Waitematā
District Health Board

Best Care for Everyone

BOARD MEETING

Wednesday 10 July 2019

9.45am

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.

Waitematā District Health Board
Best Care for Everyone

MEETING OF THE BOARD
10 July 2019

Venue: Waitematā DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time:** 9.45am

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

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 I – Items to be considered in public meeting

AGENDA

	1.	**AGENDA ORDER AND TIMING**
	2.	**BOARD AND COMMITTEE MINUTES**
9.45am	2.1	Minutes of the Meeting of the Board (29/05/19) Actions arising from previous meetings
	2.2	Minutes of the Special Meeting of Board (26/06/19)
	2.3	Minutes of the Hospital Advisory Committee (19/06/19)
9.50am	**3.**	**CHAIR REPORT:** Board decision-making and communications in the district health board election period
	4.	**EXECUTIVE REPORTS**
9.55am	4.1	Chief Executive Officer's Report
10.05am	4.2	Health and Safety Performance Report
10.15am	4.3	Communications Report
	5.	**PERFORMANCE REPORT**
10.25am	5.1	Financial Performance
	6.	**INFORMATION PAPER**
10.35am	6.1	Statement of Performance Expectations Performance Report: Quarter Three 2018/19
10.45am	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Judy McGregor (Chair)	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	28/03/19
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
Kylie Clegg (Deputy Chair)	Trustee - Well Foundation Director - Auckland Transport Director - Sport New Zealand Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary, M&K Investments Limited (includes a share of less than 1% in Orion Health Group). Orion Health Group has commercial contracts with Waitemata DHB and healthAlliance Director of High Performance Sport New Zealand Limited Board member, Counties Manukau District Health Board Shareholder – Genesis Energy Ltd.	03/04/19
Sandra Coney	Member - Waitakere Ranges Local Board, Auckland Council Patron - Women's Health Action Trust Member - Portage Licensing Trust Member - West Auckland Trusts Services	15/12/16
Warren Flaunty	Member - Henderson–Massey Local Board Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health Director - Life Pharmacy Northwest Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd Trustee – Hospice West Auckland (past role) Shareholder - Genesis Energy	12/09/18

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Dr Matire Harwood	Senior Lecturer - Auckland University Director - Ngarongoa Limited, which is contractor providing services to National Hauora Coalition GP at Papakura Marae Health Clinic Advisory Committee Member - State Foundation NZ (Māori Health) Member Te Ora, Māori Medical Practitioners Step-daughter is a surgical registrar at Waitemata DHB	10/05/18
James Le Fevre	Emergency Physician - Auckland Adults Emergency Department Trustee - Three Harbours Foundation Member - Medical Protection Society Member - Northern Regional Clinical Practice Committee Shareholder - Pacific Edge Ltd DHB Representative (Auckland and Waitemata DHBs) - Air Ambulance Co-design Procurement Governance Board (past role) James' wife is an employee of the Waitemata DHB, Department of Anaesthesia and Perioperative Medicine and a Medico-Legal Advisor for the Medical Protection Society Board Member - Auckland District Health Board (past role) Shareholder - Genesis Energy	21/11/18
Brian Neeson	Member - Upper Harbour Local Board Member - Human Rights Review Tribunal Member - Auckland District Licensing Committee Managing Director - BK & VS Neeson Limited Managing Director - Apollo Property Investments Limited Property Development Consultant Chair – Wilson Home Committee of Management (past role)	19/12/18
Morris Pita	Owner/operator - Shea Pita and Associates Limited. Shareholder - Turuki Pharmacy Limited Member - Eden Park Trust Board Shareholder and Director of Healthcare Applications Limited. In December 2018 this company won an RFP with Waitemata DHB for provision of the Emergency Q software service to reduce overcrowding in the ED and the company is currently (as at 27 March 2019) in the final stages of negotiation for a potential contract for service at both North Shore and Waitakere EDs. Morris' wife is a: Board member - Northland District Health Board Board member - Auckland District Health Board Director - Healthcare Applications Limited Director - Shea Pita & Associates	27/03/19
Allison Roe	Chairperson - Matakana Coast Trail Trust Member - Rodney Local Board, Auckland Council Member - Wilson Home Committee of Management (past role)	22/08/18

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 29 May 2019

Recommendation:

That the Minutes of the Board meeting held on 29 May 2019 be approved.

DRAFT Minutes of the meeting of the Waitemata District Health Board

Wednesday, 29 May 2019

held at the Awhina Conference Centre, Snelgar Building, Waitakere Hospital
commencing at 9.48am

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT:

Judy McGregor (Board Chair)
Edward Benson Cooper
Kylie Clegg (Deputy Board Chair)
Sandra Coney
Warren Flaunty
Matire Harwood
Brian Neeson
Morris Pita
Allison Roe

ALSO PRESENT:

Dale Bramley (Chief Executive Officer)
Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Debbie Holdsworth (Director Funding)
Jocelyn Peach (Director Nursing and Emergency Planning)
Cath Cronin (Director of Hospital Services)
Tamzin Brott (Director of Allied Health, Scientific and Technical Professions)
Fiona McCarthy (Director Human Resources)
Peta Molloy (Acting 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:

Teresa Taylor, T&T Consulting Limited
Tracy McIntyre, Waitakere Health Link
Samuel Cho, Waitakere Health Link

There were no media representatives present.

WELCOME:

The Board Chair welcomed everyone to the meeting, acknowledging the members of public and staff in attendance.

APOLOGIES:

Apologies were received and accepted from James Le Fevre and Max Abbott.

Morris Pita and Kylie Clegg advised they would need to leave the meeting early.

DISCLOSURE OF INTERESTS

There were no additions or other amendments to the Interests Register.

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 17 April 2019 (agenda pages 7-18)

Resolution (Moved Edward Benson-Cooper/Seconded Matire Harwood)

That the Minutes of the Board meeting held on 17 April 2019 be approved.

Carried

Actions arising from previous meetings (agenda pages 19)

No issues were raised.

2.2 Draft Minutes of the Hospital Advisory Committee Meeting held on 08 May 2019 (agenda pages 20-27)

Resolution (Moved Brian Neeson/Seconded Warren Flaunty)

That the draft minutes of the Hospital Advisory Committee meeting held on 08 May 2019 be received.

Carried

2.3 Draft Minutes of the Disability Support Advisory Committees Meeting held on 04 April 2019 (agenda pages 28-32)

Resolution (Moved Edward Benson-Cooper/Seconded Kylie Clegg)

That the Draft Minutes of the Disability Support Advisory Committees meeting held on 04 April 2019 be received.

Carried

3 CHAIR REPORT

3.1 Board Chair's Report (agenda pages 33-35)

The Board Chair summarised this report. She acknowledged the work done in establishing the DHB's Consumer Council and that the candidates had been outstanding; the interviews had been held for panel members and included a range of ethnicities, gender and age.

In response to question about candidates who had applied for a single issue, it was noted that the interview questions were not framed around single issues. However, some candidates had indicated they applied for a single issue but that they were broad enough to not be a direct focus. The Chief Executive further noted that the candidates interviewed were looking to improve health services to all people; one of candidate had organised a network on Facebook which involved provided assistance to families in need including support, meals, rosters and care.

4 EXECUTIVE REPORTS

4.1 Chief Executive's Report (agenda pages 36-51)

The Chief Executive introduced the report and a video was shown on 'Rural Point of Care Testing'; Debbie Holdsworth and her team were acknowledged in the production of the video. In response to a question about the testing undertaken, it was noted that there are five tests that can be completed to prevent an unnecessary transfer to hospital. Training is undertaken by the Waitematā DHB as part of laboratory services. It is not used for regular testing.

Other matters highlighted and response to questions included:

- The recent tragic events in the He Puna Waiora Service were noted.
- Noting the CE Lecture Series from Professor Ron Paterson, where he discussed the 2018 Government Inquiry into Mental Health and Addiction process.
- Noting the maximum possible accreditation received from the Royal Australasian College of Physicians. In response to a question, Matt Rogers (Director Communications) advised that he would investigate media interest in this achievement for the DHB.
- The progress in the development of an Iwi-DHB Partnership Board.
- Noting the invitation to the Waitakere Hospital Spiritual Centre Dedication on Tuesday 4th June. The donations given to allow the re-development of the Spiritual Centre were acknowledged along with the community involvement in the re-opening of the Centre.
- In response to a question about staff receiving influenza vaccinations, the steady increase was noted and the DHB intends to send out an opt-in form to target those who still wish to receive a vaccination and also collect data on staff they may have received their vaccination outside of the DHB. It was also noted that staff have been advised that they may not be aware they have the flu and be infectious, passing it on.

4.2 Health and Safety Performance Report (agenda pages 52-61)

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

Matters covered in discussion and response to questions included:

- Clarifying that physical harm events from incidents where people have no intent to harm include people who are not cognisant of what they are doing. There are three categories to record harm: those that know what they are doing, partial intent to cause harm (usually substance abuse) and no intent to cause harm (serious mental health issues, response to medication, people who are not cognitively aware of their actions).

- In response to a question about the granular detail for aggressive incidents, it was noted that the DHB does not currently capture time of incidents; the DHB is in the process of rolling out map training and apply security or clinical teams where a service may be anticipating someone who is coming in or someone who is aggressive at the time. All services are aware of steps to be taken in an incident of aggression.
- Kylie Clegg noted a staff safety forum held at Counties Manukau DHB following assaults in the carpark. She advised that she attended the forum and that it was empowering. A similar forum could be held at Waitematā DHB.

The Chair noted that the Board is concerned about aggression and would like to ensure adequate staff training around aggression.

4.3 Communications Report (agenda pages 62-71)

Matthew Rogers (Director Communications) was in attendance for this item. The report was taken as read.

Matters covered in discussion and response to questions included:

- The Rural Point of Testing Care video shown during item 4.1 was the fifth most popular story on Stuff at the time of release.
- There are 69 confirmed cases of measles in the Auckland area; 42 of these are in the Waitemata DHB catchment area. The Planning and Funding immunisation team is actively working to increase awareness around immunisation; a recent Facebook post had been successful. The DHB has also posted a video on social media of a young dad whose infant daughter had been infected with measles, in addition a Waitakere Hospital ED nurse video had also been posted and reached had 26,000 views.
- The volume of OIA requests continues. It was suggested that an invitation should be extended to the Ombudsman to meet and visit with the Waitemata DHB.
- The DHB continues to report all media activity to the Ministry of Health.

5 PERFORMANCE REPORTS

5.1 Financial Performance (agenda pages 72-83)

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

In response to a question it was noted that regardless of other DHB deficits, the Waitematā DHB's funds held in the collective sweep (joined as part of NZ Health Partnerships Limited) should be protected. In addition, it was noted that there are benefits to the DHB to be part of the sweep, including transaction costs.

With regard to the additional costs incurred with the over allocation of registrars in the Surgical and Ambulatory Service, it was noted that there is an over-allocation to accommodate the drop-off rate during the year, a natural attrition that occurs yearly.

The costs associated with the increase in caesareans being undertaken and what steps are in place to reduce the rate will be reported to the Hospital Advisory Committee.

8. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 84-89)

In response to a query around items excluded from the public, it was noted that the Chair, Chief Executive and Board Secretary will review each paper and its reason for confidentiality.

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

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

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

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1.	Minutes of Meeting of the Board - Public Excluded (17/04/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2.	Minutes of the Audit and Finance Committee – Public Excluded (08/05/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **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 (08/05/19)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**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.

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
4.	2019/20 Northern Region Service Plan – First Draft Version	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
5.	Community Pathology Parent Company Change of Ownership	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
6.	Regional Information Systems Strategic Plan Workspace 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. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
7.	Radiology Service – Proposal for Continuation of MRI and Ultrasound Outsourcing for FY 2019/20	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. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
8.	Endoscopy Service (Gastroenterology): Proposal for Continuation of Outsourcing for the FY2019/20	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. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
9.	Expansion of the Special Care Baby Unit at Waitakere 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. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
10.	Supporting the Establishment of the Northern Iwi-DHB Partnership Board	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
11.	Diabetes Retinal Screening	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
12.	Bilateral Policy Alignment	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
13.	ProCare Governance	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
14.	Establishment of Child Health Information Platform – Coordination Hub	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
15.	Mason Clinic - Tanekaha Replacement Unit Main Works Contract	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
16.	Mason Clinic Sale and Purchase Agreement: Due Diligence	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
17.	Resolution for Patient Dispute	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
18.	Legal 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)]	**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)]

The open meeting concluded at 10.51 a.m.

SIGNED AS A CORRECT RECORD OF THE MEETING OF THE WAITEMATA DISTRICT HEALTH BOARD - BOARD MEETING HELD ON 29 MAY 2019

_____CHAIR

Actions Arising and Carried Forward from Previous Board Meetings as at 03 July 2019

Meeting Date	Agenda Ref	Topic	Person Responsible	Expected Report back	Comment
06/03/19	4.3	**Communications** - give thought on possibility of elevating public debate on key population health issues and provide comment to the Board.	Matt Rogers		Matt to provide a verbal update at meeting.
06/03/19	5.2	**Leapfrog Programme Stage 3** – consider whether there are possibilities of assisting those DHBs who have limited resources to undertake this type of work.	Robyn Whittaker		Currently (April 2019) having discussions with our CIO including about proposed Digital Academy. Will be giving consideration to this request from the Board.
17/04/19	4.1	**Telehealth** – paper to be provided at an appropriate time on telehealth in comparison to face to face appointments, including what patients and clinicians think about it and also the safety aspects.			

2.2 Confirmation of Minutes of the Board meeting held on 26 June 2019

Recommendation:

That the Minutes of the Board meeting held on 26 June 2019 be approved.

Minutes of a Special Meeting of the Waitematā DHB Board

Wednesday, 26 June 2019

held at Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 3.33p.m.

PART 1 – Items considered in public meeting

BOARD MEMBERS PRESENT:

Judy McGregor (Board Chair)
Edward Benson-Cooper
Kylie Clegg (Deputy Board Chair) (by teleconference)
Sandra Coney (by teleconference)
James Le Fevre (by teleconference)
Matire Harwood (by teleconference)
Brian Neeson (by teleconference)

ALSO PRESENT:

Dale Bramley (Chief Executive Officer) (by teleconference)
Andrew Brant (Deputy Chief Executive Officer and Chief Financial Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Peta Molloy (Acting Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

APOLOGIES:

Apologies were received from Max Abbott, Warren Flaunty, Morris Pita and Allison Roe.

WELCOME:

The Board Chair welcomed those present and those participating by teleconference.

DISCLOSURE OF INTERESTS

There were no additions or other amendments to the Interests Register.

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

1 Resolution to Exclude the Public

Resolution: (Moved Kylie Clegg/Seconded Edward Benson-Cooper)

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

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

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1	Waitakere Hospital Redevelopment	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
2	Elective Capacity and Inpatient Beds (ECIB) Preliminary Design Phase to Project Completion Professional Services Procurement	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
3	2019/20 Annual Plan	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**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)]

Carried

The meeting in open session concluded at 3.34 p.m.

SIGNED AS A CORRECT RECORD OF THE SPECIAL MEETING OF THE WAITEMATĀ DISTRICT HEALTH BOARD HELD ON 26 JUNE 2019

_____CHAIR

2.3 Minutes of the Hospital Advisory Committee meeting held on 19 June 2019

Recommendation:

That the Draft Minutes of the Hospital Advisory Committee meeting held on 19 June 2019 be received.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday 19 June 2019

held at Waitematā District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 1.39 p.m.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

James Le Fevre (Committee Chair)
Judy McGregor (Board Chair)
Max Abbott
Edward Benson-Cooper
Kylie Clegg (Deputy Board Chair) (from 2.12pm, item 3.1)
Sandra Coney
Warren Flaunty
Brian Neeson
Allison Roe

ALSO PRESENT

Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer)
Cath Cronin (Director of Hospital Services)
Jocelyn Peach (Director of Nursing and Midwifery)
Fiona McCarthy (Director Human Resources)
Tamzin Brott (Director of Allied Health)
Lorraine Bailey (IDF Performance Manager)
Peta Molloy (Acting 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 PRESENT

There were no members of the public or media present.

WELCOME

The Committee Chair welcomed those present.

APOLOGIES

Apologies were received and accepted from Matire Harwood and Morris Pita.

DISCLOSURE OF INTERESTS

There were no additions to the Interests Register.

There were no interests declared that might give conflict with a matter on the open agenda.

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 08 May 2019 (agenda pages 8 - 16)

Resolution (Moved Allison Roe/Seconded Warren Flaunty)

That the Minutes of the Hospital Advisory Committee meeting held on 08 May 2019 be approved.

Carried

Actions Arising (agenda pages 17)

The actions were noted. No issues were raised.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Provider Arm Performance Report – March 2019 (agenda pages 18 - 82)

Executive Summary/Overview

Andrew Brant summarised the executive summary and overview.

Matters covered in discussion and response to questions included:

- That there had been a number of people presenting with influenza at the DHBs hospitals, however, it was not a particularly strong strain. The number of presentations was not higher than the previous year.
- That the Faster Cancer Treatment graph (page 27 of the agenda) shows a drop in the Māori population; it was noted that this figure is n <20 and that one or two people no longer receiving treatment will show a significant drop. It was noted that the forecast for the month will be 91%.
- With regard to the financial performance table, the difference for allied health with a positive to budget and how that relates to other services is turnover and vacancies.

Human Resources

In response to a question, Fiona McCarthy advised that approximately 62% of staff had received the influenza vaccination. This is not expected to increase due to vaccine availability.

Acute and Emergency Medicine Division

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

Alex Boersma introduced the report. Matters covered in discussion and response to questions included:

- That the scorecard shows the turnover rate remains high.
- The patients seen graph for North Shore Hospital has been duplicated in the report; the graph shows an improvement in the North Shore Hospital data.
- Chest pain clinic wait times under six weeks continue to improve with 63% against a target of 80% met in May; the target is expected to be reached in July.
- ECHO wait times under 12 weeks has seen a downward trend. Resources are being used appropriately. The waiting list has decreased from approximately 3,000 to approximately 2,000. The decrease is partly due to increase in resource.

Specialty Medicine and Health of Older People Division

Dr John Scott (Head of Division), Brian Millen (General Manager) and Melody-Rose Mitchell is the Acting Associate Director of Nursing Acute and Emergency Medicine and Specialty Medicine and Health of Older People were present for this item.

John Scott introduced the report. Matters covered in discussion and response to questions included:

- Noting the highlight of the month (page 48 of the agenda) 'Innovation in practice – Telehealth Outpatient Physiotherapy'; it was noted that group education sessions have been acceptable and people are happy to take part. Travel times can be an issue and video conference options are being investigated. In response to a question about how this idea was developed, it was noted that four services from different divisions took part in a pilot led by i3. The initial idea came about due to personal experience from the person leading it. A briefing on the programme and its initiation will be presented to the Committee at a later date.
- Brian Millen summarised the key issue 'lower than anticipated volumes for fracture liaison services. John Scott noted that future fractures can be reduced by as much as half with treatment in people who have had a first fragility fracture. The best intervention for lower level people at risk is an in home strength and training programme; uptake for this had not been as high as hoped. In response to a comment regarding taking medication in these instances and potential side effects, John Scott said that the programme is not about medication. The programme is run in close partnership with a patient's GP, who primarily initiate treatment, and provides options for patients. It was suggested and agreed that a fracture liaison nurse present to the Committee at a later date. A further update will also be provided to the Committee at its next meeting.

Child, Women and Family Services

Stephanie Doe (General Manager) and Emma Farmer, Head of Division Midwifery) were present for this item. An apology was received from Dr Meia Schmidt-Uili.

Emma Farmer summarised the highlight of the month reported 'Completion of the Pregnancy and Parenting Improvement Plan'.

Stephanie Doe noted that oral health and dental therapy vacancies remain high, with 14.5 current vacancies. There has been a lot of internal movement across teams; the three main reasons for leaving the service are: retirement, moving out of the area or moving to a private practice. In response to a question about retention of staff, Stephanie advise that a lot of work had been done and feedback received showed a lot of support was provided, but not for long enough. It was also noted that new graduates want to maintain a dual scope and the DHB is looking at how to support therapists in maintaining hygiene skills, to address this options of private/public roles are being offered. A site visit for Board members to a mobile dental unit will be arranged.

Matters covered in discussion and response to questions included:

- That the Pregnancy, Parenting Improvement Plan includes immunisation advice.
- That in the past year there were 13 babies Oranga Tamariki care; of which nine babies were Māori (four transitioned to whānau care), two pacific babies (one into whānau and one into non-whānau foster) and two European babies. It was noted that all of these cases were planned, with a process followed. The DHB has well developed child protection systems in place, with appropriate training for staff. The DHB has a very positive relationship with Oranga Tamariki and communicate regularly with them.

Specialist Mental Health and Addiction Services

Dr Susanna Galea-Singer (Director and Head of Division), Pam Lightbown (General Manager) and Alex Craig (Head of Division Nursing) were present for this section of the report.

Alex Craig introduced the report and summarised the highlight of the month reported 'Ngā Poutama Oranga Hinengaro – An HQSC Quality in Context Survey'.

Susanna Galea-Singer noted the update provided on Zero Seclusion. At a recent national Zero Seclusion forum in Christchurch, the DHB team was awarded the best –co-design and consumer participation project. The Committee Chair congratulated those involved.

Matters covered in discussion and response to questions included:

- The recent tragic events at He Puna Waiora were noted; reviews are underway, including on the function of the unit. There is also regular contact with the families involved.
- With regards to length of time a client may be a resident in the DHBs service, it was noted that this can be related to general housing issues. There are options including respite beds in the community and step-down beds.
- Noting that there is movement and generalised concern in the area of mental health for a firmer stance on substance abuse such as alcohol, as well as gambling, obesity and the like.
- The region is undertaking a deep dive on population health with three priorities. The first of these is the stabilisation of ARPHS. The second is a series of risk factors including drugs, alcohol, tobacco, mental health promotion in earlier years. The third is the determinants of health. The work is progressing well.

Surgical and Ambulatory Services

This section as considered before Speciality Medicine and Health of Older People.

Debbie Eastwood (General Manager) and Michael Rodgers (Chief of Surgery) were present for this item.

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

- Noting the positive change made by the orthogeriatrician model of care, led by a dynamic individual, Dr Min Yee Seow.
- There is a large amount of work going into time to surgery for neck of femur fracture.
- Noting the update provided on support and developing theatre culture.
- That the utilisation metrics are positive. It was also noted that a list can be impacted by someone who calls in unwell and that this is not a system failure. This data can now be shown on Click; the Committee Chair suggested that a presentation be given on this, including how other hospitals record this information.
- The Committee Chair acknowledged the balance scorecard.
- In response to a question about theatre utilisation across the region and nationally, Michael Rodgers noted that there is a national metric (called DAP) which removes any turnaround time from the numerator as well as start and finish. It was noted that the measure can be difficult to measure there are times ten cases could be completed in a day and other times when one case will take a full day. A more detailed report around the metrics will be provided to the Committee at a later date.

3.2 Provider Arm Performance Report – April 2019 (agenda pages 82 - 92)

The report was noted.

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 93 - 105)

Dr Andrew Brant (Chief Medical Officer and Deputy Chief Executive Officer), Tamzin Brott (Director of Allied Health, Scientific and Technical Professions) and Dr Jocelyn Peach (Director of Nursing and Midwifery; Emergency Systems Planner) were present for this item.

Medical Staff

Andrew Brant noted the presentation scheduled on Friday 21st June from Heather Gunter.

Allied Health, Scientific and Technical Professions

Tamzin Brott summarised this section of the report.
The Committee Chair acknowledged the Laboratory staff achievements celebrated and the Committee agreed to send a thank you letter.

Nursing and Midwifery

Jocelyn Peach summarised this section of the report.

In response to a query about the clinical monitoring and management data for Patient and Whanau Centre Care Standards (page 103 of the agenda), Jocelyn Peach noted that the scores had been low since monitoring commenced and that it is audited weekly.

In response to question about the CCDM (Care Capacity Demand Management) update provided, it was noted that it was too soon to note Union expectation in this area.

4.2 Quality Report (agenda pages 106 - 339)

Penny Andrew (Clinical Lead, Quality), Jacky Bush (Quality and Risk Manager) and David Price (Director of Patient Experience) presented this report.

Jacky introduced the report, noting the updates reported around infection, prevention and control, measles, influenza vaccines, falls and pressure injuries and the Learning from Adverse Events week.

In response to a query Jocelyn Peach advised that the lavender round is an assessment and monitoring round to ensure a proper care plan is in place.

With regards to the influenza vaccination rate, it was noted that there is a 'roving' vaccinator and that processes are in place to target certain groups needing to be vaccinated. The shortage of vaccine stocks was also noted.

David Price summarised the Patient and Whanau Centred Care section of the report. He noted that the inaugural meeting of the Consumer Council is scheduled to be held on Wednesday 3rd July from 2pm to 4pm. Board members are welcome to attend.

Matters covered in discussion and response to questions included:

- That the Committee can be provided with visibility of complaint trends; the information is available by division and trends over time. This will also be provided as it relates to SAC 3 and 4 information.

Penny Andrew summarised the i3 report provided to the Committee. The success with the PROMS programme was highlighted, this will be presented to the Board later in the year.

The Board Chair acknowledged the CIO award presented to the Leapfrog team.

4.3 Human Resources Report (agenda pages 340-345)

Fiona McCarthy (Director HR) presented this item, she noted two new workforce development initiatives underway. The first is accelerating the cohort for 2020, with 14 final year students. Secondly, in relation to the update provided on Māori nursing

students, work is underway with AUT for a joint appointment into the nursing school.

5. INFORMATION PAPERS

There were no information papers.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda page 346)

Resolution (Moved Warren Flaunty/Seconded Allison Roe)

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 08/05/19	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
3. Human Resources Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official	**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)]

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

Carried

The open session of the meeting concluded at 3.46 p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 19 JUNE 2019

_____COMMITTEE CHAIR

MINISTRY OF HEALTH
MANATŪ HAUORA

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1 July 2019

Dr Judy McGregor
Chair
Waitemata DHB
Private Bag 93503
Takapuna
AUCKLAND 0740

Dear Judy

Board decision-making and communications in the district health board election period

The 2019 district health board (DHB) election period is almost upon us. The election period poses particular challenges for DHBs, boards and members, to ensure that policies which touch on election-related matters are being appropriately followed.

This letter provides general guidance around issues that often arise in the context of the elections. I would appreciate it if you could bring it to the attention of all board members.

Board decision-making

The general practice with the local body and DHB elections is to treat the three months before the elections as the 'pre-election period'. The pre-election period, and the weeks after the election before new board members take office, is a sensitive time when additional protocols are frequently required. In 2019, the pre-election period will start on 1 July, the date of the commencement of the Electoral Commission campaign, with new board members due to take office on 9 December (58 days after election day on 12 October).

The makeup of boards may change significantly once election and appointment processes are completed. Given this, binding long-term significant decisions – such as signing off new plans and making key appointments (for example, to the Chief Executive Officer position) – should be approached with additional caution during this time. However, because the pre- and post-election period is close to five months long, it would be impractical for boards to entirely restrict their decision-making to minor or non-controversial matters.

In the past, we have observed that it is helpful for new board members to be given observer status at board meetings from the time final results are announced until they take office on 9 December. While this is a decision for each individual board to make, it may allow for a smoother transition from the current membership to the new board.

Communications

The following guidance on communications is based on the Auditor-General's report, *Good Practice for Managing Public Communications by Local Authorities*, which is available on the Auditor-General's website at: http://www.oag.govt.nz/2004/public-communications. A copy is also attached for your reference. Although the report's main focus is on local bodies, it contains useful information that is also relevant to DHBs at election time. This includes a principles-based approach to looking at communicating with the public, which will be of interest if your DHB is planning communications around health topics such as fluoridation.

Comments from the Auditor-General's report on the 2014/15 local government audits are also useful.[1]

Communications by DHB board members

All communications by board members, acting in that capacity, should be guided by relevant DHB and board policies. The Auditor-General has suggested that local authorities look out for the following risks:

- the use of publicly-funded (or in the case of DHBs, board-funded) events as a platform for incumbent members to promote their achievements; In the pre-election period, board members may wish to consider actively reducing the number of major events they attend
- the use of newspaper columns and other communication channels, in case they change from being a useful vehicle for communicating ordinary business to something that could be seen as a vehicle for political campaigning.

Board members should be reminded that they are often aware of matters of high sensitivity or confidence, and that these confidences must be strictly maintained. Members have a legal duty under section 57 of the Crown Entities Act 2004 not to disclose information obtained in their capacity as board members that would not otherwise be available to them. Members should also be aware of their other individual duties under sections 53 to 56 of the Crown Entities Act (that is, to comply with the Crown Entities Act and the New Zealand Public Health and Disability Act 2000; to act with honesty and integrity; to act in good faith and not at the expense of the DHB's interests; and to act with reasonable care, diligence and skill).

Communications by DHBs

DHBs should not promote, or be perceived to be promoting, the re-election prospects of a sitting board member or any other candidate. Therefore, any use of DHB resources – such as stationery, postage, internet, email or phone – by members for re-election purposes – is unacceptable and a possible breach of the principles of the Local Electoral Act 2001.

A DHB's communications policy should also recognise the risk that communications by or about members (in any capacity as spokesperson for the DHB) during the pre-election period could result in the member achieving an electoral advantage at taxpayers' expense. The DHB's Chief Executive Officer should actively manage this risk.

Established DHB communication channels (for example, websites, newsletters, and 'advertorial' content in newspapers) may also present a risk during the pre-election period. This is because they could have the effect of raising a board member's personal profile in a manner that may appear to promote their re-election. For example, a photograph of a board member launching a DHB initiative in a board magazine may not be appropriate in the pre-election period because it could have the effect of raising that member's profile in the community.

This does not mean that a DHB should cease to publish news and information that is relevant to its activities. Rather, caution should be exercised over such matters. For example, while board member profiles should be removed from a DHB's website in the pre-election period, it would be appropriate to have the candidate profile statements of all candidates on the website once these are available to be published.

The Auditor-General has also cautioned local authorities about ensuring that their annual reports and annual report summaries do not have the effect of promoting or favouring existing members who are candidates for re-election. DHBs are asked to monitor any accountability documents that may be published in the pre-election period to ensure that they also meet these expectations.

---

1 http://www.oag.govt.nz/2016/local-govt/part5.htm – see Part 5, 'Local body elections'.

Communications from DHB staff

Chief Executives are advised to brief staff about the risks of inappropriate communications that may be perceived as a staff member contributing directly to the political debate and supporting a particular side. DHBs may wish to introduce special or temporary procedures in the pre-election period that cover such matters, and also set out protocols for dealing with media enquiries very clearly.

Another issue to manage is the contact between staff and those who are working on election campaigns. Candidates and their staff may ask for information about current activities, policies and costs. It is important that election candidates are treated equally in these circumstances and that the information they receive is neutral and factual. Protocols to ensure the equal treatment of requests from current members and candidates can provide important protection.

I trust that you find this information useful. Should you require clarification around any of the matters raised in this letter, Lisa McPhail, Chief Advisor, DHB Appointments Project, would be happy to assist. You can contact Lisa on 021 719 865 or lisa.mcphail@health.govt.nz.

Yours sincerely

Sarah Turner
Deputy Director-General
Office of the Director-General

cc Dr Dale Bramley, CEO, Waitemata DHB, dale.bramley@waitematadhb.govt.nz
Dale Ofsoske, dale.ofsoske@electionservices.co.nz

Encl.

The Controller and Auditor-General

Tumuaki o te Mana Arotake

Good Practice for Managing Public Communications by Local Authorities

April 2004

ISBN 0-478-18117-5

Foreword

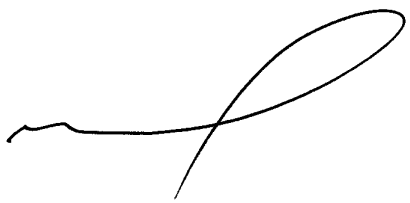
We first published our *Suggested Guidelines for Advertising and Publicity by Local Authorities* in 1996. We published a revised version of those *Guidelines* in 1999.

Since 1999, a number of factors have contributed to significant change in the environment in which local authorities are involved in "advertising and publicity". Probably the two major factors are the advances in communications technology and the rate of adoption of the new technology, and (more recently) the enhanced requirements for communication in the Local Government Act 2002.

We saw as a consequence of that significant change the clear need to revisit the *Guidelines* to reassess their validity and determine what changes might be needed to preserve their usefulness. This publication reflects the fresh approach we have taken to the subject – still principles-based, but with an emphasis on the wider concept of "communication" rather than "advertising and publicity".

As previously, this update represents what we believe is a code of good practice. The guidance it contains is no more authoritative than that. Further, the guidance is intended neither to be an operating manual nor to cover every conceivable situation.

Local authorities will have to determine what practical application they make of our good practice guidance in particular situations. To do so, and to reflect the more open approach to disclosing how local government manages itself, we recommend that the adoption and application of the guidance in this publication be incorporated in a formal communications policy.



K B Brady
Controller and Auditor-General

14 April 2004

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1 Introduction

The importance of Council communications

1.1 Communication with the public is a major part of any Council's activities. It can consume large amounts of ratepayers' money.

1.2 Some types of public communications are mandatory – for example, notifying Council meetings, or issuing a statutory plan for consultation. Others are discretionary – for example, a Council-funded newsletter, a media release explaining a recent decision, or a pamphlet about disposal of household waste.

1.3 Councils communicate with the public by many different means. For any communication, a Council has a broad range of choices – both as to the medium to be used (e.g. whether to pay for newspaper advertising or use the Council's web site) and the degree of sophistication involved.

1.4 Choice introduces judgment and subjectivity. The dilemma of the communicator is in reconciling the potentially conflicting criteria of:

- making the communication attractive so that the audience will give it their attention, absorb it, understand it, and (if that is what is expected) act on it;
- meeting acceptable standards of probity; and
- presenting accurate, complete, and fairly expressed information.

1.5 The skill required of the communicator is to observe the relevant principles and apply the highest possible standards, and, importantly, to learn from experience.

Why this guide?

1.6 Communication of information at public expense or in an official capacity always carries the risk of criticism. The commonest complaints (except for statutory notifications) are that a communication is unnecessary, unbalanced, or politically biased. The best defence to any complaint is that the communication meets acceptable standards.

1.7 The Auditor-General is often asked to express a view on whether a particular communication is acceptable. Some requests come from the Council, before publication. Others come from members of the public afterwards, complaining about what has been done.

1.8 Until 1996, there was no authoritative guidance as to what standards were acceptable in Council communications. Our suggested guidelines – first published in that year, and now updated for the second time – have aimed to fill that vacuum. Just as we bring an independent perspective to our job as the auditor of local authorities, we try to describe good practice that reflects not only the theory and practice of communications but also the expectations of the public.

1.9 We derive our guidance from:

- our knowledge of the kinds of official communications that may cause concern in both the central and the local government sectors;
- our experience, not only in giving help to communicators but also in dealing with complaints from the public; and
- our consultations with a range of Council communications staff and advisers and with Local Government New Zealand.

1.10 The feedback we received from our consultations was that independent guidance is a valuable and necessary aid, not only for Council Members but also for communications staff and advisers. Guidance can:

- provide a general framework for the conduct of a Council's communications activities;
- help with clarifying roles and responsibilities – especially as between Members and communications staff and advisers; and
- set benchmarks for particular types of communications – especially as to what is acceptable in the political context and at critical times such as during a pre-election period.

The objects and scope of the guide

1.11 The statements of good practice in this guide are designed to meet three objectives in relation to a Council's communications practices:

- to ensure that Council communications resources are applied effectively and efficiently, and in a manner that produces good value for money;
- to ensure that those who are permitted to use Council communications facilities do so for legitimate purposes; and
- to promote appropriate standards of conduct by those who consume Council communications resources, or use Council facilities, or otherwise communicate on behalf of the Council.

1.12 This wide scope is consistent with our role as the auditor of local authorities, which includes examining the extent to which they, and their members and staff:

- carry out activities effectively and efficiently, consistent with Council's own policies;
- comply with statutory obligations;
- avoid wasteful use of resources; and
- act with probity and financial prudence.[1]

1.13 The guide itself is produced under the authority of section 21 of the Public Audit Act, as a report on matters arising out of the performance and exercise of those functions.

What is the status of the guide?

1.14 Our guidance is not binding on Councils. Each Council is free to adopt its own standards – which must of course be consistent with the relevant principles of the Local Government Act 2002 (LGA).[2]

1.15 We recommend that every Council consider adopting a formal communications policy framed to suit its particular needs. The policy should:

- embrace these guidelines – or a variation of them (stricter or otherwise) that the Council considers appropriate to its circumstances; and
- clearly direct Members and communications staff and advisers[3] on how the policy is to be applied in particular cases.

1.16 Although this guide is not binding on Councils, they and the public should be aware that it establishes the criteria that we will use in future in order to form a view on the appropriateness of a Council's public communications.

1 Public Audit Act 2001, section 16.
2 Section 14 of the LGA.
3 Including those engaged as consultants.

2 Scope – What are "Communications"?

2.1 Our guidance applies to any communication by a Council, or a Member or employee or office holder of a Council, or a Member of a Community Board, where:

- the Council meets the cost (wholly or in part); or
- the person making the communication does so in an official capacity on behalf of the Council or a Community Board.

2.2 We make no distinction between:

- mandatory and discretionary communications;
- communications in the Council's own publications and the news media generally;
- Council-funded advertisements and other forms of publicity; or
- electronic (including web site or e-mail) and hard copy publication.

The underlying principles are the same in each case.

2.3 Common examples of communications by Councils include:

- statutory documents – such as draft, final, and summary versions of the Long Term Council Community Plan or an Annual Report under the LGA;
- information on a web site, or in a poster or pamphlet, about Council services available to the public, or the rights, entitlements, and responsibilities of people affected by a Council activity;
- newspapers and newsletters reporting Council news and activities;
- material explaining a particular proposal, decision, policy, or bylaw of the Council;
- marketing material promoting the Council, its communities, or a regional brand;
- Council-funded advertising about a particular event, proposal, or Council policy;
- educational material about issues affecting the community; and
- media releases initiating or responding to public comment about matters affecting the Council or its communities.

2.4 In a different category are communications by Members using Council resources or facilities. We address this type of communication in paragraphs 4.33-4.40 on pages 19-20.

2.5 The guide does not apply to:

- normal day-to-day correspondence between Members and their constituents on appropriate matters, ***except*** during a pre-election period when the content of the correspondence should not be inconsistent with Principle 12 on page 22; and

- communications by Members using their own resources.

3 Communications – Whose Responsibility?

3.1 Corporate governance principles stress the different roles of the governing body and the management of an organisation. For local authorities, section 39 of the LGA reflects these principles.

3.2 Members (i.e. the governing body) and management of a Council share different elements of the communications function. In essence:

- Members are accountable to the community for the Council's decisions and actions. What the Council says in its communications is, therefore, ultimately the Members' responsibility.

- The mechanics of communications are operational activities, which form part of the everyday business of the Council. Moreover, effective communication often requires professional input. Most Councils employ (or engage on contract) professional advice and assistance for some or all of their communications activities. The chief executive is responsible for the effective and efficient management of those people and their activities.

- Communications is also an area of risk. Those who are authorised to communicate on behalf of a Council, and those who exercise editorial or quality control, need to have access to sources of professional advice when necessary (including legal and strategic communications advice). Obtaining that advice is also a management responsibility.

3.3 The communications function thus straddles the divide between governance and management in the Council organisation. Each Council should allocate the respective roles and responsibilities according to its own size and needs. For example, in a small Council the Mayor might be the primary spokesperson on all issues, whereas in a larger Council the role might be shared between the Mayor and a communications manager.

3.4 The governance/management divide also affects the crucial elements of policy development, quality control, and editorial supervision. We think these elements are best regarded as management functions, for which the chief executive is responsible.

3.5 The respective roles and responsibilities need to be well understood by all concerned and put into practice effectively.[4] This is especially important when the Council employs professional communications staff – who could, for example, feel undermined by Members intervening in editorial decisions.

[4] See section 39(e) of the LGA. The local governance statement required by section 40 of the LGA could be the appropriate place to record particulars of the division of roles and responsibilities.

3.6 A useful approach is to regard the roles of Members and management as complementary, and to encourage everyone to work together in partnership for the good of the Council and the community.

4 Principles and Practice

4.1 In this section we set out 13 principles that we believe should underpin a Council's policy and practice on communications. We supplement each of the principles with commentary.

4.2 We stress that the principles are intended as general statements, which are to be applied in a flexible and common sense manner. Likewise, the commentary cannot expect to foresee all possible situations that might arise.

Legitimacy and justification

Principle 1 –
A Council can lawfully, and should, spend money on communications to meet a community's (or a section of a community's) justifiable need for information about the Council's role[5] and activities.

4.3 Communications are a necessary and legitimate Council expense. Councils are also justified in employing, or otherwise engaging, professional advice and assistance for their communications activities.

4.4 However, no communication should be undertaken without justification or regard for the cost.

4.5 The main elements of justification are:

- establishment of an identifiable need for information on the part of a particular audience;
- the chosen method of communication should be one that is effective in reaching those who have the need; and
- once the method has been identified, the communication should be made in the most cost-efficient manner.

4.6 Consideration should also be given to evaluating the effectiveness of the communication. What is known to have been an effective communication supports the justification for that communication and can be a benchmark to support future communications.

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5 *The role of a local authority is to—*
(a) give effect, in relation to its district or region, to the purpose of local government …; and
(b) perform the duties, and exercise the rights, conferred on it by or under this Act and any other enactment.
(LGA, section 11)

4.7 A communication will be lawful when it:

- is authorised by a Council resolution or under a delegation; and
- complies with any specific legal requirements as to form, content[6], timing, or method of publication[7].

4.8 A Council can also exercise significant power over individuals and groups in the community. Consequently, a Council has an obligation to ensure those people know how they are being affected by the Council's actions, and what their rights and responsibilities are in relation to those actions.

4.9 Council communications are all the more important in the environment of the LGA. Consultation with the community is fundamental to the working of the Act, and effective communication is vital to effective consultation.

Principle 2 –
Communications should be consistent with the purpose of local government[8] and in the collective interests of the communities the Council serves.

4.10 A Council is a corporate entity, with statutory role and purpose. The role and purpose include promoting the well-being of communities in its district or region. A Council may serve many communities, both in the geographical sense and in the sense of communities of interest. It should always act within the scope of its role and purpose, and in the collective interests of its communities.

4.11 Sometimes, a Council will need to communicate with only some of its communities about a particular issue, or with part of a community. But it should always be able to justify any communication as being in the collective interests of them all.

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6 Including the avoidance of defamatory comment, or misleading or deceptive conduct under the Fair Trading Act 1986.

7 E.g. use of the special consultative procedure under the LGA.

8 *The purpose of local government is—*
(a) to enable democratic local decision-making and action by, and on behalf of, communities; and
(b) to promote the social, economic, environmental, and cultural well-being of communities, in the present and for the future.
(LGA, section 10)

Principle 3 –
Communications should comply with any applicable Council policies and guidelines as to process (including authorisation) and content.

4.12 We encourage all Councils to adopt a policy on communications: see paragraph 1.15 on page 9.

Collective position

Principle 4 –
Communications on Council policies and decisions should reflect the collective position of the Council.

4.13 Wherever possible, the Council should "speak with one voice", and its communications should represent the corporate or collective position.

4.14 A communication by an authorised spokesperson appointed by the Council (whether that person is a Member or an employee) should identify that person in his or her official capacity (for example, as a Committee chairperson). The purpose of the communication should always be to meet the Council's, not the spokesperson's, communications objectives. The person responsible should be careful to ensure that what is being said is portrayed as the Council's position, not the personal views of the spokesperson.

4.15 Some Councils allow the Mayor to produce a regular "column" in a Council-funded or other local publication, or to make regular broadcasts on local radio or television. The purpose of such communications should be to give voice to the Council's corporate position on its activities, through the elected leader.

4.16 Communication of a Member's personal perspective, views or opinions (including in a regular "column", broadcast, etc) should be the exception rather than the rule, and should be subject to Principles 9 to 11 (see pages 19-21).

Principle 5 –
Communications on Council business should always be clearly attributed to the Council as the publisher.

4.17 A communication might, for example, identify the Council by reference to the name of the Council or by use of its corporate logo. A communication designed to meet the Council's statutory obligations (such as a draft annual plan) should not only say who authorised its publication (usually the chief executive officer) but also identify the statutory provision under which it is being published.

4.18 For commentary about the identification of sponsors, see paragraphs 5.3-5.7 on pages 25-26.

Standards of communication

Principle 6 –
Factual and explanatory information should be presented in a way that is accurate, complete, fairly expressed, and politically neutral.

4.19 **Accurate** means what it says. That which is held out to be true should be founded on ascertainable facts, and be carefully and precisely expressed consistently with those facts. No claim or statement should be made that cannot be substantiated.

4.20 A communication will be **complete** when it consists of all the information necessary for the audience to make a full and proper assessment of the subject matter.

4.21 Information will be **fairly expressed** when it is presented in an objective, unbiased, and equitable way. In particular:

- the audience should always be able to distinguish facts from analysis, comment, or opinion; and

- when making a comparison, information should state fully and accurately the nature of what is being compared, and inform the audience of the comparison in a way that does not mislead or exaggerate.

4.22 Information will be **politically neutral** when it presents the Council's collective position, or, where there is no collective position, sets out the issues in a manner that does not refer to the positions taken by any individual Member or political party or group of Members.

Consultation and public debate

Principle 7 –
Communications about matters that are under consideration by the Council, or are otherwise a matter of public debate, should present the issues in an even-handed and non-partisan way.

4.23 Communications about matters that will be the subject of a future decision by the Council should be distinctly different from those that follow a decision.

4.24 In the "before" phase, all relevant facts and other considerations should be taken into account, and all significant points of view should be aired. The aim is to enable the Council to make itself aware of, and then to have regard to, the views of all its communities in relation to a particular decision[9], while also meeting all its statutory obligations in respect of consultation[10].

4.25 In particular, a "before" phase communication should:

- avoid the appearance and reality of bias or pre-determination – especially when summarising facts or arguments;
- present the issues in an objective manner, avoiding subjective opinion or comment; and
- mention both the advantages and the disadvantages of particular options.

4.26 Mention of individual Members' or political parties' positions should always be avoided.

4.27 In the "after" phase, the emphasis should be on what has been decided and its implications for the Council and its communities.

4.28 This principle applies whether the purpose of the communication is to satisfy LGA requirements, or otherwise.

Principle 8 –
If engaging in public debate with an interest group or a section of the community, a Council should use the news media (rather than a Council funded publication) and designated spokespersons (rather than professional communications advisers) unless there is a particular justification for not doing so.

4.29 A Council may be justified in responding to publicity that is unfair, unbalanced, or inaccurate. The object should be to put the record straight, including a measure of rebuttal.

4.30 But it is important to keep a balance and perspective. Council resources should not be used merely to engage in a public argument.

4.31 The preferred approach in such cases should be to make use of the news media, through release and publication of a written statement or making an authorised spokesperson available for interview. Use of Council-funded publications or professional advisers to engage in debate with interest groups could create the perception that Council resources are being used for the benefit of one section of the community against another, or in a way that results in an unequal public relations contest.

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9 LGA, sections 14(1)(b) and 78.
10 LGA, sections 82-90.

4.32 An example of where a Council-funded publication to engage with an interest group could be justified is when the group has issued public statements encouraging citizens to commit acts of civil disobedience or to actively break the law.

Communications by Members

Principle 9 –
If the Council's Communications Policy permits them, communications by Members of their personal perspective, views or opinions (as opposed to communication of Council matters in an official capacity) should:

- **be clearly identified as such; and**
- **be confined to matters that are relevant to the role of local authorities[11].**

4.33 Members are collectively responsible for Council decisions. Communication of Council business to the community often falls to a designated spokesperson. See Principle 4 and paragraphs 4.13-4.15 on page 16.

4.34 But Members are also individually responsible to the communities that elected them. It is for the Council to decide whether and, if so, on what terms to make resources available to Members to communicate with constituents or the wider community in their capacity as individual Members.

4.35 An example of a communication that could involve a Member expressing personal views is a "Members' column" in a Council-funded newspaper or on a Council web site.

4.36 It is important that the Communications Policy, and the relevant part of the communications budget, also sets out clearly the limits in relation to such communications. The policy should say:

- What types of communications are permitted and in what circumstances, and the range of permitted subject matter.
- Whether the material can or should be subject to editing and, if so, by whom.
- What procedures apply in respect of authorisation, attribution, and editorial and quality control. These are for the Council to determine. However, whether or not material is edited, the Member must formally subscribe to what is being published.

[11] Under sections 10 and 11 of the LGA – see footnotes 5 (page 14) and 8 (page 15).

4.37 Note, however, that a Member's freedom to talk about Council business is subject to confidentiality requirements (such as under Standing Orders) and the Council's Code of Conduct – especially as regards Members' conduct towards each other and their disclosure of Council information.[12]

4.38 Here are our views on some other examples of a Member communicating personally:

- It is not appropriate for a Member to use a Council newsletter or web site to express views on a matter of central government responsibility (such as defence and foreign relations) that has no direct bearing on the Council's activities.

- It may be appropriate (but only when the Council is undertaking no formal consultation process) for a Member to use Council facilities to consult with the public on an issue under consideration by the Council, or to explain his or her position on a contentious decision, but not to seek political support on an issue that the Council has not considered. References to, or the use of a logo or slogan of, a political party or grouping are unacceptable.

- Members should not be permitted to use Council communications facilities for political or re-election purposes. (See Principles 12 and 13 on pages 22-24 for more information on communications in the pre-election period.)

- Staff protocols on the use of the Internet, e-mail, and other communications facilities for personal purposes should also apply to Members. The minimal cost of allowing use of such facilities can easily be outweighed by the perception that public resources are being misused.

Principle 10 –
Politically motivated criticism of another Member is unacceptable in any Council-funded communication by a Member.

4.39 Neither the inherently adversarial nature of much Council politics nor the right of free speech can justify Council communications resources being used to enable one Member to engage in political debate with, or to criticise, another Member. Preventing such misuse should be an objective of the Council's policy on where editorial control and the power to authorise communications should lie.

4.40 Members are, of course, free to use their own resources for such purposes.

[12] LGA, Schedule 7, clause 15.

Members' personal profile

Principle 11 –
Care should be exercised in the use of Council resources for communications that are presented in such a way that they raise, or could have the effect of raising, a Member's personal profile in the community (or a section of the community). In permitting the use of its resources for such communications, the Council should consider equitable treatment among all Members.

4.41 Two related objectives underlie this principle:

- It is important that the public know who their Councillors are. Councils are justified in using, or in some circumstances permitting Members to use, Council facilities for communications that have the objective of raising a Member's personal profile.

- Giving a "human face" to a piece of information can be an effective communications strategy to attract attention and make the information relevant and understandable to its audience.

4.42 It is acceptable for Councils to use photographs of Members, personal quotes/attributions, and other standard journalistic techniques provided they are consistent with these objectives. However, Councils need to bear in mind the inherent risks of favouritism and unequal treatment of members.

4.43 For example, a "photo opportunity" shot, in a Council-funded publication, of a Mayor or Committee Chairperson announcing a Council decision helps to draw the reader's attention to the decision, and thereby improve the effectiveness of its communication, but could also have an unintended and beneficial spin-off effect for the Member's personal or political profile in the community.

4.44 Allowing Members representing a particular Ward to issue their own newsletter to constituents could have a similar effect. There is nothing wrong with such an idea in principle. However, the principle of equitable treatment makes it important that the same communications opportunity is available to Members representing other Wards. Matters such as editorial and quality control and attribution should also rest with the Council's communications staff in accordance with Council policy.

Communications in a pre-election period[13]

Principle 12 –
A local authority must not promote, nor be perceived to promote, the re-election prospects of a sitting member. Therefore, the use of Council resources for re-election purposes is unacceptable and possibly unlawful.

4.45 Promoting the re-election prospects of a sitting Member, directly or indirectly, wittingly or unwittingly, is not part of the proper role of a local authority.

4.46 A Council would be directly promoting a Member's re-election prospects if it allowed the member to use Council communications facilities (such as stationery, postage, internet, e-mail, or telephones) explicitly for campaign purposes.

4.47 Other uses of Council communications facilities during a pre-election period may also be unacceptable. For example, allowing Members access to Council resources to communicate with constituents, even in their official capacities as members, could create a perception that the Council is helping sitting Members to promote their re-election prospects over other candidates.

4.48 For this reason, we recommend that mass communications facilities such as –

- Council-funded newsletters to constituents; and
- Mayoral or Members' columns in Council publications –

be suspended during a pre-election period.

4.49 Promoting the re-election prospects of a sitting Member could also raise issues under the Local Electoral Act 2001. For example:

- Local elections must be conducted in accordance with the principles set out in section 4 of the Local Electoral Act – see Appendix 1 on page 27. The principles apply to any decision made by a Council under that Act or any other Act, subject only to the limits of practicality. A breach of the principles can give rise to an "irregularity" which could result in an election result being overturned.[14]

[13] By "pre-election period" we mean the three months before the close of polling day for the purposes of calculating "electoral expenses": see Local Electoral Act 2001, section 104. However, a Council may decide to apply restrictions over a longer period.

[14] See *Aukuso v Hutt City Council* (District Court, Lower Hutt, MA 88/03, 17 December 2003).

- The publication, issue, or distribution of information, and the use of electronic communications (including web site and e-mail communication), by a candidate are "electoral activities" to which the rules concerning disclosure of electoral expenses apply.

4.50 "Electoral expenses"[15] include:

- the reasonable market value of any materials applied in respect of any electoral activity that are given to the candidate or that are provided to the candidate free of charge or below reasonable market value; and

- the cost of any printing or postage in respect of any electoral activity.

4.51 A Member's use of Council resources for electoral purposes could therefore be an "electoral expense" which the Member would have to declare – unless it could be shown that the communication also related to Council business and was made in the candidate's capacity as a Member.

Principle 13 –
A Council's communications policy should also recognise the risk that communications by or about Members, in their capacities as spokespersons for Council, during a pre-election period could result in the Member achieving electoral advantage at ratepayers' expense. The chief executive officer (or his or her delegate) should actively manage the risk in accordance with the relevant electoral law.

4.52 Curtailing all Council communications during a pre-election period is neither practicable nor (as far as mandatory communications, such as those required under the LGA, are concerned) possible. Routine Council business must continue. In particular:

- Some Councils publish their annual reports during the months leading up to an October election, which would include information (including photographs) about sitting Members.

- Council leaders and spokespersons need to continue to communicate matters of Council business to the public.

[15] Also defined in section 104.

4.53 However, care must be taken to avoid the perception, and the consequent risk of electoral irregularity, referred to in the commentary to principle 12. Two examples are:

- journalistic use of photographic material or information (see paragraph 4.42 on page 21) that may raise the profile of a Member in the electorate should be discontinued during the pre-election period; and

- access to Council resources for Members to issue media releases, in their capacities as official spokespersons, should be limited to what is strictly necessary to communicate Council business.

4.54 Even if the Council's Communications Policy does not vest the power to authorise Council communications solely in management at normal times, it should do so exclusively during the pre-election period.

5 Other Commonly Arising Issues

Use of surveys and market research

5.1 Councils should target their communications resources to best effect. In appropriate cases, professional advice should be sought, and soundly obtained survey and market research information may be used.

5.2 Councils should meet acceptable standards in survey and market research information. To assist Councils to meet those standards:

- we reproduce in Appendix 2 on page 28 the ten principles identified by Statistics New Zealand underpinning its *Protocols for Official Statistics*; and
- they can find useful guidance in the Statistics New Zealand publication *A Guide to good survey design*[16].

Joint ventures and sponsorship

5.3 Many Councils seek to be involved with their communities, and may engage in collaborative ventures with other public agencies and business and community groups.[17] Communication (for example, to promote public education or changes in people's behaviour) may be a feature of such ventures.

5.4 There is no reason in principle why a Council should not join with another agency or group to publish information for the benefit of the community – provided the activity is consistent with the Council's role and purpose. The use of private or community sponsorship for a Council communication may be a feature of such co-operation.

5.5 Examples of joint communication could include:

- a joint venture with the Police to issue information about individual and community safety in the Council's district; and
- the use of business sponsorship for a Council advertisement of a community event.

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16 ISBN 0-477-06492-2; revised July 1995. Copies can be ordered through the Statistics New Zealand web site at: www.stats.govt.nz/domino/external/web/prod_serv.nsf/htmldocs/A+Guide+to+Good+Survey+Design+(2nd+edition)

17 Section 14(1)(e), LGA.

5.6 The Council's Communications Policy should, if the Council wishes to involve a partner, address:

- the types of communications for which joint ventures or sponsorship are appropriate; and

- the controls and procedures designed to manage the associated risks – such as perception of Council "capture" by a business or community group, actual or potential conflict of interest, and community attitude to the nature of the problem.

5.7 As a minimum, the Communications Policy should:

- require all mandatory communications to be funded solely by Council;

- require every communication joint venture or sponsorship proposal to be supported by a sound business case that is approved at an appropriate level within the Council organisation;

- set out the criteria for selecting a communication joint venture partner or sponsor, in order to avoid conflict of interest and prevent a partner or sponsor from gaining (or being perceived to gain) inappropriate commercial or political advantage;

- require both the Council and the joint venture partner or sponsor to adhere to the principles (including those in respect of editorial control) that it has adopted in the Communications Policy; and

- contain clear guidance as to the placement of logos, slogans, and other sponsorship references.

Appendix 1

Principles of the Local Electoral Act 2001

4 Principles

(1) The principles that this Act is designed to implement are the following:

- (a) fair and effective representation for individuals and communities:
- (b) all qualified persons have a reasonable and equal opportunity to–
  - (i) cast an informed vote:
  - (ii) nominate 1 or more candidates:
  - (iii) accept nomination as a candidate:
- (c) public confidence in, and public understanding of, local electoral processes through–
  - (i) the provision of a regular election cycle:
  - (ii) the provision of elections that are managed independently from the elected body:
  - (iii) protection of the freedom of choice of voters and the secrecy of the vote:
  - (iv) the provision of transparent electoral systems and voting methods and the adoption of procedures that produce certainty in electoral outcomes:
  - (v) the provision of impartial mechanisms for resolving disputed elections and polls.

(2) Local authorities, electoral officers, and other electoral officials must, in making decisions under this Act or any other enactment, take into account those principles specified in subsection (1) that are applicable (if any), so far as is practicable in the circumstances.

(3) This section does not override any other provision in this Act or any other enactment.

Appendix 2

Statistics New Zealand Principles Applicable to the Production of Official Statistics

1 The need for a survey must be justified and outweigh the costs and respondent load for collecting the data.

2 A clear set of survey objectives and associated quality standards should be developed, along with a plan for conducting the many stages of a survey to a timetable, budget and quality standards.

3 Legislative obligations governing the collection of data, confidentiality, privacy and its release must be followed.

4 Sound statistical methodology should underpin the design of a survey.

5 Standard frameworks, questions and classifications should be used to allow integration of the data with data from other sources and to minimise development costs.

6 Forms should be designed so that they are easy for respondents to complete accurately and are efficient to process.

7 The reporting load on respondents should be kept to the minimum practicable.

8 In analysing and reporting the results of a collection, objectivity and professionalism must be maintained and the data impartially presented in ways which are easy to understand.

9 The main results of a collection should be easily accessible and equal opportunity of access is enjoyed by all users.

10 Be open about methods used; documentation of methods and quality measures should be easily available to users to allow them to determine if the data is fit for their use.

A full copy of *Protocols for Official Statistics* can be obtained by contacting Statistics New Zealand through its web site www.stats.govt.nz .

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:

Wairua Tapu - Several days of multi-faith celebrations (4 to 7 June) marked the opening of Wairua Tapu, Chapel of the Holy Spirit at Waitakere Hospital. The week started with a Māori dawn blessing followed by an official dedication later that day with hundreds of people in attendance. Local schools and churches, including the Liston College kapa haka group and the Massey High School choir, helped to make this an incredible event for our DHB. Celebrations continued through the week with a Pacific-themed day (5 June), a community and Asian-themed day (6 June) and a multi-faith day (7 June). The chapel and its outdoor gardens are for all staff, patients and whānau to enjoy. It is a special place for refuge, contemplation, quiet reflection and, if people are inclined, prayer. My thanks go to the project team and the Well Foundation and the many donors for making this chapel possible.

About 200 guests were at the opening.

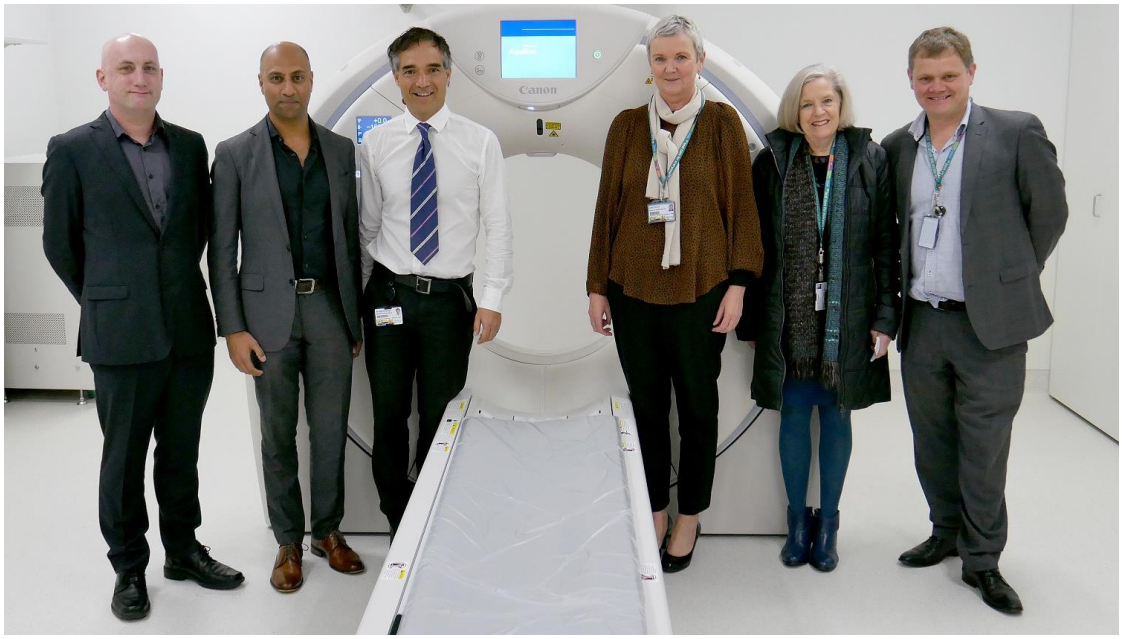
Students from Liston College started the event with a haka pōwhiri

Catholic Bishop of Auckland Patrick Dunn, Board Chair Professor Judy McGregor, CEO Dr Dale Bramley and Rev. Deacon Robert Mitchell

Transforming healthcare: We celebrated the success of our Leapfrog programme, which won the Business Transformation through Digital and IT category of the NZ CIO Awards on 12 June. Leapfrog projects have transformed the way in which staff use and engage with technology to reduce unnecessary administration so they can spend more time on direct patient care. It is great to see the rapid implementation of new ideas such as telehealth, eVitals and ePrescribing being embraced by our workforce and benefitting so many of our patients. Leapfrog is led by Associate Professor and Clinical Director of Innovation Robyn Whittaker in partnership with Chief Information Officer Stuart Bloomfield. Their exceptional leadership has been integral to the success of the programme.

The Leapfrog team: Pictured left-to-right in front row: Project Manager Renee Kong; Head of Digital Transformation Sharon Puddle; Director of i3 Dr Penny Andrew; Waitematā DHB CEO Dr Dale Bramley; Digital Innovations Lead Dr Lara Hopley; Head of Analytics Delwyn Armstrong; and Associate Professor and Clinical Director of Innovation Dr Robyn Whittaker. Back row: Chief Information Officer Stuart Bloomfield; Project Manager Kelly Bohot; Project Manager Clayton Redfern; Associate Director of i3 Jarrard O'Brien; Information Systems Change Manager David Ryan; and Health Informatics Manager (HIG) Andrew Cave.

New CT Scanner opening – We officially opened a third CT scanner in our radiology department at North Shore Hospital on Friday, 28 June, which is a major step toward enhancing our radiology service and delivering better health outcomes for our community. The installation of the new machine takes the total number of CT scanners at the hospital to three. Last year, we received around 37,000 requests or referrals for radiology CT services at North Shore Hospital and this year we expect that number to be closer to 40,000.



Pictured with the newly opened CT Scanner at North Shore Hospital is General Manager and Head of Division – diagnostic services and clinical support services Dr Jonathan Wallace; Clinical Director of Radiology Dr Hament Pandya; CEO Dr Dale Bramley; Director of Hospital Services Cath Cronin; Waitematā DHB Chair Professor Judy McGregor, Chief Medical Officer Dr Andrew Brant.

Queen's Birthday Honours - It was wonderful to see Matua Levao Tiava'asu'e from our Pacific Health Team receiving a Queen's Service Medal in the Queen's Birthday Honours on 1 June for services to health and the Pacific. Matua Levao plays an integral role in our DHB by speaking on behalf of our Pacific people at special events. Congratulations also to Susan Wynyard and Sally Wilson, midwives who worked with the Warkworth community to found the Waitematā DHB-funded Warkworth Birthing Centre, which opened in 2000. Sally and Sue were made Members of the New Zealand Order of Merit for services to midwifery. The centre has provided maternity care to more than 10,000 mothers and babies. Both women have held long-term roles on the Waitematā DHB Maternity Clinical Governance Committee.

Matua Levao Tiava'asu'e at the opening of Wairua Tapu, Chapel of the Holy Spirit at Waitakere Hospital

Surgical Hospital - Site works will soon begin for our new surgical hospital on the North Shore campus. This will be the biggest construction project our DHB has seen since the construction of the main North Shore Hospital tower block more than 30 years ago. The initiation works phase is set to begin in late July and will see the demolition of our old Taharoto-Pupuke building, which is now empty. This will see the building effectively demolished from the inside out as specialist contractors remove asbestos from the building. The building will be progressively demolished with sections of the building wrapped in plastic to prevent the spread of any contaminated products and contractors will be adhering to rigorous safety standards.

Artist impression of the new surgical hospital

Learning from adverse events – The death of 15-year-old Matt Gunter at a West Coast DHB hospital in 2012 was the topic of a talk during Learning from Adverse Events Week (17-21 June). ACC has partnered with Heather, Matt's mother, to speak at hospitals nationwide. Around 200 of our people attended her talk on 21 June at Whenua Pupuke to hear about the tragic and avoidable circumstances of Matt's death, in what was an important learning opportunity. Matt died of global hypoxia due to negative pressure pulmonary edema following surgery to remove his appendix.

A large crowd attended the presentation by Heather Gunter during Adverse Events Week

Bowel health in schools – Young people play an important role in sharing information and supporting their whānau to make good decisions, which is why the DHB's Health Promotion Team worked directly with a group of Year 12 students at Massey High School in West Auckland to teach them the importance of early detection through regular bowel screening as part of a health expo on 28 June. New Zealand has one of the highest rates of bowel cancer in the world, with around 100 people dying every month. However, if caught in the early stages, most bowel cancer can be successfully treated.

Pictured in front of Waitematā DHB's inflatable bowel are (left to right): Health Promotions Manager Sandra Skipwith with Massey High School students Emnita Sogivali, Rejieli Niurou, Poi Afeveti, Mele Alefaio and Health Promoter Wiki Shepherd-Sinclair.

Get up and get moving – We were proud to lead this year's national DHB #EndPJParalysis Campaign on 4 July and developed a number of resources that could be used by DHBs across the country. The campaign is about supporting the recovery of patients by encouraging them to get out of bed, get dressed and move around each day. As part of our campaign, Brian Dolan (OBE), the founder of the international #EndPJParalysis and #last1000days movements, hosted a master class on 2 July aimed at reducing falls and pressure injuries. We also presented (via Zoom online conference tools) at the Global #EndPJParalysis Summit (10-12 July 2019).

Electric charging bays - North Shore Hospital is the proud new owner of two electric vehicle charging bays, which are available for staff and the public to use on the lower ground floor of the main parking building.

Here is a short video about them:
https://www.facebook.com/WaitemataDistrictHealthBoard/videos/2360078990983699/

Thanks to our volunteers - Volunteer Awareness Week (17-21 June) was a chance for us to thank the many volunteers across our DHB who help us achieve the best care for all of our patients. These people choose to take time out of their weeks to ensure our patients and visitors receive friendly visits at their bedside, a helping hand when navigating the corridor or have beautiful gardens to look out onto. Weaving the compassion and willingness of our volunteers with our services and facilities ensure patients are truly supported.

Matāriki Awards - The Matāriki Awards took place on Thursday, 4 July in the Whenua Pupuke auditorium. This was the second awards ceremony of its kind and the event included Dr Lance O'Sullivan as a special guest speaker and kapa haka performances from Te Rōpū Kapa Haka o Te Korowai. The Matāriki Awards recognised all staff living our values as they work for better health outcomes for Māori, a critically important population within our DHB as we strive to reduce health inequities. Congratulations to all of the winners, finalists and the whānau who have supported them.

- *Creating a culture of appreciation*

A further **92 staff** have been recognised in the CEO Awards, launched in mid-2014 to celebrate those staff, nominated by their colleagues and patients, who demonstrate our organisational values through their work. Each staff member whose nomination is considered worthy of acknowledgement receives a personalised letter of thanks, a certificate of appreciation and a small gift. Staff acknowledged with a CEO Award since the last Board meeting are included as ***Appendix One.***

2. Upcoming events

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

- Late July – Demolition of the Taharoto-Pupuke buildings commences in preparation for construction of the new surgical hospital.
- 23 July – 'Hello, My Name Is' campaign to encourage communication between staff and patients.
- 3 August – Pacifica Ball, Maritime Museum.
- 29 October – Health Excellence Awards at ASB Waterfront Theatre.

3. Future Focus

The Leapfrog programme was established as a means to support a focused, intensive burst to take a large leap in moving the DHB from where we are to where we want to be. The programme consists of a small number of strategic organisation-wide projects that are resourced to achieve significant change and impact on health outcomes and patient/family experience.

eProgress notes went live on 23 June in ward 3 and will be rolled out across the DHB in the coming weeks. eProgress notes eliminate the need for manual paper-based processes and provide staff with real-time updates throughout the patient's recovery.

For the phase two of the eOrders project, the new soft patient wristbands are going to be available at Waitakere Hospital.

In Outpatients, the SOS card measures indicate positive changes in the proportion of follow-up appointments and DNA rates for General Surgery, Orthopaedics and Otolaryngology. Gynaecology and Paediatrics are currently in planning for SOS implementation. Approximately 55% of clinic profiles have been reviewed.

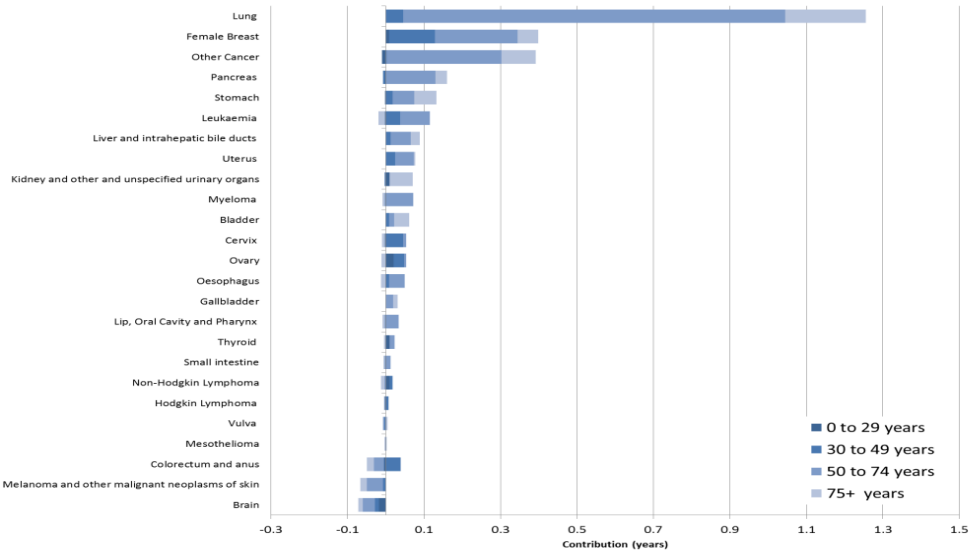
4. Outcomes discussion

This month, I have asked Dr Karen Bartholomew Director of Health Outcomes to summarise the Māori lung cancer screening research programme.

Each year lung cancer causes more deaths in New Zealand than melanoma, breast and prostate cancer combined. Most lung cancers are diagnosed at a late stage, resulting in a poor survival rate. With a five-year net survival rate of 15.3% (age-standardized, 2010-2014), New Zealand has a worse five-year survival rate than similar countries.

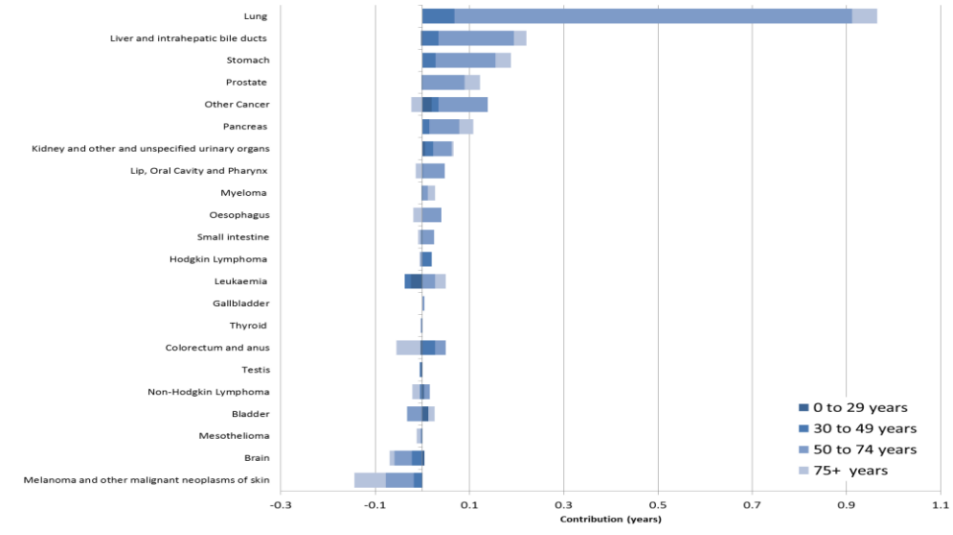
Lung cancer is a significant health issue for Māori and has been found to be the greatest contributor to the absolute inequity in mortality for Māori compared to NZ European/Other. Figures 1 and 2 below (where lung cancer is the top contributor for both women and men) visually demonstrates the substantial contribution of lung cancer to the cancer related life expectancy gap for Māori men and women.

Figure 1. Contribution of Cancer to the life expectancy gap - Māori Female



*5.0 years of the gap attributable to non-cancer deaths not shown

Figure 2. Contribution of Cancer to the life expectancy gap - Māori Male



*7.0 years of the gap attributable to non-cancer deaths not shown

Source: Walsh, Michael. Life Expectancy Gap disaggregation, 2019 (unpublished).

Māori develop lung cancer six to eight years earlier than non-Māori and while high smoking prevalence is a significant contributor, local research has indicated that Māori have worse outcomes at every level of smoking than non-Māori. With the very high incidence of lung cancer for Māori women and an on-going very high mortality from the disease, it is likely that differences in mortality from lung cancer will persist for some time even with further investment in smoking cessation efforts.

Low dose CT screening

Lung screening using a low-dose computerised tomography (LDCT) scan in people who are not showing symptoms enables cancer nodules to be detected at an early stage, greatly improving the chance of successful surgical, radiation or pharmaceutical treatment. Many countries – including the US, Canada, UK, Netherlands/Belgium, Italy, Australia – have trialled, or are in the process of trialling, 'high risk' or targeted approaches to lung cancer screening – focused on smokers and former smokers. Results from large trials in the US and Europe indicate a favourable 20-26% reduction in lung cancer mortality, as well as a reduction in all-cause mortality. The most recent NELSON trial (not yet published) suggests an even greater benefit for women with a 39% mortality reduction, and this newer trial evidence also suggests a much more favourable risk profile of screening (for example much lower false positive rate with newer nodule management procedures). Alongside breast, cervical and bowel; lung cancer screening is recommended in the US and Canada, and a recent European consensus statement urges planning for screening programmes.

Māori lung cancer screening research programme

Reducing Māori mortality from lung cancer through screening has potential to reduce the life expectancy gap and address a key Māori health priority. A research programme into lung cancer screening targeting Maori smokers and ex-smokers is being developed under the leadership of Associate Professor Dr Sue Crengle and as a collaborative with Planning, Funding and Outcomes (Health Gain and Māori Health), Māori health clinical and academic partners and key clinicians. This project was initiated when Dr Crengle worked as a Māori Public Health Physician at Waitematā DHB, and is consistent with the national call for a focus on equity in cancer planning at the Cancer at a Crossroads conference at Te Papa earlier this year. The research is the flagship programme for the Waitematā DHB and Auckland DHB Māori Health Pipeline.

The lung cancer screening research programme has two parts:

- Study 1: Qualitative study – focus group hui and survey
- Study 2: Demonstration trial – with initial feasibility assessment

Study 1 has been funded by the A+ Trust and is now underway to better understand knowledge, attitudes and beliefs about lung cancer and screening among Māori potentially eligible for screening. This is a mixed method study that will use a survey of approximately 300 people alongside a series of focus group hui. The study aims to identify psychological, cultural, emotional and practical enablers and barriers to making an informed choice about participating throughout the screening pathway; including issues around stigmatisation and treatment. Presenting unbiased and clear information in the context of reflection on personal values and preferences is particularly important and resources and processes for optimal shared decision making for Māori will be co-developed. Issues for Māori associated with blood sampling, bio-banking and the optimal integration of smoking cessation into the project are also being explored in the study. The first focus group is expected to be held this July and the survey, which will be conducted primarily face to face is anticipated to be underway towards the end of the year.

It is intended that the findings from this preliminary study inform the design of a proposed lung cancer screening Demonstration trial (Study 2), which is currently being developed as a research proposal for funding. The trial intends to examine the impact for Māori of current best practice risk-prediction based invitation, as well as provide evidence on the stage distribution of any cancers identified and a range of other policy relevant parameters. Participants would be offered a LDCT scan along with lung function tests, and be invited to provide a blood sample for biomarker

assessment. Participants who have positive scan results would have full investigation and management.

Planning for the trial includes the potential impact on the lung cancer diagnostic and treatment pathway. A range of other work is also underway including planning key elements of the design and clinical consideration, considering linkages to other international demonstration trials, development of data and quality assurance systems, workforce requirements and optimal strategies for incorporating smoking cessation within the context of lung cancer screening that would be optimal for eligible Māori. Specific work examining previous and recent cost-effectiveness analyses and their relevance for Māori is underway; the trial will also include parameters with specific relevance for cost-effectiveness in a New Zealand context. Learnings from the Abdominal Aortic Aneurysm (AAA) and Human papilloma virus (HPV) screening research projects has been incorporated into the proposed research programme.

No lung cancer screening research programme to date has addressed a primary equity consideration, despite the disproportionate burden on indigenous populations internationally. Therefore this research will have policy relevance to the National Screening Advisory Committee (Dr Bartholomew is a member) and to Hei Āhuru Mowai the national Māori Cancer Leadership Group (the Hei Āhuru Mowai Chair Dr Nina Scott is a member of the project steering group) as well as to indigenous colleagues and lung cancer screening researchers internationally. Locally the findings may have translation to other screening programmes and interventions to address inequities as well as the lung cancer tumour stream and the broader Northern Region cancer work programme.

5. Board performance priorities

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

Progress: ✔

Patient Experience

Better Outcomes ✔
Progress: On track
National Inpatient Survey

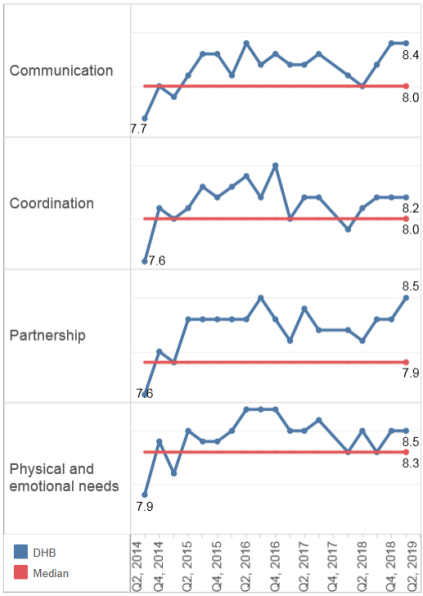
1.0 PATIENT EXPERIENCE FEEDBACK

1.1 National Inpatient Survey

HQSC weighted results			
Communication	**Partnership**	**Co-ordination**	**Needs**
8.4 WDHB	**8.5 WDHB**	**8.2 WDHB**	**8.5 WDHB**
8.3 National Average	**8.5 National Average**	**8.3 National Average**	**8.6 National Average**

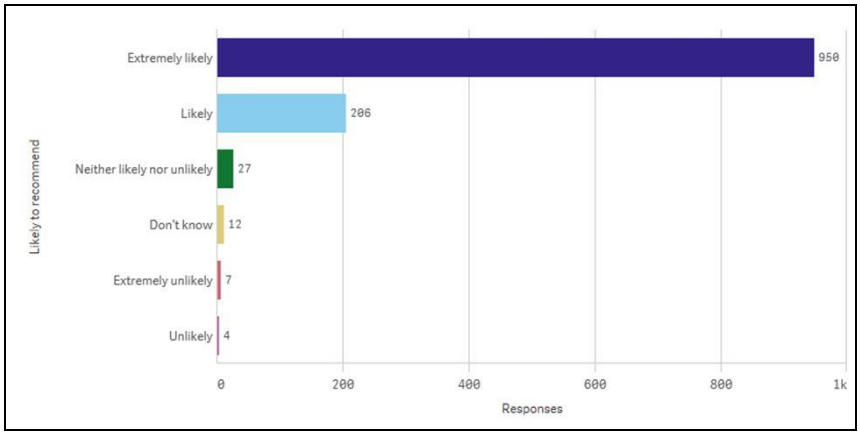
National Survey Quarter One (January- March 2019)

We achieved our highest scores for Communication and Partnership since the national survey was introduced. A positive increase is illustrated by the following graph:



Friends and Family Test

In May 2019, our Net Promoter Score (NPS) increased one point to 76 and we received feedback from 1,206 people, which is a 24% increase from the previous month. The NPS continues to score above the DHB target of 65.



This month, all ethnicities have met the NPS target. All scores have increased since last month, with the highest gain for Pacific, which increased 20 points from 64 to 84.

Achieving the health targets – May 2019

- Better help for smokers to quit (maternity) – 88% (target 90%)
- Improved access to elective surgery – 105% (target 100%)
- Shorter waits in ED – 95% (target 95%)
- Faster cancer treatment – 86%* (target 90%) **Target is back on track in June with 90% achieved.*

- Increased immunisation – 92% (target 95%)
- Raising healthy kids – 100% (target 95%)

Health Quality and Safety markers

Falls
Falls risk assessment audits that inform the Health Quality and Safety Commission data continue and are conducted monthly. Overall, Acute & Emergency Medicine completed 96% of falls risk assessments, Specialist Medicine & Health of Older People completed 100% and Surgical & Ambulatory completed 92% on admission. Of those, Acute & Emergency Medicine completed 85%, Specialist Medicine & Health of Older People completed 85% and Surgical & Ambulatory completed 52% within eight hours of admission (against a target of 90%).

Hand Hygiene
The Hand Hygiene Compliance Audit result for May 2019 is 89%; this exceeds national target of 80% compliance.

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

Māori Health

Māori scorecard

- Shorter waits in ED – 95% (target 95%)
- Helping smokers to quit (hospitalised) – 99% (target 95%)
- Older patients assessed for falling risk – 100% (target 90%)
- Raising healthy kids – 100% (target 95%)

Ngā Pōu Akoranga o Pae Ora
Ensuring we have a committed and capable health workforce is a continued priority for our DHB. We are currently developing a new Māori Cultural Competency framework for the DHB - Ngā Pōu Akoranga o Pae Ora. Once this is completed we will be able to clearly articulate the minimum level of Māori cultural competence required by our workforce and strengthen our training, recruitment and development offerings. A draft framework will be completed by August 2019.

Pacific Health

Pacific scorecard
- Shorter waits in ED – 96% (target 95%)
- Faster cancer treatment (62 days) – 91% (target 90%)
- Better help for smokers to quit – primary care – 89% (target 90%)
- Increased immunisation (8-month old) – 93% (target 95%)
- Raising Healthy Kids – 100% (target 95%)

Pacific Symposium
Pacific Allied Health Association of NZ will hold a symposium in August sponsored by LeVa. This national group (largely made up of Auckland Metro DHB representatives) aims to lift the number of

Pacific people in Allied Health roles such as occupational health, dietetics, psychology, psychotherapy, physiotherapy and social work.

PAHANZ group meeting with co-chairs Eti Televave (forth from left) and Alexis Cameron (fifth from right).

Chapel opening
The team was able to support the opening of Wairua Tapu, Chapel of the Holy Spirit at Waitakere Hospital (4-7 July). The awe-inspiring week invited many cultures to consider it a place of refuge and solace during a time of need.

Partnership in the Pacific Islands
Waitematā DHB is helping to boost the local capability of medical staff and improve health outcomes in the Cook Islands and Fiji through a work exchange and mentoring programme.

In the Cook Islands, the work exchange agreement between Waitematā DHB and The Cook Islands Government (signed 10 July) involves medical, technical and allied health staff. The exchange has been a few years in the making and is led by Cook Islands Secretary of Health Dr Aumea Josephine Herman, a public health physician. Dr Herman has been working hard to standardise practices and improve health outcomes, particularly in the area of communicable disease management.

In Fiji, the country's first gastric surgeon Dr Illy Delasau will be trained and supported by Waitematā DHB general surgery team lead by Clinical Director Dr Richard Harman. This agreement is similar to the one we have with Cook Islands and will involve providing clinical nurses and junior doctors via work exchange as well as mentoring support for Dr Delasau and his team at Colonial War Memorial Hospital Suva. A business case has also been developed to fund the junior doctors coming from Fiji for their placements in Waitematā DHB.

CEO SCORECARD

Waitematā DHB Monthly Performance Scorecard

CEO Scorecard
May 2019
2018/19

Health Targets

		Actual	Target	Trend
m.	Better help for smokers to quit - maternity	88%	90%	▼
m.	Better help for smokers to quit - primary care	87%	90%	▼
	Improved Access to Elective Surgery - WDHB	105%	100%	--
	Shorter Waits in ED	95%	95%	--
	Faster cancer treatment (62 days)	86%	90%	--
	Increased immunisation (8-month old)	92%	95%	--
	Raising Healthy kids	100%	95%	--

Provider Arm - Service Delivery

	Waiting Times	Actual	Target	Trend
	ESPI			
	ESPI 1 - 90% OP Referrals processed w/n 10 days	*Compliant*		
	ESPI 2 - % patients waiting > 4 months for FSA	*Non-Compliant*		
	ESPI 5 - % patients not treated within 4 months	*Non-Compliant*		
	Diagnostics			
	% of CT scans done within 6 weeks	74%	95%	▲
	% of MRI scans done within 6 weeks	81%	90%	▲
	Urgent diagnostic colonoscopy (14 days)	100%	90%	▲
	Diagnostic colonoscopy (42 days)	48%	70%	▼
	Surveillance colonoscopy (84 days)	53%	70%	▲
	Patient Flow			
	Elective Surgical Discharges (YTD)			
	Elective Discharges - Total	18,897	18,505	▲
	Elective Discharges - Provider Arm	12,735	12,772	▲
	Elective Discharges - IDF Outflow	6,162	5,733	▼
	Efficiency			
	Outpatient DNA rate (FSA + FUs)	7%	≤10%	--
a.	Average Length of Stay - Electives	*1.49 days*	*≤1.49 days*	▲
a.	Average Length of Stay - Acutes	*2.71 days*	*≤2.41 days*	▼

Best Care

	Patient Experience	Actual	Target	Trend
	Complaint Average Response Time	14 days	≤14 days	▼
	Net Promoter Score FFT	76	65	▲
m.	**HQSC Quality and Safety Markers - Quarterly**			
	Older patients assessed for falling risk	98%	90%	▲
	Older patients assessed sig. fall risk with care plan	94%	90%	▼
	Good hand hygiene practice	89%	80%	--
	Occasions insertion bundle used - ICU	99%	90%	▼
	Occasions maintenance bundle used - ICU	92%	90%	▼
e.	Surgical site infection rate per 100 procedures	*0.8*	*≤0.93*	▼
b.	Antibiotic in the right time	*97%*	*100%*	▲
	Improving outcomes			
	Better help for smokers to quit - hospitalised	99%	95%	--
a.	Ambulatory Sensitive Hospitalisation rate (ASH) 0-4	*5641*	*≤5263*	
f.	Annual amenable mortality rate (per 100 000)	*62.9*	*≤63*	▲
	Population coverage/Access			
m.	Cervical Screening	71%	80%	--
m.	Breast screening	65%	70%	--
c.	Bowel Screening			
	% referred for colonoscopy (45 days) following +ve iFOBT	*95%*	*95%*	▼
	Treatment			
a.	HSMR (Source: Health Round Tables)	*0.79*	*≤1*	▲
a.	Surgical intervention rates (per 10,000 pop)			
	- Angioplasty	*16.1*	*12.5*	▲
	- Angiography	*42.0*	*34.7*	▼
	- Major joints	*22.7*	*21*	▼
	- Cataract	*43.0*	*27*	▲
g.	# NOF patients to theatre (48 hours)	*97%*	*85%*	▲
m.	ST elevation MI receiving PCI (120 mins)	85%	80%	▼
	AT&R referrals assessed (2 working days)	98%	90%	▲

Managing our Business

	Staff Experience	Actual	Target	Trend
	Sick leave rate	3.3%	≤3.4%	--
d.	Turnover rate - external	13%	≤14%	--
	Lost time injury frequency (12 mth rolling average)	17	≤10	--
	Financial Result			
	Expense/Revenue (YTD Total)	1,698,072 k	1,682,375 k	▼

Major Capital Programmes	Time	Budget	Quality
Elective Capacity and Inpatient beds	●	●	●
Mason Clinic Tanekaha replacement	●	●	●

Maori Scorecard

	Health Targets - Monthly	Actual	Target	Trend
k.	Shorter Waits in ED	95%	95%	--
	Increased immunisation (8-month old)	84%	95%	▼
	Better help for smokers to quit - hospitalised	99%	95%	--
	Faster cancer treatment (62 days)	67%	90%	--
k.	**Quality and Safety Markers - Monthly**			
	Older patients assessed for falling risk	100%	90%	--
	Older patients assessed sig. fall risk with care plan	100%	90%	--
g.	# NOF patients to theatre (48 hours)	*100%*	*85%*	--

m.	Health Targets - Quarterly	Actual	Target	Trend
	Better help for smokers to quit - maternity	93%	90%	▲
	Better help for smokers to quit - primary care	86%	90%	▼
	Raising Healthy kids	100%	95%	--
	Quality and Safety Markers - Quarterly			
h.	Surgical site infection rate per 100 procedures	*0*	*0.93*	
m.	**Maori Workforce - Quarterly**			
	Māori percentage of overall workforce	6.7%	7.0%	▼
	Māori percentage of priority workforce group	5.6%	5.8%	▼
	New employee ethnicity not specified	0%	≤5%	--
	Existing employee ethnicity not specified	2%	≤5%	▲

How to read

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

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

Key notes

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

a. Reported quarterly - latest available Dec Q2 18/19
b. Sep Q1 2018/19 (latest HQSC data available).
c. Bowel Screening - New Indicator - % referred for colonscopy (within 45 days) following positive iFOBT (Sep 16 - Dec 18).
d. Employees taking positions outside of the hospital/DHB Prelim Data Sep Q1 18/19
e.
f. Annual data - latest available 2015
g. Coding dep, rolling 3 mths - Apr 19
h. Reported quarterly - latest available, Jun Q4 17/18
k. Small volumes result in sensitivity to traffic light criteria
m. Reported quarterly - Mar Q3 18/19

A question?

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

APPENDIX ONE – CEO RECOGNITION

Linda Thompson - District Nurse, Home Health Support West. Nominated by Julie Holliday.
"Linda keeps us all sane and smiling with her cheerful, positive attitude. Our team really appreciates her calming influence and bad jokes."
Shannon McMinn - Registered Nurse, Ward 14. Nominated by Kirsten Ter Braak.
"Feedback provided to me from a patient during rounding for the compassionate and expert care Shannon provided to this patient during a night shift with very little sleep."
Helen Bowen - Registered Nurse, Health for Older Adults. Nominated by Alexandra Kelly.
"For recognition of her efforts and for bringing our values to life, Helen has exceptional kindness and compassion for patients and their whanau. Helen has gone to great extremes to support staff faced with unfamiliar situations. Patients and staff are very fortunate to have her on our ward."
Nick Wiki - Charge Nurse Manager, Tanekaha Unit. Nominated by Trudie Field and the Te Aka team.
"Nick has been a part of many initiatives specific to Kaupapa Māori Forensic Psychiatric Services; presenting at Melbourne Indigenous Conference and recently in Croatia. He also drove the research team which initiated 'Strategies to reduce the use of seclusion and restraint with Tangata Whai i te ora'. Furthermore, Nick piloted the Level 4 HCA Careerforce program. Nick carries many hats not only as Unit Manager but also overseas. Clearly there have been huge benefits to his commitment."
Lavinia Hurrell and Judy Wills - Administration Clerks, Forensics Service, Mason Clinic. Nominated by Shivika Singh.
"Lavinia and Judy not only manage diaries but also manage many other administrative tasks. They both go over and above their own jobs to help the other staff sharing the same workspace. Thank you."
Jill Armstrong-Wood and Mary McNamara - Administration Clerks, Forensics Service, Mason Clinic. Nominated by Shivika Singh.
"Jill and Mary are usually the first people that our visitors or clients interact with and on occasion have had to deal with challenging clients as well. They are doing all that while fielding phone calls, coordinating schedules and handling deliveries! You both are knowledgeable, friendly and super helpful."
Margaret Scott - Administration Clerk, Forensics Service, Mason Clinic. Nominated by Shivika Singh.
"Margaret not only greets everyone with a welcoming smile, she also does an excellent job of managing the Mason Clinic Trust office. Thank you for being so efficient and having such a positive attitude."
Devika Judd - Occupational Therapist. Forensics Service, Mason Clinic. Nominated by Shivika Singh.
"Devika challenges herself to pull out the best in her care recipients. She always strives to do her best so she can influence and help others. She also ensures that staff who share the workspace are able to engage in team building activities outside of work."
Crystal Maliha - Alcohol & Drug Clinician, Te Ātea Marino - Maori Mental Health. Nominated by Craig Heta.
"Crystal embodies all of the values of Waitematā DHB. Her passion, skill and dedication have contributed to outstanding outcomes. Crystal has taken a leadership role within her team where she has been guiding and supporting exceptional clinical practice and service delivery. She is a valued member of Te Ātea Marino and is contributing towards demonstrable improvements to wellbeing for Māori."
The following people have been nominated by Kirsten Pierre-Louis.
Dr Margaret Mitchell-Lowe - Psychiatrist, Marinoto Youth & Child West.
Dr Oliver Rooke - Psychiatrist, Marinoto Youth & Child West.
Dr Jamie Speeden - Psychiatrist, Marinoto Youth & Child West.
Dr Kaye Brightley - Psychiatrist, Marinoto Youth & Child West.
"Our amazing psychiatrists are not only outstanding supports to the young people and the whānau we see but are also a huge support to our clinical team on a daily basis. They continue to have an

open door policy and make themselves available for any questions regarding patient care, despite also feeling the increased pressure of our growing workload."

Rhys McDonald - Alcohol & Drug Clinician, CADS Central. Nominated by Asena Lameko.

"Rhys exemplifies that 'everyone matters' from the clients to the staff. He is helpful and always willing to help those in need, giving of his time and his knowledge to benefit others, and to also lend a listening ear and give support for a colleague that may be having a challenging time. Rhys shows great leadership skills to his peers, and those around him are able to learn and gain so much knowledge."

Namrata Gulani - Alcohol & Drug Clinician, CADS Central. Nominated by Asena Lameko.

"Namrata is very hard working, always willing to put her hand up to help and support her colleagues and clients with empathy and compassion. She does it with such love, humour and a BIG SMILE! She is an asset to the unit with her bubbly personality and the clients just love her."

Hwa Jung - Social Worker, CADS Central. Nominated by Asena Lameko.

"Hwa is a diligent, passionate and hardworking AOD clinician, recently celebrating his 20 years of service in the DHB. This shows his determination and passion to serve the clients in the community. His compassion for the clients is second to none, showing them kindness and love while helping them to find strategies and tips to help them dealing with their addictions."

Benedict Bendoy - Registered Nurse, Detox Centre, CADS. Nominate by Astrid Smith.

"Benedict is an amazing nurse and he displays the value of 'connected' through building relationships with each client as well as being a much loved member of staff. He shows 'better, best, brilliant' through the way he works with clients; especially on the weekends when he endeavours to take clients on walks or arrange activities in the unit. The clients mention him every week, and he role models recovery capital to the clients in order to show them a different way of being."

Karen Himiona - Alcohol & Drug Clinician, CADS South. Nominated by Astrid Smith.

"Karen is an amazing counsellor who shows great leadership through Tikanga; she often leads waiata or karakia before meetings and has helped other staff build their confidence in this area which in turn makes us all 'better, best, brilliant'. Karen shows 'with compassion' by supporting staff and clients on days which are special to them as well as receiving positive client feedback about her positive and compassionate interactions with clients. We are so lucky to have her."

Hamish Hutchinson - Registered Nurse, Community Home Detoxification Team. Nominated by Astrid Smith.

"Hamish is a lovely person to work alongside and shows connectedness through his interactions with people. He clearly explained at an MDT how he worked with one particular client and concentrated on building their recovery capital while also supporting them medically. It was inspiring to hear how he fostered a relationship where the client felt heard."

Mark Baker - Health Care Assistant, He Puna Waiora. Nominated by Shane Lencse.

"Mark consistently makes himself available as an invaluable resource for both service users and staff alike. He conducts himself with professionalism and integrity, and should be commended for the pivotal role he played in a recent incident on the ward in which he prioritised patient safety and ensured an optimal health outcome for a high risk individual."

Matthew Hohaia - Orderly, Clinical Support Services. Nominated by Denise Morris.

"Matthew is always happy in his work. He greets our team often, throughout the day, in a pleasant manner and a cheery smile."

Claire Dixon - Registered Nurse, Duty Nurse. Nominated by Susan Rae.

"Claire is an exceptional RN and incredibly valuable to our team. Recently she was required to ensure the hospital remained safe whilst the senior members of her team where in an extended resuscitation. She remained calm, worked efficiently and continued with her positive attitude throughout her shift. Claire demonstrates the WDHB values of 'compassion', 'everyone matters' and 'better, best, brilliant'."

Filipo Nariva - Security Coordinator, Security Services. Nominated by Jo Bartlett.

“For his unfailing dedication to duty and his calm and steady demeanour that assisted me in a very difficult situation recently. Filipo is a staff member who demonstrates the values of this DHB in his everyday interactions with staff and patients alike. We are lucky to have him.”

Alison Bowden - Manager, Elective & Outpatient Services. Nominated by Susan Rae.
“Alison is always available and supportive, checking in with me to see how I am managing and setting up meetings to continue this on-going support. Alison embodies the DHB values of 'everyone matters', 'with compassion' and 'connected' on a daily basis.”

Renee Kong - Innovation Manager, i3 Quality Leadership. Nominated by Sharon Russell.
“Renee has been instrumental in working tirelessly behind the scenes for the up and coming #endpjparalysis national day on 4 July. She has undertaken this extra responsibility, working over and above her remit for this project with passion and drive to ensure this day runs smoothly. Renee has demonstrated 'best care for everyone', and her commitment to the project has been overwhelming.”

Gloria Paterson - Acting Team Leader, North Therapies. Nominated by Angela Nicholson.
“Our department is going through a time of change with the implementation of new systems and processes. Gloria has had the responsibility of overseeing this process and taken this increased workload, while remaining clam and positive. Gloria, you are doing an amazing job and I appreciate all your support. Thank you.”

Debbie Howard - Associate Clinical Charge Midwife, Waitakere KYM. Nominated by Rebecca Eade.
“Debbie provides a connection to enable the best care for women and families using the maternity service. She is driven to provide the best possible care and is able to connect with clinicians to enable this. Debbie is always friendly and positive and is a pleasure to work with.”

Sharleen Poinga - Data Administrator, Child & Family West. Nominated by Ruth Noel.
“Sharleen's role is to support the efficient delivery and data entry for the School Based Immunisation Programme (SBIP). Sharleen goes above and beyond her role to support the public health nurse team in the safe delivery of Boostrix and Gardasil 9 to thousands of West Auckland children”

Michelle Bavastro - Staff Support Assistant, Staff Support. Nominated by Mickey Willard & Inge Andersen.
“Michelle is 'connected', taking our simple ideas and makes them 'better, best, brilliant'. She supports the trust value of 'everyone matters', and nothing is ever too big or too much trouble. Her work is showcased throughout our department and we would like her to know how much she is valued.”

Debbie Hogan - Operations Manager, General Medicine. Nominated by Laura Chapman.
“Debbie stepped up and outside the boundaries of her role to help someone for whom she has no responsibility other than as a fellow human being. She sought no credit but it is actions like Debbie's that give you faith in the world.”

Marcus Stembridge - Registered Nurse, Rata Unit, Mason Clinic. Nominated by Shivika Singh.
“Marcus has been fantastic at organising and co-ordinating the Calm and Restraint trainers and has been open to new ways of delivering the training at Mason Clinic. He has devoted a lot of his time towards the reducing seclusion and restraint project and the humour at the training is enjoyed by many staff.”

Jenny Singh - Clinical Nurse Specialist, Tanekaha Unit, Mason Clinic. Nominated by Shivika Singh.
“Jenny has such enthusiasm in developing and delivering the wellness group for our service-users and also for picking up and recommencing the nurses’ forum at Mason Clinic. Her initiative for starting Dialectical Behaviour Therapy informed nursing at Mason Clinic is an excellent idea.”

Sharon Price - Charge Nurse Manager, Forensic Prison Team. Nominated by Shivika Singh.
“Sharon has been doing a fabulous job at managing the team with minimal staff and also holding her own caseload. She managed to achieve a good balance between clinical practice and managing the team. Well done.”

Azizun Nisha - Charge Nurse Manager, Forensics Management. Nominated by Shivika Singh.
"Azizun has faced some challenges transitioning from working as a colleague to a charge nurse manager on the unit, however, she dealt with those challenges really well. Her key behaviours of ensuring there is open communication on a regular basis with her team is a factor that enables her team to be involved in decision-making. Azizun values their views and enables them to take greater clinical operational leadership in day to day matters."
Mae Alipao - Registered Nurse, PACU Theatres. Nominated by Jaymelyn Panteleon.
"Mae cares for her patients with compassion and kindness. She also cares for the staff while in her coordinator role in Recovery. She is always ready to give a hand to other staff, even though she has many of her own, and she maintains calmness in a very busy day. She happily passes her knowledge and skills to new staff. A very dedicated nurse."
All staff listed below have been nominated by Sarah-Jane Reweti.
Cayla Jensen - Registered Nurse, He Puna Waiora
Shane Lencse - Registered Nurse, He Puna Waiora
Martin Jones - Health Care Assistant, He Puna Waiora
Tony Dawson - Registered Nurse, He Puna Waiora.
"During a recent challenging and volatile situation, Tony, Cayla, Shane and Martin acted with integrity and professionalism. Despite all parties sustaining injuries, they continued to safely manage the situation above and beyond what would be expected, encompassing the DHB's values, specifically they worked 'with compassion', 'everyone matters' and 'better, best and brilliant'."
Justine Echavez - Registered Nurse, Intensive Care Unit. Nominated by Marcelle Mafi.
"Justine is an excellent nurse and calmly and competently manages whatever comes her way. She always has a smile even though she will often have the heaviest workload and is always willing to help her colleagues. Justine is a team player that we are all really grateful to have on our team at ICU."
Dr Pawan Singhal - Medical Officer, Urology. Nominated by Susan Rae and Tony Beaven.
"Dr Singhal carries out his duties with excellence and is an asset to the Urology Service and to the DHB as a whole. Without a doubt he embodies our DHB values of 'everyone matters', 'with compassion' and 'connected'."
All staff listed below have been nominated by Dilruskshi Champika de Silva.
Sheetal Naidu - Occupational Therapist, Isa Lei Services
Diana Mathew - Registered Nurse, Isa Lei Services
Annette Ulame - Registered Nurse, Isa Lei Services
Lucia Vosataki - Cultural Worker, Isa Lei Services
Katie Sale - Administration Clerk, Pacific Mental Health
Tafale Crichton - Cultural Worker, Pacific Mental Health
Rima Tiller - Cultural Worker, Pacific Mental Health
"For their outstanding contribution to the service, to the clients and families we serve. They fulfil Waitematā DHB values in everything they do."
Wendy Lee-Mace - Charge Nurse Manager, Ward 10. Nominated by Wendy Matthew.
"Wendy is an amazing Charge Nurse and always shows compassion to our palliative patients. We had an especially sad case and Wendy showed such kindness."
Dr Jenna Young - Registrar, Ward 10. Nominated by Wendy Matthew.
"Jenna has worked with our team with several of her patients. She always tries her very best and shows kindness and compassion in all that she does. She is an excellent doctor."
Diane James - Registered Nurse, Ward 10. Nominated by Wendy Matthew.
"Di is a fabulous nurse who always advocates for her patients and sees the bigger picture. She is a fantastic nurse."
Stephanie Ayles - Registered Nurse, Ward 10. Nominated by Wendy Matthew.
"Steph is compassionate with our patients and she communicates well and cares for palliative care patients beautifully."

Cynthia Wheeler - Administration Clerk, Quality Leadership. Nominated by Nigel Swain-Williams.
“Cynthia compassionately and empathetically provides an ear for our patients to provide feedback and work through their concerns, diligently ensuring the right people get involved to help. Thank you Cynthia, you are a valued member of the Quality and Risk team and consistently work with compassion.”
Carole-Anne Miller - Clinical Clerical Worker, Outpatients Waitakere. Nominated Libby Simmonds.
“Carol-Anne displays the DHB values in her caring friendly helpful manner. No matter how busy she is, Carole-Anne is ready with a smile and a ‘Yes’, to whatever I request of her. Her friendly manner with patients and staff create warmth wherever she is working.”
June Nicholls - Lactation Consultant, NSH Maternity. Nominated by Eleanor Gates.
“June was my role model in becoming an IBCLC – her clinical skills and knowledge are amazing. She supports our in-patients with gentleness, understanding, kindness and compassion. June excels in this niche role and especially builds women’s self-confidence in being able to breastfeed their babies. In addition, June supports the Maternity Suite Midwives and Nurses in their clinical breastfeeding learning.”
Sinead O'Malley - Clinical Coach, Emergency Care Centre NSH. Nominated by Rose.
“Sinead is an asset to the Emergency Department - particularly to our new graduate nurses starting their nursing careers. Sinead goes above and beyond to support and develop our DHB’s new graduate nurses and absolutely lives the DHB’s value 'everyone matters'. Thank you so much for all of the hard work that you do to help support and nurture our newest nurses.”
Tabitha Parker - eLearning Designer, Learning & Development. Nominated by Rachel Wetere (Wananga Academy) and Susan Turcich.
“I wanted to let you know that we are very grateful for one of your staff, Tabitha, who is also enrolled on the programme. She has been extremely supportive in helping us get our online learning platform off the ground – her expertise and ‘can I help?’ attitude is truly appreciated.” Rachel Wetere.
"As Tabitha’s manager, I am proud of the way she is demonstrating our values of 'better, best, brilliant' and 'everyone matters’.” Susan Turcich.
Gill Kennedy - Document Coordinator, Information Management, Decision Support Service. Nominated by Angela Nicholson.
“Gill does such an amazing job. She has facilitated a system to enable our department to request the return of patient charts from Crown Records; something that in the past has been a difficult process. Jill has gone over and above to assist the Outpatient Physio Department ('better, best, brilliant') and this is our way of saying thank you.”
Ariane Araquel-Lacamiento - Associate Clinical Charge Nurse, Urology Theatres NSH. Nominated by Neroli Blight and Susan Rae.
“Ariane is cheerful and approachable and since her commencement, the communication and collaboration between the Urology B&S Team and Urology Theatres has improved immensely. Ariane raises issues and concerns early and she is flexible while able to think outside the box when it comes to solutions.”
Jenny Bos - Occupational Therapist, Child Development North. Nominated by Courtney Coe and Cheryl Toh.
“Jenny has been absolutely amazing at supporting our learning needs. She is very accommodating, helping us to achieve accreditation in the needed areas while still managing her own case load. She is fantastic with sharing knowledge and experience, allowing useful learning opportunities. Jenny is able to remain calm despite challenging situations and has a lovely manner with families. She is compassionate and embodies the DHB value of 'everyone matters'.”
Dharmindar Bhardwaj - Registered Nurse, Kauri Unit, Mason Clinic. Nominated by Azizun Nisha.
“Despite the challenges that Dharam faces whilst working in an acute forensic unit, he maintains a calm approach. He incorporates the WDHB values in to his practice when providing nursing care and

treatment to the service users. Dharam is extremely hardworking, works well with the team, and is a great role model."

Hugh Robinson - Registered Nurse, Kauri Unit, Mason Clinic. Nominated by Azizun Nisha.
"Although a new graduate staff member on the unit, Hugh has transitioned smoothly into his new role. Hugh has worked with some acutely unwell and challenging service users. Recently Hugh's immediate response to an unexpected situation prevented a staff member from getting further injuries."

Jackie Turner - Manager, Booking Centre. Nominated by Susan Rae.
"The PNC Lead role is not an easy one and Jackie is unwaveringly supportive, encouraging, and always available to as a sounding board. She makes a point of checking in with me on a daily basis (and even more often) during difficult and particularly stressful times. I simply could not do my job without her support. Jackie embodies the DHB values of 'everyone matters', 'with compassion', and 'connected' on a daily basis."

Kelly Webster - Physiologist, Respiratory Service. Nominated by Claudia Thomson.
"Kelly is a blessing to have on our physiology team. Thank you for all of your support and encouragement during our path to become certified respiratory physiologists. A massive congratulations again and thank you for your continuous strong work ethic and good sense of humour. So grateful to have you on our team!"

Manmeet Malhotra - Dental Assistant, Dental North 3. Nominated by Donna Bartholomew, Lidvina Kim, Siksha Kumar, Leona Osten, Ann Bray-Taylor and Alisha Olsen.
"Manmeet always ensures patients and staff are well cared for. She is positive and happy to assist in any way possible, always going the extra mile. She is genuine in her care and sets a high standard to ensure everything in a clinic is operating smoothly. Manmeet is consistent in her service no matter where she is working and clinicians and patients fully appreciate her generosity and care."

Elly Richards - Clinical Nurse Educator, CADS. Nominated by Jason Cabral-Tarry.
"Elly is encouraging and inspiring in her work of supporting nurses in their professional development and raising the profile of addiction nursing in the sector. Truly a champion of our DHB values of 'better, best, brilliant' and 'everyone matters'."

Paul Hanson - Medical Imaging Technologist, Radiology Services WTH. Nominated by Paula Edwards.
"Paul has worked very hard and patiently in making the AV installation in Ultrasound happen. He has used his technical expertise and has gone beyond the standard scope of his role to co-ordinate stakeholders, and to produce a quality functional set-up of additional ultrasound monitors in the ultrasound work area. This will greatly assist with our supervision of trainees and with our obstetric sessions. Thank you, Paul."

Marcia Ball - Administration Clerk, NASC West. Nominated by Minetta Mendonza.
"Marcia is always efficient and combines this with a wonderful warmth and calmness. Particularly with managing the car fleet bookings, she is a wizard and consistently manages to accommodate requests, including changes without ever appearing frustrated or flustered. Marcia really embodies our DHB values, particularly 'everyone matters' and 'better, best, brilliant'. Marcia is such an asset to the team and her pleasant smile never fails to make people feel welcome."

Arlene Gill - Registered Nurse, Home Based Treatment. Nominated by Wayne Forsyth.
"Arlene for her collaborative support with other mental health teams. She demonstrates both tenacity and a caring attitude in helping to ensure clients access appropriate supports."

Bonita Burton-Watt - Registered Nurse, NSH Gastroenterology. Nominated by Alison Bowman, gastroenterologists and our team.
"Bonita is dedicated to all our endoscopy patients and staff, applying all the principles of our WDHB values. She shows deep compassion and a supportive connection, while encompassing 'everyone matters', and achieving 'better, best and brilliant' in her high standards of nursing professionalism."

The following staff were nominated by Tennille Junge.

Carolyn Cordes - Clinical Nurse Specialist, Paediatrics.

Melanie Sutherland - Clinical Nurse Specialist, Paediatrics.

Sue Wilson - Clinical Nurse Specialist, Child and Family North.
Lorraine Glover - Clinical Nurse Specialist, Child and Family West.
"All of these nurses have been a wonderful source of knowledge and support as people who have gone before me on the senior nursing journey. They have been nothing but positive and encouraging and it has made settling into my new job so much easier. I appreciate each and every one of them for supporting me when they are already so busy in their own roles."
The following staff were nominated by Jane Galea-Singer.
Katrina Edmonds - Social Worker, Moko Services.
Ben-Jean Ryder - Cultural Worker, Maori Mental Health.
"For their work and innovation in the 'Let's Kick Butt Challenge' - encouraging people in mental health and addictions to reduce and quit smoking. Katrina and Ben were inspirational in introducing Maori interventions as part of the eight week challenge, aiding a number of people to reduce and quit smoking."
Rima Tiller - Cultural Worker, Malaga a le Pasifika. Nominated by Jane Galea-Singer.
"For her dedication and support to provide Smokefree in a culturally respective way to Pacific peoples. Rima designed a lasting booklet to help support a Pacific team through the 'Let's Kick Butt Challenge', encouraging people in mental health and addictions to reduce and quit smoking."
Parth Patel - Parking Attendant, Traffic and Fleet. Nominated by Beverley McGregor.
"For his professionalism and support whilst I was visiting a whānau member at North Shore Hospital. I appreciate that Mr Patel was obliging and all the Waitematā DHB values were evident - 'everyone matters', 'with compassion', 'better, best and brilliant' and 'connected'."
Laisa Mucunabitu - Administrator, Forensics Management. Nominated by Jen McCamish.
"Laisa has a beautiful smile and a friendly nature which makes her a pleasure to work with. She is well-informed and extra tolerant with those of us who are less educated around her specialty! Laisa has strict time lines which must make her job very stressful, but this does not stop her from supporting the rest of the Mason Clinic team in a delightful and professional manner."
Umit Holland - Clinical Nurse Specialist, Research & Knowledge Centre. Nominated by Seema Vinish.
"Umit goes out of her way to promote the value 'everyone matters'. Umit has made huge efforts to accommodate short notice requests in to her busy schedule to ensure patient safety is the main focus."
Peter Groom - Specialty Nurse, Directorate of Nursing. Nominated by Seema Vinish.
"Peter is a great team leader whom staff relies on in difficult situations. He is always very pleasant, willing to help, and encourages his team to achieve success. Peter has done amazing things to ensure 'better, best, brilliant' not only for patients but for the team."
Wayne Miles - Clinical Director, Mental Health Service. Nominated by Seema Vinish.
"I was totally amazed by how Wayne handled a very difficult situation that could potentially compromise patient confidentiality in a very professional way. He went the extra mile to ensure safety of our patients encompassing 'better, best, brilliant'."
Keryn Bradley - Project Manager, Funding - Primary Care. Nominated by Seema Vinish.
"Keryn worked as the Quality and Patient Safety Lead for the Surgical and Ambulatory service previously. Keryn is always willing to help and upholds patient safety mantra. It was an amazing opportunity to work with Keryn and learn so much - she really does make a difference."
Donna Harrat - Social Worker, Inpatient North Therapies. Nominated by Rani Scott.
"Donna is an amazing asset to our MDT. Recently she has chosen to stay late due to workload and will always be available for people in their greatest time of need. She is great at following up after-hours referrals and will feedback on these referrals. Thanks so much Donna!"
Dr Jeevithesh Shivanna - SMO, Crisis West Team. Nominated by Taryn Broughton.
"Patients are consistently reporting that they feel listened to, and valued by Dr Shivanna. He has such a friendly approach and genuinely listens to people."
The following staff have been nominated by Selena Griffith.
Christine Prince - Social Worker, Maternal Mental Health.

Katharina Kercher - Occupational Therapist, Maternal Mental Health.
Kirsty Rorke – Psychologist, Maternal Mental Health.
"These staff members went above and beyond to ensure a mother and her children were kept safe. They all displayed empathy, care and compassion, during a very difficult time. They all reflect the DHB core values and the service is proud to have them as part of the team."
The following staff have been nominated by Susan Turcich.
Karen Sayer - Charge Nurse Manager, Psychiatric Liaison.
Paula Framhein - Registered Nurse, Psychiatric Liaison.
"For demonstrating the values 'connected' and 'everyone matters'! We potentially were faced with cancelling an important training programme due to unforeseen events. Due to Karen's leadership and willingness to appreciate the importance of the training she released her team member Paula to co-facilitate. A great example of teamwork and leadership."
Claire Dixon - Registered Nurse, Duty Nurse WTK. Nominated by Jo-Ann Blomfield.
"Claire is an exceptional RN and incredibly valuable to our team. Recently she was required to ensure the hospital remained safe whilst the senior members of her team where in an extended resuscitation. She remained calm, worked efficiently and continued with her positive attitude throughout her shift. Claire demonstrates the WDHB values of 'compassion', 'everyone matters' and 'better, best, brilliant'."

4.2 Health and Safety Performance Report

Recommendation:

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

Community, whanau and patient centred model of care	This report comments on issues and risks that impact on staff health and safety and therefore patient care and organisational culture.
Emphasis and investment on both treatment and keeping people healthy	This report comments on organisational health and safety information via incident reports, health monitoring and identified hazards.
Intelligence and insight	This report provides information and insight into staff workplace incidents and what Waitematā DHB is doing to respond to these and other workplace risks.
Evidence informed decision making and practice	The leading and lagging indicator dashboard is based on current best practice indicators and targets. Risk controls are regularly audited to align to an evidence base.
Outward focus and flexible, service orientation	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.
Operational and financial sustainability	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.

3. Executive Summary

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

A particular highlight is our influenza vaccination rate which is 64% against a target of 60%. Although the campaign was set to run until the end of August, a national shortage of influenza

vaccine will significantly limit our ability to increase vaccination rates further. For the entire campaign last year we vaccinated 60% of staff.

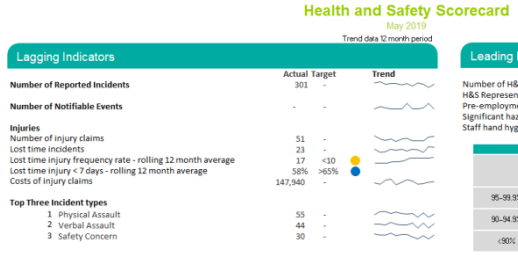
Our target for pre-employment health screening prior to commencement was 51% against a target of 70%. Managers have been contacted to follow up staff that have not been screened and to clarify the expectation that all staff complete their pre-employment health screening prior to commencement. As previously advised, we are employing extra nursing resource for six months to help screen and follow up staff to ensure pre-employment screening has occurred before commencement.

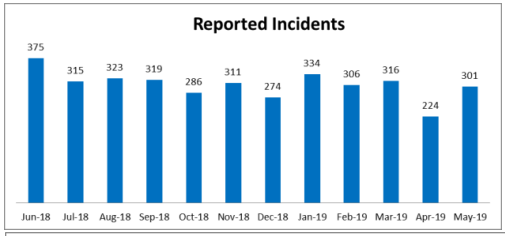
The Lost Time Injury Frequency Rate (LTIFR) remains challenging, with a higher number of incidents requiring lost time per million hours worked than our target (17 against a target of 10). Programmes to address incident rates are ongoing, with regular communications and advice being provided to staff, both electronically, through posters and during face-to-face Divisional meetings. Although the LTIFR remains challenging, the Lost Time Incidents (LTIs) requiring less than 7 days off work remains strong at 58%, compared with a target of 65%. This shows that many of the actions we have undertaken to reduce the consequence of incidents are delivering positive results.

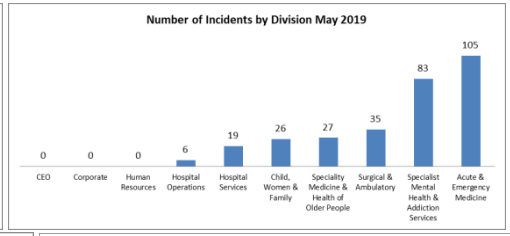
Overall, reported incidents have reduced with a downwards trend since June 2018. In relation to top accident types:

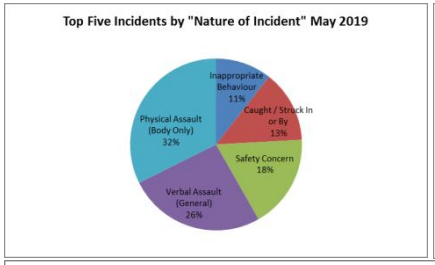
1. Slips, trips and falls decreased by two this month to a total of 10; 3 tripped over equipment or objects, 3 slipped on wet surfaces; 3 fell while dealing with patients; 1 slipped while trying to move equipment.
2. Moving and Handling incidents increased this month from 8 in April to 15 in May with the Moving and Handling team reviewing and following up on all incidents, including auditing moving and handling equipment in the areas injuries were sustained.
3. Aggression incidents overall have decreased over the past few months. The number of physical injuries has steadily decreased from 89 in March to 65 in April to 61 in May. As previously reported, a number of actions are in place to manage the likelihood of incidents occurring and/or to reduce the severity of consequence when incidents occur. As an example, although the number of aggression incidents remains the same, since introducing the new PPE for the security officers, we have seen a significant reduction in injuries to these staff.
4. In May, most incidents were caused by people who had no intent to cause harm (88%) and 95% of incidents were instigated from patients or visitors.
5. We have successfully finalised our Worker Participation Agreement (WPA), in collaboration with the Unions, and this has now been fully signed off. We wish to extend our deepest gratitude to the WDHB Unions for their engagement and assistance in this process, especially the PSA. The main focus of the WPA is to ensure we have clear guidance for all managers regarding the level of involvement workers, especially Health and Safety Representatives (HSRs), must have in the management of health and safety hazards. This includes the setting up of local level health and safety committees, involvement in the investigation of incidents and the required communication with workers when processes or systems are being changed, where that process or system may impact on the workers' health and safety. The WPA will be communicated to all managers in the next two weeks.

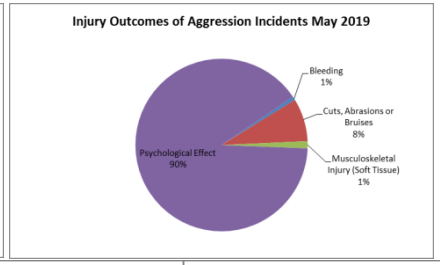
4. Performance Dashboard

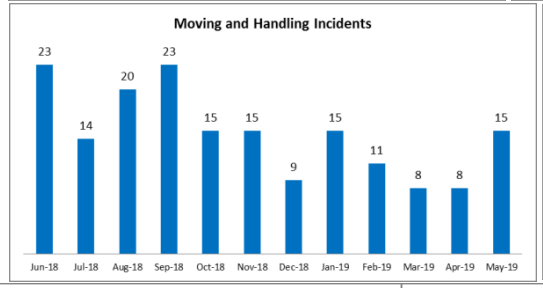


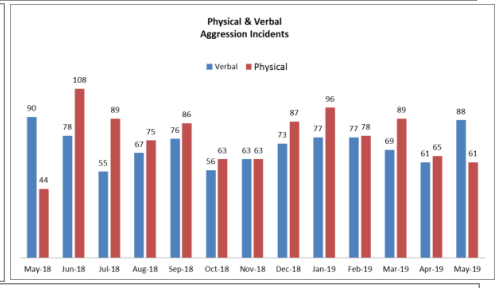


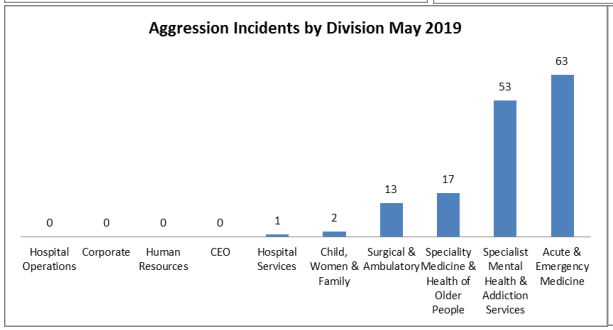


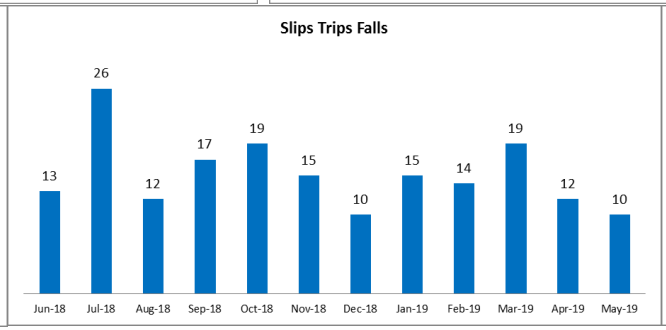


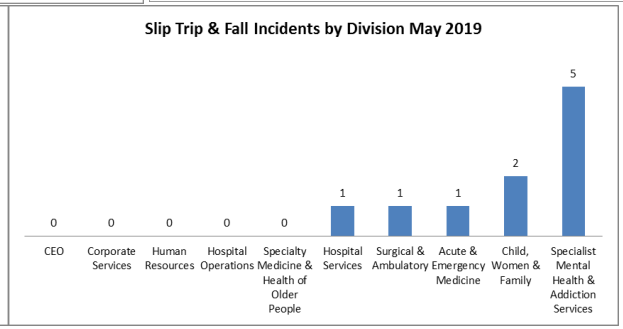












5. Work related injury Claim Data for May 2019

Outlined below is our injury claims data for May. Work injury claims data is for all work injuries currently managed by the DHB, including injuries that occurred in previous years, up to and including injuries for May 2019.

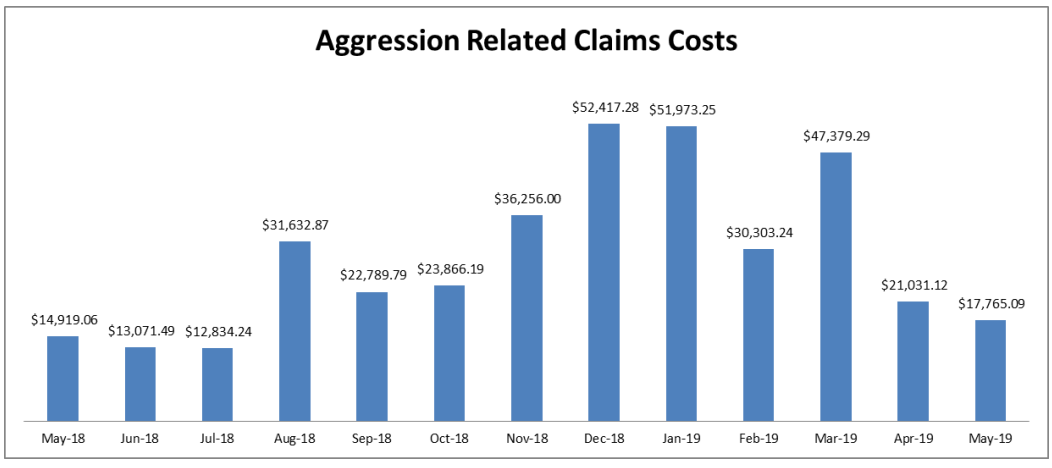
INJURY CLAIM DATA				
Total: Injury Claim Report for May 2019				
Lost days	**Treatment cost**	**Weekly compensation costs (80% of salary)**	**Staff cover cost**	**Total**
Number of lost days for month	$ total for month	$ total for month	$total cover cost for month	Total $ cost for month
191	$60,370.11	$38,920.30	$48,650.38	$147,940.79

High accident events account for approximately 71% of the claims, as below:

High Accident Injury type	Lost days this month	% of cost this month	Cost this month	Year to date trend for injury claims
Moving and handling	62	31%	$45,622.29	↓
Slips Trips Falls	40	21%	$30,595.70	→
Aggression	21	12%	$17,765.09	↑* please see note below

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

As requested in the last Board meeting, 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 unfavourable due to higher costs in prior months. Please note: these costs are those expensed by WDHB 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 that injuries can span

multiple report periods, sometimes over multiple years, depending on the severity and time required to return to work (RTW).

6. Stakeholder feedback

6.1 Facilities and Development – Health and Safety Management Systems

Nine training modules on the Facilities and Development health and safety management systems have now been delivered. Our thanks to the Learning and Development team who collaborated on this work.

An internal review of the F&D Risk Register regarding Contractor Management, has been completed. The findings demonstrate F&D have developed and established appropriate controls imbedded into the Facilities Contractor Management process.

Work is continuing with the development of an effective asbestos management process including:

- Establishing a 'permit to work' system for all asbestos related tasks.
- Development of an orientation pack for new/external project managers to ensure training and guidance is provided for contractors and staff.

F&D Health and Safety Statistics - May 2019	Facilities Development	Facilities Maintenance	Total
Incidents and accidents			
Lost Time Injuries	0	0	0
Serious Harm Accidents	0	0	0
Accidents Requiring Medical Attention	0	0	0
Accidents Requiring First Aid	1*	0	1
Near Miss Incidents			
This Month	0	0	0
Monthly Average			0
Year to Date			28
H&S / Toolbox Meetings this Month			
Projects	100%		
Facilities Operations		100%	
Contractor Site Inductions			
This Month			8
Year to Date			451

KPI comments:

***** An external contractor was working above his head on the CT scanner project. When he removed his safety eye wear a drop of glue fell into his eye. First aid was administered. All tool box meetings have reinforced the

importance of using PPE at all times.

Injuries and Accidents	Incidents and accidents are monitored across all DHB sites and include data for staff and contractors.
Near Miss / Incidents	Near Miss and Incidents are monitored across all DHB sites and include data for staff and contractors
Health and Safety Toolbox meetings	All contractors and staff are expected to attend one health and safety / toolbox meeting per construction week for projects. Facilities maintenance staff are expected to attend fortnightly health and safety / toolbox meetings.
Contractor site inductions	This is an indication of the number of new contractor staff on site and will vary significantly with construction project work load.

7. Health and Safety Risks

As discussed during the Board H&S Workshop, we have introduced new reporting of our key hazard areas and the resulting actions. 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.

Key	
Progress Indicator	
Red	Major delays
Amber	Minor delays
Green	On track
Risk Measure Addressed	
L	Likelihood
C	Consequence

Risk	Update	Start Date	Est. Date to Complete	Progress Indicator	Risk Measure Addressed
Biological Risks	**Blood and Body Fluid Exposures (BBFE)**				
Needle stick injuries	Needleless Systems: Both North Shore and Waitakere Hospital audits have been completed and recommendations either closed or being followed up. Audits Complete: 100% Audit findings to be discussed at the next Executive Health, Safety and Wellbeing meeting.	Sep 2018	Dec 2018		L
	A 'sharps safety week' has been scheduled for December 2019, in-line with the international sharps awareness month. Complete: 0%	Dec 2018	Dec 2019		L
Splashes	Incorporated within all BBFE related projects, including Personal Protective Equipment (PPE).	Ongoing	Ongoing		L/C
Substances hazardous to health					
Asbestos Register	Work has commenced with uploading information from Management,	Oct 2017	July 2019		L

	Refurbishment and Demolition surveys. 95% of existing surveys have been uploaded. Final review of uploaded content underway. Complete: 85% 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.	Ongoing	Ongoing		
Mould	OH&SS continue to review all air testing reports relating to mound and provide advice to the relevant Service managers and Facilities. No concerns to date.	Ongoing	Ongoing		C
Chemicals	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% Business case for Hazardous Goods Store for Waitakere Hospital: Not due yet. Trial on transferring HSNO waste within the main hospitals: 6 week trials at North Shore and Waitakere Hospitals have been completed. Due to low uptake at Waitakere Hospital, trial will be repeated In Jul/Aug. New Trial: Complete: 0%	Sept 2016 Dec 2016 Jun 2018	Dec 2020 Dec 2019 Aug 2019	 	L L L/C
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	Ongoing	Ongoing		L

	schedule. There are no concerns to date.				
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. Complete: 100%	Ongoing	May 2019		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. BIEMS Upgrade: Delivery Complete: Stage 1 build: 100% and Stage 2 rollout: 50%	On-going Dec 2017	On-going July 2019	 	L/C L
Roading	Pedestrian Crossings: Stage 1 of the North Shore Hospital pedestrian crossings programme (repainting of existing crossings) has been completed. Stage 2 – Scoping for new pedestrian crossings completed. Costing and planning works underway. Helipad: The pedestrian crossing to service the helipad, including appropriate lighting, has been scheduled for completion in Q1 2019. Construction has been delayed, as the SRO has requested the ED works at WTH be the priority, due to level of risk. Once this work is completed, the raised crossing at the helipad will commence and will take a total of 16 days. Helicopters will need to be diverted during this time. The estimated time for this work to start is around July 2019. Planning complete: 40% Physical works complete: 50%	Oct 2017 Oct 2017 Feb 2017	March 2019 April 2019 August 2019	 	L L L
Buildings	Loading Docks: CAPEX has been approved to finalise the concept design. A Business Case is due to the Executive Leadership Team once confirmation has been received from Fire Engineer regarding the proposed location for the waste/recycling bins. Estimate time for construction to start will be July 2019. Fire engineer to be engaged to complete fire protection design under MRI	Feb 2017	July 2019		L

	podium. Business case to be endorsed at June Steering Group for issue to ELT/ PIC for approval to proceed with physical works. Planning complete: 85%				
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. Responsibility for hospital based emergency management sits with the Director Hospital Services and for Community Services sits with the Director of Nursing.	Ongoing	Ongoing		L/C
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 audit on emergency preparedness is planned for 2020.	Ongoing	Ongoing		C
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). Drills are completed annually.	Ongoing	Ongoing		C
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. Drills are completed annually.	Ongoing	Ongoing		C
Psychological					
Aggression	The new Managing Aggression and Potential Aggression (MAPA) training is currently being arranged across the DHB and implementation started. The following actions have been completed: • Four educators are now accredited to deliver the MAPA Foundation programme • All four educators are scheduled to attend the MAPA Advanced programme and be accredited beginning of August 2019 • Scheduling of 5 MAPA Foundation (2 day) programmes for ED, Security and Duty Manager staff confirmed for June 2019	Feb 2018	Aug 2019		L/C

	• Engagement with Mental Health and Addiction Services to discuss their staff training requirements in non-inpatient environments. • Meeting with trainer managers to discuss and clarify the scheduling and other role commitments to plan delivery schedule for the next 12 – 18 months. Complete: 85% (due Aug 2019) 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: 0% (completion due Aug 2019)	Oct 2016	Install from Aug 2019		L/C
Bullying and harassment	Toolkit on Speaking up about bullying and harassment on Staffnet. Complete 100% Manager communication on the launch is planned for 23 July at the new monthly HR Learn sessions.	Ongoing	Ongoing		L/C
Lone workers	A new project has commenced relating to a review of all organisational policies and procedures covering lone worker emergency response plans. This is to determine if response plans are available within all areas with lone workers and that they are complete and communicated to staff. Complete: 0%	Jun 2018	Dec 2019		C
Stress/Distress/ Fatigue	Wellbeing research pilot survey complete and data being analysed for staff feedback. Complete: 100% EAP services in place. No issues. Partnering with the Mental Health Foundation on: Development of wellbeing resources. Pilot – 5 ways of wellbeing and creating positive work environments. Pilot commencing in August. Evaluation of Mental Health Wellbeing education Complete: 80% Guideline on Healthy Sleep Complete: 100%	Aug 2018 Ongoing	Jan 2018 Ongoing Aug 2019 July 2019 Available on staffnet	 	L/C
Safe staffing	<u>Centralisation of nursing rosters:</u> Complete: 100%	Sep 2018	Dec 2018		L

	<u>RMO rosters:</u> House Officers rosters developed, consulted and implemented: 100% Registrar rosters: rosters developed, consulted and implemented: 25% 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% <u>Nursing Care Capacity Demand Management (CCDM) and NZNO MECA Accord recruitment:</u> CCDM: Trend care team recruitment: Complete 100% CCDM: Services completing CCDM FTE reviews: 0% Accord recruitment: Complete: ICU 100%; ED 0%; Midwifery 100%; Critical Care Outreach 100%; RNs/Shift Co-ordinators 100% District Nurses 100%; Health Care Assistants 73%	Dec 2018 Nov 2018 Feb 2019 Dec 2018	Jun 2019 Feb 2019 Jun 2021 Jun 2019	 	

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:

- MMR vaccination social media campaign
- He Puna Waiora reviews
- NSH CT scanner opening
- Opening of new WTH chapel
- Staff flu immunisation programme
- Learning from adverse events promotion
- Hello, My Name Is campaign
- Staff parking
- Leapfrog CIO award
- Welcome to Waitematā booklet
- New combined parking/security card for staff
- End PJ Paralysis campaign
- Health Excellence Awards promotion
- Matāriki Awards promotion
- Site works staff communications
- Career profiles for Recruitment Team
- Compassion campaign
- Annual Plan content
- Ongoing implementation of Board decision re incorporation of macron
- Major facilities development communications
- 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 responses
- Liaison with Well Foundation Marketing and Communications
- Ongoing liaison with Metro Auckland DHB communications leads
- Ongoing after-hours and weekend media line cover and senior management communications support
- Proof-read leaflets, booklets and brochures for various departments
- Ongoing compilation and distribution of proactive media material
- Event photography and video
- Drafting of correspondence from the corporate office
- CEO Board Report

- Review of copy for DHB website
- Management of organisation-wide screen saver content
- Approval of all-user staff emails
- Weekly Board briefing
- Fortnightly *A Note From the CEO* email to all staff
- Weekly National Health Targets and clinically-led metrics updated and communicated

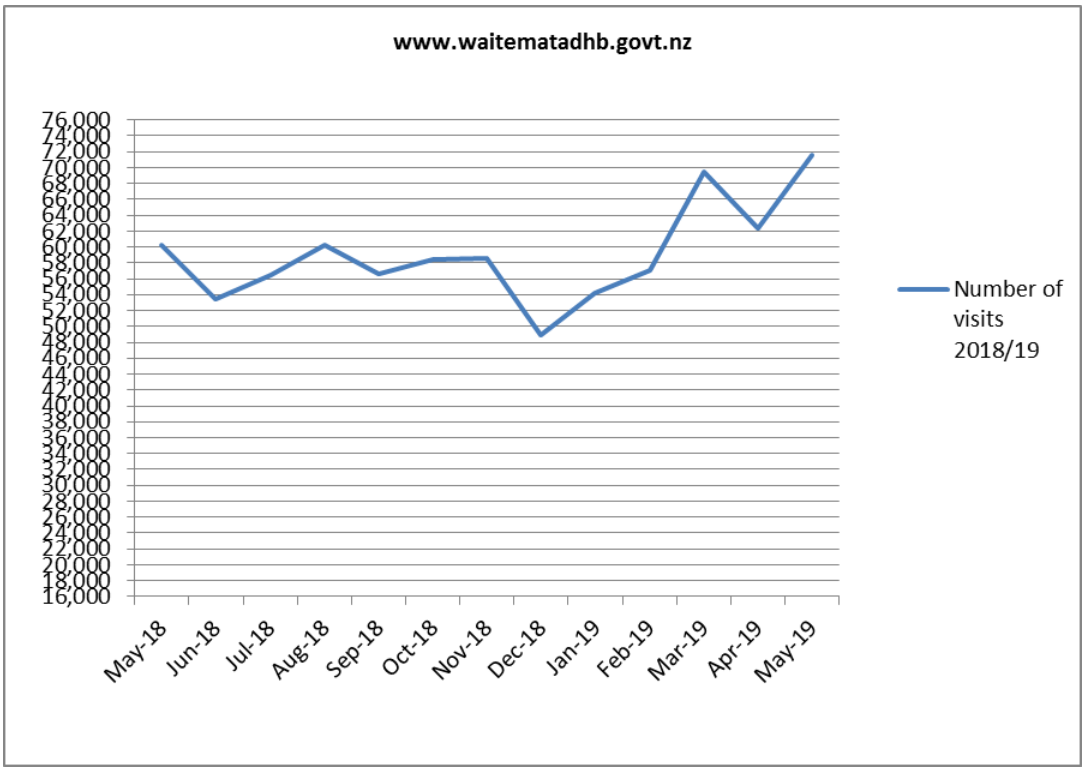
Waitematā DHB website – Google Analytics Statistics

Waitematā DHB website

Number of visits	**May 2018**	**May 2019**
Total visits to this site	60,238	71,559 (+18.79%)
New Zealand	28,588	32,352
Australia	767	1,080
USA	380	774
United Kingdom	250	231

Top areas	**May 2018**	**May 2019**
Waitematā DHB staff page	30,579	37,665
Home page	14,393	13,849
North Shore Hospital	6,717	4,568
Waitakere Hospital	3,032	3,334
Contact us	2,661	3,064

Traffic sources	**May 2018**	**May 2019**
Search traffic	73%	73%
Direct traffic	22%	24%
Referral traffic	5%	3%



Social media

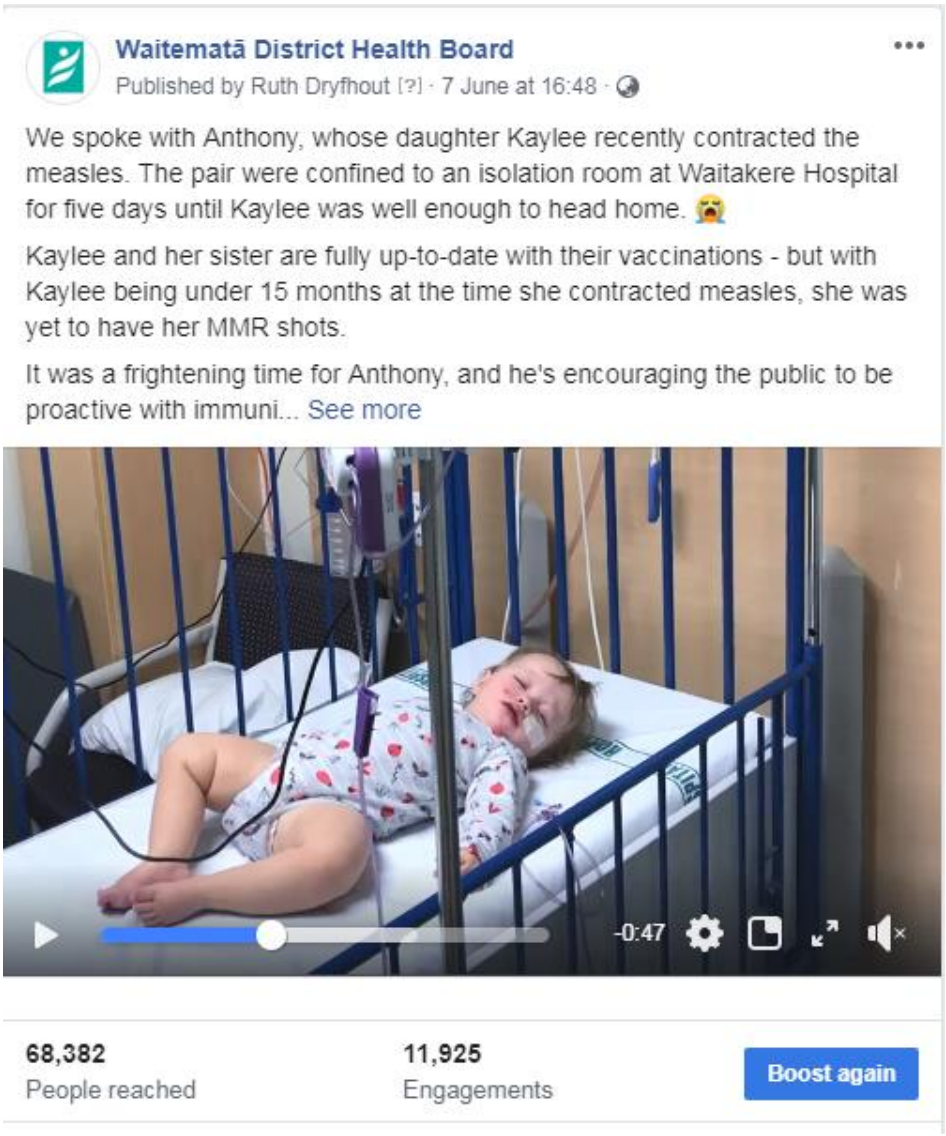
Facebook

Waitematā DHB Facebook page likes have increased by 93.6% since May 2018, with 7,437* current likes (3,841 likes - May 2018).

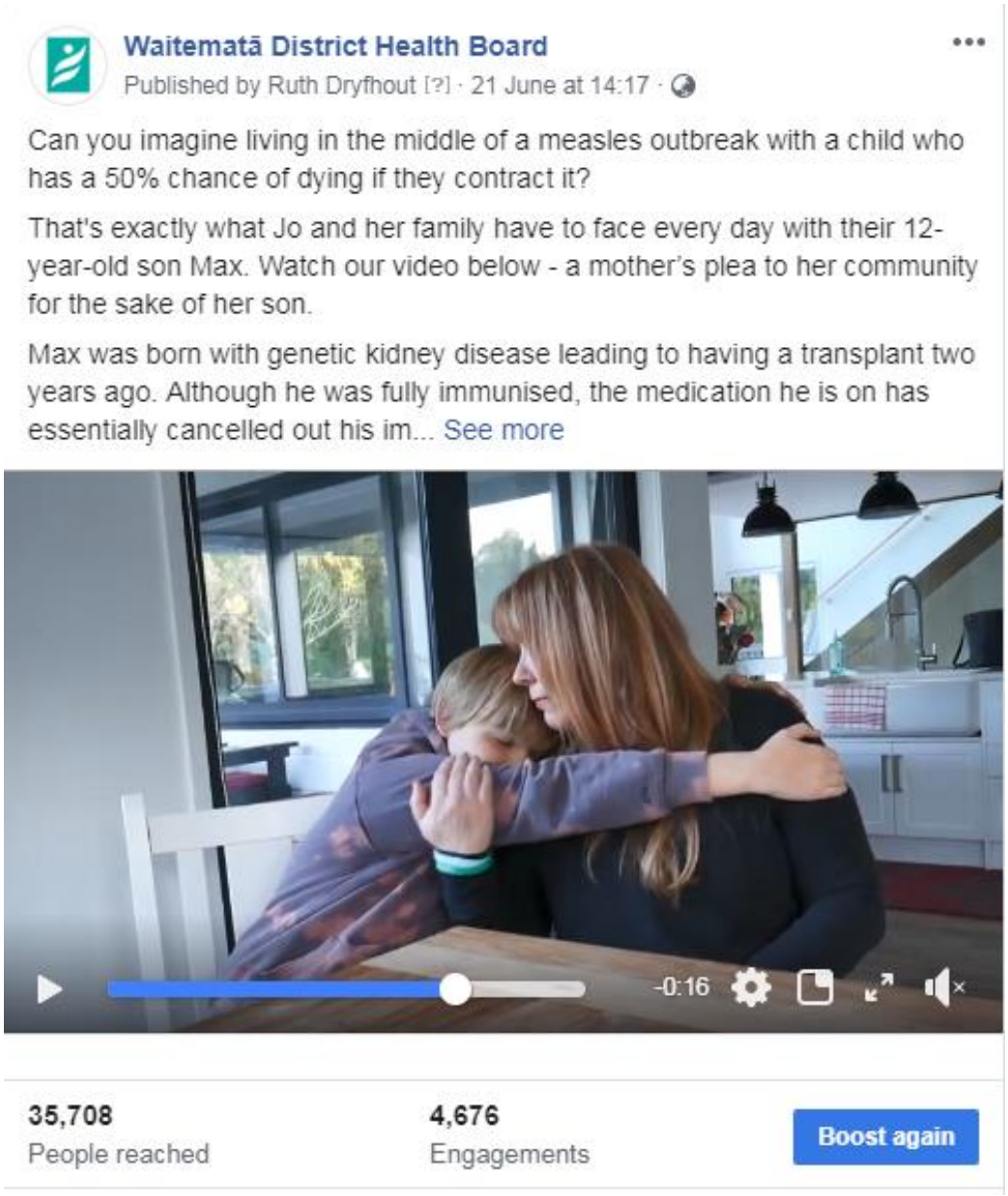
Total audience reach between 1 May 2019 and 31 May 2019 was 91,831 views.

Top three posts between 1 May 2019 and 31 May 2019:

1. **Measles patient story – Kaylee's measles story (Audience reach: 68,382 including 11,925 engagements)**



2. **Immunocompromised child measles story (Audience reach: 35,708 including 4,676 engagements)**



3. FOMO youth measles message (Audience reach: 35,871 including 4201 engagements)

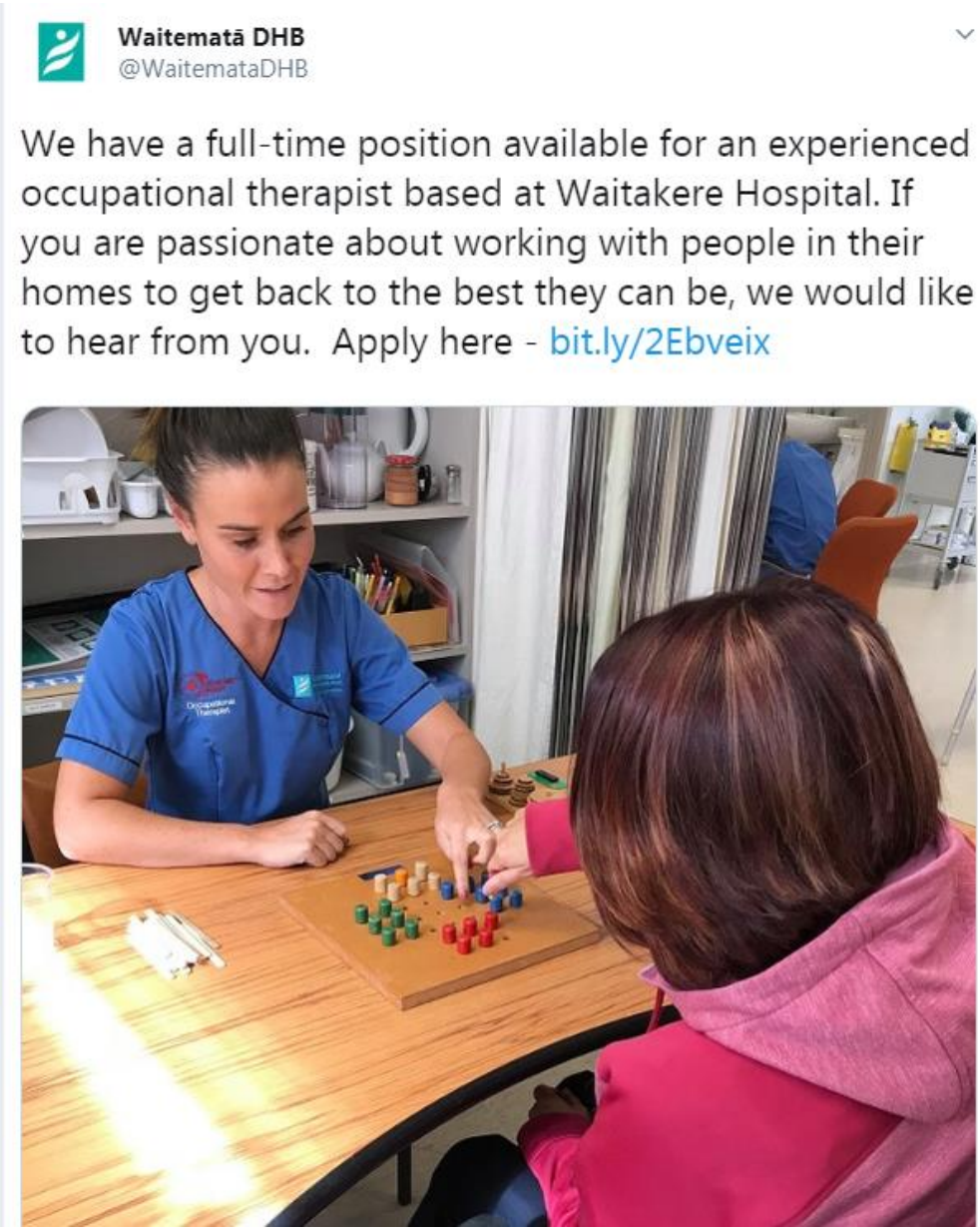
*As at 25 June 2019.

Twitter
Waitematā DHB Twitter followers have grown by 10.7% since May 2018, with 2,458 current followers* (2,220 followers as at May 2018).

Total audience reach between 1 May 2019 and 31 May 2019 was 23,800.

Top tweet between 1 May 2019 and 31 May 2019:

Career profile – Occupational therapists (1,863 reach)



*As at 25 June 2019.

OIAs received

A total of 27 new Official Information Act requests were received between 15 May and 25 June 2019:

- B. Keogh (Stuff) - Data regarding number of people who received publicly funded fertility treatment
- N. Akoorie (NZ Herald) - Information regarding Elective Surgery Centre including output figures, number of staff and remuneration
- M. Dobbyn (RDA) - Remuneration paid to employees and any costs incurred as a result of junior doctor strikes
- A. Wiggins (NZ Herald) - Information regarding unreturned / overdue medical equipment
- M. Earley (Stuff) - Number of patients who have died in past year in inpatient mental health units
- J. Chiang (Radio NZ) - Number of self-harm incidents at He Puna Waiora mental health unit in the last five years
- J. Whyte (APEX) - Details of sonographers employed by the DHB
- M. Osman - Details of clinical staff complaints and processing times for 2017-2019
- Private individual - Suicide statistics for patients in mental health care for the past five years
- M. Woodhouse MP (National Party) - Treasury assessment of Waitakere Hospital redevelopment
- L. Owen (RNZ) - Various questions re the operation of He Puna Waiora mental health inpatient unit
- A. Singh (FYI website) - Number of assaults on staff in 2018
- A. Singh (FYI website) - Number of mental health doctor vacancies in 2018 – 2019
- C. Broughton (Stuff) - Number of children assessed for sexual abuse for 2016 – 2018
- B. Burke (RNZ) - Volume and nature of letters issued to assist in the assessment of those in-need of housing and other social services
- H. McCarron (Mediaworks) - Annual cost of treatment for people ineligible for public healthcare
- G. Woodside (Prostate Cancer Foundation) - Wait times for prostate cancer consultation, biopsy and treatment options
- N. Akoorie (NZ Herald) - Average package-of-care rates for ESC surgical procedures
- S. Campbell (Pacifecon NZ Ltd) - Successful tenders for Mason Clinic infrastructure and programme business case-writers
- J. O'Callaghan (Stuff) - Questions regarding ethnic diversity
- K. Hellyer (Collingwood Health) - Information regarding primary health providers who have had contracts terminated for failing to achieve foundation standards
- B. Keogh (Stuff) - Eligibility criteria and wait times for publicly funded fertility treatment
- P. Pennington (Radio NZ) - Information regarding priority spending and cancer treatment
- E. Russell (NZ Herald) - Information regarding colonoscopies in relation to the National Bowel Screening Programme
- B. Fraser (FYI website) - Number of transgender patients referred to endocrine services
- A. Hudson (Healthwest) - Copy of Board's written minutes regarding NCHIP
- T. Page (TVNZ) - Cancer treatment wait times for the past six months

Media Clippings – 15 May – 25 June 2019

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

Page no.	**Listener New Zealand**	
14	Lessons from the heart	0
46	Facing up to suicide	-
66	'No one was willing to listen'	-

Page no.	**Mahurangi Matters**	
53	Too many chemists	0

Page no.	**North Shore Times**	
7	What's on: Volunteers needed	0
20	External review after two patients die	-
54	Student collaboration enhances patient care	+
58	Dad makes vaccination plea	+

Page no.	**North Harbour News**	
55	Student collaboration enhances patient care	+

Page no.	**NZ Doctor**	
27	Auckland husband-and-wife GP team says Ramadan month a spiritual boost	0
29	How health's planned plundering of Government's coffers is panning out	0
32	Northland GPs 'nervous' about broader approach of new PHO Mahitahi Hauroa	0
35	Primary care weight loss study	0
51	Prognosis good for Southern Cross' remote-access medical records app	0
70	Rural point-of-care testing programme passes the test, says Wellsford GP	+
71	There's always a bigger fish	0

Page no.	**NZ Herald / Weekend Herald**	
1	Mall rescue	+
4	Clark gets his teeth into dental care	+
6	Measles outbreak spikes to five-year high	0
11	Father's grief: Clinic warned before death	-
36	Mum slams reaction to measles	0
44	Family fears being 'ripped apart' by deportation	0
50	Squeeze on hospital parking	0

59	Care concerns in maternity units	0

Page no.	**Otago Daily Times**	
60	Most NZ maternity wards without onsite senior doctors at night	0
61	Risk in limited bowel screening results	0
65	Govt appoints Crown monitor to support Canterbury DHB	0

Page no.	**Pharmacy Today**	
48	Muted pharmacy optimism for ARRC plan but thumbs down from aged care	0

Page no.	**Rodney Times**	
21	What's on: Volunteers needed	0
40	Blood test saves teen	+

Page no.	**Sunday Star Times**	
37	'Why wouldn't people listen'	-
68	Bus fears	0

Page no.	**The Press, Christchurch**	
56	Cash crisis a risk to disability care	0
64	Cuts forecast as CDHB gets Crown monitor	0

Page no.	**Western Leader**	
2	Person in hospital after fire	0
24	What's on: Volunteers needed	0
42	Rural blood service saves teen's life	+

TOTAL:

Positive +	**8**
Neutral 0	**24**
Negative -	**5**
Total items	**37**

5.1 Financial Report for May 2019

Recommendation:

That the report be received.

Prepared by: Simon Watts (Deputy Chief Financial Officer), 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
DHB	-	District Health Board
ED	-	Emergency Department
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
PHO	-	Primary Health Organisation
RMO	-	Resident Medical Officer
SLA	-	Service Level Agreement

Background

The format and content of this report has been revised after consideration and recommendations from an EY review, in order to ensure we are meeting current best practice financial reporting standards. This month a new section has been included in the report (7. Clinical Activity) which highlights key operational activities that impact financial performance.

The report summarises the financial performance of the DHB for the YTD and month of May 2019. The report covers all operating units of the DHB, being the Funder Arm, Provider Arm and Governance.

At a DHB level, overall financial performance continues to improve with the forecasted deficit being revised down from the original $14.7m to $7.0m. The DHB is on track to achieve this revised target this financial year.

1. Executive Summary

1.1 Highlights

- $6.2m deficit for May 2019, $0.6m favourable to budget.
- $15.7m deficit YTD May 2019, $0.2m unfavourable to budget.
- $7.0m deficit forecast for 2018/19, in line with the budget.

The original forecast deficit of $14.7m has been revised down to a deficit of $7.0m due to improving financial performance. This impact has been the result of an improved forecast result in the Funder, offset by cost pressures within the provider. The net effect is an overall improvement in financial performance.

Key financial impacts on the Funder Arm include;

- Lower than planned demand, especially in pharmaceuticals.
- An assessment of certain provisions as at 30/06/2018, as recommended by Audit New Zealand.
- Lower than forecast IDF outflow.

Key financial impacts on the Provider Arm include;

- timing and cost of MECA settlements,
- industrial action impacting elective surgery,
- extraordinary winter acute demands,
- delays in the realisation of savings under the financial sustainability programme.

The financial sustainability programme has contributed savings of $9.3m against a plan of $11.1m, with delays in the implementation of some initiatives. Monthly updates on the programme are reported to the Audit and Finance Committee.

Looking ahead, the DHB has now engaged EY consultants to peer-review the current savings programme and work with the executive to assess potential areas of opportunity for efficiency gains and revenue generation. In the next financial year the financial sustainability programme will be tracked via the DHB's enhanced project management solution due to go live in July. A new programme manager was appointed in April to manage the programme, to provide guidance on individual projects and ensure momentum is maintained.

The financial position as at May 2019 indicates a net worth of $597.4m.
Refer to section 5.1 for a detailed statement of financial position.
Refer to section 5.3 for a detailed statement of cash flow.

1.2 Financial Indicators

Table 1: Financial Indicators for May 2019

FINANCIAL PERFORMANCE									
$ millions	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder Arm	4.4	0.5	3.9	22.8	12.7	10.1	35.7	14.7	21.0
Provider Arm	-11.0	-7.3	-3.7	-40.2	-28.2	-12.1	-44.5	-21.7	-22.8
Governance Arm	0.4	0.0	0.4	1.7	0.0	1.7	1.8	0.0	1.8
DHB Result : Surplus / (Deficit)	-6.2	-6.8	0.6	-15.7	-15.5	-0.2	-7.0	-7.0	0.0

FINANCIAL POSITION									
$ millions	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Crown Equity (net worth)	597.4	597.6	-0.2	597.4	597.6	-0.2	606.1	606.1	0.0
Capital Expenditure	2.8	3.1	0.3	21.1	31.7	10.6	24.7	34.5	9.8
Cash Flow Balance	29.4	23.6	5.7	29.4	23.6	5.7	38.6	10.7	27.9

CLINICAL ACTIVITY	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
ED Attendances	9,874	9,769	-105	104,699	101,457	-3,242	115,910	111,220	-4,690
Acute Volumes (WIES)	5,691	5,618	-73	60,349	60,712	363	65,396	66,149	753
Elective Volumes (WIES)	1,551	1,766	-215	15,933	16,801	-868	17,496	18,246	-750

ED (emergency department) attendance figures are per the activity volume report (AVR) excluding primary care voucher attendances

The unfavourble variances in ED Attendances reflects higher than planned presentations

The unfavourble variances in Acute Volumes (WIES) reflects a higher than planned acute demand

The negative variance in Elective Volumes (WIES) reflects under delivery

1.3 Financial Forecast 2018/19

Waitematā DHB forecast a $7m deficit by year end, a breakeven result against budget 2018/19.

The financial performance is anticipated to improve over the remaining months despite surgical pressures. This is due to the expected benefits of continued focus on financial management.

The operational outlook for the remaining months of the current financial year relate to on-going cost pressure notably in surgical services. There are also concerns around industrial action that may impact service delivery.

Key impacts on the year end forecast 2018/19:

- Revision of the 2018/19 Annual Plan from $8.7m to $7.0m
- Industrial action impacting elective services
- Higher than planned acute presentations in winter
- Delays in financial sustainability benefits
- MECA settlements.

2. Waitematā DHB Consolidated Financial Performance

2.1 Financial Result

Table 2: Waitematā DHB Consolidated Financial Result for the month ended May 2019

CONSOLIDATED FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	153,429	147,552	5,877	1,655,452	1,622,006	33,446	1,769,451
Other	3,113	2,520	592	26,922	27,044	-122	29,542
Total Revenue	156,541	150,072	6,469	1,682,375	1,649,050	33,324	1,798,993
EXPENDITURE							
Personnel	63,524	59,978	-3,546	626,737	607,721	-19,016	660,287
Outsourced Personnel	1,947	1,404	-543	19,597	14,614	-4,983	15,936
Outsourced Services	5,384	5,112	-272	58,105	57,049	-1,057	62,120
Clinical Supplies	12,109	11,120	-989	117,383	115,561	-1,822	126,344
Infrastructure & Non-Clinical Supplies	9,684	9,345	-340	105,292	108,206	2,914	111,574
Funder Provider Payments	70,091	69,869	-221	770,957	761,363	-9,594	829,732
Total Expense	162,738	156,828	-5,910	1,698,072	1,664,513	-33,559	1,805,993
DHB Result : Surplus / (Deficit)	-6,197	-6,755	559	-15,697	-15,463	-234	-7,000

2.2 Financial Performance May 2019

Revenue ($6.469m favourable)

- The favourable revenue variance includes MECA timing benefits offset by expenses, and revenue from PHARMAC rebates that are now accounted for as revenue relating to the new MoH Combined Pharmaceutical Budget (CPB) strategy. Up until December 2018 the rebates had been accounted for and budgeted as an offset in pharmaceutical expenditure. From January onwards the rebate has been accounted for as revenue (unbudgeted).

Expenditure ($5.910m unfavourable)

- Personnel costs are anticipated to track unfavourably to budget this year due to MECA impacts partially offset by additional funding support from the MoH, adjustments for the accrual of Holiday Pay provisions, and additional FTE appointments approved after the formation of the annual plan necessitated in order to maintain safe clinical services.
- Refer to section 3.0 for commentary on Funder Financial Performance.

2.3 Financial Performance YTD

Refer to section 3.0 for Funder Arm commentary on YTD financial performance.
Refer to section 4.0 for Provider Arm commentary on YTD financial performance.

Revenue ($33.324m favourable)
The favourable variance in the year to date was made up of:

- Funder revenue $19.7m favourable to budget.
- Governance revenue $0.4m unfavourable to budget.
- Provider revenue $14.0m favourable to budget.

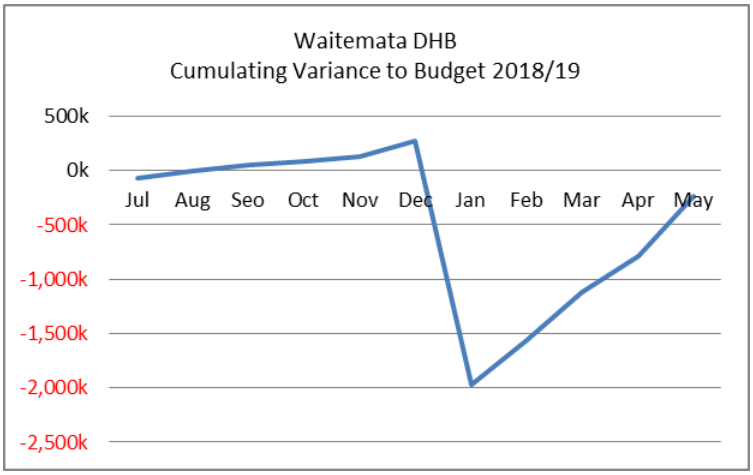
Expenditure ($33.559m unfavourable)
The unfavourable variance in the year to date was made up of:

- Funder expenditure $9.6m unfavourable to budget.
- Governance expenditure $2.1m favourable to budget.
- Provider expenditure $26.1m unfavourable to budget.

2.4 Trend in Financial Performance YTD

Figure 1: Cumulative Variance to Budget 2018/19

The movement in January reflects the revision of the 2018/19 Annual Plan from $8.7m to $7.0m.



3. Funder Arm Commentary On Financial Performance

3.1 Financial Performance: May 2019

The Funder Consolidated Core result variance was $3.93m favourable for the month and $10.13m 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 consisting mostly of community services providers. Approximately 80% of such services are demand based, delivered by means of a National Agreement, with little or no opportunity for individual DHBs to directly influence either the number of service providers and/or the number of patient presentations.

The Funder consolidated $10.13m favourable year to date position consists of a favourable Funder NGO variance of $7.57m, a favourable Funder Own Provider variance of $0.89m, a favourable Funder IDF variance of $1.67m and nil variance within Funder Governance. It is important to note that a significant component of Funder variances are in effect offsets resulting mostly from Ministry mandated strategies and changes introduced after DHB budgets have been confirmed. For example, the significant additional funding for MECA settlements was received after the final Ministry Funding Advice which results in a large revenue variance and an equivalent large expenditure variance when paid over to the Provider as required.

The table below summarises the key components of the Funder Core Result from a Revenue and Expenditure perspective and across the four Funder Divisions.

Table 3: Funder Arm Financial Performance

FUNDER & GOVERNANCE FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Funder NGO	48,203	44,218	3,985	504,592	486,396	18,195	530,614
Finder Own Provider	75,827	72,437	3,390	809,047	796,807	12,240	869,244
Funder IDF	26,162	26,152	11	288,306	287,667	639	313,818
Funder Governance	1,292	1,281	11	14,214	14,090	124	15,371
Total Revenue	151,485	144,087	7,397	1,616,158	1,584,959	31,199	1,729,047
EXPENDITURE							
Funder NGO	43,861	43,718	-143	484,326	473,696	-10,630	515,914
Finder Own Provider	75,667	72,437	-3,230	808,154	796,807	-11,347	869,244
Funder IDF	26,229	26,152	-78	286,631	287,667	1,035	313,818
Funder Governance	1,292	1,281	-11	14,214	14,090	-124	15,371
Total Expense	147,050	143,587	-3,463	1,593,325	1,572,259	-21,066	1,714,347
CORE RESULT							
Funder NGO	4,342	500	3,842	20,266	12,700	7,566	14,700
Finder Own Provider	160	0	160	893	0	893	0
Funder IDF	-67	0	-67	1,674	0	1,674	0
Funder Governance	0	0	0	-0	0	-0	0
FUNDER RESULT Surplus / (Deficit)	4,435	500	3,935	22,833	12,700	10,133	14,700

3.2 Total Funder Arm Revenue

The Funder consolidated total revenue variance was $7.40m favourable for the month and $31.20m favourable for the year to date. Most of this variance is a consequence of new and/or changes in Ministry initiatives introduced after budgets had been set and have equivalent expenditure variances that offset.

Funder NGO Revenue

Funder NGO revenue variance was $3.99m favourable for the month and $18.20m favourable for the year to date. The year to date variance consists of $4.69m favourable in baseline revenue, $0.07m favourable in CFA variations/contracts revenue and $13.44m favourable in Other Government revenue.

The $4.69m favourable YTD variance in baseline revenue is mainly due to the post budget funding by the Ministry for the Mental Health Pay Equity Settlement and the 2017-18 In Between Travel wash up, partially offset by a reduction in the 2018-19 In Between Travel wash up revenue.

The $0.07m favourable YTD variance in CFA/Contracts revenue is as a result of additional revenue for funding new Primary Health Initiatives relating to Zero Fees for Under 14s, Community Service Card holders and reduction in First Contact Care prices which is mostly offset by an adverse adjustment for Pay Equity on Home Based Support Services.

The $13.44m favourable YTD variance in Other Government revenue is mainly due to revenue received from PHARMAC relating to the new Ministry Combined Pharmaceutical Budget (CPB) strategy. DHBs are now receiving revenue from PHARMAC that is being funded out of what was previously budgeted and funded as CPB Drug rebate. This had previously been accounted for as a rebate offset in pharmaceutical expenditure but is now accounted for as revenue (post budget setting).

Funder Own Provider Revenue

The Funder Own Provider revenue variance was $3.39m favourable for the month and $12.24m favourable for the year to date. The year to date variance consists of a $3.19m favourable variance in baseline revenue, a $5.87m favourable variance in CFA variations/contracts revenue and a $3.18m favourable variance in Other Government revenue.

The $3.19m favourable YTD variance in baseline revenue is mainly due to the Mental Health component of MECA settlements.

The $5.87m favourable YTD variance in CFA variations/contracts revenue is mainly due to the Personal Health component of the MECA settlements and the Safe Nursing funding.

The $3.18m favourable YTD variance in Other Government revenue is related to the CPB policy change mentioned earlier and results from the unbudgeted Hospital Medicines rebate component of the CPB rebate now received as a combined rebate to the Funder rather than separately to the Provider Arm.

Funder IDF Revenue

The $0.64m favourable YTD variance in Funder IDF mostly relates to the 2017-18 National MOH IDF wash-up process which was settled in October 2018.

3.3 Total Funder Arm Expenditure

The Funder total net expenditure variance was $3.46m adverse for the month and $21.07m adverse for the year to date. The year to date expenditure variance consists of a $10.63m adverse in Funder NGO expenditure,

$11.35m adverse variance in Funder Own Provider expenditure, $1.04m favourable in Funder IDF outflow expenditure and $124k adverse in Funder Governance expenditure.

Of note and as previously explained, the most significant variance drivers within Funder have a converse, equivalent offset either between Funder divisions and/or between Funder revenue and Funder expenditure. As a consequence Funder revenue and expenditure variances can be relatively large but with little or no impact on the Funder Core Result. The main and underlying cause of such offsetting variances are Ministry funded strategies that are implemented after budgets have been finalised.

Funder NGO Expenditure

The $10.63m adverse YTD variance in Funder NGO expenditure is the net consolidated position across all services. The key adverse component of the variance is a consequence of Pharmaceutical expenditure and mostly driven by the previously explained PHARMAC/MOH CPB strategy. Budgeted CPB drug rebate funding that was budgeted as an offset (reduction) against Community Pharmacy expenditure now accounted for as revenue. This is a post budget change which results in a significant favourable revenue variance offset by an equivalent significant adverse expenditure variance.

This aside, the month and year to date variances are contributed to by the normally expected variations in business as usual factors across Funder NGO services. The business as usual variances mostly arise out of variations in demand/utilisation within Community Pharmacy, GP Demand, Age Related Residential Care (ARRC) and Primary Health Organisations (PHO) noting that these services constitute the most substantial component of Funder NGO expenditure.

As previously explained there are also the standard variances related to new Ministry Funded Initiatives expenditure (initiated after budgets had been set) that are offset by equivalent revenue variances and have a nil net impact on the core result. Funded initiatives variances include the variations in Pay Equity and new expenditure for Primary Health Initiatives relating to Zero Fees for Under 14s, Community Service Card holders and reduction in First Contact Care prices. Conversely also is the favourable impact relating to budgeted Funder NGO initiatives not yet contracted. Other factors influencing the NGO variances include adjustments in PHO expenditure related to patients and GPs moving between DHBs with the equivalent offsetting variances in IDF Outflows.

Funder Own Provider Expenditure

The $11.35m adverse YTD variance in Funder Own Provider expenditure mostly relates to the additional funding allocated (paid) to the Provider Arm for the NZNO Nursing Settlement, the PSA Nurses MECA Settlement, the PSA Allied MECA Settlement, Safe Nursing Funding and Capital Charge Revaluation 2018-19.

Funder IDF Expenditure

The $1.04m favourable YTD variance in Funder IDF expenditure mostly results from adjustments relating to the 2017/18 national IDF wash-up process.

4. Provider Arm Commentary on Financial Performance

4.1 Financial Statement

Table 4: Summary of Provider Arm Financial Performance for May 2019

PROVIDER ARM FINANCIAL PERFORMANCE							
$ 000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
Crown	77,651	75,902	1,749	847,932	833,854	14,078	909,648
Other	3,089	2,515	573	26,944	26,989	-45	29,482
Total Revenue	80,740	78,417	2,323	874,876	860,843	14,033	939,130
EXPENDITURE							
Personnel	62,519	58,852	-3,667	616,791	595,335	-21,456	646,775
Outsourced Personnel	1,739	1,156	-583	17,212	11,882	-5,330	12,955
Outsourced Services	5,167	4,649	-518	53,094	51,948	-1,146	56,555
Clinical Supplies	12,104	11,120	-984	117,350	115,560	-1,791	126,343
Infrastructure & Non-Clinical Supplies	10,195	9,897	-298	110,646	114,281	3,635	118,201
Total Expense	91,724	85,672	-6,051	915,093	889,006	-26,088	960,830
Provider Result : Surplus / (Deficit)	-10,984	-7,255	-3,729	-40,217	-28,163	-12,054	-21,700

Performance against the 2018/19 Annual Plan for the month of May shows a deficit of $11.0m which was unfavourable to a deficit budget of $7.3m, by $3.7m.

Performance against the 2018/19 Annual Plan for the YTD May shows a net deficit of $40.2m which was unfavourable to a net deficit budget of $28.2m by $12.1m.

4.2 Service Commentary on YTD result

Table 5: Provider Arm Financial Performance for May 2019 by Service

$000's	Direct Revenue YTD			Direct Expenditure YTD			Total
	Actual	Budget	Variance	Actual	Budget	Variance	Variance
PROVIDER ARM FINANCIAL PERFORMANCE YTD							
Acute & Emerg Medicine	3,704	3,283	422	135,877	130,266	-5,612	-5,190
Sub Specialty Med HOPS	7,792	8,384	-591	89,737	86,920	-2,816	-3,407
Surgical Services	8,463	7,568	895	166,481	164,429	-2,052	-1,157
ESC	0	0	0	25,310	25,490	180	180
Child, Women & Family	6,520	6,436	84	86,847	85,939	-908	-825
Mental Health	7,776	5,275	2,501	128,426	123,775	-4,651	-2,150
Corporate & Provider Support	840,620	829,897	10,723	282,416	272,187	-10,229	494
Total Provider	874,876	860,843	14,033	915,093	889,006	-26,088	-12,054

Acute and Emergency Medicine ($5.190m unfavourable YTD)
The unfavourable variance was due to premium cover costs for medical staff, additional sessions to shorten the patient waiting list, RMO strike cover cost by senior medical officers, extra beds and resources required to meet high winter demand and high watch costs. The service has a number of initiatives to get back on track including; flexing beds, managing staff turnover, a review of patient watches, nursing models of care in ED.

Specialty Medicine and Health of Older Persons Services ($3.407m unfavourable YTD)
The unfavourable variance was due to increased patient watches in the Kingsley Mortimer Unit, increased demands in District Nursing, and increased demand for mobility aids. The service has a number of initiatives to get back on track including a review of ACC events, and enhanced services for mobility aid managements.

Surgical and Ambulatory Services ($1.157m unfavourable YTD)
While tracking close to budget overall the service continues to benefit financially from additional revenues from orthopaedic ACC cases, and lower volumes due to the impact of industrial action and acute bed encroachment from medical services. Offsetting this, additional costs have been incurred with over-allocations of registrars, outsourced skin lesions, and unplanned repairs and maintenance costs. The service is facing cost pressures in the remaining months to ensure Elective Services Performance Indicators (ESPI) compliance, plans to deliver to plan on outsourced MRI and ultrasound scans, and unbudgeted outsourced costs to meet Interventional Radiology demands that exceed internal capacity.

Elective Surgery Centre (ESC) ($0.180m favourable YTD)
Three factors have reduced the capacity to deliver to plan and resulted in the favourable financial variance YTD; industrial action, acute bed encroachment at North Shore Hospital impacting ESC, and the holiday closure. This has resulted in lower costs. Offsetting this, the service has realised higher than budgeted non-volume related clinical supplies, e.g. repairs and maintenance, and minor purchases.

Child, Women and Family Services ($0.825m unfavourable YTD)
The unfavourable result YTD was the result of on-going patient demand driven cost increases across predominately Maternity (antenatal assessments and caesarean section activity) and Neonatal services involving use of external staffing resource and overtime to cover vacancies and roster gaps, cleaning outsourced costs, patient food and to a lesser extent increased maintenance costs in the mobile dental units and fixed dental facilities. These cost increases have been partly mitigated by service wide vacancies and an improved revenue position. The service remains focused on achieving its identified cost reduction initiatives. Examples of these being; the Auckland Regional Dental Services transition to an electronic based patient communication platform as part of the overarching Outpatient Flow Tool initiative (traditional postage to email), renegotiation of service contracts and product pricing reviews.

Specialist Mental Health and Addiction Services ($2.150m unfavourable YTD)
The unfavourable result YTD was due to the use of locums to cover medical vacancies and increasingly 'acute' caseloads. This is particularly the case in the Rodney region, both for adult and child and youth specialist psychiatrists. There remains a difficulty recruiting to nursing vacancies, again specifically in more specialist areas such as child and youth as well as intellectual disability. Also, vacancies in both the adult inpatient units and forensics are covered with overtime rates which are paid at a premium. To minimise vacancies, a Retention and Recruitment Committee continues to explore and implement initiative to attract and retain staff.

Corporate and Provider Arm Support Services ($0.494m favourable YTD)
Revenue is favourable $10.723m due to additional revenue from MoH for Care Capacity and Demand Management (CCDM), Capital Charge and MECA settlements, along with additional cost recoveries and includes additional interest income $434k and back-dated SLA in Primary Health Care Nursing for vaccination program at Auckland DHB $307k. Also contributing were favourable personnel costs due to vacancies along with risk pool provisions $431k; this was offset with unfavourable variances driven primarily by a lag in

implementing some of the financial sustainability initiatives and unfavourable expenditure in Facilities outsourced maintenance and consultants costs $1.395m. Overall the cost overspends in Facilities have improved and the financial result has remained closer to breakeven over the past five months.

5. Waitematā DHB Financial Position

5.1 Summary of Financial Position

Table 6: Summary financial position as at May 2019

$000's	31st May 2019			Apr-19	Variance to	Jun-18
	Actual	Budget	Variance	Actual	Last Month	Actual
Crown Equity	**597,430**	**597,615**	**(185)**	**603,626**	**(6,196)**	**613,126**
Represented by:						
Cash & Bank Balances	39,371	23,640	15,731	68,277	-28,906	29,078
Other Current Assets	106,084	81,309	24,775	95,319	10,765	63,872
Current Liabilities	-290,921	-252,370	-38,551	-302,612	11,690	-241,042
Net Working Capital	**-145,466**	**-147,421**	**1,955**	**-139,016**	**-6,450**	**-148,092**
Fixed Assets	729,511	734,017	-4,506	729,257	254	751,387
Long Term Investments in Associates	44,564	44,495	69	44,564	0	43,277
Term Liabilities	-31,179	-33,476	2,297	-31,179	0	-33,446
Total Employment of Capital	**597,430**	**597,615**	**-185**	**603,626**	**-6,196**	**613,126**

5.2 Financial Position Commentary

The Net Working Capital negative balance of $145.5m at 31 May 2019 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 considered unlikely as accrued entitlements tend to offset leave claims over time.

The Cash and Bank balance of $39.4m at 31 May 2019 was favourable by $15.7m against the budgeted cash balance of $23.6m. The favourable variance in cash is driven by:

- Higher than budgeted Crown revenue of $29.0m as a result of changes in Ministry initiatives introduced after budgets were set
- Timing differences in supplier payment phasing versus budget of $3.6m
- Timing of capital expenditure being incurred of $7.6m
- Offsetting the above favourable variances in cash flow is a ($15.8m) unfavourable variance in personnel payments driven due to MECA impacts, funded by the additional MoH revenue.
- The cash and bank balance of $39.4m at 31 May includes $10m in term deposits with HBL, maturity on 28-Jun-19.

5.3 Detailed Statement of Cash Flow

Table 7: Detailed Statement of Cash Flow as at May 2019

$000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Cash flows from operating activities:						
Inflows						
Crown	150,527	147,552	2,975	1,643,279	1,614,311	28,968
Interest Received	161	129	32	2,083	1,670	413
Other Revenue	-2,791	2,519	-5,310	23,808	31,428	-7,620
Outflows						
Staff	65,448	59,978	-5,470	620,510	604,666	-15,844
Suppliers	38,575	21,265	-17,310	222,813	226,414	3,601
Other Providers	70,090	70,122	32	770,957	771,336	379
Capital Charge	0	0	0	18,326	18,474	148
GST (net)	479	0	-479	1,272	639	-633
Net cash from Operations	**-26,695**	**-1,165**	**-25,530**	**35,292**	**25,880**	**9,412**
Cash flows from investing activities:						
Outflows						
Capital Expenditure	2,209	3,514	1,305	23,713	31,318	7,605
Investments	0	0	0	1,286	0	-1,286
Net cash from Investing	**-2,209**	**-3,514**	**1,305**	**-24,999**	**-31,318**	**6,319**
Cash flows from financing activities:						
Outflows						
Funds to Deposit	10,000	0	-10,000	10,000	0	-10,000
Net cash from Financing	**-10,000**	**0**	**-10,000**	**-10,000**	**0**	**-10,000**
Net increase / (decrease)	**-38,904**	**-4,679**	**-34,225**	**293**	**-5,438**	**5,731**
Opening cash	**68,275**	**28,319**	**39,956**	**29,078**	**29,078**	**0**
Closing cash	**29,371**	**23,640**	**5,731**	**29,371**	**23,640**	**5,731**
Closing Cash Balance in HBL Sweep acco	**29,371**	**23,640**	**5,731**	**29,371**	**23,640**	**5,731**

Note: In addition to the Closing Cash Balance of $29,371k, the DHB is holding a $10m deposit with BNZ through NZHPL. The closing cash forecast at 30th June 2019 is $38.6m.

Note: Other Revenue is negative $2,791k in the month due to an increase in accounts receivables

6. Statement of Capital Expenditure

Expenditure on the development of major capital programmes is assumed to be recouped from the Crown and as such is being funded from cash reserves outside of the capital envelope. The Portfolio Investment Committee continues to robustly prioritise all investment requests to ensure best value is achieved from the available capital budget.

Table 8: Summary of Capital Expenditure as at May 2019

$000's	Month			YTD			Full Year
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
Capital Expenditure							
Land	0	0	0	0	0	0	0
Buildings & Plant	1,725	1,351	-374	10,802	12,753	1,951	13,957
Clinical Equipment	617	1,102	485	5,426	12,124	6,698	13,227
Other Equipment	174	342	168	1,849	3,762	1,913	4,105
Information Technology	315	100	-215	2,547	400	-2,147	400
Motor Vehicles	0	230	230	447	2,614	2,167	2,844
Total Capital Expenditure	2,831	3,125	294	21,071	31,653	10,582	34,533

7. Clinical Activity

YTD ED attendances are 1.1% higher than this time last year.

YTD acute volume WIES are 1.0% higher than this time last year. The budget was set in anticipation of 2.9% increase. The lower than planned acute volumes (WIES) are despite the seasonal demands last winter.

YTD elective volume WIES are 5.3% less than this time last year. Lower than planned volumes are attributed to a difficult and challenging year, directly influenced by nursing and resident medical officer strikes, as well as a winter bed crisis which saw a combined total of over 300 postponed/cancelled elective procedures. This was coupled with an inability to recruit in the AIR and ORL services, which has contributed to a further 350+ lost discharges.

7.1 Clinical Activity Scorecard

Table 9: Clinical Scorecard for May

CLINICAL ACTIVITY	Month			YTD			Full Year		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
ED Attendances	9,874	9,769	-105	104,699	101,457	-3,242	115,910	111,220	-4,690
Acute Volumes (WIES)	5,691	5,618	-73	60,349	60,712	363	65,396	66,149	753
Elective Volumes (WIES)	1,551	1,766	-215	15,933	16,801	-868	17,496	18,246	-750

ED (emergency department) attendance figures are per the activity volume report (AVR) excluding primary care voucher attendances

The unfavourble variances in ED Attendances reflects higher than planned presentations

The unfavourble variances in Acute Volumes (WIES) reflects a higher than planned acute demand

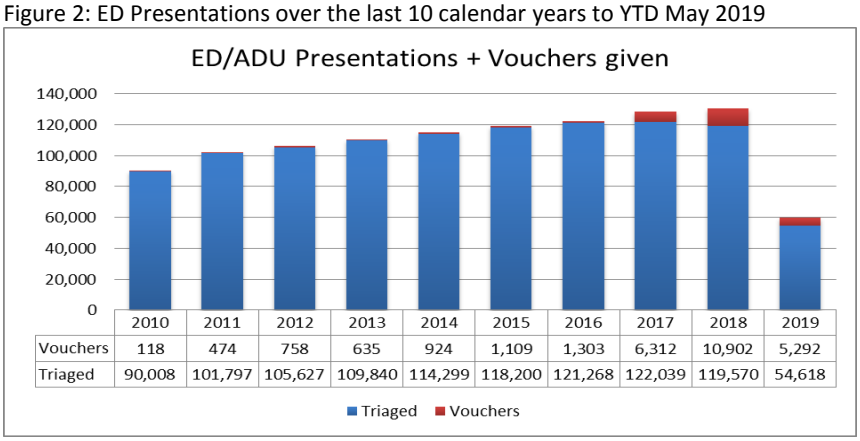
The negative variance in Elective Volumes (WIES) reflects under delivery

7.2 Highlighted this month: ED Presentations

ED presentations are a strong indicator of the demand on the hospital services. ED presentations provide a clear indication of the year on year growth in demand for hospital services.

Figure 2 below highlights the DHBs success in stemming growth in ED presentations in the last two years through the implementation of the primary care voucher system.
Issued vouchers have increased from 1,303 to 10,902 since 2017.
While this initiative have been very successful it is noted that the average acuity of patients within ED has increased over the same period due to the lower numbers of Triage 4-5 (lower acuity) patients.

Figure 2: ED Presentations over the last 10 calendar years to YTD May 2019



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Vouchers	118	474	758	635	924	1,109	1,303	6,312	10,902	5,292
Triaged	90,008	101,797	105,627	109,840	114,299	118,200	121,268	122,039	119,570	54,618

6.1 Statement of Performance Expectations (SPE) Performance Report: Quarter Three 2018/19

Recommendation:

That the report be received.

Prepared by: Lily Yang (Reporting Analyst, Auckland and Waitematā DHBs)
Endorsed by: Executive Leadership Team (Waitematā DHB), Karen Bartholomew (Acting Director Health Outcomes, Auckland and Waitematā DHBs) and Wendy Bennett (Planning and Health Intelligence Manager, Auckland and Waitematā DHBs)

Glossary

CPHAC	-	Community and Public Health Advisory Committee
HAC	-	Hospital Advisory Committee
HQSC	-	Health Quality and Safety Commission New Zealand
SIR	-	Surgical intervention rate
SLM	-	System level measure
SPE	-	Statement of Performance Expectations
YTD	-	Year-to-date

1. Introduction

This is a regular quarterly report of the indicators in the Statement of Performance Expectations (SPE), a key component of the Annual Plan (Section 3). SPE measures represent the outputs or activities we deliver to meet our Annual Plan goals and objectives, and provide a reasonable representation of the vast scope of business-as-usual services we provide. These performance measures help to assess the quantity, quality, coverage and timeliness of service delivery. Actual performance against these measures is published in our Annual Report and audited by Audit NZ.

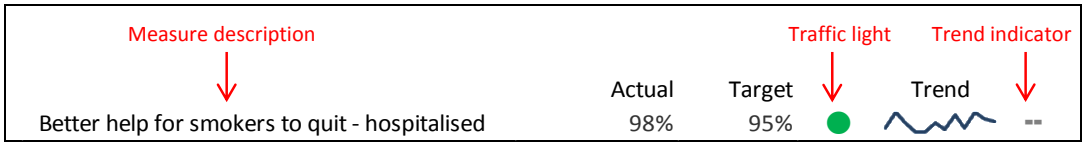
The measures in this report reflect those in the 2018/19 Annual Plan. This report excludes indicators that measure volumes without a specified target or those for which data is available only annually.

Waitematā DHB achieved three and was close to achieving the other five Health Targets in Q3. Five of the seven Health Quality and Safety Commission indicators were achieved, as well as a large number of the SPE indicators. Key areas of focus include cervical cancer screening, influenza vaccination in Māori and Pacific aged 0-4 years and hospitalised for respiratory illness, Primary Care enrolment in Māori, non-urgent diagnostic colonoscopy within 42 days, and diagnostic CT and MRI scans completed within 6 weeks.

How to Interpret the Scorecards

Traffic lights

For each measure, the traffic light indicates whether the actual performance is on target for the reporting period (or previous reporting period as indicated by the ***grey bold italic*** font).



The traffic light colours align with the Annual Plan (with the HQSC exceptions, listed below):

Traffic light	Annual Plan criteria: relative variance actual vs. target	Interpretation
●	On target or better	Achieved
●	0.1–5% away from target	Substantially achieved but off target
●	5.1–10% away from target and improvement from previous reporting period	Not achieved, but progress made
●	>10% away from target or 5.1–10% away from target and no improvement from previous reporting period	Not achieved

HQSC criteria are applied wherever possible (these measures are labelled with '*'):

Traffic light	HQSC criteria: thresholds are set by HQSC		Interpretation
●	Upper better	Varies with each indicator	Achieved
●	Middle group	Varies with each indicator	Not achieved but near target
●	Lower group	Varies with each indicator	Not achieved

Trend lines and trend indicators

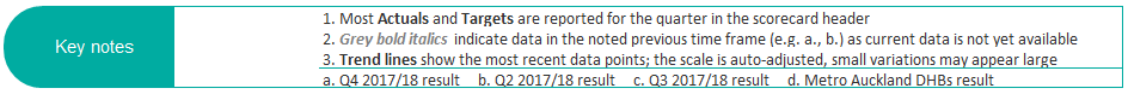
A trend line and a trend indicator are reported against each measure. Trend lines represent the available data for the latest 12-month period. All trend lines use auto-adjusted scales, and small variations may appear to be large.

YTD measures (e.g. Green Prescriptions, B4 School Checks) are cumulative by definition, and their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

Trend indicator	Rules	Interpretation
▲	**Current > Previous** quarter (or reporting period) **performance**	Improvement
▼	**Current < Previous** quarter (or reporting period) **performance**	Decline
--	**Current = Previous** quarter (or reporting period) **performance**	Maintained

By default, the performance criteria is the actual:target ratio. However, in some exceptions (e.g. when target is 0 and when performance can be negative i.e. net result), the performance reflects the actual.

Scorecard-specific notes are provided beneath each scorecard:



SPE scorecards: Quarter three 2018/19

Metro Auckland DHBs Performance Scorecard - Health Targets and key indicators

Quarter 3, 2018/19

	Auckland DHB			Waitemata DHB			Counties Manukau DHB		
Health Targets	Actual	Target	Trend	Actual	Target	Trend	Actual	Target	Trend
Shorter stays in EDs	93%	95%	▲	96%	95%	▲	86%	95%	▼
Improved access to elective surgery	93%	100%	--	106%	100%	▲	98%	100%	▼
Faster cancer treatment - within 62 days	92%	90%	▼	88%	90%	▼	76%	90%	▼
Increased immunisation at age 8 months (total)	94%	95%	▼	92%	95%	--	92%	95%	▼
Better help for smokers - Primary Care	87%	90%	▼	87%	90%	▼	88%	90%	▼
Better help for smokers - Maternity	97%	90%	▼	89%	90%	▼	94%	90%	▼
Raising healthy kids	100%	95%	--	100%	95%	--	100%	95%	--
Key indicators	Actual	Target	Trend	Actual	Target	Trend	Actual	Target	Trend
PHO-enrolled smokers with cessation support	30%	28%	▼	34%	31%	--	23%	25%	▼
a. Breast screening coverage	*63%*	*70%*	--	*65%*	*70%*	--	*72%*	*70%*	▲
a. Cervical screening coverage	*64%*	*80%*	▼	*71%*	*80%*	--	*69%*	*80%*	▼
Preschoolers enrolled in DHB oral health services	83%	95%	▼	96%	95%	▲	80%	95%	--
a. Surgical intervention rate (SIR) - major joints	*18.8*	*21.0*	▼	*22.7*	*21.0*	▼	*23.0*	*21.0*	▼
a. SIR - cataracts	*45.0*	*27.0*	▲	*43.0*	*27.0*	▲	*44.9*	*27.0*	▲
a. SIR - cardiac surgery	*5.2*	*6.5*	--	*5.5*	*6.5*	--	*5.7*	*6.5*	▲
a. SIR - percutaneous coronary revascularisation	*12.2*	*12.5*	▲	*16.1*	*12.5*	▲	*12.8*	*12.5*	▲
a. SIR - coronary angiography	*31.3*	*34.7*	▼	*42.1*	*34.7*	▼	*29.8*	*34.7*	▲
Urgent diagnostic colonoscopy in 14 days	92%	90%	▼	96%	90%	▼	100%	90%	▲
b. Opportunities for hand hygiene taken*	*86%*	*80%*	▲	*89%*	*80%*	▼	*87%*	*80%*	--
b. Hip/knee operations given prophylactic antibiotic*	*98%*	*100%*	▲	*97%*	*100%*	▲	*93%*	*100%*	▼
a. 0-19 Mental Health waiting within 3 weeks	*63%*	*80%*	▼	*76%*	*80%*	--	*70%*	*80%*	▼
a. 0-19 Mental Health waiting within 8 weeks	*79%*	*95%*	▼	*95%*	*95%*	--	*91%*	*95%*	▼
a. 0-19 Addictions waiting within 3 weeks	*90%*	*80%*	▼	*91%*	*80%*	--	*98%*	*80%*	--
a. 0-19 Addictions waiting within 8 weeks	*99%*	*95%*	--	*99%*	*95%*	--	*100%*	*95%*	--

Waitemata DHB Performance Scorecard - Statement of Performance Expectations

Quarter 3, 2018/19

Output Class 1: Prevention Services

	Health promotion	Actual	Target	Trend
a.	Pregnant smokers referred to incentives programme (YTD)	*76*	*166*	▼
	Clients engaged with Green Prescriptions (YTD)	3,619	4,050	▲
	Immunisation			
a.	Pertussis vaccination in pregnancy	*52%*	*50%*	--
a.	Flu vaccine in 0-4 yo hospitalised for respiratory illness	*14.8%*	*15.0%*	▲
a.	- Māori	*8.9%*	*15.0%*	▲
a.	- Pacific	*7.6%*	*15.0%*	▲
	Increased immunisation at age 8 months (Māori)	87%	95%	▼
	Population-based screening			
a.	Bowel screening - correctly completed kits returned	*61%*	*60%*	▼
a.	- Māori	*58%*	*60%*	▼
a.	- Pacific	*44%*	*60%*	--
a.	- Asian	*52%*	*60%*	▼
a.	- Other	*64%*	*60%*	▼
	Bowel screening - referred for colonoscopy within 45 days	95%	95%	--
	B4 School Checks completed (YTD)	68%	68%	▲
a.	Chlamydia testing in 15-24 yo	*11%*	*15%*	
	Auckland Regional Public Health Service			
c.	Tobacco retailer compliance checks conducted (YTD)	369	150	▲
c.	Tuberculosis treatments with a recorded start date	92%	90%	▼
c.	By-protocol initial contact for high risk enteric disease	87%	90%	▲

Output Class 2: Early Detection and Management

	Primary health care	Actual	Target	Trend
	Primary Care enrolment rate (Māori)	78%	90%	▼
	POAC referrals (YTD)	10,001	8,108	▼
	CVD risk assessed w/in 5 years (Māori)	85%	90%	--
a.	Māori with prior CVD prescribed triple therapy	*60.1%*	*58.5%*	▲
a.	Pacific with prior CVD prescribed triple therapy	*63.4%*	*61.9%*	▼
a.	ASH rate per 100,000 in 45-64 yo - Māori	*7686*	*<7311*	▼
a.	ASH rate per 100,000 in 45-64 yo - Pacific	*11363*	*<10633*	▼
a.	ASH rate per 100,000 in 45-64 yo - COPD	*202*	*<170*	▼
a.	ASH rate per 100,000 in 45-64 yo - CHF	*116*	*<121*	▲
a,c.	PHO-enrolled population with login access to a portal	*23%*	*20%*	▲
c.	Practices participating in patient experience survey	90%	90%	
	Patient experience survey response rate - Māori	13.5%	14.1%	▲
	Patient experience survey response rate - Pacific	7.5%	6.7%	▼

Output Class 3: Intensive Assessment and Treatment

	Acute services	Actual	Target	Trend
a.	ED admissions 'unknown' to be alcohol related (10-24 yo)	*65%*	*<10%*	▲
a.	Eligible stroke patients thrombolysed	*6.1%*	*10.0%*	▼
	ACS patients with coronary angiography in 3 days	80%	70%	▲
	Elective (inpatient/outpatient)			
	Non-urgent diagnostic colonoscopy in 42 days	49%	70%	▼
	Patients waiting >4 months for FSA (ESPI 2)	*Non-compliant*		
	CTs completed within 6 weeks	71%	95%	▼
	MRIs completed within 6 weeks	70%	90%	▼
	Quality and patient safety (HQSC)			
a.	Staph bacteraemia rate per 1,000 inpatient bed days	*0.07*	*<0.11*	▼
a.	Older falls risk patients with an individualised care plan*	*96%*	*90%*	▼
a.	#NOF from falls per 100,000 admissions (rolling 12 m)	*13.5*	*<8.4*	▲
b.	Hip/knee procedures given right antibiotic in right dose*	*99%*	*95%*	▲
b.	Surgical site infections per 100 hip and knee operations	*0.00*	*<0.93*	▲
	Mental health			
a.	Mental health service access (age 0-19 years)	*3.8%*	*3.5%*	▼
a.	Mental health service access (age 20-64 years)	*3.6%*	*3.4%*	--
a.	Mental health service access (age 65+ years)	*2.1%*	*2.0%*	--

Output Class 4: Rehabilitation and Support Services

	Home-based support	Actual	Target	Trend
a.	HBSS clients with clinical interRAI and care plan	*99%*	*95%*	--
	Palliative care			
	Hospice patient deaths that occur at home	36.1%	32.5%	▲
	Referrals that wait >48 hours for a hospice bed	23%	<5%	▼

Traffic light criteria

- Achieved; target met
- Substantially achieved; 0.1 to 5% variance from target
- Not achieved, but progress made; 5.1% to 10% variance from target
- Not achieved; >10% variance from target

*** HQSC criteria**
- Upper group
- Middle group
- Lower group

Key notes

1. Most **Actuals** and **Targets** are reported for the quarter in the scorecard header
2. *Grey bold italics* indicate data in the noted previous time frame (e.g. a., b.) as current data is not yet available
3. **Trend lines** show the most recent data points; the scale is auto-adjusted, small variations may appear large

a. Q2 2018/19 result b. Q1 2018/19 result c. Metro Auckland DHBs result

Health Targets

Scorecard Variance Report

Indicator	On target	Variance commentary
1. Shorter stays in EDs	✓	
2. Improved access to elective surgery	✓	
3. Faster cancer treatment – within 62 days	✓	
4. Increased immunisation at age eight months	✓	
5. Better help for smokers – Primary Care	✓	
6. Better help for smokers – Maternity	✓	
7. Raising healthy kids	✓	

Key Indicators

Scorecard Variance Report

Indicator	On target	Variance commentary
8. PHO-enrolled smokers with cessation support	✓	
9. Breast screening coverage	✘	Although the number of women screened in the past five quarters increased in all ethnicities and the total population, the screening rate for Māori and total trended down over the last three years, with a steadier rate in Pacific. The data match initiative to invite and recall Māori women through the Māori health pipeline is progressing, with project protocols agreed; implementation is expected next quarter, although it is dependent on availability of the National Enrolment Service (NES) database.
10. Cervical screening	✘	Coverage rates declined in all ethnicities in the 3 years to Dec 2018, although the number of screens remained stable, with a small increase from 117,564 (in the 3 years to Dec 2015) to 120,423 (in the 3 years to Dec 2018), suggesting that the level of activity delivered may not be keeping pace with population growth. The Cervical Screening Coordination Service continues to work with Primary Care, Independent Service Providers and the National Cervical Screening Programme to improve engagement with cervical screening, with a focus on quality improvement and screening opportunities for Māori and Pacific women.

Indicator	On target	Variance commentary
11. Pre-schoolers enrolled in DHB oral health services	✓	
12. Surgical intervention rate (SIR) – major joints	✓	
13. SIR – cataracts	✓	
14. SIR – cardiac surgery	✗	Our service provider is Auckland DHB. We continue to work closely with Auckland DHB to assess and plan prioritisation for cardiothoracic surgery. Auckland DHB CVICU saw a high number of ECMO patients with extended LOS in November and December, which placed pressure on the service's ability to deliver elective cardiac surgery. The service insourced cases throughout this period to manage waitlist growth. The service continues good communication with regional stakeholders and the opening of four regional cardiology beds at Auckland City Hospital to improve equity of access for regional patients is working well.
15. SIR – percutaneous coronary revascularisation (angioplasty)	✓	
16. SIR – coronary angiography	✓	
17. Urgent diagnostic colonoscopy in 14 days	✓	
18. Opportunities for hand hygiene taken	✓	
19. Hip and knee operations given prophylactic antibiotic	✗	Although 100% of patients receive prophylactic antibiotic at the right time, due to clinical priority, documentation of this is on occasion delayed and is reflected in the result against this indicator. The anaesthesia team is currently reviewing this for future improvements.
20. Mental Health waiting within three weeks in 0-19 year olds	✓	
21. Mental Health waiting within eight weeks in 0-19 year olds	✓	
22. Addictions waiting within three weeks in 0-19 year olds	✓	
23. Addictions waiting within eight weeks in 0-19 year olds	✓	

Output Class 1: Prevention Services

Scorecard Variance Report

Indicator	On target	Variance commentary
Health promotion		
24. Pregnant smokers referred to incentives programme (YTD)	✘	Referrals are generally fewer in December, contributing to a lower result for the quarter. The DHB-employed midwives will soon start using an opt-off approach to refer pregnant women who smoke to stop smoking services (i.e. unless a woman objects, she will be referred to the stop smoking service). Self-employed Lead Maternity Carers are also encouraged to use this approach.
25. Clients engaged with Green Prescriptions (YTD)	✘	The provider increased their engaged clients and achieved 100% of their quarterly target in Q3, by increasing their community promotional activities for self-referrals; these will continue in Q4. However, due to low numbers of engaged clients in Q1 and Q2, they are at 89% of the year-to-date target.
Immunisation		
26. Pertussis vaccination in pregnancy	✓	
27. Flu vaccine in 0-4 year olds hospitalised for respiratory illness – total	✓	
28. Flu vaccine in 0-4 year olds hospitalised for respiratory illness - Māori	✘	The overall uptake of flu vaccine for eligible children has increased. PHOs met and identified a need for further education on the importance of this vaccine in this population for practices and the general public. There will be an increased focus on practice-level follow-up to support Māori and Pacific uptake in 2019.
29. Flu vaccine in 0-4 year olds hospitalised for respiratory illness – Pacific	✘	
30. Increased immunisation at age 8 months (Māori)	✘	Our tamariki Māori coverage fell this quarter and reflects the national trend of coverage below the herd immunity threshold for several diseases. We are collaborating with PHOs on strategies to improve coverage and with our Treaty partners to explore ways to better engage Māori with immunisation. New promotional material to increase on-time immunisation was tested with consumers and is being finalised for release. Collaboration with Plunket for an additional outreach immunisation service is focused on Māori and Pacific babies.

Indicator	On target	Variance commentary
Population-based screening		
31. Bowel screening – correctly completed kits returned (total) 32. Bowel screening – correctly completed kits returned (Māori) 33. Bowel screening – correctly completed kits returned (Pacific) 34. Bowel screening – correctly completed kits returned (Asian) 35. Bowel screening – correctly completed kits returned (Other)	✓ ✓ ✖ ✖ ✓	We continue with activities designed to raise awareness and promote the benefits of screening, focusing on priority populations. • Māori and Tongan health promoters participate in a wide range of community events and meetings, including targeting Tongan churches • The inflatable bowel attracted excellent attention at Māori and Pacific events • Distribution of promotional postcards with Māori/Pacific art work; Asian artwork to be developed next quarter • Findings from the research into people who participate only once are being used to develop initiatives • The trial of follow up calls to people who asked for a test kit continues • Voice overs in Asian languages were recorded for the 'how to do the test kit' video on the MoH website • A trial of text message reminders from GPs will begin next quarter
36. Bowel screening – referred for colonoscopy within 45 days	✓	
37. B4 School Checks completed (YTD)	✓	
38. Chlamydia testing in 15-24 year olds	✖	At a population level, screening rates appear to have dropped when compared with the same time last year and after a period of gradual increase over time. This needs further monitoring to understand if there is a data quality issue or a real decline. While the target of 15% coverage is not achieved for the total population (in Metro Auckland DHBs), it is achieved for females alone, at 18%.
Auckland Regional Public Health Service		
39. Tobacco retailer compliance checks conducted (YTD)	✓	
40. Tuberculosis treatments with a recorded start date	✓	
41. By-protocol initial contact for high risk enteric disease	✓	

Output Class 2: Early Detection and Management

Scorecard Variance Report

Indicator	On target	Variance commentary
Primary health care		
42. Primary Care enrolment rate (Māori)	✘	A joint project between Planning Funding and Outcomes, the Māori Health provider, Primary Care and PHOs is under development. Exploratory data analyses are underway, including data matching to ascertain PHO enrolment in maternity services, ED admissions, hospitalisations and for specified services and conditions. The purpose is to develop a facilitated PHO enrolment process for Māori whānau who access hospital services and are not enrolled with a PHO. A Māori data oversight group is being established following agreement by Māori providers to share data. The facilitated enrolment project will engage all major players across the sector to ensure PHO enrolment is captured at multiple points (community to hospital services) and that facilitated enrolment occurs when non-enrolment is identified.
43. Primary Options for Acute Care (POAC) referrals (YTD)	✓	
44. CVD risk assessed within 5 years (Māori)	✘	The main cause for this decline is a result of the significant number of people receiving a CVD risk assessment during July to September 2014 to achieve the 90% target in 2014, who are now due for their next assessment. It is expected that performance will improve as PHOs and general practices work to achieve this target.
45. Māori with prior CVD prescribed triple therapy	✓	
46. Pacific with prior CVD prescribed triple therapy	✓	
47. ASH rate per 100,000 in 45-64 year olds – Māori	✘	A key focus will be on improving primary care diagnosis recording for CVD and other long-term conditions so that interventions in Primary Care can be monitored appropriately.
48. ASH rate per 100,000 in 45-64 year olds – Pacific	✘	
49. ASH rate per 100,000 in 45-64 year olds – chronic obstructive pulmonary disease (COPD)	✘	
50. ASH rate per 100,000 in 45-64 year olds – congestive heart failure (CHF)	✓	

Indicator	On target	Variance commentary
51. PHO-enrolled population with login access to a portal	✓	
52. Practices participating in patient experience survey	✓	
53. Patient experience survey response rate – Māori	✓	
54. Patient experience survey response rate – Pacific	✓	

Output Class 3: Intensive Assessment and Treatment

Scorecard Variance Report

Indicator	On target	Variance commentary
Acute services		
55. ED admissions 'unknown' to be alcohol related (10-24 year olds)	✘	Work is underway to improve the quality of data captured.
56. Eligible stroke patients thrombolysed	✘	Afterhours patients with clinically likely strokes who call an ambulance are diverted to Auckland City Hospital for acute treatment and are reported in the Auckland DHB thrombolysis rates.
57. ACS patients with coronary angiography in three days	✓	
Elective (inpatient/outpatient)		
58. Non-urgent diagnostic colonoscopy in 42 days	✘	We experienced increased inflows this quarter vs. the same period last year. Capacity was reduced in December-January, due to public holidays, SMO leave and withdrawal of labour by junior doctors. In addition, our outsourcing provider was closed for 4 weeks. Work led by the Director of Hospital Services and the endoscopy leadership group to review demand management strategies and improve internal production was successful in producing consistently high utilisation and low DNA rates. The first of two additional Fellows was appointed in December. Our March result of 48.5% compliance for P2 <42 days is 10.2% higher than that on 1 February, and is the highest since December. The number of people waiting for a gastroscopy and colonoscopy peaked at 2,980 in January 2019; this has since reduced to 2,658, which is our lowest since mid-July 2018.

Indicator	On target	Variance commentary
59. Waiting >4 months for FSA (ESPI 2)	✖	Volumes are down due to a number of factors, including industrial action. We are not ESPI 2 (or ESPI 5) compliant and are developing a recovery plan to meet ESPI treatment times.
60. CTs completed within 6 weeks	✖	Following a decrease in production over the Christmas/New Year period, production increased as planned in February and March. Additional outsourcing occurred in February, although issues with private providers resulted in this not having the expected impact on compliance. Outsourcing is planned for the remainder of 2018/19 and the new CT scanner is planned to address the shortfall of internal capacity from the end of June 2019. Fourteen patients waited outside 147 days and all were outsourced. Of these, two patients no longer required their scan, one patient did not attend the appointment, and 11 patients have now received their scans.
61. MRIs completed within 6 weeks	✖	Following the drop in production over the Christmas/New Year period, production increased as planned in February and March. Increased outsourcing commenced in February and staffing levels also improved. This contributed to the steady increase in compliance rate. Two patients waited outside the 147 days; one patient has now received their scan, the second patient was a complex case that required multiple attempts at contacting the patient, who now resides in another DHB.
Quality and patient safety (HQSC)		
62. Staph bacteraemia rate per 1,000 inpatient bed days	✓	
63. Older falls risk patients with an individualised care plan	✓	
64. Fractured NOF from falls per 100,000 admissions (rolling 12 months)	✖	Work continues as part of the quality and safety initiatives to improve practice so there is reduced chance of falls with harm or development of pressure injuries. Staff are aware of key practices to assess risk and the recommended key preventative actions. Staff education continues. We signed up with ACC to be part of a national pressure injury collaborative.

Indicator	On target	Variance commentary
65. Hip and knee procedures given right antibiotic in right dose	✓	
66. Surgical site infections per 100 hip and knee operations	✓	
Mental health		
67. Mental Health service access (age 0-19 years)	✓	
68. Mental Health service access (age 20-64 years)	✓	
69. Mental Health services access (age 65+ years)	✓	

Output Class 4: Rehabilitation and Support Services

Scorecard Variance Report

Indicator	On target	Variance commentary
Home-based support		
70. HBSS clients with clinical interRAI and care plan	✓	
Palliative care		
71. Hospice patient deaths that occur at home	✓	
72. Referrals that wait >48 hours for a hospice bed	✖	The result is primarily due to the closure of the overnight IPU at Hospice West Auckland; patients are managed with a day stay and increased home care, or transfer to another hospice. The majority of transfers to another hospice are completed within 48 hours.

7. Resolution to Exclude the Public

Resolution:

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

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

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1.	**Minutes of Meeting of the Board - Public Excluded (29/05/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2.	**Minutes of the Special Meeting of the Board - Public Excluded (26/06/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**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.
3.	**Minutes of the Audit and Finance Committee – Public Excluded (19/06/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **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)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
4.	**Minutes of the Hospital Advisory Committee – Public Excluded (19/06/19)**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**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.	**Chair's Report**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
6.	**healthAlliance C Class Share Issue**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
7.	**Living Wage**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)] **Commercial Sensitivity** The disclosure of information would not be in the public interest because of the greater need to protect information where the making available of the information would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information. [Official Information Act 1982 S.9 (2) (b)

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
8.	**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. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
9.	**Funding for ARPHS**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence. [Official Information Act 1982 S.9 (2) (ba)]
10.	**Wilson Centre - New Lease and Development Agreement**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
11.	**Cash Flow**	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	**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)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
		Schedule 3, S.32 (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)]
12.	**Elective Capacity and Inpatient Beds (ECIB) Initiation Works**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
13.	**Interventional Radiology Update**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)]
14.	**Procurement Update**	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S.9 (2) (i)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

	General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
15.	**Legal 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)]	**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)]