, assessment and release of accruals for prior periods as well as accruals relating to indicative initiatives budgets not yet contracted/committed in the current period. The favourable impact of this process was $9.12m for the year to date. Another significant factor impacting on the result relates to PHARMAC and their most recent DHB forecast advice which resulted in a $2.83m upside, of which $2.14m pertains to drug rebates. The PHO Capitation Agency adjustment resulted in an adverse variance of $149k for the month and $970k for the year to date which is offset in the IDF Outflows and has a nil impact on the core result.

Other factors relating to year to date variances include the normally expected variations across Funder services as previously explained. These variances apply particularly within Funder NGO services and typically arise out of variations in demand/utilisation within Community Pharmacy, General Practice, Age Related Residential Care, Home Support Services and PHO Capitation Services. Additional to this are the usual variances related to Ministry Funded Initiatives implemented and/or changed after budgets had been set. Funded Initiatives variances mostly have a nil net impact on the core result and include the Ministries Pay Equity initiative.

**Funder Own Provider Expenditure**
The Funder Own Provider Expenditure variance is $207k adverse for the month and $2.88m favourable for the year to date. A key driver of this variance relates to the under delivery of the Planned Care Initiative for WDHB by the WDHB Provider Arm for the July – December period. The resulting clawback creates a favourable variance of $2.03m for the year to date which is offset by an equivalent reduction in revenue received/expected from the Ministry. Another key driver of the variance relates to a $2.07m adjustment for the Wilson Centre which is now accounted for directly within the Provider Arm. Further minor drivers of the variance include adjustments relating to the PSA Clerical MECA settlements, MERAS Settlements, additional Funding for Forensic Mental Health – Prison In-Reach Services and additional Hospital Medicines rebates based on PHARMAC’s latest DHB forecasts ($106k for the month and $745k for the year to date).

**Funder IDF Expenditure**
The Funder IDF expenditure variance is $188k adverse for the month and $1.78m favourable for the year to date. The key driver of this variance relates to the under delivery of the Planned Care Initiative for WDHB at other DHBs. The resulting clawback creates a favourable variance in the year to date of $2.91m which is offset by an equivalent revenue reduction as received from the Ministry. There is an adverse variance of $164k for the month and $1.24m for the year to date as a result of PHO Capitation wash up offset by a favourable variance for the month of $149k and year to date of $970k due to an additional agency adjustment between IDF Outflows and PHO Capitation expenditure in Funder NGO. There is also an adverse variance of $172k for the month and $860k year to date for a budgeted reduction in IDF Outflows for inpatient services which have not been accounted for in the national budgets.
Funder Governance Expenditure
No variances of note for the month and year to date.

4. Provider Arm Commentary on Financial Performance

4.1 Financial Statement

Table 4: Summary of Provider Arm Financial Performance for YTD January 2020

<table>
<thead>
<tr>
<th></th>
<th>Month</th>
<th>YTD</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown</td>
<td>82,359</td>
<td>80,719</td>
<td>1,640</td>
</tr>
<tr>
<td>Other</td>
<td>2,293</td>
<td>2,003</td>
<td>290</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>84,652</td>
<td>82,722</td>
<td>1,930</td>
</tr>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>63,226</td>
<td>63,814</td>
<td>588</td>
</tr>
<tr>
<td>Outsourced Personnel</td>
<td>1,795</td>
<td>1,158</td>
<td>-637</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>4,787</td>
<td>4,947</td>
<td>-160</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>10,920</td>
<td>10,636</td>
<td>-286</td>
</tr>
<tr>
<td>Infrastructure &amp; Non-Clinical Supplies</td>
<td>10,902</td>
<td>8,326</td>
<td>-2,577</td>
</tr>
<tr>
<td>Total Expense</td>
<td>91,631</td>
<td>89,107</td>
<td>-2,524</td>
</tr>
<tr>
<td>Provider Result : Surplus / (Deficit)</td>
<td>-6,979</td>
<td>-6,385</td>
<td>-594</td>
</tr>
</tbody>
</table>

The Provider Arm result YTD January 2020 was a deficit of $26.125m against a budgeted deficit of $14.278m, and therefore unfavourable to budget by $11.847m.

4.2 Service Commentary on YTD result

Table 5: Provider Arm Financial Performance by Service for YTD January 2020

<table>
<thead>
<tr>
<th></th>
<th>Direct Revenue YTD</th>
<th>Direct Expenditure YTD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>Provider Arm Financial Performance YTD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical &amp; Ambulatory</td>
<td>6,212</td>
<td>5,587</td>
<td>626</td>
</tr>
<tr>
<td>Acute &amp; Emergency Medicine</td>
<td>2,234</td>
<td>2,053</td>
<td>182</td>
</tr>
<tr>
<td>Specialty Medicine and HOPS</td>
<td>5,877</td>
<td>5,103</td>
<td>774</td>
</tr>
<tr>
<td>Specialist Mental Health &amp; Addiction</td>
<td>9,781</td>
<td>8,682</td>
<td>1,098</td>
</tr>
<tr>
<td>Elective Surgery Centre</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>166</td>
<td>111</td>
<td>56</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>3,004</td>
<td>2,415</td>
<td>588</td>
</tr>
<tr>
<td>Corporate and Provider Support</td>
<td>550,752</td>
<td>550,789</td>
<td>-37</td>
</tr>
<tr>
<td>Total Provider</td>
<td>583,021</td>
<td>580,011</td>
<td>3,011</td>
</tr>
</tbody>
</table>

Waitematā District Health Board, Meeting of the Board 26/02/20
Surgical and Ambulatory Services (YTD $0.808m unfavourable to budget)
Refer section 7 for a summary of clinical activity performance.

The unfavourable variance is driven by:

- High overtime rates in nursing. Theatre nursing bureau and overtime reliance has been as a result of vacancies and higher sick leave rates in the first 4 months this financial year. Addressing this, the service has initiated a recruitment drive in advance, and due to this have managed to fill vacancies more quickly.
- Locum costs in Anaesthesia and ORL due to SMO vacancies, the latter resulting in ORL volumes below plan.
- Over-allocations in current RMO runs.
- Over delivery in outsourced Skin Lesions against the production plan.

The above costs are partially offset by savings in implants and prostheses due to the under-delivery in Orthopaedic volumes.

Acute and Emergency Medicine Services (YTD $0.742m unfavourable to budget)
ED attendances are 2.2% higher than plan and 4.18% higher than at the same time last year. The service has realised high costs of medical cover in ED, and high nurse watch demands in ED. Nursing cover primarily in ED and ADU is $900k above budget YTD.

The service has realised some savings driven by a skill mix benefit in medical personnel costs.

The service has a number of savings initiatives including: flexing beds, a review of patient watches, and a review of nursing models of care. However on-going financial pressure is anticipated over the remaining months this financial year with recruitment underway for the introduction of Home Based Ward in WTH.

Specialty Medicine and Health of Older Persons Services (YTD $0.407m unfavourable to budget)
The unfavourable variance is driven by unbudgeted RMO over-allocations ($240k) and increased clinical supply costs for medical aids and MHSOA respite. The service has a number of savings initiatives including a review of ACC events, and enhanced services for mobility aids management.

Child, Women and Family Services (YTD $0.777m unfavourable to budget)
The unfavourable variance is driven by:

- Previously high / now fluctuating admission rates across both Neonatal units. Neonatal units are tracking at 88% of CWD YTD. This measure can at times not fully represent the actual demand of the units due to the lengthy occupancy and timing of discharge. Actual cot numbers have been significantly higher this year compared with last year.
- Maternity services continue to be impacted by a national midwifery workforce shortage which, compounded by high demand for antenatal assessment and caesarean section services, has necessitated the interim reliance on high cost overtime from existing staff in order to cover maternity roster gaps. The service is focused on mitigations including a retention payment for 43 staff that have agreed to increase their base FTE and reduce overtime (effective from February 20), as well as a focus on attracting as many new graduates as possible in early 2020.
- Inpatient and community based services demand and price driven clinical supplies increases.
- Obstetrics & Gynaecology medical costs track above budget to date with significant demand for acute gynaecology (101% of contact) and elective gynaecology (118% of contract).
The service continues to make good progress with its tactical savings initiatives with benefits being realised across the following - Obstetric and Anaesthetic on call accommodation, changes in Child Rehabilitation contract costs with ADHB and changes in the provision of clinical supplies to families accessing Community Child Nursing services.

Specialist Mental Health and Addiction Services (YTD $1.405m favourable to budget)
The favourable variance is driven by:
- Additional revenue for Intellectual Disabilities (currently 3 supernumerary service users) $478k and Court reporting, $245k.
- Staffing costs are below budget ($0.5m), this being attributed to vacancies: Medical (15 FTE), Nursing (96 FTE) and Allied Health (51 FTE). While the service has a natural vacancy rate current vacancies are higher than anticipated and includes new positions yet to be filled, for example with recruitment underway for Rodney Assertive Interventions and the Inpatient Unit Clinical leadership positions. YTD vacancies have been partially met through leave creep, nursing overtime (YTD $1.2m, circa 18 FTE), and external agency medical personnel ($626k).

The SMHAS has been under considerable pressure due to nursing vacancies. Addressing this in part, the service has focused on new graduate intakes and seen considerable success in the New Entrants to the Specialist Practice (NESP) programme. Over 50% of all entrants, circa 400, have stayed on with SMHAS, with a significant percentage of the remaining trainees remaining in the region at one of the other two Auckland DHBs. And encouragingly the retention rate in the first three years after they complete the programme is over 70%.

Elective Surgery Centre (YTD $0.243m unfavourable to budget)
The unfavourable variance is driven by:
- Higher than planned numbers of day cases impacting on nursing costs.
- Change in casemix resulting in higher than budgeted laparoscopic consumables partially offset by lower treatment disposables and prostheses costs.
- Prior-year package of care costs.

Clinical Support Services (YTD $0.962m unfavourable to budget)
The unfavourable variance is driven by:
- Increased equipment and bed repairs in Clinical Engineering, ($288k).
- Traffic management costs are high than plan due to delays in the implementation of integrated rosters pending union consultation, and recent changes in available spaces and shuttles from the North Shore Event Centre, ($312k).

Diagnostics Services (YTD $1.781m favourable to budget)
The favourable variance is driven by:
- Lower inpatient drug costs $223k and the one-off receipt of additional rebates, $350k.
- Outpatient pharmacy $280k profit YTD.
- Laboratories $285k favourable due to the write-off of a prior year accrual.
- Radiology services under delivery due to SMO and MIT vacancies:
  - Advanced Interventional Radiology (AIR) services, partially met by outsourced procedures
  - Computerised Tomography (CT) services at NSH

Corporate and Provider Arm Support Services (YTD $11.093m unfavourable to budget)

Waitematā District Health Board, Meeting of the Board 26/02/20
The unfavourable variance is driven by:

- Delayed realisation of financial savings obligations, ($11.2m).
- Adjustment to planned care revenue based on current under delivery of YTD volumes, ($1.7m).

Offsets to the shortfall in savings obligations include:

- Release of residual provisions for settled MECA, $1.0m.
- Various, including savings due to vacancies $0.9m
5. Waitematā DHB Financial Position

5.1 Summary of Financial Position

Table 6: Summary financial position as at January 2020

<table>
<thead>
<tr>
<th>$000's</th>
<th>31-Jan-20</th>
<th>Dec-19</th>
<th>Variance</th>
<th>Actual</th>
<th>Last Month</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown Equity</td>
<td>489,609</td>
<td>605,335</td>
<td>-115,726</td>
<td>495,983</td>
<td>-6,374</td>
<td>486,268</td>
</tr>
</tbody>
</table>

Represented by:

- Cash & Bank Balances: 39,826 vs. 16,408, variance of 23,418, 58,959 vs. 19,133, and 36,685
- Other Current Assets: 83,921 vs. 84,009, variance of -88, 77,518 vs. 6,403, and 86,472
- Current Liabilities: -382,847 vs. -257,827, variance of -125,020, -388,300 vs. 5,453, and -364,569

Net Working Capital: -259,100 vs. -157,410, variance of -101,690, -251,823 vs. -7,277, and -241,412

- Fixed Assets: 748,457 vs. 761,131, variance of -12,674, 747,458 vs. 999, and 726,180
- Long Term Investments in Associates: 42,949 vs. 42,959, variance of -10, 42,949 vs. 0, and 42,940
- Term Liabilities: -42,697 vs. -41,345, variance of -1,352, -42,602 vs. 95, and -41,440

Total Employment of Capital: 489,609 vs. 605,335, variance of -115,726, 495,983 vs. -6,374, and 486,268

The Financial position reflects the final position on the Waitematā DHB’s balance sheet as at 30 June 2019. This includes a $112.8m increase in the provision now totalling $124.0m for the potential under-payment of Holiday Pay.

5.2 Financial Position Commentary

The negative ‘Net Working Capital’ balance of $259.1m at 31st January 2020 is expected, due to the nature of current liabilities including annual leave provisions and the current portion of other staff entitlements, such as continuing medical entitlements (CME). While these liabilities are considered current, any significant draw down is unlikely as accrued entitlements tend to offset leave claims over time.

The June 2019 opening balance of Current Liabilities has been adjusted to account for the increased provision of $112.8m for the potential under-payment of Holiday Pay.

The ‘Cash and Bank Balance’ of $39.8m at 31st January 2020 includes a term deposit of $15m invested via NZ Health Partnership Limited (NZHPL). A further $1.0m equity injection was received in December for Etu Tanekaha project.

The revised cash forecast at 30 June 2020 is $22.2m as the finalization and settlement on the sale of Taharoto building are expected to be realised during following financial year. This forecast will be further informed by revised plans for capital expenditure (refer section 6 below).

5.3 Detailed Statement of Cash Flow

Table 7: Detailed Statement of Cash Flow as at January 2020
The ‘Cash and Bank Balance’ of $39.8m at 31st January 2020 includes a term deposit of $15m invested via NZ Health Partnership Limited (NZHPL). A further $1.0m equity injection was received in December for Etu Tanekaha project.
6. Statement of Capital Expenditure

The Portfolio Investment Committee (PIC) continues to robustly prioritise all investment requests to ensure best value is achieved from the available capital budget.

Signals from the Centre are that Crown funding may be lower than requested. PIC has considered a number of investment scenarios to ensure priority projects will proceed in the event that the level of funding differs from that requested. The year to date capital expenditure of $16.3m for land relates to the purchase of the Mason Clinic land at Carrington Road in December 2019.

The year to date underspend of buildings and plant $8.310m is attributed to revised project timelines in the ECIB and infrastructure programmes which includes Pupuke demolition, ECIB and Tanekaha remediation.

The year to date underspend of clinical equipment includes delays in key clinical projects such as x-ray. The capital investment team are reviewing plans for next year’s critical asset replacement programme with a view to bringing some forward to mitigate further deferred investment in critical asset replacement.

Table 8: Summary of Capital Expenditure as at January 2020

<table>
<thead>
<tr>
<th>$000's</th>
<th>Month</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16,373</td>
<td>17,000</td>
</tr>
<tr>
<td>Buildings &amp; Plant</td>
<td>1,823</td>
<td>4,521</td>
<td>2,698</td>
<td>10,503</td>
<td>18,813</td>
</tr>
<tr>
<td>Clinical Equipment</td>
<td>1,148</td>
<td>1,047</td>
<td>-101</td>
<td>4,187</td>
<td>10,235</td>
</tr>
<tr>
<td>Other Equipment</td>
<td>113</td>
<td>12</td>
<td>-101</td>
<td>1,248</td>
<td>234</td>
</tr>
<tr>
<td>Information Technology</td>
<td>49</td>
<td>146</td>
<td>91</td>
<td>1,649</td>
<td>1,482</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>0</td>
<td>23</td>
<td>23</td>
<td>19</td>
<td>198</td>
</tr>
<tr>
<td>Total Capital Expenditure</td>
<td>3,133</td>
<td>5,743</td>
<td>2,610</td>
<td>33,979</td>
<td>47,962</td>
</tr>
</tbody>
</table>

7. Clinical Activity

- YTD ED attendances are higher (2.2%) than plan with a full year forecast of around 2,000 more attendances than plan.
- YTD acute volume WIES appears close to plan, however, at a service level there are significant offsetting variances to plan:
  - YTD acute WIES is 519 lower (2.1%) than plan in Medical services, notably in Cardiology, General and Emergency Medicine.
  - YTD acute WIES is 474 higher (2.9%) than plan in Surgical and CWF services, notably in Orthopaedics. The FY19/20 budget assumes demographic growth of 2.9% on FY18/19 forecast acute volumes, noting that Surgical and CWF acute delivery YTD is another 2.9% above this, creating severe pressure on available capacity and resources in these divisions.
- YTD elective volume WIES are below plan. For the month of January, the Surgical & CWF elective WIES is 233 behind contract, although only 40 WIES behind the same period last year. This difference may be generated by a contract phasing challenge, as the agreement on total surgical elective delivery for FY20 was based on FY19 actuals (i.e. no uplift).
Notwithstanding this, Orthopaedics has had several key challenges in elective delivery leading to their position of being 406 WIES below contract YTD, which include:

- Orthopaedic WIES below plan due to:
  - Cancelled lists arising from nursing shortages (Jul-Oct)
  - Acute volumes (8% over budget) on elective lists including Counties Manukau NOF patients in December and January in order to release capacity for White Island patients
  - Radiology strikes which resulted in the need to put through simpler cases with a lower WIES
  - January also saw the use of Fellows to backfill SMO annual leave which resulted in the scheduling of fewer less complex cases.

- ORL WIES are below plan due to on-going SMO vacancies and difficulties securing locum cover to backfill.

- The under-delivery above has been partly offset by 8.6% over-delivery in General Surgery.

### 7.1 Clinical Activity Scorecard

Table 9: Clinical Scorecard for January

<table>
<thead>
<tr>
<th>CLINICAL ACTIVITY</th>
<th>Month</th>
<th>YTD</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>ED Attendances</td>
<td>9,543</td>
<td>9,494</td>
<td>-49</td>
</tr>
<tr>
<td>Acute Volumes (WIES)</td>
<td>5,541</td>
<td>5,702</td>
<td>161</td>
</tr>
<tr>
<td>Elective Volumes (WIES)</td>
<td>1,132</td>
<td>1,406</td>
<td>-274</td>
</tr>
</tbody>
</table>

A negative variance in ED Attendances reflects higher than planned presentations.
A negative variance in Acute Volumes (WIES) reflects a higher than planned acute demand.
A negative variance in Elective Volumes (WIES) reflects under delivery.

The shortfall in elective surgical delivery has a direct impact on waiting lists, and as an outcome there are a large number of Orthopaedic patients (over 300) that are deemed to be non-compliant (have been waiting over 4 months for surgery). This, coupled with the risk of the MoH potentially withholding the normal ‘additional’ elective funding paid, has generated urgent and focused plans to mitigate and address the situation. This is the absolute priority for the division. Plans and progress will be advised monthly to A&F.
7.1 Position Statement: Reducing Harms from Hazardous Alcohol Use in our Communities

Recommendation:

That the Board:

a) Receives the report and provides feedback on the proposed Position Statement.
b) Notes the alignment with the He Ara Oranga Mental Health Inquiry Report recommendations regarding alcohol.
c) Notes the further work to scope the Waitematā DHB role of preventing and reducing hazardous alcohol use and alcohol-related harm.
d) Notes that an accompanying action plan for the Position Statement is being developed and will be presented to the Board for approval.

Prepared by: Dr Andrew Old (Acting Clinical Director Health Gain), with input from Auckland Regional Public Health Service (ARPHS) and the Planning, Funding and Outcomes Health Intelligence Team

Endorsed by: Dr Karen Bartholomew (Director, Health Outcomes)

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABI</td>
<td>Alcohol Brief Intervention</td>
</tr>
<tr>
<td>BPS</td>
<td>Better Public Service</td>
</tr>
<tr>
<td>CMH</td>
<td>Counties Manukau Health</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community and Public Health Advisory Committee</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>Hazardous Drinking</td>
<td>‘Hazardous drinking’ refers to an established alcohol drinking pattern that carries a risk of harming the drinker’s physical or mental health or having harmful social effects on the drinker or others. The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item questionnaire that covers three aspects of alcohol use: alcohol consumption, dependence and adverse consequences. A score of eight or more indicates a hazardous drinking pattern. A respondent can reach a score of eight from the alcohol consumption items of the questionnaire alone, for example, by consuming six or more drinks on each occasion, twice a week.</td>
</tr>
<tr>
<td>HEEADSSS</td>
<td>Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety Assessment</td>
</tr>
<tr>
<td>SLM</td>
<td>System Level Measures</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>

1. Executive Summary

The Board is asked to endorse the Reducing Harms from Hazardous Alcohol Use in our Communities Position Statement (Appendix 1). Alcohol-related harm is increasingly recognised as a health issue with widespread impacts across health, social, and economic sectors. The burden is not only on the individual consuming alcohol, but also on their whānau, friends, and the wider community. Since 2011/12, the prevalence of hazardous drinking has been increasing among men and women, and in
particular among Māori women and New Zealanders aged 35-54 years. Those living in more socioeconomically deprived areas at greater risk of alcohol-related harm. Alcohol use is the leading risk factor for health loss for New Zealanders aged 15-49 years and is a major contributor to non-communicable disease burden e.g. cancers.

The harmful health impacts of hazardous alcohol use in New Zealand are divided almost equally between injury and chronic disease outcomes, burdening both inpatient and outpatient hospital services, and primary care services in the community. Having a DHB alcohol position statement provides a strong foundation for Waitematā DHB’s alcohol harm minimisation work, ensuring the social and environmental determinants of hazardous alcohol use and alcohol-related harm are recognised and evidence-based policy supported. The position statement provided in Appendix 1 is based on the substantive work that other DHBs have undertaken, particularly Counties Manukau Health and the DHBs in the Wellington region.

The position statement covers four key actions; a description of alcohol in our communities; the rationale for the DHB position; and outlines the national policy and legislative environment. Having the statement available on the Waitematā DHB website (supported by a preceding communication plan) will act as our starting point towards more coordinated work.

Following Board endorsement, we will bring back recommendations about actions as the next phase of work.

This paper presents background information about alcohol related harm and then presents the position statement in Appendix 1.

2. **Strategic Alignment**

The suggested position statement on alcohol is consistent with the Board’s purpose of promoting wellness and particularly the focus on improving equity. It resonates with the Board priority of achieving better outcomes both in the short term and longer time periods.

| Emphasis and investment on both treatment and keeping people healthy | Waitematā DHB was a contributor to the Auckland Alcohol Action Plan 2013-2018 via Auckland Regional Public Health Service (ARPHS) and CADS involvement. The goals of this collaborative plan of action were
1. Reduced rates of risky drinking behaviors
2. Safer environments that support alcohol related harm prevention/reduction
3. Communities and services are equipped to address alcohol issues and maintain desired outcomes.
ARPHS continue to champion an Auckland free from alcohol harm. It remains one of their six strategic health improvement programs. Their focus is on exploring alcohol datasets, agreeing opportunities for collaboration, and influencing the alcohol licensing system. |

| Intelligence and insight | This report presents the local, national and international data to provide context for the adoption of the position statement. |

| Evidence informed decision making and practice | The position statement identifies Waitematā DHB as a collaborative partner supporting local, regional, and |
national evidence-based strategies that reduce alcohol-related harms. Consistent with other DHB alcohol position statements, the suggested position statement references the wider definition of alcohol-related harm, identifies inequities in alcohol related harm, and recognises the need for collaboration both within health and across sectors. The majority of DHBs specifically support the World Health Organization (WHO) policy directives that inform Alcohol Action NZ’s 5+ solution.

3. Introduction/Background

A robust evidence base and best practice interventions informs alcohol policy and strategy both globally (WHO SAFER alcohol control initiative 2018) and nationally (Ministry of Health National Drug Policy 2015 to 2020). Although the existence of alcohol-related harm policy identifies alcohol as an important New Zealand health issue, there is no clear national leadership for DHBs around prevention and reduction of hazardous alcohol use and minimisation of alcohol-related harm. In comparison, Alcohol Industries actively engage in corporate political activity internationally/nationally and are influential lobbyists.

Of the 20 DHBs, at least 14 have externally available position statements on alcohol. Regionally we are aligning with the position statement adopted by Counties Manukau Health (CMH) in 2017, and by the Auckland DHB Board in December 2018. The CMH position statement development process took three years and included extensive consultation, including the Auckland Regional Public Health Service. Alongside the position statement, they have now developed a CMH System Alcohol Action Plan 2016-2020, and are rolling out an Alcohol Brief Intervention (ABI) programme.

What is a position statement and why have one?

An alcohol position statement meets the following legislative requirements and objectives for DHBs:

- To improve, promote and protect the health of people and communities
- To promote the integration of health services
- To reduce health disparities by improving health outcomes for Māori and other population groups
- To show a sense of social responsibility and foster community participation in health improvement.

Harm reduction in alcohol, like tobacco, requires multiple health agencies and intersectoral working. A position statement on alcohol supports communities and intersectoral partners to influence the social and environmental determinants of hazardous drinking and alcohol-related harm. The position statement is strongly underpinned by a robust and unequivocal evidence base of international, and when available, national research.

Consistent with other DHB alcohol position statements, the metro Auckland position statement references the wider definition of alcohol-related harm, identifies inequities in alcohol related harm,
and recognises the need for collaboration both within health and across sectors. The majority of DHBs specifically support the World Health Organization (WHO) policy directives that inform Alcohol Action NZ’s 5+ solution.

The main point of difference between the suggested position statement and others is the exclusion of specific DHB actions at this time. This document clearly states the policies and general actions that the Waitematā DHB supports; however, it does not detail DHB specific actions or priorities. We propose a subsequent piece of work to scope out actions and/or priorities for presentation back to the Board.

4. Analysis

4.1 Alcohol Related Harms - General

The harmful use of alcohol is a significant public health problem globally. The World Health Organisation (WHO) estimates that in 2016, 3 million deaths occurred as a consequence of harmful alcohol use. This corresponds to 2.2% of total age-standardised deaths among females and 6.8% among males. The burden attributable to alcohol varies with life stage: for populations aged 50 years and older, cancers accounted for a large proportion of total alcohol-attributable deaths in 2016 [2].

Of all alcohol related deaths, 28.7% were due to injuries, 21.3% due to digestive diseases, 19% due to cardiovascular diseases, 12.9% due to infectious diseases and 12.6% due to cancers [1]. It is a significant contributor to morbidity and mortality in general; for example, the harmful use of alcohol is a causal factor in more than 200 diseases and injuries. The most comprehensive estimate of the global burden of alcohol use, to-date, found that no level of alcohol consumption improves health — “the risk of all-cause mortality, and of cancers specifically, rises with increasing levels of consumption, and the level of consumption that minimises health loss is zero”

The WHO also acknowledges the impact of harmful alcohol use extends beyond the individual’s health. It creates considerable negative social and economic consequences for other individuals and for the society at large. New Zealand is certainly no exception to these impacts. For example, estimates in New Zealand indicate that at least 800 people die each year from alcohol-related causes [3]. Business and Economic Research Limited estimated harmful alcohol use cost New Zealand society $4.9 billion in 2005/6 [4], and this has recently been updated to 7.9 billion.

Drinking alcohol is a popular activity in NZ with 80.3% of New Zealanders drinking alcohol in the past 12 months [5]. However, hazardous patterns of drinking are having a major impact on our health and society. According to the 2018/19 New Zealand Health Survey, 20.0% of New Zealanders aged 15 and above were classified as hazardous drinkers. In the short-term, alcohol is associated with increased rates of injury and criminal offending [6,7]. Longer-term alcohol consumption increases risk of chronic diseases, such as liver cirrhosis, a range of cancers, and some cardiovascular diseases (e.g., stroke) [8]. The total net harm to health is increased above 100 grams of alcohol per week [9]. Indeed, there is six months’ life expectancy loss estimated for chronic consumption at only >100 to ≤200 g of alcohol per week (10 to 20 standard drinks per week [9].

In addition to harms for the drinker, various NZ studies show how important harm to others from alcohol is in this country [10-13]. Some of the most detrimental examples are where alcohol is a component of road traffic deaths involving others, violent crime against others, and lifetime harm to others via fetal alcohol spectrum disorder and child neglect. The total health harm from alcohol use makes it the fifth most important risk factor (albeit with other drugs) for health loss in NZ [14].

Waitematā District Health Board, Meeting of the Board 26/02/20
4.2 Alcohol harm is a key driver of inequalities and reduced well-being

Alcohol harm is a key driver of inequalities and reduced well-being for the drinker and others. In New Zealand, Māori continue to be disproportionately burdened by alcohol related harm. The figure below from the most recent New Zealand Health Survey (18/19 data) shows a wide distribution by ethnicity in the prevalence of hazardous drinking. Consequently, harms from alcohol are not spread out evenly across our communities.

Figure 1: Prevalence of Hazardous Drinking by Ethnicity for Males - New Zealand Health Survey

Figure 2: Prevalence of Hazardous Drinking by Ethnicity for Females
Unadjusted prevalence (%) of hazardous drinking among the total female population, by ethnicity

- Māori women
- Pacific women
- European/Other women
- Asian women

Prevalence of hazardous drinking, %


- Māori women: 24.2, 20.9, 23.1, 25.2, 27.0, 29.4, 24.8, 27.6, 25.3, 27.1
- Pacific women: 14.0, 10.7, 8.1, 8.6, 13.7, 13.7, 13.3, 14.1, 15.2, 13.3, 14.6
- European/Other women: 10.2, 8.1, 8.6, 10.8, 10.4, 12.3, 13.9, 12.2, 12.1, 13.5
- Asian women: 1.8, 1.8, 2.2, 2.6, 1.7, 2.0, 2.2, 3.2, 2.2, 2.4
4.3 Local data in the Auckland Region

We know from our local data that alcohol harm in Auckland is significant. As a previous part of the Action on Alcohol Plan [15] which includes a set of outcome indicators, Huckle [16] et. al., report regularly on alcohol related harm indicators in Auckland. For two of the three alcohol-related harm indicators, rates in Auckland were higher compared to rates in the rest of New Zealand: wholly alcohol-attributable hospitalisations (7% higher in 2015) and Police calls for service for late night assaults (21 % higher in the time period midnight to 3:59 pm, 49% higher between 4:00 am and 6:59 pm in 2015). Figure 3 shows rates of Police calls for service for late night assaults. At least 75% of assaults between 9:00pm and 6:00am were estimated to be alcohol-related by the New Zealand Police.

Figure 3: Rates of Late Night Assaults Auckland vs Rest of NZ (2015)

High levels of alcohol outlet density and longer trading hours are associated with increased alcohol-related harm. As an example the Auckland CBD is host to large number of alcohol outlets. Auckland City Hospital, due to its proximity, sees a lot of this harm including the consequences of late night assaults. Restrictions to the trading hours of on-licences and off-licences are associated with reduced emergency department injury presentations [17].

Figure 4 (over) presents alcohol off-licence density in Waitematā DHB, and also shows central Auckland. The index map illustrates the density of residential addresses in close proximity to alcohol off-licences. It provides a good representation of how accessible an alcohol outlet is from where people live. The red dots on the map represent the off-licence premises. The different colours shaded on the map illustrate the number of residential addresses that can access a liquor store within 1200m. Note distance is measured by travelling from the address point along the road network to the off-licence, and is not a direct straight line measurement from point to point (i.e. as the crow flies). The darker colours (i.e. purple, red etc) indicate that a higher density of residential addresses can access an off-licence within 1200m, indicating more people have an opportunity to either drive or walk to a liquor outlet close by. The yellow shading signals that there are either no or very few residential addresses that can access an off-licence within 1200m.
Figure 4: Waitematā DHB Alcohol Off-Licence density (ARPHS Analysis 2019)
A survey commissioned by ARPHS in 2014, to assist Auckland Council in developing a policy that was reflective of the community’s views, showed majority support for policies that restrict trading hours, reduce the number of on and off-licences, and keeps these outlets away from schools [18].

The Waitematā DHB Emergency Departments have been collecting data since August 2019 on alcohol-related presentations (ARPs) which will give us greater local insights in the future. At the end of 2019, Svensen, Kool and Buller, from Auckland DHB, published an article in the New Zealand Medical Journal entitled ‘The burden of alcohol-related presentations to a busy urban New Zealand hospital emergency department’. This 12 month analysis of ARPs to the Auckland Hospital Emergency Department (ED) found that 5,130 out of 73,381 ED presentations (7%) were alcohol-related. Here is a summary of some key findings of the ARPs recorded:

- Over half were male
- 16% of injury-related presentations in the present study were alcohol-related
- The highest ED presentations were from those aged between 20-29 years (33.7%)
- Māori were over represented in the study, accounting for 17% of ARPs while only representing 8% of the Auckland DHB population
- A higher proportion of those in more deprived areas (NZDep 9–10) found for ARPs compared to non-ARPs

Results from the most recent New Zealand Health Survey [20] showed that the prevalence of hazardous drinking is lower in Waitematā DHB, however it is still a significant problem. In Waitematā DHB, the age-standardised prevalence of hazardous drinking is 16.4% for adults above 15 years old. Men in Waitematā DHB have a higher prevalence of hazardous drinking at 22% compared to women at 11%. These rates are highest amongst the 15-44 years’ age group and decline with age, being lowest in the 65+ years age group. Prevalence of hazardous alcohol use in Māori is approximately 28%, Other 20%, Pacific 13% and Asian 5%.

5. Linkages

What alcohol related work is Waitematā DHB already committed to?

Waitematā DHB continues to work with stakeholders such as Auckland Regional Public Health Service, PHOs and Alcohol Healthwatch to reduce the harm from alcohol in Auckland.

The overarching goals of these collaborations are to:
1. Minimise the rates of hospitalisation and ED admission related admissions from alcohol use
2. Create safer environments that support alcohol related harm prevention
3. Ensure that communities and services are equipped to address alcohol issues and maintain desired outcomes.

Alcohol work is part of the Annual plan in the following areas:

- HEEADSSS assessments
- The introduction of more intentional screening and brief interventions for alcohol misuse as part of the System Level Measures (SLM) work programme (focused in CM Health)
- Supporting Vulnerable Children Better Public Service
- Faster Cancer Treatment Health Target (by contributing to the prevention of cancer)
- Mental Health – a range of services including CADS provision and Pregnancy and Parental Services.
Impact on reducing inequities and Māori Health Gain

Publication of the position statement demonstrates the commitment of Waitematā DHB to evidence-based policy and to achieving equitable health outcomes.

Suggestions for future engagement and impact to uphold Te Tiriti o Waitangi obligations include consultation with Iwi/MoU partners on:

- Identification of what services are available to help Māori reduce drinking and whether these services are Māori focused
- Focus on drinking in Māori women (e.g. work with Māori to develop actions for reducing drinking among pregnant women)
- Consider adopting an “ABC approach” with alcohol-related admissions (based on CM Health experience)
- Strengthen the referral process for alcohol support and treatment (particularly such as in the Rodney District)
- Utilizing the Waitangi Tribunal Hauora Kaupapa Inquiry report (Wai2575) on issues of alcohol, tobacco and substance abuse for Māori as a guide to inform Waitematā DHB’s work in reducing inequalities and advancing Māori health.

6. Consultation/Engagement

Substantive work for the position statement content was undertaken by Counties Manukau Health which involved extensive consultation and expert review. This has not been repeated in the Waitematā area. Review has been provided by the Waitematā DHB Director Specialist Mental Health and Addictions Services (who oversees CADS), CADS Clinical Director, the Funding and Development Manager, Mental Health and Addiction Services, Auckland Regional Public Health Service and Counties Manukau Health. Consultation with communications staff in ARPHS, ADHB and Waitematā DHB has also occurred.

7. Implementation

7.1 Initial Steps and Dissemination

The position statement identifies Waitematā DHB as a collaborative partner supporting local, regional, and national evidence-based strategies that reduce alcohol-related harms. Dissemination of the position statement internally to staff and externally to stakeholders and the public provides the opportunity to raise awareness of and promote prevention and reduction of hazardous alcohol use and alcohol-related harm. Importantly, dissemination provides the opportunity to contribute towards shifting thinking and behaviour – a priority Government action area identified in the National Drug Policy 2015 to 2020.

The position statement is proposed to be made available on our external website after promulgation to key internal stakeholders (and the agreement of a communications strategy/ key spokesperson should media interest arise). It has not been specifically developed for the general public however there is text that accompanies the statement which summarises the intent and content at a lay level, this is also presented in the Appendix.

The proposed internal and external dissemination process is below:
a. Internal
   • Clinical Directors and senior management via email
   • General staff via StaffNet

b. External
   • Relevant stakeholders (ARPHS, CM Health, PHOs, Alcohol Healthwatch) via email
   • General public via availability on the Waitematā DHB external website

7.2 Risks and Communications

There may be media interest in the publication of the media statement (Auckland DHB had a small amount, there was none when CMH published theirs). The impact for people affected by alcohol related harm, and on DHB staff and resourcing, will be included in a holding statement in case there is any interest in the media. The communication content and themes will be agreed with input from the DHB Communications staff, CADS and MHS Clinical Directors.

7.3 Justification/reasons for recommended option

Alcohol related harms are broad and substantial, with specific impacts seen in the health sector. These harms are not spread out evenly across our communities with some groups affected more than others. The proposed statement provides a strong base by clearly stating the evidence based policies and actions that the DHBs support. From here both DHBs can refine and contribute to sector wide work to prevent and reduce hazardous alcohol use and minimise alcohol-related harm, particularly with a focus on reducing inequalities and Māori health gain.

8. Costs/Resources/Funding

There is no specific funding implication from adoption of the position statement. As noted previously, we propose a subsequent piece of work to scope out actions and/or priorities for presentation back to the Board with associated costs.

9. Conclusion

Hazardous alcohol use and alcohol-related harm cause large health, social, and economic burdens in Waitematā DHB. There is an inequitable burden of harm on Māori, males, youth, and socio-economically deprived populations. The position statement (based on the substantive work of CMH and therefore regionally consistent in content) is strongly underpinned by a robust and unequivocal evidence base of international, and when available, national research.

Publication of the position statement demonstrates the commitment of Waitematā DHB to evidence-based policy and to achieving equitable health outcomes. A subsequent piece of work is proposed to scope out alcohol harm reduction actions and/or priorities for the DHB, for presentation back to the Board.
References

19. Data for Alcohol Related Presentations Auckland City Hospital Adult Emergency Department Internal Report. Sarah Buller
20. NZHS Data 2017/18 Special extract provided for metro Auckland DHBs New Zealand Health Survey. Wellington: Ministry of Health
Appendix 1

Waitematā DHB Position Statement

Proposed text to accompany position statement on alcohol on internal and external website:

Alcohol is seen by most as a normal part of New Zealand life, yet it causes more harm than any other drug. The way alcohol is viewed, sold, supplied and marketed in New Zealand influences how much and the way people drink alcohol. Alcohol use can affect peoples’ physical and mental health, relationships, and ability to work or study meaning that whānau (family), friends and communities are affected as well as the person drinking alcohol. Harm from alcohol is not limited to those with alcohol addiction and dependence, but affects even those that drink low to moderate amounts. Harms from alcohol are not spread out evenly across our communities with some groups affected more than others. Waitematā District Health Board cares that everyone in the population we serve is able to have good health and wellbeing and supports the following evidence-based position statement.

A position statement is a brief, evidence-based, high level statement about a specific issue. This statement has been reviewed by alcohol-related harm experts. It provides a strong base for Waitematā DHB’s alcohol harm minimisation work by clearly stating the policies and actions that Waitematā DHB supports.
Reducing harms from hazardous alcohol use in our communities

Position statement
Waitematā District Health Board (WDHB) cares about the achievement of equitable health and wellbeing for the population we serve. Alcohol-related harms are major contributors to inequities in health and wellbeing outcomes. We support working together with people, whānau, families, communities, health agencies and other partners to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm.

1. We support a broad and comprehensive package of evidence-based strategies that equitably prevent and reduce hazardous alcohol use and alcohol-related harm including:
   - restricting the availability of alcohol
   - increasing the minimum legal purchase age
   - increasing the price of alcohol
   - reducing alcohol advertising, promotion and sponsorship
   - drink driving countermeasures.

2. We support equitable access to high quality and culturally-appropriate healthcare services including assessment for hazardous alcohol use, brief and earlier intervention, and referral to treatment when indicated.

3. We support improving and refining information on hazardous alcohol use and alcohol-related harm in the WDHB population and the geographical area we serve.

4. We support and encourage research and evaluation to ensure interventions targeting hazardous alcohol use and alcohol-related harm are effective and equitable.

Alcohol in our communities
Alcohol is not an ordinary commodity. It is an intoxicant, toxin, and addictive psychotropic drug. Alcohol has been normalised and largely accepted by society, and causes more harm than any other drug in society. Hazardous alcohol use contributes to large physical and mental ill-health, social, and economic burdens in New Zealand and globally, with impacts extending across sectors. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whānau, friends, and the wider community.

In New Zealand, inequitable outcomes are apparent with men, Māori, young people, and those living in more socioeconomically deprived areas at higher risk of alcohol-related harm. Although many Pacific people do not drink alcohol at all, Pacific adults that do drink alcohol are more likely to have a hazardous drinking pattern than non-Pacific adults. The harmful health impacts of hazardous alcohol use in New Zealand are divided almost equally between injury and chronic disease outcomes and burden both inpatient and outpatient hospital services, and primary care services in the community. Alcohol-related health conditions are not confined to the minority that experience alcohol dependence with even low consumption increasing the risk of some chronic conditions (e.g. breast cancer).

In WDHB, it is estimated that 16.4% of adults aged 15 years and over have hazardous alcohol use. Prevalence of hazardous alcohol use in Māori is approximately 28%, Other 20%, Pacific 13% and Asian 5%.

Hazardous and harmful alcohol use is identified as a major contributor to inequities and is amenable to healthy public policy. Each of the evidence-based strategies below is identified as an area for national action in the World Health Organization 2010 Global strategy to reduce the harmful use of alcohol.

1. **Equitable prevention of hazardous alcohol use and alcohol-related harm**
   - Restricting the availability of alcohol
increased alcohol outlet density is associated with increased alcohol-related harm. Alcohol outlets are inequitably distributed in New Zealand with more alcohol outlets situated in socioeconomically deprived areas, further contributing to the unequal distribution of harm. There is strong evidence pertaining to the beneficial effects of reduced trading hours on alcohol-related harm.xiv

- Increasing the minimum legal purchase age
  - Young people are more vulnerable to alcohol-related harm than other age groups. Alcohol use during mid-to-late adolescence is associated with impacts on brain development.xv
  - Raising the purchase age reduces adolescent access to alcohol, reduces harmful youth drinking, and raises the age at which young people start drinking.1

- Increasing the price of alcohol
  - Raising alcohol prices is internationally recognised as an effective way to reduce alcohol-related harm.xvi
  - Policies that increase the price of alcohol delay the start of drinking, reduce the volume consumed per occasion by young people, and have a greater effect on heavy drinkers.xvii

- Addressing alcohol advertising, promotion and sponsorship
  - Alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, drink more if they are already consuming alcohol, and makes it more difficult for hazardous users of alcohol to abstain.xviii

- Drink driving countermeasures
  - The risk of motor vehicle accident increases exponentially with increasing alcohol consumption.xix
  - In New Zealand, it has been estimated that over a quarter of road traffic injuries across all road user groups involve alcohol.x
  - Laws setting a low level of blood alcohol concentration at which one may drive legally and well-publicised enforcement significantly reduce drink-driving and alcohol-related driving fatalities.x

2. **Equitable access to high quality and culturally-appropriate healthcare services**

- Assessment, brief advice, and referral to specialist services when indicated in healthcare settings (e.g. general practice and Emergency Departments) reduce hazardous drinking and alcohol-related harms. Detoxification is an effective treatment for alcohol dependence and addiction.1

3. **Improving and refining information on hazardous alcohol use and alcohol-related harm**

- Robust data are needed to accurately describe the burden from alcohol, inform decisions on what strategies and initiatives to develop and fund, and support our communities and intersectoral partners with their alcohol data needs.

4. **Research and evaluation to ensure effective and equitable interventions**

- Research is needed to identify evidence-based interventions for the communities we serve. Evaluation is required to measure the effectiveness of implementation and impact on equity.

**Policy and legislative environment**

WDHB’s position on alcohol in our communities has been developed in the context of the national policy and legislation outlined below. Additionally, the principles of Te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Māori and non-Māori.

**National Drug Policy 2015 to 2020**

The National Drug Policy frames alcohol and other drug (AOD) problems as, first and foremost, health issues. The Policy aims to minimise AOD-related harm and protect health and wellbeing by delaying the uptake of AOD by young people, reducing illness and injury from AOD, reducing hazardous drinking of alcohol, and shifting attitudes towards AOD. Evidence-based strategies included in the Policy are:

1. Te Tiriti o Waitangi principles: **Participation, partnership, and protection**
2. Ratified by New Zealand in 2010
- **Problem limitation:** Reduce harm that is already occurring to those who use AOD or those affected by someone else’s AOD use through safer use, ensuring access to quality AOD treatment services, and supporting people in recovery.

- **Demand reduction:** Reduce the desire to use AOD through education, health promotion, advertising and marketing restrictions, and influence conditions that promote AOD use.

- **Supply control:** Prevent or reduce the availability of AOD through border control, supply restrictions, licensing conditions and permitted trading hours.

The Sale and Supply of Alcohol Act 2012

This Act\(^{1}\), replacing the previous Sale of Liquor Act 1989, adopts a harm minimisation approach. Its adoption followed a lengthy review by the Law Commission\(^8\) which recommended greater restrictions to the sale and supply of alcohol. Compared to the previous Act, alcohol-related harm is more broadly defined as both direct and indirect harm to an individual, society or the community caused by the excessive or inappropriate consumption of alcohol. The Act provides for Territorial Authorities (TAs) to develop and implement a Local Alcohol Policy (LAP). The aim of a LAP is to minimise alcohol-related harm through measures to control the local availability of alcohol. Ideally, they should address local concerns and target inequities in alcohol-related harm. LAPs are drafted in consultation with the police, alcohol licensing inspectors, and Medical Officers of Health (MOoH), and include community input.

Auckland Council has developed Auckland’s Provisional LAP however it has not been implemented. It has many elements to minimise alcohol-related harm in the Auckland region, including reducing off-licence trading hours and providing additional protections to the Auckland CBD and 23 priority areas which experience high levels of harm. Legal processes are delaying the adoption. The Act has increased the role of the MOoH in the licensing process, whereby they are now required to inquire into most licensing applications\(^{[1]}\) and provide input into LAPs. In the Auckland region, this role is provided by the Auckland Regional Public Health Service on behalf of all three metro Auckland District Health Boards. District Health Boards are required to respond to TA requests for alcohol-related health information to inform their LAP. The involvement of the MOoH (provided by Auckland Regional Public Health Service on behalf of the three Auckland District Health Boards) is ultimately to continue to support Auckland Council to arrive at a reasonable and effective LAP that contributes to reduced alcohol-related harm, and in particular harm to health, within the Auckland region.

\(^{[1]}\) Includes on, off, and club license applications
References

7.2 System Level Measures – Quarter 2 Report

Recommendation:

That the Board notes the Quarter Two results for the third System Level Measures Improvement Plan.

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager – Auckland and Waitematā DHBs)
Endorsed by: Dr Karen Bartholomew (Director Health Outcomes – Auckland and Waitematā DHBs) and Tim Wood (Acting Director of Funding – Auckland and Waitematā DHBs)

Glossary

ACP - Advance Care Plan
ALT - Alliance Leadership Team
ARPHS - Auckland Regional Public Health Service
ASH - Ambulatory sensitive hospitalisations
CEO - Chief Executive Officer
CVD - Cardiovascular disease
DHB - District Health Board
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

<table>
<thead>
<tr>
<th>Community, whānau and patient centred model of care</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis and investment on both treatment and keeping people healthy</td>
<td>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 2019/20 System Level Measures Improvement Plan.</td>
</tr>
<tr>
<td>Intelligence and insight</td>
<td>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.</td>
</tr>
<tr>
<td>Evidence informed decision making and practice</td>
<td></td>
</tr>
</tbody>
</table>
2. Introduction

The System Level Measures (SLMs) Framework was developed by the Ministry of Health with the aim of improving health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. This provides a framework for continuous quality improvement and system integration.

System Level Measures are set nationally and designed to be outcomes focused, requiring all of the health system to work together to achieve. They are focused primarily on children, youth and those parts of the population who experience poorer health outcomes than others. DHBs are able to choose from a suite of ‘contributory’ measures or devise their own – which they have identified as having the biggest impact on achievement of each system level measure. These in turn are connected to local clinically led quality improvement activities.

System Level Measures recognises that good health outcomes require health system partners to work together. Therefore the district alliances are responsible for implementing SLMs in their districts.

The Counties Manukau Health and Auckland Waitematā Alliance Leadership Teams (the Alliances) have jointly developed the 2019/20 System Level Measures Improvement Plan and are firmly committed to achieving the SLM milestones over the medium to longer term. This year’s plan is a consolidation of the 2018/19 plan. Some activities have been removed as they have been successfully achieved or where they have been found to be impractical or not easily measurable. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. New contributory measures have been added where data collection processes have been developed in response to identified clinical priorities.

The steering group continues to meet 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. PHO Implementation Groups also meet to support and enable implementation of SLM improvement activities.

This paper provides quarter two results on the current (fourth) improvement plan: 2019/20. The six System Level Measures are:

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 2019/20. 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. In 2019/20, the Auckland Metro Region has continued focusing on cross-system activities which have application to multiple milestones. Activities with a prevention focus may show collective impact across the life course over time. It seems pragmatic for each milestone to benefit equally from activities which add value in multiple areas. The work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

This report includes the most up-to-date data available at quarter two for each DHB for both the SLMs and contributory measures. It also outlines progress against the improvement activities identified in for each SLM in the SLM Improvement Plan.
## Scorecard – Part 1

<table>
<thead>
<tr>
<th>Measure</th>
<th>DHB / Region</th>
<th>Target 2019/20</th>
<th>Performance</th>
<th>Actual</th>
<th>Data Period</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Ambulatory Sensitive Hospitalisations: 0-4 Year-Olds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate per 100,000 domiciled 0-4 year-olds - Total Population</td>
<td>Auckland</td>
<td>6,756 (max.)</td>
<td>7,113</td>
<td>12-monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>6,917</td>
<td>6,737</td>
<td>to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td>5,472</td>
<td>5,745</td>
<td>Sep-19</td>
<td></td>
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<tr>
<td></td>
<td>Metro Auckland</td>
<td>6,343</td>
<td>6,472</td>
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<td></td>
<td></td>
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<tr>
<td>Rate per 100,000 domiciled 0-4 year-olds - Maori</td>
<td>Auckland</td>
<td>6,096 (max.)</td>
<td>6,826</td>
<td>12-monthly</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td>Counties Manukau</td>
<td>6,602</td>
<td>6,053</td>
<td>to</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td>Waitemata</td>
<td>6,181</td>
<td>6,758</td>
<td>Sep-19</td>
<td></td>
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</tr>
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<td></td>
<td>Metro Auckland</td>
<td>6,365</td>
<td>6,435</td>
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<tr>
<td>Rate per 100,000 domiciled 0-4 year-olds - Pacific</td>
<td>Auckland</td>
<td>15,079 (max.)</td>
<td>15,286</td>
<td>12-monthly</td>
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<td></td>
<td>Counties Manukau</td>
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<td>11,426</td>
<td>to</td>
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<td></td>
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<tr>
<td></td>
<td>Waitemata</td>
<td>12,044</td>
<td>12,236</td>
<td>Sep-19</td>
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<td></td>
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<td>12,405</td>
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<td><strong>2. Acute Hospital Bed Days</strong></td>
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<td></td>
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<tr>
<td>Age-standardised rate per 1,000 domiciled population - Maori</td>
<td>Auckland</td>
<td>559 (max.)</td>
<td>592</td>
<td>12-monthly</td>
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<tr>
<td></td>
<td>Counties Manukau</td>
<td>699</td>
<td>739</td>
<td>to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td>576</td>
<td>599</td>
<td>Jun-19</td>
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<td></td>
<td>Metro Auckland</td>
<td>622</td>
<td>655</td>
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<tr>
<td>Age-standardised rate per 1,000 domiciled population - Pacific</td>
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<td>791 (max.)</td>
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<td>12-monthly</td>
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<td>764</td>
<td>to</td>
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<td></td>
<td>Waitemata</td>
<td>767</td>
<td>834</td>
<td>Jun-19</td>
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<td></td>
<td>Metro Auckland</td>
<td>751</td>
<td>793</td>
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<tr>
<td><strong>3. Patient Experience of Care</strong></td>
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<tr>
<td>DHB Adult Inpatient Experience Survey: medication side effects question answered “yes completely”</td>
<td>Auckland</td>
<td>55%</td>
<td>47%</td>
<td>Quarterly</td>
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<td></td>
<td>Counties Manukau</td>
<td>53%</td>
<td>59%</td>
<td>to</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td>49%</td>
<td>45%</td>
<td>Dec-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metro Auckland</td>
<td>51%</td>
<td>49%</td>
<td></td>
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<tr>
<td>Primary Care Survey - time to get GP appointment</td>
<td>Auckland</td>
<td>6.70</td>
<td>5.70</td>
<td>Quarterly</td>
<td></td>
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<tr>
<td></td>
<td>Counties Manukau</td>
<td>5.90</td>
<td>4.90</td>
<td>to</td>
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<td></td>
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<tr>
<td></td>
<td>Waitemata</td>
<td>6.00</td>
<td>5.00</td>
<td>Dec-19</td>
<td></td>
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<td></td>
<td>Metro Auckland</td>
<td>6.20</td>
<td>5.20</td>
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<tr>
<td>Weighted response: 10 = same</td>
<td></td>
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</table>
Scorecard – Part 2

4. Amenable Mortality

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Age-standardised rate per 100,000 domiciled 0-74 year-olds.</th>
<th>Target 2019/20:</th>
<th>6% reduction by 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>70.4 (max.)</td>
<td>69.6</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>99.2</td>
<td>93.7</td>
</tr>
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<td>Waitemata</td>
<td>62.1</td>
<td>63.3</td>
</tr>
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<td></td>
<td>Metro Auckland</td>
<td>75.4</td>
<td>77.4</td>
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<table>
<thead>
<tr>
<th>Measure:</th>
<th>Age-standardised rate per 100,000 domiciled 0-74 year-olds - Maori</th>
<th>Target 2019/20:</th>
<th>2% reduction by June 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>154.8 (max.)</td>
<td>173.0</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>215.2</td>
<td>184.6</td>
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<td>Waitemata</td>
<td>110.8</td>
<td>146.8</td>
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<tr>
<td></td>
<td>Metro Auckland</td>
<td>167.2</td>
<td>175.6</td>
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</table>

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Age-standardised rate per 100,000 domiciled 0-74 year-olds - Pacific</th>
<th>Target 2019/20:</th>
<th>2% reduction by June 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>159.3 (max.)</td>
<td>154.9</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>195.2</td>
<td>181.7</td>
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<td></td>
<td>Waitemata</td>
<td>136.8</td>
<td>146.4</td>
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<td></td>
<td>Metro Auckland</td>
<td>173.5</td>
<td>172.1</td>
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5. Youth Health

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Chlamydia testing coverage for 15-24 year-old males.</th>
<th>Target 2019/20:</th>
<th>6% coverage rate by June 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>6%</td>
<td>4.7%</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>6%</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td>6%</td>
<td>4.6%</td>
</tr>
<tr>
<td></td>
<td>Metro Auckland</td>
<td>6%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Alcohol-related ED presentations</th>
<th>Target 2019/20:</th>
<th>Reduce ‘unknown’ alcohol related ED presentation status to less than 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>10% (max.)</td>
<td>2.8%</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>10%</td>
<td>4.3%</td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td>10%</td>
<td>96.5%</td>
</tr>
<tr>
<td></td>
<td>Metro Auckland</td>
<td>10%</td>
<td>30.3%</td>
</tr>
</tbody>
</table>

6. Babies Living in Smokefree Households

<table>
<thead>
<tr>
<th>Measure:</th>
<th>Proportion of babies living in smokefree homes at 6 weeks postnatal</th>
<th>Target 2019/20:</th>
<th>2% increase on baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>68%</td>
<td>66%</td>
</tr>
<tr>
<td></td>
<td>Counties Manukau</td>
<td>54%</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>Waitemata</td>
<td>63%</td>
<td>57%</td>
</tr>
<tr>
<td></td>
<td>Metro Auckland</td>
<td>61%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Legend

- Target met / on track
- Improvement needed
- Significant improvement needed
- Data or target unavailable

Waitematā District Health Board, Meeting of the Board 26/02/20
Overarching activities for Q2:

- Implementation of the 2019/20 SLM Improvement Plan is on-going and has become business as usual for many of the stakeholders involved.
- Q2 reporting approved by the Ministry
- Reporting is released quarterly or more frequently where available to PHOs via Citrix Sharefile or from Healthsafe, which allows safe and secure sharing of confidential information.
- The 2020/21 SLM Improvement Plan is being developed.

3. System Level Measures Report

Keeping children out of hospital

ASH rates per 100,000 for 0–4 year olds

Improvement Milestone: 3% reduction (on Dec-18 baseline) (by ethnicity) by 30 June 2020

<table>
<thead>
<tr>
<th></th>
<th>Milestone Target</th>
<th>Actual – 12 months to September 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>Counties</td>
</tr>
<tr>
<td>Total pop.</td>
<td>6,756</td>
<td>6,917</td>
</tr>
<tr>
<td>Māori</td>
<td>6,096</td>
<td>6,602</td>
</tr>
<tr>
<td>Pacific</td>
<td>15,079</td>
<td>11,491</td>
</tr>
</tbody>
</table>

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 2019/20, the overall improvement milestone and the milestone for both Māori and Pacific ASH rates are to achieve a reduction of 3% for 0-4 year olds by June 2020. Ethnic specific targets are important to ensure that interventions reduce, not worsen inequity. Metro Auckland’s rate is 6,472 per 100,000 for the 12 months to September 2019 for the total population. This is a 1.0% decrease (improvement) on the results to December 2018 (baseline) of 6,538 per 100,000 population. At an ethnic-specific level, the Māori and Pacific rates also improved (by 1.9% and 2.6%) from baseline.
The higher rates for Auckland DHB Pacific children persist – non-standardised rates, particularly for asthma, respiratory infections, pneumonia, gastroenteritis/dehydration, dental conditions and cellulitis results far outweigh those for other ethnicities.
Using health resources effectively

Total acute hospital bed days
Improvement Milestone: 3% reduction (on Dec-18 baseline) for Māori and Pacific population by 30 June 2020 (standardised)

<table>
<thead>
<tr>
<th></th>
<th>Milestone Target</th>
<th>Actual – 12 months to June 19 (latest available)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
<td>Counties Manukau</td>
</tr>
<tr>
<td>Māori</td>
<td>575.9</td>
<td>720.4</td>
</tr>
<tr>
<td>Pacific</td>
<td>815.9</td>
<td>753.1</td>
</tr>
</tbody>
</table>

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 as follows as at December 2018 with a target set to reduce the rate by:

- 3% for the Māori population – baseline 640.9, target 621.7 standardised acute bed days/1000 by June 2020
- 3% for the Pacific population – baseline 774.1, target 750.9 standardised acute bed days/1000 by June 2020

It must be noted that the opening of new beds within the region will impact on this indicator.

While overall standardised rates have been generally declining over time, metro-Auckland ethnic specific rates to June 2019 are underperforming against the December 2018 target at 655 standardised acute bed days/1000 for Māori and 793 for Pacific.

At a DHB level, both Auckland and Waitematā have rates better than target for Māori, with Counties Manukau some way from achievement. For Pacific, no DHBs met the target, and rates deteriorated for all three DHBs. Both Auckland and Waitematā rates are now 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
**Patient Experience**

‘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 enhanced patient safety and experience of care.

**Hospital inpatient survey**

The nationally applied DHB Adult Inpatient Survey has been conducted quarterly since 2014 and the SLM Improvement Plan continues to include a focus on the Adult Inpatient Experience Survey. This survey captures four measured domains - communications, partnership, coordination, and physical and emotional needs. The 2019/20 target is to achieve a 5% improvement on the inpatient survey question: ‘Did a member of staff tell you about medication side effects to watch for when you went home?’ by 30 June 2020.

Interventions take a multidisciplinary approach, focusing on culturally appropriate patient-centred information, co-design of patient experience initiatives with a focus on Māori and Pacific people, developing an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms and developing a Māori Patient Experience plan endorsed by the Māori Health Equity Committee.

Learnings are to be shared with primary care through established networks and forums. There is also a focus on improving response rates, especially for Māori and Pacific, and monitoring this through regular reporting.

Waitematā DHB recently convened a Consumer Council to advise on DHB priorities, strategy, health literacy and patient experience. At Counties Manukau DHB, the Patient & Whānau Centred Care Consumer Council meets monthly. Auckland DHB established a Patient and Whānau Centred Care Board, with consumers and community partners, to lead and monitor the delivery of the participation and experience work programme.

Improvement milestone: 5% improvement on the inpatient survey question: ‘Did a member of staff tell you about medication side effects to watch for when you went home?’ by 30 June 2020.

Hospital Inpatient survey – percentage of respondents who answered ‘yes, completely’, to the inpatient survey question: ‘Did a member of staff tell you about medication side effects to watch for when you went home?’

<table>
<thead>
<tr>
<th>Targets</th>
<th>% of ‘yes, completely’ result for Q2 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB CMDHB WDHB</td>
<td>ADHB CMDHB WDHB Metro-Auckland</td>
</tr>
<tr>
<td>55.2% 52.5% 47.0% 51.4%</td>
<td>47.4% 58.8% 44.8% 49.4%</td>
</tr>
</tbody>
</table>

With the exception of Counties Manukau DHB, the improvement target was not achieved for this measure in Q2 2019/20. The Metro-Auckland results improved slightly against the CY2018 baseline (49.0%), the Waitematā DHB result did not change from baseline (44.8%), and Auckland DHB’s performance is lower than the baseline (52.6%).

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Waitematā District Health Board, Meeting of the Board 26/02/20
Primary health care patient experience survey (PHC PES)

Primary care survey: 10% relative improvement on PES question: ‘When you ring to make an appointment how quickly do you usually get to see your current GP?’ by 30 June 2020

The PHC PES was implemented in practices over the 2017/18 year. Since then, practice participation has steadily increased. The focus this year has been on improving practice response to patient feedback.

Primary health care patient experience survey – percentage of respondents who answered ‘same day’ or ‘next day’, to the survey question: ‘When you ring to make an appointment how quickly do you usually get to see your current GP?’

<table>
<thead>
<tr>
<th>Targets (by practice location)</th>
<th>% of ‘same day/next day’ result for Q2 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>CMDHB</td>
</tr>
<tr>
<td>6.7</td>
<td>5.9</td>
</tr>
</tbody>
</table>

None of the three DHBs are meeting target in Q2 2019/20. While Auckland DHB’s results are fairly stable, Waitematā and Counties Manukau DHB results are declining.

Preventing and detecting disease early

Amenable mortality

Improvement milestone 6% reduction for each DHB (on 2013 baseline) by 30 June 2021.

2% reduction for Māori and Pacific by 30 June 2020.

<table>
<thead>
<tr>
<th>Milestone Target</th>
<th>Actual – 2016 deaths (* draft data)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Auckland</td>
</tr>
<tr>
<td>Total Pop</td>
<td>70.4</td>
</tr>
<tr>
<td>Māori</td>
<td>154.8</td>
</tr>
<tr>
<td>Pacific</td>
<td>159.3</td>
</tr>
</tbody>
</table>
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. This indicator considers all deaths for those aged 0-74, in the relevant year with an underlying cause of death included in the defined list of amenable causes. It takes several years for some coronial cases to return verdicts, therefore results for this indicator are approximately 2-3 years delayed. 2016 coded mortality data has been delayed, so we are unable to provide updated results currently.

Based on trends over time, all three Metro Auckland DHBs show consistently declining rates as illustrated in the graph above, despite some fluctuation. Comparing current (2016) rates with baseline (2015) rates, there is a 2% decline in rates for metro-Auckland, or 1% when comparing the 5 year rates. Given that there will always be some annual fluctuation and that the target extends to 2021, we should be on track to meet the 6% reduction by 2021.

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.
Youth access to and utilisation of youth-appropriate health services

Chlamydia testing coverage in 15-24 year old males

Improvement milestone: increase coverage of chlamydia testing for males to 6% for 15-24 year olds by June 2020.

Results for the 6 month period to June 2019: males only.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Ethnicity</th>
<th>No of people having chlamydia tests</th>
<th>Population</th>
<th>Chlamydia test rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>Māori</td>
<td>184</td>
<td>4,230</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>244</td>
<td>5,480</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>256</td>
<td>16,480</td>
<td>1.6</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,344</td>
<td>17,380</td>
<td>7.7</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>Māori</td>
<td>454</td>
<td>8,700</td>
<td>5.2</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>553</td>
<td>11,500</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>261</td>
<td>9,880</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>663</td>
<td>12,720</td>
<td>5.2</td>
</tr>
<tr>
<td>Waitematā</td>
<td>Māori</td>
<td>263</td>
<td>6,110</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>190</td>
<td>4,170</td>
<td>4.6</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>161</td>
<td>9,270</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,387</td>
<td>24,060</td>
<td>5.8</td>
</tr>
<tr>
<td>Metro-Auckland</td>
<td>Māori</td>
<td>901</td>
<td>19,040</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>987</td>
<td>21,150</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>678</td>
<td>35,630</td>
<td>1.9</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3,394</td>
<td>54,160</td>
<td>6.3</td>
</tr>
</tbody>
</table>

* 6 with unknown gender excluded

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth, whose healthcare needs are unmet, can lead to increased risk of poor adult health and overall poor life outcomes.

The focus for 2019/20 has been on sexual and reproductive health – specifically on Chlamydia Screening for 15-24 year old males for whom testing coverage has been very low. Chlamydia is the most commonly reported sexually transmitted infection in Auckland, usually diagnosed in females aged 15-19 years and in males aged 20–24 years. However, in the context of SLMs, chlamydia screening is being used as a proxy for access to sexual health services.
At a population level, screening coverage rates for men have improved when comparing the six months to December 2018 and the six months to June 2019. This will need further monitoring to understand if these rates continue to trend upwards. Overall, the target of 6% coverage for males is not being reached, despite the upward trend.

**Healthy start**

**Proportion of babies who live in a smoke-free household at six weeks post-natal**

Improvement milestone: Increase the proportion of babies living in smokefree homes by 2% (Jan 18 – Jun 18 baseline)

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>DHB of domicile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Metro-Auckland</td>
</tr>
<tr>
<td>Jan 18 - Jun 18</td>
<td>59.5%</td>
</tr>
<tr>
<td>Jul 18 – Dec 18</td>
<td>60.9%</td>
</tr>
<tr>
<td>Jan 19 - Jun 19</td>
<td>54.6%</td>
</tr>
<tr>
<td>2019/20 Targets</td>
<td>60.7%</td>
</tr>
</tbody>
</table>
Due to the changes in methodology for calculating measures on previous Ministry of Health releases, it is therefore only possible to compare the results for the last three time periods. Results show that none of the metro-Auckland DHBs are reaching their individual targets and performance has declined since the last reporting period.

This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy to birth and the home environment within which they will initially be raised.

Data is sourced from Well Child Tamariki Ora providers and shows that around 58-66% of metro-Auckland babies live in a smokefree household at 6 weeks post-partum and that this has reduced between reporting periods.

Fewer Māori babies live in smokefree homes - 23% in Counties Manukau DHB, 37% in Waitematā DHB and 43% in Auckland DHB compared with other ethnicities. Rates for Pacific are also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.
Proportion of babies aged <56 days living in a smokefree household at six weeks post-natal: Metro-Auckland

Maori | Pacific Peoples | Others
---|---|---
Jan 18 - Jun 18 | Jul 18 - Dec 18 | Jan - Jun 19
4. Improvement Activities and Contributory Measures

Improvement activities create change and contribute towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2019/20, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Respiratory Admissions in 0-4 year olds

*SLM Milestones impacted: Ambulatory Sensitive Hospitalisation (ASH) Rates per 100,000 for 0 – 4 Year Olds*
- Amenable mortality
- Babies in Smokefree Homes
- Acute hospital bed days

Respiratory conditions are the largest contributor to ASH rates in Metro Auckland. Pertussis (whooping cough) and influenza are potentially very serious conditions in infants and young children, and can lead to further respiratory complications; both of these are vaccine preventable. Social factors like housing and smoking also contribute to poor respiratory health. We are working to increase referrals to healthy housing programmes and help more pregnant women quit smoking. eReferrals for smoking and healthy housing went live in early 2019, which will support a reduction in ASH admissions. We are working with healthAlliance to develop a process for matching e-referral data to PHO registers with a view to driving increased referrals from practices.
### Commentary

- Overall coverage has increased from 13.6% in December 2018 to 15.8% in December 2019. Coverage rates have consistently increased since monitoring and improvement activities began.
- While a coverage rate of more than 15% has been achieved for the total population, rates for Māori and Pacific children continue to be much lower.
- Auckland DHB domiciled individuals have the highest coverage at 20%.
- No PHOs have reached the 15% target for their eligible Māori children, however, two have surpassed this target for their Pacific children.

Implementation of the special immunisation programme had wide support by PHOs, although a national shortage of influenza vaccine may have adversely affected these results. The data matching process conducted by DHBs produced valuable lists for action supported by PHOs. Further integration of processes in practice PMS and workflow will likely see greater gains. Vaccination rates should improve – particularly for Māori and Pacific children – with integration into wider systems such as inpatient services – where the first vaccination is given in hospital, socialisation of the importance of flu vaccination for children can occur alongside more effective use of discharge summaries.
**Indicator**
Increase influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific women

**Target**
50%

**Results**

**Influenza and pertussis vaccination coverage rates for pregnant Māori and Pacific women who birthed in the previous 12 months enrolled in metro-Auckland PHOs**

**Commentary**
Combined antenatal influenza and pertussis vaccination rates have improved markedly over the last 12 months. Results for Māori have improved by around 40% for both Counties Manukau and Waitematā DHBs. Improvements for Pacific are also obvious. Despite this, coverage for both Māori and Pacific pregnant women is still well below the target of 50% and below that of ‘Other’ ethnicities.

Antenatal vaccination coverage rates have improved markedly over time. Antenatal pertussis vaccination rates for Māori and Pacific were below 10% for all the metro-Auckland DHBs in 2016 and are now over 25%. Across 2018 and 2019 there has been a significant uplift across multiple ethnicities. To December 2019, the highest vaccination coverage rates (12 month period) are seen among women domiciled in Auckland DHB (59.6%), followed by Waitematā DHB (52.9%) and Counties Manukau DHB (41.5%).

By ethnicity, Auckland and Waitematā DHBs have the best results for Māori at 32.7% and 33.5% respectively, with Counties Manukau at 21.4%.

Maternal vaccination rates should continue to improve with the implementation of the recently developed Early Pregnancy Assessment Tool. This decision support tool supports this approach for vaccination, referral to smoking cessation, and referral to healthy housing. It has been successfully piloted to confirm usability and work flow in five practices in one PHO with positive feedback and is currently being implemented across multiple PHOs.

**Increase referrals to maternal incentives smoking cessation programmes, for pregnant women**

<table>
<thead>
<tr>
<th>ADHB</th>
<th>WDHB</th>
<th>CMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>58</td>
<td>180</td>
</tr>
</tbody>
</table>

= 265 per quarter
All three DHBs met their quarterly target in the quarter ended 30 September 2019, with referral numbers continuing to grow - overall a 69% increase since March 2018.

A system whereby pregnant women are required to opt out of referral to smoking cessation was successfully trialled in one DHB and has been adopted by the other two and is being considered by PHOs. Implementation has been incomplete and will be further supported over the next year. Better integration with Maternity Services is also needed.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commentary</strong></td>
<td></td>
<td>All three DHBs met their quarterly target in the quarter ended 30 September 2019, with referral numbers continuing to grow - overall a 69% increase since March 2018. A system whereby pregnant women are required to opt out of referral to smoking cessation was successfully trialled in one DHB and has been adopted by the other two and is being considered by PHOs. Implementation has been incomplete and will be further supported over the next year. Better integration with Maternity Services is also needed.</td>
</tr>
</tbody>
</table>
Alcohol Harm Reduction

Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm and the populations and communities most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry has taken some time to implement. The mandatory question is “Is alcohol associated with this event?” Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality has been a significant issue, particularly for Waitematā DHB, with significant missing data in some areas. However, quality improvement work undertaken during 2018/19 resulted in the question becoming mandatory for Waitematā DHB Emergency Departments, therefore once 2019/20 data becomes available, results should show a significant improvement.

A regional approach to Alcohol ABC in primary care is in development. A SLM Implementation group specifically for Alcohol ABC has been established and will consider the resource required to offer practice support and quality improvement.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Results</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of ED presentations where alcohol involved</td>
<td>Baseline</td>
<td>2018/19 data quality at Waitematā DHB was insufficient to be able to baseline metro-Auckland results currently.</td>
<td>Data capture is now mandatory at Waitematā DHB resulting in improved quality for 2019/20 reporting.</td>
</tr>
<tr>
<td>Reduce ‘unknown’ alcohol related ED presentation status</td>
<td>&lt;10%</td>
<td>Results (latest available) to June 2019 (DHB of service): Auckland DHB = 2.8% Counties Manukau DHB = 4.3% Waitematā = 96.5%</td>
<td>See above.</td>
</tr>
<tr>
<td>Percentage of the enrolled population aged over 14 years with alcohol status documented</td>
<td>40%</td>
<td>Percentage of enrolled Patients who have had their alcohol status Asked/Assessed in the last three years: metro-Auckland enrolled</td>
<td>The data is only available from practices with Medtech PMS and represents 73% of the enrolled population aged over 14 years. We are working with PMS vendors to reduce the amount of missing data. A quality improvement approach across all DHBs is in development.</td>
</tr>
</tbody>
</table>
Smoking Cessation

**SLM Milestones impacted:**  
- Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds  
- Acute bed days  
- Amenable mortality  
- Babies in smokefree homes

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of referral to smoking cessation providers by PHO</td>
<td>6%</td>
<td>Referral rates have previously been measured using Read codes in the practice PMS. This has been found to be inaccurate – thus performance cannot be measured against the target set. A definition is being developed for an alternative performance indicator that measures referrals received by Ready Steady Quit and CMH Living Smokefree. However, these referral rates appear to be very low. PHOs are working to validate this data. Simpler electronic systems for referral have been implemented and the focus in the future will be on improving referral rates.</td>
</tr>
<tr>
<td>Rate of prescribing of smoking cessation medications by PHO</td>
<td>12%</td>
<td>Measuring prescribing rates using Read codes under reports primary care prescribing. Again, performance cannot be measured against the target set and a definition is being developed for an alternative performance indicator that measures prescriptions supplied, sourced from PHOs’ PMS systems.</td>
</tr>
</tbody>
</table>

Cardiovascular Disease (CVD) Risk Assessment and Management

**SLM Milestones impacted:**  
- Acute bed days  
- Amenable mortality

CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

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Waitematā District Health Board, Meeting of the Board 26/02/20
CVD Risk Assessment rates for Māori

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVD Risk Assessment rates for Māori</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

Commentary

*Note: no updated data is available.*

Results show performance is declining over time, particularly for Waitematā DHB. Various strategies have been tried by PHOs to engage with young Māori men to measure cardiovascular risk. Considerable resource has been required with minimal results. Many of these men do not engage with primary care. PHO led initiatives at work places and at social events have encountered barriers including:

- Difficulty in obtaining blood results
- No clear criteria for referral and follow-up for patients at different levels of clinical acuity
- Lack of processes resulting in poor flow of data between systems including practice management systems, Testsafe and risk assessment tools
- Patients being enrolled in different PHOs
- Cost of running initiatives

Extensive discussions on approaches and results have been had at both Implementation and Steering Group level with the resulting view that a nationally driven health promotion approach is more likely to result in success. The inequality between Māori and the rest of the population appears to have increased.

The introduction of the new CVDRA algorithms following the 2018 consensus statement has likely contributed to lower CVDRA rates. The process for risk assessment was less clear. The number of people eligible for risk assessment was increased. Considerable work has been done by PHOs to implement the new risk assessment algorithms.

Increase prescribed triple therapy for those Māori with a prior CVD event.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Increase prescribed triple therapy for those Māori with a prior CVD event</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>

Waitematā District Health Board, Meeting of the Board 26/02/20
### Influenza vaccination rate for patients with a prior CVD event under 65 years of age

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>CY 2018</th>
<th>To June 2019*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>31.6%</td>
<td>30.6%</td>
<td></td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>30.4%</td>
<td>29.4%</td>
<td></td>
</tr>
<tr>
<td>Waitematā</td>
<td>25.6%</td>
<td>26.3%</td>
<td></td>
</tr>
</tbody>
</table>

* note: flu vaccination season incomplete at this date.

Only Waitematā DHB’s coverage is improving overall when comparing the two time periods available, and this is driven by the improvement in coverage for European/Others, with results declining for the other ethnic groups. However, Pacific rates are closest to target.

A key challenge with this indicator is the under recording of vaccinations in the NIR. Vaccinations delivered at work places are not recorded in either the NIR or the practice PMS. This makes setting recalls in primary care an inefficient process.
Improving chronic condition hospital admission rates for adults requires improved integration of services and a ‘whole of system’ approach that engages patients and their families, as well as community and hospital based services. A number of activities have been shown to be effective in reducing avoidable hospitalisations for chronic conditions, including system or institution-wide programmes to improve access to health services, comprehensive disease management programmes which are patient-focused and involve multidisciplinary teams, education and self-management programmes in association with disease management programmes and disease-specific management programmes for long-term conditions.

<table>
<thead>
<tr>
<th>Indicator</th>
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<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in the overall ASH rate for Māori adults aged 45-64 years old.</td>
<td>8,184 per 100,000 (2% reduction) (Baseline = 8,351 per 100,000 at December 2018)</td>
<td><img src="image1.png" alt="Graph" /></td>
</tr>
<tr>
<td>Reduction in the overall ASH rate for Pacific adults aged 45-64 years old.</td>
<td>9,457 per 100,000 (2% reduction) (Baseline = 9,650 per 100,000 at December 2018)</td>
<td><img src="image2.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

**Commentary**

The target of increasing utilisation of POAC for Māori and Pacific patients aged 45 – 64 years with ASH conditions has not been measured as it requires improved coding for ASH in primary care. We are monitoring utilisation of POAC for ASH related conditions for this cohort. Data sharing between primary and secondary care to improve coding for ASH conditions contributing to acute hospital bed days has been agreed under the Metro Auckland Data Sharing Framework. Data has been supplied from the Ministry of Health. Processes for improving coding are in development. Improved coding of long term conditions in primary care will support targeting appropriate cohorts with QI activity.
Primary Options for Acute Care

*SLM Milestones impacted: Acute bed days, Amenable mortality*

Primary Options for Acute Care (POAC) provides healthcare professionals with access to investigations, care or treatment for their patient, when the patient can be safely managed in the community. Access to existing community infrastructure and resources is utilised to provide services that prevent an acute hospital attendance or shortens hospital stay for patients who do attend or are admitted. The aim of POAC is to deliver timely, flexible and coordinated care, meeting the healthcare needs of individual patients in a community setting. We aim to have more individuals being treated (where appropriate) through the POAC pathway, thus preventing unnecessary and costly acute hospital admission.

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<tr>
<td>Increased POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions</td>
<td>3 per 100 (3%) per PHO</td>
<td><img src="chart" alt="Bar chart showing POAC initiation rate for ASH conditions per 100 Māori and Pacific 45-64 year old enrolled patients by PHO" /></td>
<td>Initiation rates vary by geographic location, even where the PHO is the same. Overall rates have declined slightly between reporting periods. Regular POAC data has not been available until recently and there are data quality issues within the 2019 data, so it has not been included. Quality improvement activities have not been supported. NHI level data is now available to PHOs. See commentary above.</td>
</tr>
</tbody>
</table>

Variation by PHO (split by DHB location) across the metro-Auckland region (PHOs not identified)

*Note: due to data quality issues with 2019 data, no updates are available.*
Patient Experience

E-portals

SLM Milestones impacted: Patient experience of care

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 on patient experience. 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).

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<tr>
<td>Percentage of each PHO’s enrolled population with login access to a portal</td>
<td>30%</td>
<td></td>
<td>The increased target was achieved in three of the seven PHOs, but not for the Metro Auckland enrolled population. One PHO that did not achieve the target is actively piloting a new portal system.</td>
</tr>
</tbody>
</table>

Patient Experience Surveys in Primary and Secondary 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.

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<td>Maintain or increase practice participation in the PHC PES (as at February 2019)</td>
<td>February 2019 baseline = 90%</td>
<td></td>
<td>The majority of PHOs are meeting or nearly meeting the target to maintain baseline participation rates.</td>
</tr>
</tbody>
</table>

Note: No December 2019 data available for East Health.
<table>
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<tr>
<td>Average score in Inpatient survey question: ‘Did a member of staff tell you about medication side effects to watch for when you went home?’</td>
<td>5% improvement</td>
<td>Targets: ADHB: 55.2% CMDHB: 52.5% WDHB: 47.0% (Metro-Auckland target = 51.4%)</td>
<td>Only Counties Manukau DHB is currently surpassing target, although Waitematā has been tracking closely. Auckland DHB has not met target for the past year.</td>
</tr>
</tbody>
</table>

Q2 2019/20 Metro-Auckland result = 49.4%
8. 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:

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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| Minutes of Meeting of the Board - Public Excluded (18/12/19) | 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. | 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. |
| Minutes of the Special Meeting of the Board - Public Excluded (19/02/20) | 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. | 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. |
| Minutes of the Audit and Finance Committee – Public Excluded (05/02/20) | 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 5.9 (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 5.9 (2) (j)] |
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| 4. Minutes of the Hospital Advisory Committee – Public Excluded (05/02/20) | 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. | 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. Review of 2020/21 Annual Plan – Draft 1 | 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. | 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)] |
| 6. Vaccine Development to end Rheumatic Fever and Rheumatic Heart Disease | 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. | 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. Evergreen agreements for community pharmacy and aged residential care 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. | Commercial Activities  
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<td><strong>8.</strong> North Shore Hospital Central Sterile Services Department Upgrade</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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<td><strong>9.</strong> Waitakere Hospital Special Care Baby Unit Change Request</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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<td><strong>10.</strong> Mason Clinic Agreement with Ministry of Housing and Urban Development</td>
<td>That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
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| 11. Elective Capacity and Inpatient Bed Project - Building Importance Level Change Request | 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  
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Negotiations  
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[Official Information Act 1982 S.9 (2) (i)] |
| 12. ECIB: Early Contractor Involvement | 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  
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Negotiations  
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[Official Information Act 1982 S.9 (2) (i)] |
| 13. Waitakere Hospital – Urgent Inpatient Capacity Project Single-stage Business Case | 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  
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| 14. Waitakere Redevelopment Programme - Master Site Planning and Programme Business Case Change Request | 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  
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[Official Information Act 1982 S.9 (2) (j)] |
| 15. Construction Management Software | 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  
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| 17. Food 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 | Commercial Activities  
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| | 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)] |
| | Legal Professional Privilege
The withholding of the information is necessary to maintain legal professional privilege. [Official Information Act 1982 S.9 (2) (h)] |
| Informed Consent | 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
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| | 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) (bi)] |
| Legal Services 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
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