Open Board Meeting

Wednesday, 07 December 2016

10:00am

Note:

- **Public Excluded Session 10:00am to 12 noon**
- **Open Meeting from 12:45pm**

A+ Trust Room
Clinical Education Centre
Level 5
Auckland City Hospital
Grafton

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Published 1 December 2016

Agenda
Meeting of the Board
07 December 2016

Venue: A+ Trust Room, Clinical Education Centre
Level 5, Auckland City Hospital, Grafton

Time: 9:45am

Board Members	**Auckland DHB Executive Leadership**	
Dr Lester Levy (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Fiona Barrington	Change Director
Doug Armstrong	Karen Bartholomew	Acting Director of Health Outcomes – AHB/WDHB
Michelle Atkinson	Margaret Dotchin	Chief Nursing Officer
Judith Bassett	Joanne Gibbs	Director Provider Services
Zoe Brownlie	Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
James Le Fevre (Deputy Board Chair)	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Lee Mathias	Fiona Michel	Chief Human Resources Officer
Robyn Northey	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Sharon Shea	Rosalie Percival	Chief Financial Officer
Gwen Te Pania - Palmer	Linda Wakeling	Chief of Intelligence and Informatics
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

9.45am **Karakia and Mihimihi**
Welcome for the new Board

Apologies Members:

Apologies Staff: **Joanne Gibbs**

Agenda

Please note that agenda times are estimates only

9:50am **1. ATTENDANCE AND APOLOGIES**

2. REGISTER OF INTEREST AND CONFLICTS OF INTEREST

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?

9:55am	**3.**	**MINUTES 26 OCTOBER 2016**
	4.	**HEALTH AND SAFETY - NIL**
	5.	**ACTION POINTS 26 OCTOBER 2016 - NIL**
10:00am	**6.**	**CHIEF EXECUTIVE'S REPORT**
	6.1	Chief Executive's Report
10:10am	**7.**	**PERFORMANCE REPORTS**
	7.1	Financial Performance Report
	7.2	Funder Update Report
10:30am	**8.**	**COMMITTEE REPORTS**
		Manawa Ora
	8.1	Youth Connection Pledge
	9.	**DECISION REPORTS**
10:35am	9.1	2017/2018 Annual Plan Approach
10:40am	9.2	Statement of Performance Expectations (SPE) Reporting
10:45am	9.3	2015/2016 Quality Account
10:50am	9.4	Conflict of Interest Policy Approval
10:55am	9.5	Strategic Relationship between the District Health Boards and the Accident Compensation Corporation
11:00am	9.6	Establishment of Executive Committee of the Board During Holiday Recess
11:05am	9.7	Appointment of Chair for Hospital Advisory Committee and Finance, Risk and Assurance Committee – verbal report from Board Chair
	10.	**DISCUSSION PAPERS**
11:10am	10.1	A Value of Care Approach to Auckland DHB – A Discussion Document
11:20am	10.2	Auckland DHB Programme Management Update on EPMO Development, Programme Identification and Definition
11:30am	**11.**	**INFORMATION PAPERS**
	11.1	Auckland Water Supply – Update
	11.2	International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs
11:45am	**12.**	**GENERAL BUSINESS**
	13.	**RESOLUTION TO EXCLUDE THE PUBLIC**

PLEASE NOTE: THE PHOTOGRAPHER IS AVAILABLE TO TAKE INDIVIDUAL AND BOARD PHOTOGRAPHS

Next Meeting:	Wednesday, 22 February 2017 at 9:45am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

Members	17 Feb. 16	30 March.16	11 May. 16	22 Jun. 16	03 Aug. 16	07 Sep. 16	26 Oct. 16	07 Dec. 16
Lester Levy (Chair)	1	1	1	1	1	1	1	
Joanne Agnew	1	1	1	1	1	1	1	
Peter Aitken	1	1	1	1	1	1	1	
Doug Armstrong	1	1	1	1	1	1	1	
Judith Bassett	1	1	1	x	1	1	1	
Zoe Brownlie	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Chris Chambers	1	1	1	1	1	1	1	
James Le Fevre	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Lee Mathias (Deputy Chair)	x	1	1	1	1	1	1	
Robyn Northey	1	1	1	1	1	1	1	
Morris Pita	1	1	1	1	1	1	1	
Gwen Tepania-Palmer	1	1	1	x	1	1	1	
Sharon Shea	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Ian Ward	1	1	1	1	1	1	1	
		Key: 1 = present, x = absent, # = leave of absence						

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An "interest" can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being 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 duties under the Act then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the 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.

IMPORTANT

If in doubt – declare.

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

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

Register of Interests – Board

Member	Interest	Latest Disclosure
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman – Counties Manukau District Health Board Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Leader reviewer –review of MBIE. Review to be completed late 2016/early 2017 Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	17.11.2016
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board	01.12.2016
Michelle ATKINSON	Evaluation Officer – Counties Manukau District Health Board	10.11.2015
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare (no personal beneficial interest as it is held through a Trust) Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter is a partner – Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	10.10.2016
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Group Daughter is a shareholder of Westpac Banking Group	13.07.2015
Zoe BROWNLIE	Community Health Worker – Auckland DHB	04.11.2016
James LE FEVRE	Emergency Medicine Specialist - Adult Emergency Department, Auckland DHB Fellow - Australasian College for Emergency Medicine - FACEM Member - Association of Salaried Medical Specialists Shareholder - Pacific Edge Diagnostics Ltd Trustee - Three Harbours Health Foundation Wife - Medicolegal advisor, Medical Protection Society	01.12.2016

Lee MATHIAS	Chair - Counties Manukau Health Deputy Chair - Auckland District Health Board Chair - Health Promotion Agency Chair - Unitec Acting Chair - Health Innovation Hub Director - Health Alliance Limited Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships	11.05.2016
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation	24.08.2016
Sharon SHEA	Principal - Shea Pita Associates Ltd Contracted to Manaia PHO – delivery of workforce development training Provider - Maori Integrated contracts for Auckland and Waitemata DHBs Provider – Ministry of Health National Results Based Accountability training for Maori health organisations Provider – Plunket outcomes implementation framework Member - Children's Action Plan Directorate Advisory Group Safe Communities Foundation NZ – Work on pilot outcomes framework Project member - Te Runanga o Te Rarawa Outcomes Project Provider - multiple management consulting projects for Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua Husband - Part owner Turuki Pharmacy Ltd, Auckland Husband - Board member - Waitemata DHB	01.12.2016
Gwen TEPANIA-PALMER	Board Member - Manaia PHO Chair - Ngati Hine Health Trust Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Member - Health Quality and Safety Commission	01.12.2016

Minutes
Meeting of the Board
26 October 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 26 October 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:45am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Lester Levy (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Simon Bowen	Director of Health Outcomes – Auckland DHB/Waitemata DHB
Peter Aitken	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Judith Bassett	Dr Debbie Holdsworth	Director of Funding – Auckland DHB/Waitemata DHB
Dr Chris Chambers	Fiona Michel	Chief Human Resources Officer
Dr Lee Mathias (Deputy Chair)	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Robyn Northey	Rosalie Percival	Chief Financial Officer
Morris Pita	Linda Wakeling	Chief of Intelligence and Informatics
Gwen Tepania-Palmer	Dr Margaret Wilsher	Chief Medical Officer
Ian Ward		
	Auckland DHB Senior Staff Present	
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES (Page 4)

That the apology of Executive Leadership Team member, Sue Waters, Chief Health Professions Officer be received.

2. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 5-10)

Resolution: Moved Lee Mathias / Seconded Peter Aitken

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand 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 item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Confirmation of Confidential Minutes 7 September 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding

1.1 Confirmation of Circulated Resolution – Starship Children's Hospital Upgrade Projects – Construction Contract Approval	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Action Points 7 September 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety Performance Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.2 Presentation – Journey of Incidents through the Management and Reporting System	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982

	protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	[NZPH&D Act 2000]
5.1 Provider Arm Recovery Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Orthopaedic Update	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 2015/2016 Annual Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Business Case – Improving Adult Acute Flow at Auckland Hospital Level 2, AED Redesign	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 All of Government Electricity Contract	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982

	prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	[NZPH&D Act 2000]
8.3 Detailed Capital Expenditure Budget for 2016/2017	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.4 Amended Delegated Authority Policy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.5 Audit of PHOs – Qualification of Statement of Performance	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.6 Contract Extension for Taxis	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Human Resources Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official	That the public conduct of the whole or the relevant part of the meeting would be likely to result in

	Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Annual IEA Increases	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.3 At Risk Performance Pay Component	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.4 Chief Executive's 2015/2016 Remuneration Review	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Eating Disorder Supra Regional Services – Implications of and Response to Midland Proposal to Exit	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.2	**Commercial Activities** To enable the Board to carry out,	That the public conduct of the

Regional Working Arrangements – Clarifying roles, Accountabilities and Working Arrangements for Regional Groups	without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Primary Maternity Facility	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 Commercial Agreement with IBM re National Infrastructure Platform	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.3 New Zealand Health Innovation Hub Ltd – Stakeholder Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.4 After Hours Update	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	gain or advantage [Official Information Act 1982 s9(2)(k)]	
11.5 healthAlliance NZ Limited – Resolution in Lieu of AGM	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
12.1 Board Resolution Status – Quarterly Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

3. CONFLICTS OF INTEREST(Pages 11-13)

There were no conflicts of interest with any item appearing on the open agenda.

4. CONFIRMATION OF MINUTES 07 SEPTEMBER 2016 (Pages 14-23)

Resolution: Moved Judith Bassett / Seconded Gwen Tepania-Palmer

That the minutes of the Board meeting held on 07 September 2016 be confirmed as a true and accurate record.

Carried

5. HEALTH AND SAFETY

5.1 Rehabilitation Policy (Pages 24-47)

Ailsa Claire, Chief Executive Officer asked that the report be taken as read.

Matters covered in discussion of the policy and in response to questions included:

- Chris Chambers commented that he was concerned with the use of the word/s "appropriate" and "as appropriate" throughout the document and thought that a different description should be used.
- Lee Mathias thought that the policy was good, but too long and could be simplified.

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the Board required adjustments to the Rehabilitation of Staff Policy based on feedback provided which related to simplification of the policy resulting in a reduction of length and the use of a different descriptor for the word "appropriate" throughout the policy. Once these changes had been made the policy could be released for approval under circulated resolution to the Board.

Carried

6. ACTION POINTS 7 SEPTEMBER

There were no current action points to report on.

7. CHIEF EXECUTIVE'S REPORT

7.1 Chief Executive's Report (Pages 49-61)

Ailsa Claire, Chief Executive asked that her report be taken as read highlighting as follows:

- The passing of Dave Davies, former CEO of Waitemata DHB from 2006-2011 and expressing Auckland DHBs condolences to the family of Dave Davies.
- As part of the commitment to alleviate food poverty in Auckland DHBs neighbourhoods, senior management are exploring ways for Auckland DHB staff to donate non-perishable food items to the Auckland City Mission at regular intervals throughout the year (including Christmas as part of the Ka pai whānau programme).
- This year approximately 340 people across the organisation achieved milestones of 20, 30, 40 and even 50 years of service. Their commitment was acknowledged at three Long Service Events held on 10 and 11 October.
- Finalists for the 2016 Health Excellence Awards will be announced at the end of October. More than forty applications have been received across five categories. Winners will be announced at the 2016 Health Excellence Awards evening on 1 December at the Auckland Museum.
- A staff musical performance, "The Committed", will take place on 12 and 13 December, tickets are now available.
- The National Health Targets Performance Summary in general is looking good although, "improved access to elective surgery" should be showing red in the graph on page 57 of the agenda.
- On 12 October, Electronic Prescribing and Administration, (ePA) went live in the Awatea ward in Older People's Health. The project has had excellent clinical engagement and is a key digital health initiative to improve medication chart legibility, reduce transcription errors, improve communication between departments, provide real-time clinical decision support and easier access to information, and faster fulfilment of prescriptions. ePA is a national priority and

Auckland DHB is the fifth DHB in New Zealand to implement the solution.

Matters covered in discussion of the report and in response to questions included:

- Lester Levy advising that while the CEO report was very good, he had discussed with Ailsa Claire a confidential report to enable a shift in focus to clinical issues and not merely activities occurring across the District Health Board.

That the Chief Executive's report for October 2016 be received.

Carried

8. PRESENTATIONS

8.1 Nurses Rising to the Challenge

Margaret Dotchin, Chief Nursing Officer made a presentation "Nurses Rising to the Challenge" (see attachment 8.1).

Margaret summarised her presentation saying that it was an attempt to demonstrate the required shift from illness based care to patient led care that was being implemented at Auckland DHB. It was a care pathway that aligned with the New Zealand strategy and is coordinated around patient's wants and needs. This is being achieved by building skill flexibility within the nursing workforce, particularly in the area of nurse practitioners and RN expanded practice enabling different service delivery models to be employed.

Matters covered in discussion of the presentation and in response to questions included:

- Acknowledgement by the Chair of the contribution that these innovations within the nursing workforce were making to improved patient care.
- Gwen Tepania-Palmer acknowledged in particular, the progress that had been made with the continued focus on increasing the Maori and Pasifika nursing workforce.
- Morris Pita echoed Gwen's sentiments in relation to the Maori and Pasifika nursing workforce and endorsed in general the strategy employed of, "growing" people. Morris commented that there were 34 Maori and Pasifika nursing graduates now and asked what the numbers might look like in the future. He was advised that it would continue to grow as long as the model of care was carefully managed. Opportunities existed in the areas of Long Term Conditions and Primary Care for good nurse practitioners.

  Margaret Wilsher added that with simulation and good team work, opportunities existed to have junior doctors simply be what they should be, trainees, and allow the nurse practitioners to work to advanced and expanded scope.

That the presentation, "Nurses Rising to the Challenge" be received.

Carried

9. PERFORMANCE REPORTS

9.1 Financial Performance Report (Pages 62-68)

Rosalie Percival, Chief Financial Officer asked that the report be taken as read.

There were no questions.

That the Board receives the Financial Performance Report for September 2016

Carried

9.2 Funder Update Report (Pages 69-90)

Debbie Holdsworth, Director Funding asked that the report be taken as read.

Matters covered in discussion of the presentation and in response to questions included:

- Agreement that a deep dive report on the Tamaki Locality would be prepared for the new Board.

That the Board receives the October 2016 Funder Update report.

Carried

10. DECISION REPORTS

There were no decision reports to consider.

11. DISCUSSION PAPERS

11.1 Auckland DHB Strategy Supports New Zealand Health Strategy Themes (Pages 91-93)

Andrew Old, Chief of Strategy, Participation and Improve asked that the report be taken as read.

Matters covered in discussion of the report and in response to questions included:

- Comment from the Board Chair that this was a very good detailed depiction of alignment of the seven Auckland DHB strategic themes to those in the New Zealand Health Strategy. It would be beneficial in the future to have a higher level simplified view.

Resolution: Moved Morris Pita / Seconded Ian Ward

That the Board:

1. **Note the initial examples of District Health Board activity against the five national**

strategic themes

2. **Note how the Auckland DHB strategic themes align and support the New Zealand Health Strategy**
3. **Note that quarterly reporting to the Ministry of Health must now include information on District Health Board activity that progresses the New Zealand Health Strategy.**

Carried

12. GENERAL BUSINESS

There was none.

The meeting closed at 1.55pm.

Confirmed and signed as true and correct record of the Board meeting held on Wednesday, 26 October 2016 by the Chairperson and Chief Executive under Standing Order 2.12.2.

Chair: _____ Date: _____
Lester Levy

Chief Executive: _____ Date: _____
Ailsa Claire

Chief Executive's Report

Recommendation

That the report be received.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 17 October-18 November, 2016. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

2.1.1 Ministerial Visits

Minister Coleman is expected to visit Auckland DHB on Friday 9 December to meet with newly appointed and elected board members who take office on 5 December.

2.1.2 Thai Ministry of Public Health

The Thai Ministry of Public Health visited on 15 November, kindly accommodated by the Auckland Regional Public Health Service and the Faculty of Medical and Health Sciences, Auckland University. The visit, to study public health/medical curriculum development and delivery, was at the request of Crown agent, Education New Zealand.

2.2 DHB Board

Welcome to all appointed Board members which are expected to be announced by the Minister on Thursday 1 December. They will join the seven elected members who are Jo Agnew, Douglas Armstrong, Michelle Atkinson, Judith Bassett, Zoe Brownie, Lee Mathias, and Robyn Northey.

2.3 Patient and Community

2.3.1 Communication cards

A range of communication cards have been produced featuring a set of icons patients can use if they are having difficulty communicating their immediate needs, wants or concerns.

Patients, families, clinical staff and the Interpreting service have helped determine the icons that they believe will be the most useful for patients. The cards, designed by the Design for Health and Wellbeing Lab, have been translated into 11 languages.

2.3.2 Changes to our patient letters

From Thursday 1 December, the paragraph in our patient letters about changing or cancelling appointments will be printed in six languages - Māori, Tongan, Samoan, Hindi, Chinese and Korean. This will be determined by the language loaded in our patient information system (CMS) and whether the patient requires interpreting services.

This initiative was developed as part of a Greenbelt project this year aimed to reduce DNAs (patients who don't attend their appointments) within Gynaecology Services, specifically for Pacific women. As a result, this new initiative is now being rolled out across all our patient letters with the exception of those services which are still requesting an appointment confirmation. With the goal of enabling patients to better understand how to contact us about their appointment time when they need to.

2.3.3 Email enquiries

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 103 emails were received. Thirty-three were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2.4 External and Internal Communications

2.4.1 External

We received 75 requests for information, interviews or for access from media organisations between 17 October-18 November. Media queries included requests for information about how services were affected during the RMO industrial action, comment on Auckland DHB's serious adverse event (suicide) rate, and requests to interview Dr Jan Sinclair on Severe Combined Immunodeficiency (SCID) screening and Dr Ian Dittmer on kidney transplantation.

Approximately 30 per cent of the enquiries over this period sought the status of patients admitted following road accidents and other incidents or who were of interest because of their public profile.

The DHB responded to 18 Official Information Act requests over this period.

2.4.2 Internal

- Two CE blog posts were published, one talking about *Speak Up Kaua ē patu* and one about *amazing people doing amazing work.*
- 20 news updates were published on the DHB intranet.
- 6 eNova (weekly electronic newsletters) were published.
- An '*In the know*' session took place on 28 October, with approximately 85 managers attending.
- The refresh of the DHB intranet (internal resource) soft-launched 7 November. The new intranet is providing a much better managed approach to information with a more powerful search function. The steering committee have authorised moving to full launch in December.

2.4.3 Events and Campaigns

Tāmaki Mental Health & Wellbeing

The Tāmaki Mental Health & Wellbeing Team facilitated a pōwhiri and blessing of the name Awhi Ora at Ruapotaka marae. The community gathered to express appreciation and were touched to hear from one of the kuia, who was "closer to 90 than 89", about how much it meant to her that we were really working in partnership with the community.

Starship 25th Anniversary

On 18 November we wished Starship a happy 25th birthday. The day was a great opportunity to thank everyone in Starship for the care and service they provide to young patients around the country.

We did this through a cake cutting celebration at Starship where young patient Lesieli Ungatea Vea helped cut the cake and a mobile photo booth which roved around taking photos of our 'Starship Stars'. Anniversary celebrations continue throughout the year and to mark this, the Starship Foundation has launched a special website www.starshipbirthday.co.nz

A very special thank you to Amelia Ferrier who made the gorgeous cake to celebrate Starship's 25th birthday.

Amelia has a business called Melies Kitchen and her mum Lisa (pictured with her) was a nurse in Starship on the day the hospital opened on 18 November 1991. All three of her children have been Starship patients.

Auckland City Mission

As reported to Board last month, as part of our commitment to alleviate food poverty in our neighbourhood Auckland DHB staff are donating non-perishable food items to the Auckland City Mission at as part of our *Ka pai whānau* programme to support the Mission's Santa's Helpers Appeal.

We are hoping to donate one item for all 10,000 staff, and all staff are being encouraged to take part to really make a difference. The campaign was started early at the end of November. Starship patient Kenzie was in the atrium with her parents at the time, and asked to help put a gift under the tree.

A group of Auckland DHB volunteers will also be on hand at the Vector Arena on Christmas Day to entertain, feed and co-ordinate hosting several thousand Aucklanders.

The Christmas gifts collected at Auckland DHB will be given to children on the day.

Sustainability

Fast Facts on Sustainability at Auckland DHB

EECA partnership	Auckland DHB are partnering with EECA in a three year programme to implement energy efficiency measures at Auckland DHB sites. This will see the introduction of an energy monitoring system which means that we will be able to track our energy consumption and view our energy data live. This will allow us to see what our high energy consumers are and then implement energy saving projects around these.
CEMARS Rating	Auckland City Hospital and Greenlane Clinical Centre have successfully completed the annual requirements of CEMARS (Certified Emissions Measurement And Reduction Scheme) certification, and that our carbon emission has been reduced by 13% from last year's emissions. This savings is equivalent to driving from Auckland to Wellington in an average size car 31,999 times or the volume of 1032 Olympic swimming pools.
PVC Recycling 	Through our PVC recycling programme, to date we have prevented 1350kg of PVC from becoming landfill.
Inorganic Waste 	We have started a very successful inorganic waste recycling programme at our sites. This means inorganic items, such as clinical equipment, furniture, metal and computer equipment are being recycled. Before any items are recycled they are checked to see if the item can be fixed and put back into circulation. If not it is either sold, donated or reduced to scrap and recycled.
Lifts Upgrade Project	As part of our energy saving projects we are undertaking lift renewal projects which will see new lifts and lifts which need to be upgraded equipped with green technology such as high efficiency motors and regenerative braking. This has already started at Starship Children's Hospital, with services lifts in Building 1 at Auckland City Hospital starting early next year.

To continue on our sustainability journey we have reached out to connect with the wider community and organisations to share their insights at a series of Sustainability Forums.

In October, Rod Oram, journalist and broadcaster shared his thoughts on sustainability, and in November Dr David Galler and Debbie Wilson shared Counties Manukau Health's sustainability journey.

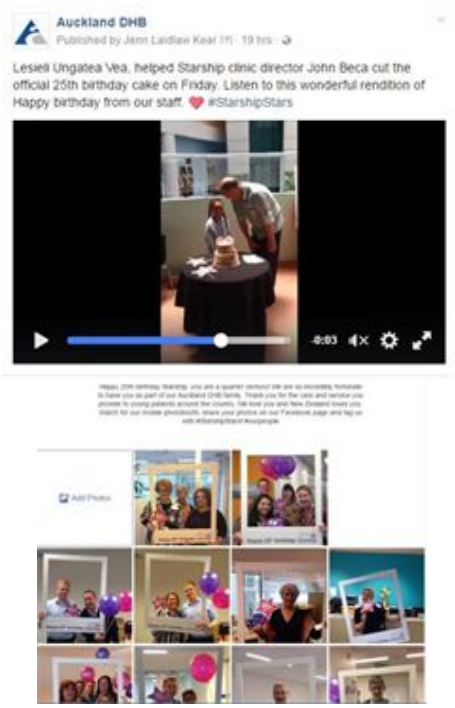
2.4.4 Social Media

Facebook likes: 4,145
Twitter followers: 2,713
LinkedIn followers: 5,363
Instagram followers: 148

Feature Campaign - #StarshipStars

We had a mobile photo booth visit staff at Starship, Auckland Hospital and Greenlane, taking photos of our staff celebrating and wishing Starship a happy 25th birthday. 90 photos were shared in a Facebook photo album and on our website. Many of these were also posted to Twitter, LinkedIn and Instagram.

To date, we reached a potential audience of more than 15,000 with an 18% engagement rate for this campaign. (High engagement rate for corporate/organisational social media accounts is +2%).



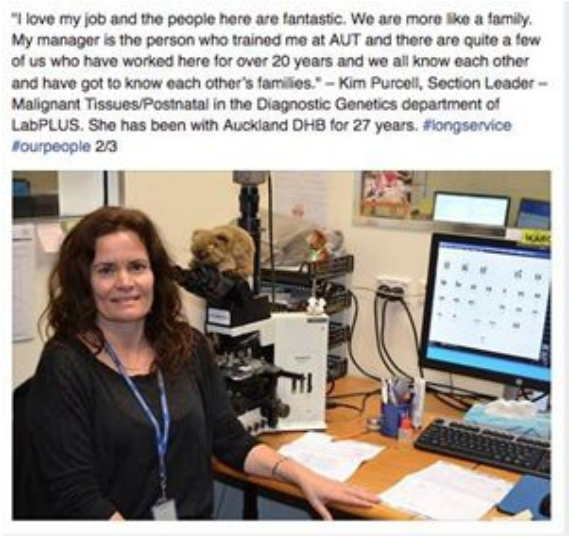
Feature Post – Antibiotic Awareness Week

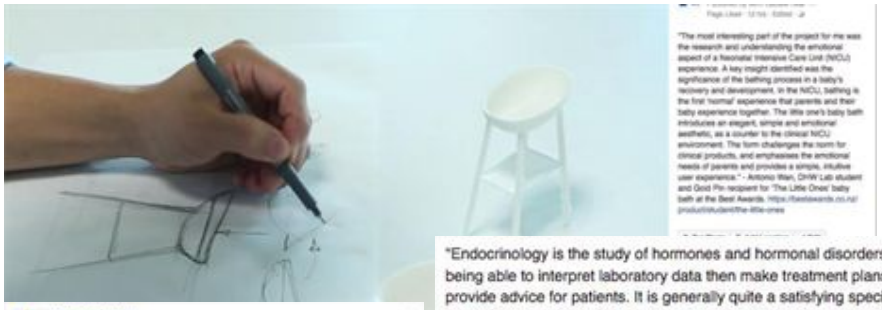
This single post reached a potential audience of more than 10,000 with an engagement rate of 4%. It was shared across our social media channels more than 60 times.

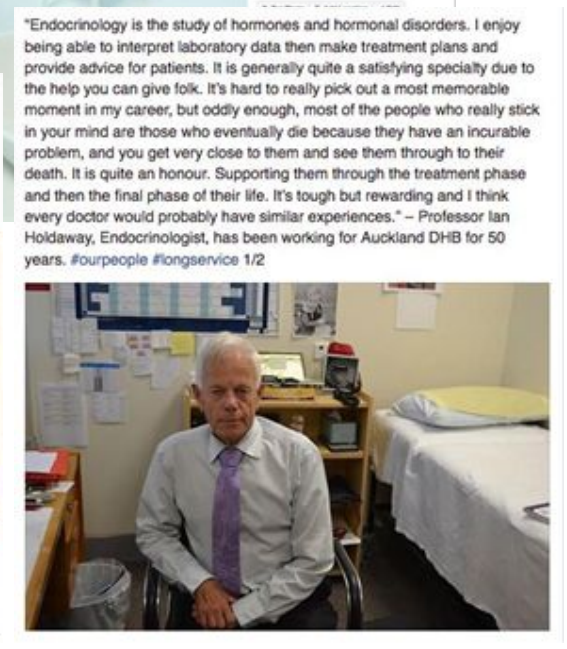
Most popular posts:

Our people

- Design Lab Best Awards
- LabPlus Careers Day staff profiles
- Trevor, a Blue Coat volunteer receiving a special thank you.
- Long Service Award – three staff profiles

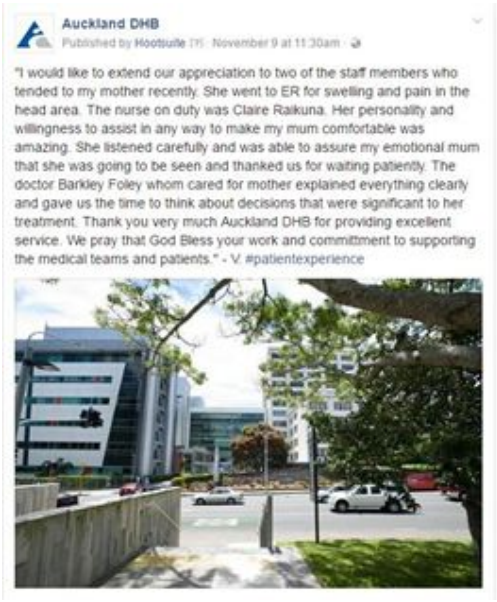






Patient experience

- #patientexperience letters



Public health alert or education

- Health Literacy Month - we are posting one item from Health Navigator's A-Z every day this month, upcoming grand round.
- Health Excellence Grand Round – colour & contrast
- Ministry of Health – free vision checks for children

Campaigns

- Stoptober
- Baby Loss Awareness Week
- Advance Care Planning Conference
- Patient Safety Week
- Diabetes Action Month
- Movember
- Rheumatic Fever

Recruitment

- Weekly round-up of new job postings

2.4.5 Our People

Employee survey

Auckland DHB's employee survey closed 13 November. Total participation rate was 57% and with some departments having more than 90% participation.

Local Heroes

32 people were nominated for Local Hero awards in September and October.

Manish Khanolkar was chosen as our October local hero. The patient who nominated Manish said: "I was admitted to the ED by ambulance and was then attended to by Manish. He listened very carefully to my description of symptoms, and I was sent for an x-ray, a CT scan, and an MRI. As a result of the tests, I was diagnosed with a tumour in the spinal cord and recently had a laminectomy surgery and excision to remove it. I am 81 years old and Manish took the trouble to find out about me. For that my family and I see him as a local hero. We believe that young men like him should be thanked and encouraged to continue to be as empathetic as he is."

Emily Sutton was chosen as our November local hero: The patient's mother who nominated Emily said: "My daughter is a special needs teenager and came to Greenlane for dentist work. She was very nervous, but when she saw Emily and the team, she was more at peace. Emily was a delight to meet and looked after my daughter very well. Anything she needed, Emily was happy to do it. Emily took pride in her work and is a lovely person. She will be shocked about this email but we have to look after the doctors and nurses, whom go out of their way to make someone's day by just smiling and being themselves. Emily is one in a million. Thank you for making my day and making my daughter happy."

Speak Up Kaua ē patu wairua

Speak Up launched to managers in November. It is a programme of work, led by Clinical Director Dr Arend Merrie, to encourage people to speak up if they see or experience harassment, discrimination or bullying. It puts in place support throughout the process when people do speak up and provides a strong endorsement of the value of respect in our culture. Above all it reinforces how respect flows through to positive patient outcomes.

Health Excellence Awards

The 2016 Health Excellence Awards take place on 1 December at Auckland War Memorial Museum. More than forty applications were received across five categories. The finalists for the Awards can be viewed on our website here:
www.adhb.health.nz/health-professionals/health-excellence-awards/

Allied Health, Scientific and Technical Awards

Congratulations to all finalists and winners of Auckland DHB's inaugural Allied Health Scientific and Technical Awards which took place on 22 November 2016. It was a great night to celebrate the achievements that this significant workforce of 49 professions and approximately 1,800 people make to the organisation. The Awards were generously sponsored by A+ Trust.

Many commented on how much they appreciated the remarks made by executive and senior leaders on the night, whether receiving an award or not. Others reflected that they themselves didn't realise the diversity of professions in Allied Health, Scientific and Technical until the evening itself.

"A lovely experience"
"So proud to see colleagues getting awards and being recognised"
"Great to see the breadth of the professions in this grouping and learn about what they do when they are not in clinical service you work in…"
"Fantastic event for AHS&T to be brought together with academic partners – maybe we could provide an award next year…."
"Fabulous venue and celebration"

Health and Wellness

To continue to support the health and wellbeing of our employees, gym memberships are available all staff, free for those earning $55k or less, and available for all others at a highly subsidised rate of $100 per year.

There are also free Bootcamp sessions held twice weekly for all staff at the Domain and at Greenlane.

Ka Pai Whānau – saying thank you to our people, and giving thanks

Ka Pai Whānau opened with a performance by the Aisda Muscionaries, a Filipino ensemble of multi-instrumentalists on Saturday 26 November. They heralded the Auckland City Mission stepping up their efforts on behalf of Aucklanders needing a hand.

Food and gift donations were promoted from mid-November as was the Mission's online fundraising campaign, Become Someone's Angel, from 28 November.

As the food collection for the Mission continued, a health excellence theme came into focus with research posters being placed up in Auckland City Hospital Level 5; the Physicians' Grand Round: Young Investigators Award and the Health Excellence Awards. Monday 5 December will continue that theme, with a Health Excellence Grand Round.

Other planned entertainment and engagement activities for *Ka Pai Whānau* include a Starship Children's Hospital performance by Michael Murphy, lead vocalist of the band *Halo*. He will be followed by a Royal New Zealand Navy Band ensemble performing the following day.

We will also welcome the return by popular demand of the puppies-in-training for the Ministry of Primary Industry Border Protection team. Not to be outdone, some of the younger members of the NZ Police Dog Squad will also visit Auckland City Hospital. While they're technically puppies, they are big kids - the dog equivalent of teenagers!

The NZ Police Dog Squad will be here as part of *Ka Pai Whānau* and in support of the *Operation Snap* security awareness outreach display that will be set up in Level 5 Auckland City Hospital.

On Monday 12 December, seven choirs will visit Auckland City Hospital for the ward-caroling rounds led by our chaplains. On 12 and 13 will be two nights of the staff performance of *The Committed*, with a pre-show DJ.

The Ta'imua Youth Ministries choir will deliver their mix of gospel, soul and R&B on Sunday 17 December, which will bring *Ka Pai Whānau* 2016 to a close.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary[1]

	Status	Comment
Acute patient flow (ED 6 hr)		Oct 96%, Target 95%
Improved access to elective surgery (YTD)		94% to plan for the year, Target 100%
Faster cancer treatment		Oct 87%, Target 85%
Better help for smokers to quit:		
• Hospital patients		Oct 95%, Target 95%
• PHO enrolled patients		Sep Qtr 87%, Target 90%
• Pregnant women registered with DHB-employed midwife or lead maternity		Sep Qtr 98%, Target 90%
Raising healthy kids		Oct 87%, Target 95%
Increased immunisation 8 months		Sep Qtr 94%, Target 95%

Key	Proceeding to plan		Issues being addressed		Target unlikely to be met	

[1] Note that effective July 2016, ***Raising Healthy Kids*** has replaced More Heart & Diabetes Checks.

Also note that although the Primary Care ***Better Help for Smokers to Quit*** has changed (50% of all current smokers will be quit at 4 weeks after entering a programme to so; 5% of the currently smoking population will be engaged in the programme), both the Hospital Target (95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking) and the Maternal Health Target (90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking) remain.

3.1.2 National Health Targets – YOY comparison Auckland region DHBs

	Auckland Region	2015/16				2016/17			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours.	**Auckland DHB**	**93**	**95**	**95**	**95**	**95**			
	Waitemata DHB	93	95	96	95	97			
	Counties Manukau	95	95	96	96	96			
	All DHBs	92	94	94	94	93			
 The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**93**	**98**	**98**	**101**	**93**			
	Waitemata DHB	101	101	102	106	105			
	Counties Manukau	99	103	105	109	110			
	All DHBs	104	105	106	108	105			
 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.	**Auckland DHB**	**66**	**70**	**75**	**77**	**79**			
	Waitemata DHB	74	68	70	75	86			
	Counties Manukau	70	72	70	74	75			
	All DHBs	69	75	75	74	78			
 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.	**Auckland DHB**	**95**	**94**	**94**	**94**	**94**			
	Waitemata DHB	93	95	93	92	94			
	Counties Manukau	95	95	94	95	94			
	All DHBs	93	94	93	93	93			
 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. (Other targets also exist)	**Auckland DHB**	**85**	**86**	**88**	**91**	**87**			
	Waitemata DHB	85	88	90	91	87			
	Counties Manukau	87	88	89	92	89			
	All DHBs	83	85	86	88	87			
 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.	**Auckland DHB**	Note: this target replaced ***More Heart and Diabetes Checks*** from July 2016				**79**			
	Waitemata DHB					83			
	Counties Manukau					29			
	All DHBS					**49**			

Source: http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing

3.2 Financial Performance

The financial performance for the four months to October 2016 was a deficit of $465K which was unfavourable to budget by $4.9M. This is attributed to an unfavourable result in the Provider arm ($12M adverse to budget), which was partially offset by the favourable performance to budget in the Funder arm of $7M. The year to date result is mainly driven by revenue realised being $10.2M less than planned, with expenditure overall favourable to budget by $5.2M. Less than budgeted revenue reflects unrealised revenue for under-delivery of additional electives volumes ($3.6M), net wash-up provision for under-delivery of IDF Inflow volumes ($1.5M), less revenue realised for ACC volumes below plan due to volume growth planned not being achieved ($1.4M) and less than budget interest and donation income ($2M). Favourable expenditure is mainly driven by Funder NGO payments ($10.3M favourable, mainly pharmaceuticals and Aged Related Residential Care services), which fully offset unfavourable expenditure realised in personnel & outsourced personnel costs ($2.2M); clinical supplies ($2.4M) and infrastructure/ non-clinical supplies ($1.3M).

The full year plan is a surplus of $4.5M. Achieving this plan is dependent on the DHB increasing momentum to fully achieve the savings plan and subject to the DHB resolving the IDF pricing issues with the help of the Ministry of Health and other DHBs.

4. Clinical Governance

4.1 Development and recognition

4.1.1 NZ's First Three-Way Kidney Transplant

A three-way kidney transplant exchange was carried out in New Zealand for the first time in October. Auckland DHB was one of the two DHBs providing this life-saving treatment. Six patients took part in in an effort that required operations involving five surgeons in our two DHBs. Minister of Health Jonathan Coleman acknowledged the New Zealand Kidney Exchange Programme and the DHBs for their part in bring about this New Zealand first.

4.1.2 2016 New Zealand Research Honours

At the Royal Society of New Zealand's 2016 Research Honours event held at the Transitional Cathedral in Christchurch on 23 November, a number of New Zealand researchers were honoured. Congratulations all those who were awarded distinctions.

Congratulations to Professor Merryn Tawhai

Deputy Director of the Auckland Bioengineering Institute at the University of Auckland, was awarded the MacDiarmid Medal by the Royal Society of New Zealand for her research to create anatomically detailed models of the respiratory system.

The medal is awarded for outstanding scientific research that has the potential for human benefit, and the models created by Professor Tawhai provide new tools for diagnosis, prognosis and treatment of lung disease. Professor Tawhai works closely with a number of Auckland DHB academic collaborators in adult radiology and respiratory services.

Congratulations to Professor Jane Harding

Distinguished Professor Jane Harding ONZM FRSNZ, from the University of Auckland's Liggins Institute, was awarded the Beaven Medal from the Health Research Council of New Zealand for her research into treating babies with low blood sugar with a cost-effective dextrose gel massaged into the inside of a baby's cheek.

This research is expected to change the way millions of babies are monitored and treated for low blood sugar around the world, given it also supports mother-baby bonding and breastfeeding.

4.1.3 Welcome to our new Medical Graduates

Auckland DHB welcomed 53 new medical graduates at the end of November, employed as first year House Officers (PGY1).

5. Funding

5.1 Applications open

5.1.1 Starship Foundation funding

The Foundation's application process has been updated and funding for projects under $2,000 is now open year round. Funding for training and conferences is available quarterly.

Financial Performance Report

Recommendation

That the Board receives this Financial Report for October 2016

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for October 2016 was a surplus of $1.3M which was unfavourable to budget by $607K. For the Year to Date (YTD), a deficit of $465K was realised, unfavourable to budget by $4.9M. This reflects a $12M unfavourable Provider arm result, partially offset by a $7M favourable Funder arm result. The overall DHB YTD result was driven by less revenue realised than planned.

YTD revenue was unfavourable to budget by $10.2M. Key drivers for this include under-delivery of: additional electives volumes ($3.6M, reflected in MoH Devolved contracts revenue); IDF inpatient services ($1.5M net IDF inflow provision), ACC volumes ($1.4M, mainly due to volume growth planned not being realised). Other unfavourable revenue variances include less than planned MoH non-devolved contracts revenue ($1.2M, mainly Public Health but with offsetting less expenditure than planned), unfavourable financial income ($1M) and unfavourable donation income ($1M), partially offset by $1.2M additional research income. YTD expenditure is favourable to budget by $5.2M. This is primarily due to favourable Funder NGO expenditure ($10.3M, mainly pharmaceuticals and Age Related Residential Care services). This fully offset adverse expenditure in personnel and outsourced personnel costs ($2.2M); clinical supplies ($2.4M) and infrastructure/ non-clinical supplies ($1.3M).

The full year plan is a surplus of $4.5M and is forecast to be achieved. However, this is dependent on the DHB resolving the IDF pricing issues with the help of the Ministry of Health and other DHBs and, stepping up the realisation of the full savings included in the plan.

Summary Results: Month of October 2016

$000s	Month (October-16)			YTD (4 months ending 31 Oct-16)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	98,862	98,860	1 F	395,446	395,442	5 F	1,188,138	1,186,325	1,813F
MoH Contracts - Devolved	7,211	9,011	1,800 U	32,387	36,044	3,657 U	108,142	108,134	8F
	106,073	107,872	1,799 U	427,833	431,486	3,653 U	1,296,280	1,294,459	1,821F
MoH Contracts - Non-Devolved	4,529	4,890	361 U	18,642	19,796	1,153 U	59,040	59,538	498U
IDF Inflows	52,770	52,772	1 U	209,567	211,087	1,520 U	638,778	633,262	5,516F
Other Government (Non-MoH, Non-OtherDHBs)	2,578	3,104	526 U	10,782	12,555	1,774 U	36,714	37,738	1,024U
Patient and Consumer sourced	1,360	1,573	213 U	5,793	6,276	483 U	19,478	19,207	271F
Inter-DHB & Internal Revenue	1,098	1,287	190 U	4,554	5,290	736 U	15,244	15,791	547U
Other Income	4,002	4,166	163 U	17,993	16,764	1,229 F	51,700	48,721	2,979F
Donation Income	390	607	217 U	1,373	2,399	1,027 U	8,483	8,907	424U
Financial Income	183	666	483 U	1,449	2,519	1,071 U	7,830	7,606	224F
Total Income	**172,984**	**176,937**	**3,953 U**	**697,986**	**708,174**	**10,188 U**	**2,133,547**	**2,125,229**	**8,318F**
Expenditure									
Personnel	72,539	72,522	18 U	291,783	293,194	1,411 F	900,183	889,213	10,970U
Outsourced Personnel	1,890	1,119	770 U	8,091	4,503	3,588 U	18,914	13,402	5,512U
Outsourced Clinical Services	1,832	2,089	257 F	7,546	8,345	799 F	25,428	24,923	505U
Outsourced Other Services (incl. hA/funder Costs)	5,129	5,041	88 U	20,258	20,163	95 U	60,493	60,488	5U
Clinical Supplies	20,116	21,126	1,010 F	87,139	84,697	2,442 U	259,945	254,983	4,962U
Funder Payments - NGOs	43,683	47,642	3,960 F	180,233	190,569	10,336 F	557,812	571,707	13,895F
Funder Payments - IDF Outflows	9,606	9,567	39 U	38,159	38,267	107 F	114,653	114,800	147F
Infrastructure & Non-Clinical Supplies	12,279	11,314	965 U	46,799	45,482	1,317 U	135,841	135,452	389U
Finance Costs	1,053	1,052	1 U	4,171	4,207	36 F	12,622	12,621	1U
Capital Charge	3,568	3,568	0 F	14,272	14,272	0 F	43,140	43,140	0
Total Expenditure	**171,694**	**175,039**	**3,346 F**	**698,451**	**703,698**	**5,247 F**	**2,129,031**	**2,120,729**	**8,302U**
Net Surplus / (Deficit)	**1,290**	**1,897**	**607 U**	**(465)**	**4,476**	**4,941 U**	**4,516**	**4,500**	**16 F**

2. Result by Arm

Result by Division	Month (October-16)			YTD (4 months ending 31 Oct-16)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	2,784	375	2,409 F	8,574	1,500	7,074 F	16,500	4,500	12,000F
Provider	(1,518)	1,522	3,040 U	(9,082)	2,976	12,058 U	(12,016)	0	12,016U
Governance	24	0	24 F	43	0	43 F	32	0	32F
Net Surplus / (Deficit)	**1,290**	**1,897**	**607 U**	**(465)**	**4,476**	**4,941 U**	**4,516**	**4,500**	**16 F**

The favourable YTD Funder result reflects lower expenditure for Community Pharmacy as a result of substantive changes in PHARMAC forecasts relative to their original budget advice. Also of note as impacting favourably are Age Related Residential Care, Mental Health and Other Personal Health expenditure positions which are one off upsides relating to 2015/16 year-end adjustments. These were offset by adverse net IDF inflow and electives wash up provisions for the under delivery of services.

The unfavourable YTD Provider Arm result is driven by less revenue than planned ($6.8M) mainly reflecting under-delivery of elective volumes, ACC volumes below plan and lower interest and donation income than planned. Expenditure was also unfavourable ($5.2M) primarily in Outsourced Personnel, clinical supplies and Infrastructure and Non Clinical Supplies costs. These variances are described further in section 3 below.

3. Financial Commentary for October 2016

Month Result

Major Variances to budget on a line by line basis are described below.

Revenue was less than budget by $4M (2.2%), mainly driven by:

- MoH devolved contracts which are $1.8M unfavourable due to unrealised revenue for under-delivery of elective volumes.
- Other Government revenue $0.5M unfavourable mainly ACC revenue less than plan due to volume growth planned not being achieved to date.
- Financial income $0.5M unfavourable due to lower interest rates than assumed in the plan.

Expenditure was less than budget by $3.3M. Significant variances are described below:

- Favourable expenditure was realised mainly in Funder NGOs, $4M (8.3%) mainly in Community Pharmacy due to upside occurring as a result of substantive changes in PHARMAC forecasts relative to their original budget advice. One off upsides relating to 2015/16 year-end adjustments were realised in Age Related Residential Care, Mental Health and Other Personal Health expenditure. Other favourable positions were from budgeted service lines not yet contracted for.
- Combined Personnel and Outsourced Personnel costs were $788K (1.1%) unfavourable, mainly in Medical and Management & Admin costs. Total FTEs at 8,544 remain consistent with the trend throughout the calendar year, but are 212 (2.5%) above budget due to FTE savings targets incorporated into the budget. The total cost variance is less unfavourable than the total FTE variance due to lower cost per FTE (reflecting initiatives to reduce overtime and other premium payments).
- Clinical Supplies $1M (4.8%) favourable, mainly due to haemophilia blood products $0.5M favourable for low product usage (bottom line neutral as offset by reduced revenue), with the balance of the favourable variance spread widely across surgical services reflecting volume activity below contract for the month.
- Infrastructure and Non Clinical Supplies $1M (8.5%) unfavourable, comprising the following key variances – Advance Care Planning project costs $0.6M unfavourable (bottom line neutral as offset by additional revenue), and facilities costs $0.3M unfavourable.

Year to Date Result
Major Variances to Budget on a line by line basis are described below.

Revenue was less than the budget by $10.2M. Significant movements underlying this included:

- MOH devolved contract revenue is $3.7M unfavourable YTD mainly due to under-delivery of additional electives volumes. To this effect $1.2M was accrued in July, $0.8M was accrued in September and a further $2.6M was accrued in October against which a prior year upside for additional electives revenue of $0.8M was also accounted for in October. To a much lesser extent there is also an element of Funded Initiatives influencing these variances. These are offset by equivalent Funded Initiatives expenditure variances.
- IDF Inflow revenue is funding received from other DHBs and much of this revenue is variable according to service delivery and therefore at risk if under delivered. IDF Inflow revenue is also influenced by post budget service changes against budget but this is usually marginal. The $1.5M adverse variance reflects provisions for under-delivery of inpatient services ($1.9M), partially offset by favourable MoH PHO quarterly wash-up of $0.4M settled in August.
- Research Income $1.2M favourable, offset by equivalent expenditure and bottom line neutral.
- ACC revenue $1.5M unfavourable, primarily lower ACC elective surgery volumes than planned. The budget was increased over last year actuals but has not been achieved to date.
- Donations $1.0M unfavourable – revenue fluctuates from month to month, depending on timing of key projects, with the full year budget still expected to be achieved.
- MOH Public Health Funding $0.7M unfavourable, in line with services delivered – this revenue is expected to be on budget by year end.
- Haemophilia funding $0.8M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure.
- Financial Income $1M unfavourable driven by lower interest rates than assumed in the budget.

Expenditure was less than budget YTD by $5.2M, with significant underlying variances as follows:

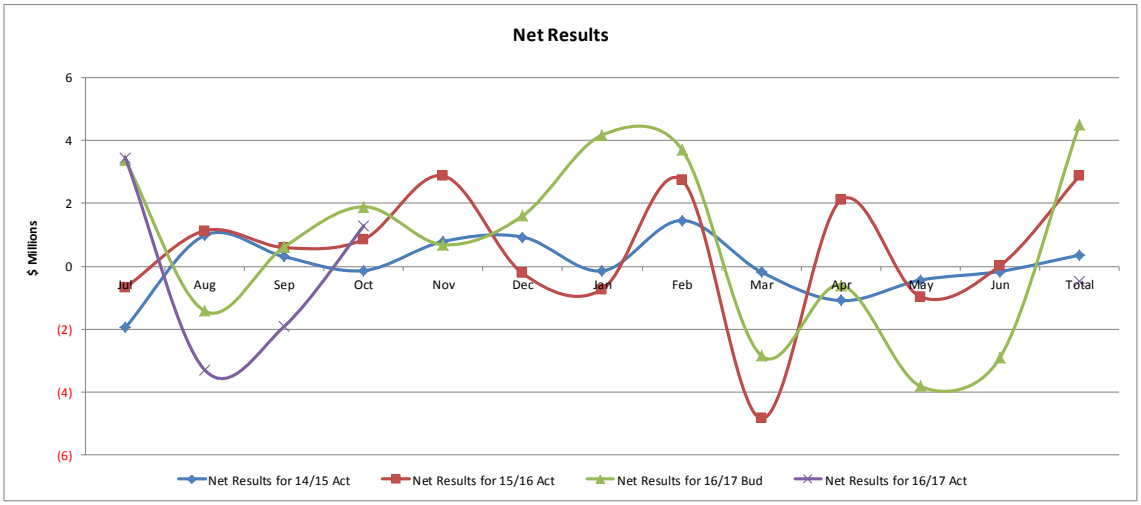
- Combined Personnel and Outsourced Personnel Costs $2.2M (0.73%) unfavourable, mainly in Medical ($1.7M), Nursing ($0.8M) and Management & Admin ($0.7M) categories. YTD combined FTEs were 130 (1.5%) above budget due to FTE savings targets incorporated into the budget not achieved. However the cost impact was partially offset by lower cost per FTE due to reductions in overtime and other premium payments.
- Clinical Supplies $2.4M (2.9%) unfavourable comprising the following key variances:
    - High transplant activity with very high drug and consumables costs, adding $0.3M costs.
    - Cardiovascular $0.9M unfavourable reflecting volume growth over the same period last year for both Cardiology and Cardiothoracic combined with a small number of patients with very high blood costs.
    - Perioperative $0.7M reflecting theatre minutes 3% above YTD budget assumption.
    - One off costs for loss on disposal of assets $0.3M.
- Outsourced Clinical Services $0.8M (9.6%) favourable, reflecting no Orthopaedic elective surgery outsourcing, and offset by an unfavourable revenue/volume position.
- Funder Payments to NGOs are YTD favourable $10.3M (5.4%) and mainly driven by favourable variances from Community Pharmacy which continues to be the predominant contributor of the favourable YTD variances with a significant component of this upside occurring as a result of substantive changes in PHARMAC forecasts relative to their original budget advice. Also of note are one off upsides relating to 2015/16 year-end adjustments impacting favourably on Community Pharmacy as well as Age Related Residential Care, Mental Health and Other Personal Health expenditure positions. Other contributions to the favourable variance are from budgeted service lines that are not yet contracted for. There are also variances related to new funded

initiatives expenditure that are offset by equivalent revenue variances and have a nil net impact on the core result.

- Infrastructure and Non Clinical Supplies $1.3M (2.9%) unfavourable reflecting Advance Care Planning project costs $0.6M unfavourable (bottom line neutral as offset by additional revenue) and facilities costs $0.3M unfavourable driven by additional health and safety related expenditure.

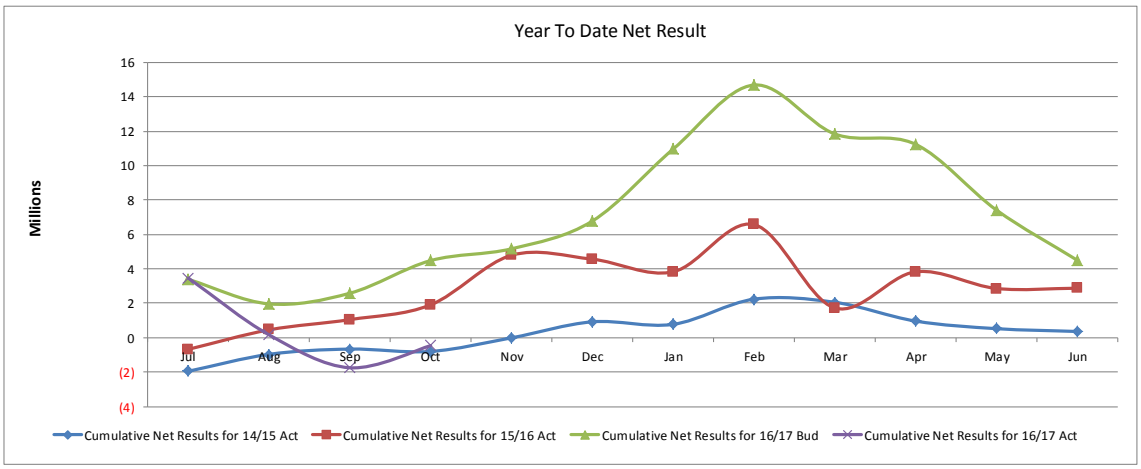
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Result for 14/15 Act	(1.957)	0.984	0.306	(0.137)	0.790	0.931	(0.147)	1.462	(0.179)	(1.093)	(0.441)	(0.164)	0.355
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747	(4.850)	2.101	(0.967)	0.015	2.871
Net Result for 16/17 Bud	3.385	(1.426)	0.619	1.897	0.686	1.610	4.182	3.727	(2.844)	(0.600)	(3.819)	(2.916)	4.500
Net Result for 16/17 Act	3.462	(3.302)	(1.914)	1.290									(0.465)

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
Cumulative Net Results for 14/15 Act	(1.957)	(0.973)	(0.668)	(0.804)	(0.014)	0.916	0.770	2.232	2.053	0.960	0.519	0.355
Cumulative Net Results for 15/16 Act	(0.683)	0.450	1.045	1.904	4.785	4.557	3.824	6.571	1.721	3.822	2.855	2.871
Cumulative Net Results for 16/17 Bud	3.385	1.959	2.578	4.476	5.161	6.772	10.953	14.681	11.836	11.236	7.417	4.500
Cumulative Net Results for 16/17 Act	3.462	0.159	(1.755)	(0.465)								
Variance to Budget for 2016/17	0.076	(1.800)	(4.333)	(4.941)								

5. Efficiencies / Savings

Savings reported for the YTD of $7.8M were unfavourable to the budget of $14.1M by $6.2M. This is mainly attributed to timing factors as a number of initiatives are in implementation mode and therefore too early to report savings. Those achieved to date mainly relate to personnel/FTE/vacancy management, bed management, Laboratory/Radiology efficiencies and supply chain and Funder reported savings.

6. Financial Position

6.1 Statement of Financial Position as at 31 October 2016

$'000	31-Oct-16			30-Sep-16	Variance	30-Jun-16	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0U
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	508,998	438,457	70,541F	508,995	3F	508,998	0F
Cashflow-hedge Reserve	(3,558)	(3,557)	1U	(3,604)	46F	(3,742)	184F
Accumulated Deficits from Prior Year's	(461,173)	(461,652)	479F	(461,173)	0F	(461,173)	0F
Current Surplus/(Deficit)	(465)	4,476	4,941U	(1,755)	1,290F	-	465U
	43,802	(22,276)	66,078F	42,463	1,339F	44,083	281U
Total Equity	**620,600**	**554,522**	**66,078F**	**619,261**	**1,339F**	**620,881**	**281U**
Non Current Assets							
Fixed Assets							
Land	282,803	249,006	33,797F	282,803	0F	282,803	0F
Buildings	617,547	587,494	30,053F	620,099	2,552U	619,402	1,855U
Plant & Equipment	81,765	88,000	6,235U	82,674	909U	92,164	10,399U
Work in Progress	48,698	52,245	3,547U	51,831	3,133U	45,236	3,462F
	1,030,813	976,745	54,068F	1,037,407	6,594U	1,039,605	8,792U
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	56,578	53,103	3,475F	53,103	3,475F	53,103	3,475F
- HBL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	-	-	0F	-	0F	5,000	5,000U
- Other Investments	503	503	0F	503	0F	503	0F
	69,501	66,026	3,475F	66,026	3,475F	71,026	1,525U
Intangible Assets	579	1,001	422U	611	32U	762	183U
Trust Funds	15,380	14,494	886F	15,462	82U	14,495	885F
	85,460	81,521	3,939F	82,099	3,361F	86,283	823U
Total Non Current Assets	**1,116,273**	**1,058,266**	**58,007F**	**1,119,506**	**3,233U**	**1,125,888**	**9,615U**
Current Assets							
Cash & Short Term Deposits	77,088	56,557	20,530F	48,797	28,291F	34,461	42,627F
Trust Deposits > 3months	10,500	11,500	1,000U	10,000	500F	11,500	1,000U
ADHB Term Deposits > 3 months	10,000	10,000	0F	15,000	5,000U	15,000	5,000U
Debtors	29,234	29,872	637U	28,772	462F	29,869	635U
Accrued Income	37,625	32,179	5,446F	42,983	5,359U	32,179	5,445F
Prepayments	2,448	1,679	769F	2,448	0U	1,679	768F
Inventory	14,373	14,239	134F	14,548	175U	14,239	134F
Total Current Assets	**181,268**	**156,026**	**25,242F**	**162,549**	**18,720F**	**138,928**	**42,341F**
Current Liabilities							
Borrowing	(429)	(429)	0U	(429)	0F	(429)	0F
Trade & Other Creditors, Provisions	(160,505)	(149,299)	11,206U	(152,892)	7,613U	(133,316)	27,189U
Employee Benefits	(172,184)	(166,085)	6,099U	(165,615)	6,569U	(166,232)	5,952U
Funds Held in Trust	(1,248)	(1,239)	9U	(1,246)	2U	(1,239)	9U
Total Current Liabilities	**(334,366)**	**(317,052)**	**17,314U**	**(320,182)**	**14,183U**	**(301,217)**	**33,149U**
Working Capital	**(153,097)**	**(161,026)**	**7,929F**	**(157,634)**	**4,536F**	**(162,289)**	**9,192F**
Non Current Liabilities							
Borrowings	(304,922)	(305,065)	143F	(304,958)	36F	(305,065)	143F
Employee Entitlements	(37,653)	(37,653)	0F	(37,653)	0F	(37,653)	0F
Total Non Current Liabilities	**(342,575)**	**(342,718)**	**143F**	**(342,611)**	**36F**	**(342,718)**	**143F**
Net Assets	**620,600**	**554,522**	**66,078F**	**619,261**	**1,339F**	**620,881**	**281U**

Comments

Category	Comment
Fixed Assets	The full revaluation of land and buildings completed at 30 June 2016 resulted in an increase in revaluation reserve of $70.5M ($33.8M for land and $36.7M for buildings), these revaluation adjustments were not included in the 2016/17 budget. Capital expenditure progressing below planned levels is also impacting on delayed capitalisations.
Cash & short term deposits	This is mainly favourable reflecting Funder NGO expenditure and capex spend behind budget.
Creditors	Trade & Other Payables reflect timing differences for creditors' payments, accruals and income in advance.

6.2 Statement of Cash flows (Month and Year to Date October 2016)

$000's	Month (October-16)			YTD (4 months ending 31 Oct-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	181,035	176,269	4,766F	699,344	705,652	6,308U
Payments						
Personnel	(65,971)	(72,249)	6,278F	(285,832)	(292,104)	6,272F
Suppliers	(35,333)	(34,953)	380U	(151,987)	(146,121)	5,866U
Capital Charge	0	0	0F	0	0	0F
Funder payments	(53,288)	(57,209)	3,921F	(218,392)	(228,836)	10,444F
GST	1,797	0	1,797F	2,349	0	2,349F
	(152,795)	**(164,411)**	11,616F	**(653,862)**	**(667,061)**	13,199F
Net Operating Cash flows	**28,241**	**11,858**	**16,383F**	**45,482**	**38,591**	**6,891F**
Investing						
Interest Income	183	666	484U	1,449	2,518	1,069U
Sale of Assets	0	0	0F	0	0	0F
Purchase Fixed Assets	(1,840)	(5,906)	4,066F	(11,475)	(23,622)	12,147F
Investments and restricted trust funds	4,499	5,000	501U	10,499	10,000	499F
Net Investing Cash flows	**2,842**	**(240)**	**3,081F**	**473**	**(11,104)**	**11,577F**
Financing						
Other Equity Movement	0	2	2U	1	2	1U
Interest paid	(2,792)	(2,772)	20U	(3,328)	(3,244)	84U
Net Financing Cashflows	**(2,792)**	**(2,770)**	**22U**	**(3,327)**	**(3,242)**	**85U**
Total Net Cash flows	**28,292**	**8,848**	**19,443F**	**42,628**	**24,245**	**18,383F**
Opening Cash	48,797	47,711	1,087F	34,461	32,314	2,147F
Total Net Cash flows	28,292	8,848	19,443F	42,628	24,245	18,383F
Closing Cash	**77,089**	**56,559**	**20,530F**	**77,089**	**56,559**	**20,530F**

ADHB Cash	74,099	**54,024**	20,075F
A+ Trust Cash	924	**479**	445F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	2,067	**2,056**	11F
	77,089	**56,559**	**20,530F**
ADHB - Short Term > 3 months	10,000	**10,000**	0F
A+ Trust Deposits - Short Term > 3 months	10,500	**11,500**	1,000U
ADHB Deposits - Long Term	0	**5,000**	5,000U
A+ Trust Deposits - Long Term	15,380	**14,494**	886F
Total Cash & Deposits	**112,969**	**97,553**	**15,416F**

Funder Update

Recommendation

That the Funder Update Report for November 2016 be received

Prepared by: Joanne Brown, (Funding & Development Manager Hospitals); Tim Wood, (Funding & Development Manager Primary Care); Kate Sladden, (Funding and Development Manager Health of Older People); Ruth Bijl, (Funding & Development Manager Women, Children & Youth); Trish Palmer, (Funding & Development Manager Mental Health & Addictions); Aroha Haggie, (Manager Maori Health Gain); Lita Foliaki, (Manager Pacific Health Gain); Samantha Bennett, (Manager Asian Health Gain)
Endorsed by: Dr Debbie Holdsworth, (Director Funding)

Glossary

AH+	-	Alliance Health Plus
AOD	-	Alcohol and Other Drugs
ARC	-	Aged Residential Care
ASH	-	Ambulatory Sensitive Hospitalisations
CAYAD	-	Community Action Youth and Drugs Auckland City Council
CEO	-	Chief Executive Officer
CMO	-	Chief Medical Officer
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance
EOI	-	Expression of Interest
GETS	-	Government Electronic Tenders Service
HCSS	-	Home and Community Support Services
IPIF	-	Integrated Performance and Incentive Framework
MALT	-	Māori workforce Alliance Leadership Team
MBIE	-	Ministry of Business, Innovation and Employment
MoH	-	Ministry of Health
NCHIP	-	National Child Health Information Platform
NRA	-	Northern Regional Alliance
NZCMHN	-	New Zealand College of Mental Health Nurses
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
PMHII	-	Primary Mental Health Innovation and Initiative
SACAT	-	Substance Addiction Compulsory Assessment and Treatment
SLM	-	System Level Measures
SPE	-	Statement of Performance Expectations

Summary

This report updates the Auckland District Health Board (DHB) Board on planning and funding activities and areas of priority, since its last meeting on 26 October 2016.

Simon Bowen, Director Health Outcomes has undertaken a six-month secondment at the NRA, from 14 November. Simon will be working on the long term investment plan for the region. This will

prioritise the region's key capital investments including facilities, IT and clinical equipment over the next 10 years.

Simon will continue to work one day per week and will oversee the Annual Plan and continue to manage the Auckland Regional Public Health Service. Karen Bartholomew, Clinical Director Health Gain, will cover other aspects of Simon's role.

1. Planning

1.1 Annual Plans

ADHBs 2016/17 Annual Plan has been signed by the Minister. The MoH have released draft guidance for 2017/18 planning, the Planning team is currently collecting feedback. There is a requirement for shorter Annual Plans.

1.2 Annual Reports

Auckland DHB's 2015/16 Annual Report has received a 'very good' rating for service performance information, systems and controls, when assessed by an audit consistency review panel. This is a great achievement.

The panel's feedback showed they found the reporting to be of the highest standard, particularly with regard to the range of performance measures and their presentation. Comments highlighted the Annual Report stands out in telling a performance story very well, based on a mix of good and relevant context, reporting of hard data and relevant case studies. They were impressed with how it weaves together the story about the DHB's performance and broader developments and trends for readers. The 'very good' grade is reserved for reporting that the Office of the Auditor-General would happily hold up as an example of good practice.

Printer's proofs of the reports are currently being prepared and they will be published later this month.

2. Hospitals

2.1 Cancer target

The ADHB provider reported result for FCT 62 day indicator for the week ending 17 November is 86.7%, this compares with 78.6% reported to the Board in mid-September. The ADHB September quarter result for the MOH measure is 79.4%, the ongoing improvement will be reflected in the next quarter result.

2.2 Auckland DHB 2016/17 Surgical Health Target

2.2.1 2016/17 ADHB Surgical Health Target

The ADHB provider continues to be ESPI 5 non-compliant due to issues within both the Adult and Paediatric Orthopaedic services, this position will not be improved within the six month dispensation timeframe agreed to with the Ministry of Health. The ADHB Chief Executive, Director Funding and Director of Provider Services met with the MoH team in early November to outline the ongoing actions being taken by the DHB to resolve the ESPI issues. The discussions also included an update regarding the Surgical Health Target discharge position, the MOH was advised the DHB would meet 95% of the Health Target at quarter 2 which is lower than the 98% previously advised in the recovery plan agreed with the MOH at the beginning of October.

2.2.2 Year to Date Performance

The provider has identified an expected shortfall in Ophthalmology discharges for Q2, the funder is working with healthAlliance to source other provider capacity with the expectation that 100 outsourced cataract procedures will be completed before 24 December. The ongoing under delivery of Orthopaedic discharges is impacting on the WIES value of elective discharges, this is placing additional elective revenue to ADHB, from the MoH at risk. This can be resolved if the Adult Orthopaedic discharge shortfall is completely addressed in Q3 and Q4.

At the end of Q1, ADHB has achieved 93.1% of the Surgical Health Target. The provider recovery plans mean the DHB is expected to achieve 95% of the health target by the end of Q2 and 98% by the end of Q3. The DHB is not expected to achieve 100% of the Health Target until the end of Q4. The funder continues to work with the ADHB provider to access appropriate outsource arrangements and closely monitor performance, in order to address any emerging or new issues in a timely way.

Elective services provided by other DHBs for the ADHB population are occurring according to the plan, however, the ADHB provider is delivering more elective services to other populations than planned. The over-delivery year to date is for the CMDHB population, the funder is seeking a decision from CMDHB regarding the ongoing management of access to the identified ADHB services. At the same time, elective services for the WDHB population are tracking at levels less than planned. This is being closely monitored to ensure the total health target volume for the WDHB population is met at the end of Q2.

2.2.3 Outsourcing Arrangements

The cataract outsourcing arrangements which commenced in Q1 have been successful, the planned volume was achieved. An RFP process has been initiated to ensure a panel of suppliers is in place to enable ongoing outsourcing of cataract procedures, as needed, to ensure the Health Targets for both the Auckland and Waitemata populations are met. Ophthalmology pro Arrangements are being finalised to ensure ongoing supply agreements are in place with a number of providers for required cataract outsourcing.

2.2.4 ESPI Compliance

At the end of October, ADHB was non-compliant (red) for ESPI 2 (outpatient specialist appointments) and non-compliant (red) for ESPI 5 (booked for surgery). As previously discussed the DHB is expected to remain ESPI 5 non-compliant as a result of Orthopaedic service issues (adult and paediatric). While the MOH has agreed to a six month dispensation from financial penalties associated with this Orthopaedic non-compliance, this agreement is associated with an expectation that all other ESPI 2 and ESPI 5 services will be compliant. The provider has a substantive weekly review process in place to ensure all non-Orthopaedic services achieve ESPI compliance at month end. Each service reports detailed actions to address month end forecast breaches.

2.3 IDF Arrangements

2.3.1 2015/16

The year end non automatic wash ups are in the process of being finalised with the WDHB/ADHB wash up funder proposal currently being considered by both DHB CFOs. CMDHB have tabled new information with data obtained from other sources that has shown an unfavourable change for ADHB for the interim wash up position. This data is in the process of being reviewed.

2.3.2 2016/17

The ADHB application to increase the payment for clot retrieval has been considered by the National Technical Pricing Group, the request will be formally approved by the end of November enabling ADHB to be paid for the full cost of delivery of this service. The new price will apply from July 1 2016.

The project manager has been appointed and a Steering Group established to support the Ophthalmology Service Improvement Plan, which will include furthering the development of the Waitakere outpatient service.

2.3.3 2017/18

IDF forecasts for the next financial year have now been finalised. CMDHB requested changes to the IDF forecasts late in the planning process that were unable to be considered in time for the December Funding Envelope advice. An initial analysis of the changes shows CMDHB is seeking to reduce funding to a level lower than forecast, it is unlikely ADHB would agree to these changes. There is the opportunity to review the CMDHB request for change further and where there is agreement to a different service level, adjustments can be made in time for the February Funding Envelope update.

2.4 Tertiary services review

ADHB's CFO is leading the development of an ADHB proposal to review the funding mechanisms for Starship Hospital. While this discussion is ongoing with the Ministry of Health, a plan is needed to seek the views of other stakeholders regarding the levels of service being provided by Starship. The Director Funding will seek feedback from National General Managers of Planning and Funding to progress further consultation.

2.5 Policy Priority areas

2.5.1 Colonoscopy Indicators

ADHB achieved all colonoscopy waiting time indicators in September, this has been validated by MOH reporting. The ADHB service will commence colonoscopy work for the Waitemata population from February 2016 to reduce WDHB's the reliance on outsourcing.

2.5.2 Radiology Indicators

The ADHB provider reports 96% outpatient CT completed within six weeks, with MRI performance deteriorating over the last month from 82% to 77%. 86% of outpatient ultrasounds were completed within six weeks against a DHB target of 95%, this improved level of performance is being sustained. The improvement in the Paediatric MRI waiting list position has also been sustained.

2.5.3 Bone Marrow Waiting Times

At the time of this report there were no patients waiting longer than the clinically recommended six weeks maximum waiting time guideline.

2.6 National services

The DHB is reporting quarterly to the MoH, regarding the recruitment and appointment of new staff to further increase capacity in Paediatric Cardiac and Adult Congenital services, in line with the agreement for additional funding in 2016/17. The increased funding in 2015/16 led to a sustained position within the service of reduced elective cancellations and reduced elective operating outside

of working hours, however increased acute demand in November has led to an increase in elective Paediatric Cardiac cancellations due to a lack of PICU beds.

ADHB has developed a proposal for increased investment in National Metabolic Services in 2017/18 however, feedback from the MoH has indicated there is a need for further justification before this can be actioned. It is unlikely this can be progressed within the time available to secure increased funding for 2017/18.

The DHB has been advised the funding for National Intestinal Failure (Coordination) Services is to be continued for a further year from 1 July 2017.

2.7 Regional Service Review Programme

The regional work plan is continuing with no new priorities identified for inclusion.

3. Primary Care

3.1 Health Targets

3.1.1 Better Help for Smokers to Quit

The PHO target was not achieved in the first Quarter. Although performance on this target has dropped we are working on having each PHO meeting the target every quarter.

3.1.2 More Heart and Diabetes Checks

All PHOs within Auckland DHB continue to meet the 90% target. Focus remains on ensuring we reach the target for the eligible Maori population, where there is a very small gap to close. From 1 July 2016 'More Heart and Diabetes Checks' is no longer a national health target. PHOs will continue to offer these checks to the eligible population and incorporate this activity as business as usual.

3.2 Auckland Waitemata Alliance

There are two key priorities within the work programme; improving diabetes care under Diabetes Service Level Alliance (DSLA), and development of an improvement plan for the new System level measures that have been introduced this year.

The DSLA has recently completed a review of retinal screening services, recommendations on service improvements were presented to the Alliance in October. A review of community based podiatry is complete and the report is being presented to DSLA before going to the Alliance for consideration.

The System Level Measures (SLM) are being introduced for 2016/17 to replace the Primary Care Integrated Performance and Incentive Framework (IPIF) with a Whole-of-System Outcomes-Focused Approach, aligning with District Health Board outcomes frameworks.

The improvement plan was submitted to the Ministry of Health for consideration, who requested a minor adjustment. The updated plan has been approved by the Alliance and re-submitted to the MoH. A work programme is in development to ensure the improvement plan is delivered and the targets are achieved.

The System Level Measures from July 2016 are:

- Ambulatory Sensitive Hospitalisations (ASH) rates for zero to four year olds
- Acute hospital bed days per capita

- Patient experience of care
- Amenable mortality

The development of the plan is on track and a full report on the plan will be presented to CPHAC.

3.3 Tamaki Primary Mental Health and Wellbeing Initiative

The Tāmaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015, linking three NGOs with two GP practices. It has shown promise delivering care responsive to client needs with positive outcomes and additional Tāmaki practices have requested to join the initiative.

The programme is now being expanded to 10 additional general practices outside of Tamaki to build upon the experience from the demonstration sites. We currently have 12 General Practices' working alongside seven Mental Health NGOs, across five PHOs to build further experience and evidence of the appropriateness of the programme.

With the assistance of Thinkplace, the insights generated during prototyping have been collated into a modular set of resources and tools, capturing everything learned to aid the development and grow the service. These include:

- Core principles for practice
- System diagrams which illustrate key relationships
- Experience journeys which map people's experience of the service and are examples of was heard and learned from intervening people during the prototyping.

The programme will become known as Awhi Ora – Supporting Wellbeing. This name will be formally blessed and gifted at Ruapotaka Marae, Glenn Innes.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

Auckland DHB participated in a virtual pilot to support the shift to a regularised HCSS workforce, including guaranteed hours, which concluded on November 6. Providers have been collecting data on support workers' rostered hours and cancelled client visits. This is a significant area to understand and quantify when preparing for guaranteed hours and its funding implications. Data collected will be used to inform a budget bid by the Ministry of Health.

The pilot highlighted a key change will be required in how the Sector operates; to date the focus has been on ensuring clients receive a service with minimal attention to replacing support workers hours for cancelled rostered visits. It will be necessary to coordinate and ensure both client service and replacement hours for support workers in the future. The Settlement Agreement requires guaranteed hours to be rolled out across the workforce from 1 April 2017.

A number of our HCSS providers have had audits on In-between Travel (IBT) payments undertaken by Audit and Compliance. Audits have focused on verification of travel claims and ensuring the IBT payments were passed on to support workers. No issues of consequence have been identified. We are also following up exceptional travel claims, which are outliers in the monthly reports, to ensure the principles of efficient rostering are being followed.

4.2 Aged Residential Care (ARC)

For a number of years there has been a cluster model operating for ARC facilities across ADHB i.e. facilities are clustered into geographical groups each with a host facility. The aim has been for the cluster groups to meet regularly to share improvement projects, disseminate information and enhance collaboration. We are currently reviewing the cluster model as engagement in the groups has been limited. The premise and structure is well received by the ARC Sector but there is significant opportunity to add value and increase usefulness for providers. A plan for the cluster groups is being developed for 2017 that will improve coordination of the groups; involve the DHB ARRC Quality & Monitoring Manger; and improve integration with the provider arm services and support. The focus will be on improving quality of care to residents.

The ARC Asian Owners Forum has been in place for one year and a review of this forum is also underway to ensure it is meeting the needs of these providers. Currently ADHB has nine facilities with Chinese owners', regular meetings address concerns and issues for this group.

A national process is underway requesting ARC facilities to submit exemplars of good dementia unit design. These examples will be used in conjunction with the new information resource Secure Dementia Care Home Design. The Health of Older People Programme Manager is a member of the advisory panel as this is a particular area of interest with the new builds underway in Auckland.

5. Women, Children & Youth

5.1 Immunisation Health Target

We are on track to achieve the immunisation health target. However, there is an equity gap for Maori infants in Auckland DHB, Waitemata DHB and Counties Manukau Health. The Ministry has requested a metro Auckland meeting to discuss and better understand this issue. We have already convened a Maori reference group, where all infants who have passed the milestone age and are not fully immunised are discussed by a range of primary care providers. This group is hosted by Ngati Whatua.

Rates for the 3 months to 5 November are:

- 94% Total
- 88% Maori
- 93% Pacific
- 97% Asian
- 90% Other

For the current quarter (October - December 2016) to date (5 November 2016), of the cohort:

- 1,364 children are eligible for vaccination before they turn 8 months of age
- 93% of the eligible cohort are fully immunised
- A further 18 children needed to be vaccinated to achieve the 95% target by 30 December 2016
- 45 children may be immunised and are on active follow up by General Practice and the outreach immunisation service.

5.2 Obesity Health Target – 'Raising Healthy Kids'

Auckland DHB continue to make very good progress against the 'Raising Healthy Kids' health target. Provisional results for Q2 suggest the DHBs may achieve target (95%) a year in advance of the date set by the Minister (December 2017). Auckland DHB has currently achieved 87%, the second highest result in the country. The decline rate for referral is relatively high (approaching 1 in 5) and will be an area for future work over the course of 2017. A breast-feeding peer support programme has now been established, associated with this target.

5.3 Rheumatic Fever Prevention Programme

The DHB has not achieved the MoH target for Rheumatic Fever in Auckland, despite significant efforts going into the programme of activities to 'fight the fever'. Housing issues and poverty are major contributors to this disease, which disproportionately affects Pacific children and families. As a result of the DHB's lack of progress against the target, the Ministry requires the Funder to provide a resolution plan to identify additional opportunities in relation to increasing awareness within Pacific communities. This will further improve services provided in Primary Care and contributing to healthy housing initiatives as outlined below.

5.4 Healthy Housing Initiative

Procurement is now open on GETS for this new service in Auckland. This is an extension of the Rheumatic Fever Auckland Wide Housing Initiative, targeting vulnerable pregnant women and children hospitalised with a range of housing related medical conditions. The expanded service has been funded by the MoH. The community based service will complement a service provided by the DHB's provider arm service, providing social work services to patients who have, or are at risk of developing housing related health conditions. There is also a co-ordination arm to this service which will sit with the Funder.

5.5 National Child Health Information Platform

The draft business case for a National Child Health Information Platform (NCHIP), for the Northern Region, is being submitted to the regional Child Health Steering Group and other governance groups for sign off. NCHIP has the potential to better identify children who are missing out on the health services they are entitled to, and to drive system and service design around meeting the health needs of vulnerable children.

5.6 Oral health emergency dental services

The Funder is in the process of entering into contracts with providers selected through the procurement process. The start date for the new services is 1 January 2017. Additional providers identified through the procurement process will increase access to services within high needs areas.

5.7 Transgender Young People

Due to a gap in services in ADHB and recommendations from the Youth Clinical Governance Group and Youth Service Level Alliance Team, the Centre for Youth Health and Counties Manukau Health have entered into an agreement to deliver services to transgender young people domiciled in Auckland DHB during 2016/17.

Following a decision late last year by the Northern Region CEOs and CMOs, planning of transgender services is now underway. This is being supported by the recent appointment of a Transgender Clinical Leader, Dr Jeannie Oliphant. A project manager role has also recently been advertised.

6 Mental Health and Addictions

6.1 Youth Peer Support Service and Workforce – Co-design and Business Case development project

ADHB have completed an Expression of Interest (EOI) to allocate a project to develop youth peer support service design and identify workforce competency framework. This is one of the 2015/16 key actions of the Integrated Child and Youth Mental Health Addiction Strategy 2013-2023. The project scope broadly defines "youth peer support service" as a formalised or semi-formalised system of younger people with lived experience of distress providing some form of support to young people currently experiencing distress. There is little published research about youth peer support services, but according to the available research, at-risk young people are less intimidated by traditional services when they are supported (Mayber, 2006); (Olsson, 2005). This is a staged project with the service design and work force competency framework as stage one being completed by end of June 2016 and includes the development of the business case to identify funding required for the next stage of project that is piloting the service, evaluating and up scaling as appropriate.

6.2 Metro Auckland Collaborative, Training Primary Care Nurses in Mental Health Addictions

Metro Auckland DHBs and PHOs have formed a Collaborative to provide a regional Mental Health and addictions credentialing programme for Primary Health Care nurses based on Te Ao Māramatanga, New Zealand College of Mental Health Nurses (NZCMHN), Primary Care Nursing Mental Health and Addiction Credentialing Framework. A Collaborative approach has been undertaken to:

- Directly respond to the Government's priority agenda of integration and Mental Health needs of our communities
- Foster positive cross-working and joint-working approaches to provide one programme of learning to the Primary Health Care nursing workforce
- Endeavour to provide a service delivery model which can be sustained over the next two to five years as an example of innovative integration, to both serve community need and support workforce gaps.

An initial 'pilot' credentialing programme for primary health care nurses has been completed with 27 practice nurses graduating in late February 2016. The programme has been independently evaluated to assess the programme of learning, the model of service delivery and future programme sustainability. Key findings of the draft evaluation have been distributed amongst stakeholders, they demonstrate the credentialing process was found to be very valuable by participants, stakeholders also rated the programme's relevance, efficiency of implementation, effectiveness, and value for money as very good to excellent.

Auckland DHB, Waitemata DHB and Counties Manukau Health have agreed to fund the programme for 2016/17, with up to 60 Practice Nurses to be enrolled in the Mental Health and Addictions Credentialing Programme over two intakes throughout the year. Waitemata PHO has agreed to be the provider of this initiative which started on 1 July 2016.

6.3 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

This new legislation had its second reading in Parliament in November 2016. The third and final reading is expected in the New Year (2017), with a proposed date of commencement being 12 months, by 1 March 2018. Running alongside this Bill's parliamentary process is a project to draft a Northern Region SACAT model of care for Northland, Waitemata, Auckland and Counties Manukau DHBs. The model aims to outline a Northern Regional system for administration and implementation of the proposed SACAT legislation to address the demand within the Northern Region. The scope includes:

- All residents in Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau Health
- DHB funded AOD services in the Northern Region (NGO and DHB provider arm)

The draft model of care is being developed by the SACAT Technical Advisory Group on the basis of contributions from a range of alcohol and other drug (AOD) stakeholders from the Northern Region, who participated in Regional Workshops held from September to November 2016. A final workshop is planned for 15 November 2016 to add more detail to the model of care. The implementation of the new Act will have significant resource implications, with new activities and roles to be developed. The SACAT TAG and the Regional Workshop Participants have worked to identify the operational detail required to implement and administer the Act in sufficient detail to start identifying potential financial resources required.

The purpose of the Model of Care will:

- Describe the principles, aims and overall components of the SACAT pathway in the Northern Region
- Describe the interventions and actions to be delivered, who will deliver them, timeframes and locations
- Describe the skills, knowledge and behaviour required to deliver each stage of the service user journey
- Facilitate a consistent SACAT response in the Northern Region
- Assist clinicians and other stakeholders to interpret the legislation as it relates to alcohol and other drug assessment and treatment

The draft model describes the key stages of the SACAT response, from the point of referral to the point at which a person successfully exits from the Act. It also provides details on continuing care treatment and support options post discharge.

The SACAT project is on track to produce a draft model of care with an estimated additional funding framework by end of November 2016. The 12-month timeline for implementation of the Bill, when passed into an Act, will be a challenging timeframe to work towards without new MoH funding, towards DHB and NGO AOD Service Providers, to develop new and expanded services.

7. Maori Health Gain

7.1 Māori workforce Alliance Leadership Team

The Māori workforce Alliance Leadership Team (MALT) had its third meeting in late September 2016. Critical to monitoring progress for MALT is the introduction of a Māori Workforce scorecard for Auckland and Waitemata DHB. The focus of the scorecard for 2016/17 is achievement of the annual

workforce targets for overall workforce and ethnicity data quality. Data from this scorecard and the 2016/17 action plan will be used to report regularly to the Māori Health Gain Advisory Committee.

7.2 Ethnicity Data

The main issue for ethnicity date is ensuring quality ethnicity data collection and reporting for new and existing staff, that is aligned with Ministry of Health ethnicity data protocols (to collect to level 4). The target is to achieve capture ADHB ethnicity for 95% or more of our workforce. The main activities in this area are:

- Collecting ethnicity information from current ADHB staff who have not specified ethnicity
- Updating recruitment and on-boarding system processes of ethnicity data capture (including Taleo and Leader systems)
- Undertake an anonymised data match against NHI to determine the level of accuracy of current workforce ethnicity data.

Work has been completed, across both Auckland and Waitemata DHBs, to coordinate resourcing to carry out projects in the MALT action plan for 2016/17. The Māori Workforce Development Consultant is bringing the team together and assigning the projects.

7.3 Youth Connections

At the most recent MALT meeting the Team received a presentation from the Youth Connections Team, which discussed the challenges for youth employment locally, nationally and globally. This presentation included a proposal to become a Youth Connections pledge partner. MALT subsequently discussed and endorsed the request with a recommendation to be taken to the Auckland and Waitemata DHBs to become a Pledge partner. This document outlines the potential development of a Pledge partnership between Youth Connections, Waitemata, and Auckland District Health Boards and is considered elsewhere on the agenda as separate items.

Youth Connections is an initiative championed by Mayor Len Brown and Deputy Mayor Penny Hulse. It is supported by Auckland Council, Tindall Foundation, Mayors Taskforce for Jobs, Hugh Green Foundation and Auckland Airport Community Trust. Youth Connections' vision is to have all young people either working and earning, or learning and training. The goal of Youth Connections is to ensure that every young person has a plan and a direction to help them reach their potential. Youth Connections works with businesses, communities, youth services and schools to create connections between young people and employers.

Youth Connections provide leadership and solutions to local issues and encourage the business community to take a leading role for the future of their workforce. Youth Connections has worked collaboratively with the Metro Auckland district health boards to identify and initiate activation of youth employment opportunities and to seek DHB support as Pledge partners through the development of a pledge partnership (Counties Manukau Health is also in the process of considering becoming a Pledge partner). The focus of the Pledge is to work together to grow the Māori and Pasifika workforce with particular emphasis on building entry level opportunities for both academically and non-academically skilled youth.

8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)

A summary of the findings of the consultation meetings regarding renewing the Pacific Health Action Plan has been emailed back to those who had given their email address during the consultation meetings.

The actions from the eight priorities of the new plan are being negotiated with other Planning and Funding Teams as well as NGOs. The focus is not on new actions but better linking services in specific areas to Pacific people and seeking better outcomes. This process is organic and on-going.

8.2 PHAP Priority 1 – Children are safe and well and families are free of violence

Parenting and Living Without Violence programmes are being negotiated for implementation in Q3 and Q4 of the current financial year.

We participated in the consultation facilitated by ACC specifically about preventing and reducing harm from sexual violence.

In relation to rheumatic fever, we have participated in a number of meetings with the Ministry of Health Pacific providers and are working on developing a Pacific cultural best practice module for sore throats rapid response clinics, to be offered to clinics through their PHO.

In relation to the Healthy Babies and Healthy Futures (HBHF) programme, in the last quarter, 110 people have been trained to brief eligible mothers about engaging with the programme, 161 mothers have had direct conversations with HBHF Co-ordinators, 97 people have enrolled onto the TextMatch component of the programme and 26 mothers completed the face-to-face 6 module workshop.

8.3 PHAP Priority 2 –Pacific People are smoke-free

The report from the consultation with Tongan male smokers is being written and will be completed by the end of November.

Healthy Village Action Zones (HVAZ) co-ordinators are working with new churches that have recently joined the programme to get them to smoke-free status.

8.4 Priority 3 – Pacific people are active and eat healthy

The HAVZ Challenge will be completed on 19 November, with prize giving on 6 December.

A proposal is being developed for submission to Skills Active for 30 HVAZ and Enua Ola participants to be trained to National Level 3 Sports and Recreation Certificate. Skills Active is New Zealand's Industry Training Organisation (ITO) for the recreation, sport and exercise industries.

8.5 PHAP Priority 4–People seek medical and other help early

We are continuing to work closely with AH+ to ensure that data collected by the Fanau Ola integrated services contract is correct and that we can use this data as a basis for reviewing the funding formula for the service. The focus of the data review now, is the number and type of activities that were delivered to individuals and families, the number of hours that it took and the

outcomes that were achieved. The current contract was renewed until 31 December 2016 based on current service specifications, we will work towards new service specifications for a contract from 1 July 2017.

8.6 PHAP Priority 5 - Pacific people use hospital services when needed

The Pacific GM for Hospital Services reports on this priority.

8.7 PHAP Priority 6 – That Pacific people live in houses that are warm and are not over crowded

The recent consultation undertaken for renewing PHAP strongly supported the need to continue to focus on housing. This was priority number six in the last plan, but became priority number four in the consultation. This is perhaps no surprise in the current housing crisis in Auckland. We have made contact with Housing NZ and we will work towards using the HVAZ networks as a mechanism of linking Housing NZ to the community.

9. Asian, Migrant and Refugee Health Gain

9.1 Increase the DHBs' capability and capacity to deliver responsive systems and strategies to targeted Asian, migrant and refugee populations

The Final draft of the Asian International Benchmarking Report has been completed and is presented to the Board as a separate agenda item. A launch will follow in February 2017 as part of Chinese New Year celebrations.

9.2 Increase Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 75% (Auckland DHB) target by 30 June, 2017 (current rates 73% (Auckland DHB) as at Q4 2016)

The Asian PHO enrolment rate sits at 84% for Waitemata DHB and 73% for Auckland DHB, as at Q4 2016 (Figure 1). During 2012, the Asian rates were close between the two DHBs around 80%, but started to diverge at Q1 2013. At that time point, the rate began to progressively decrease for Auckland and increase for Waitemata DHB.

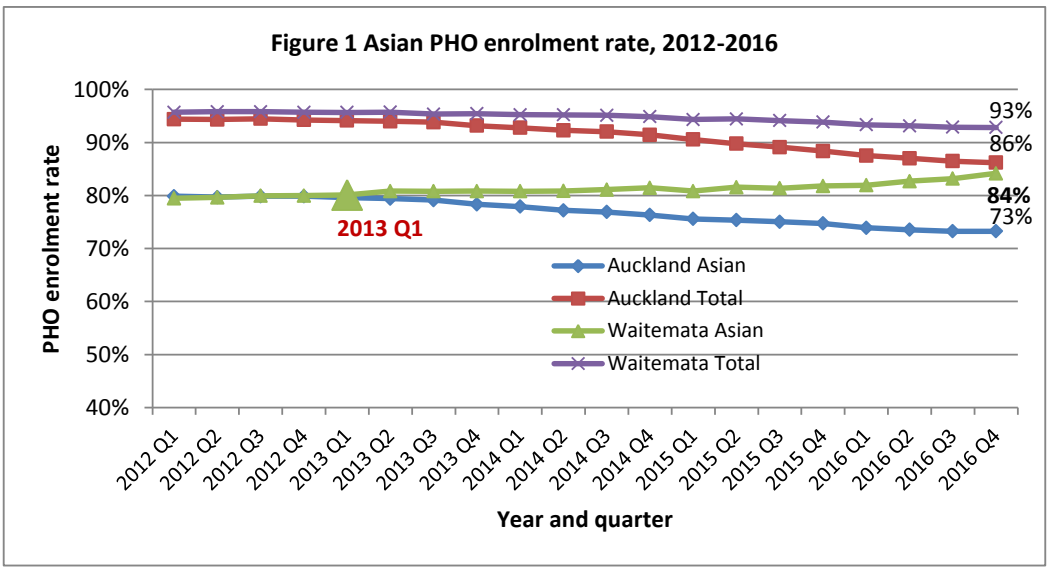
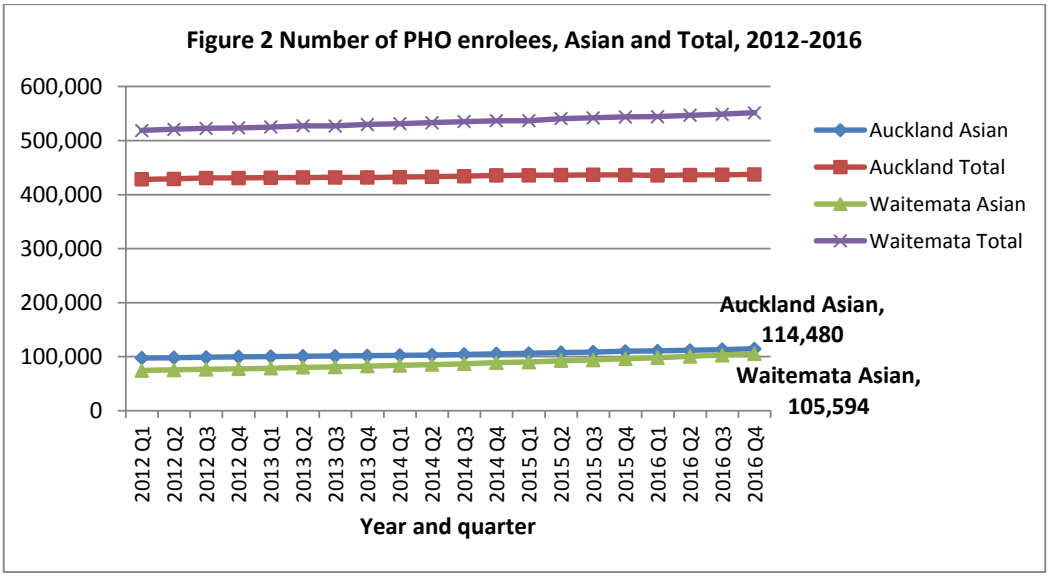
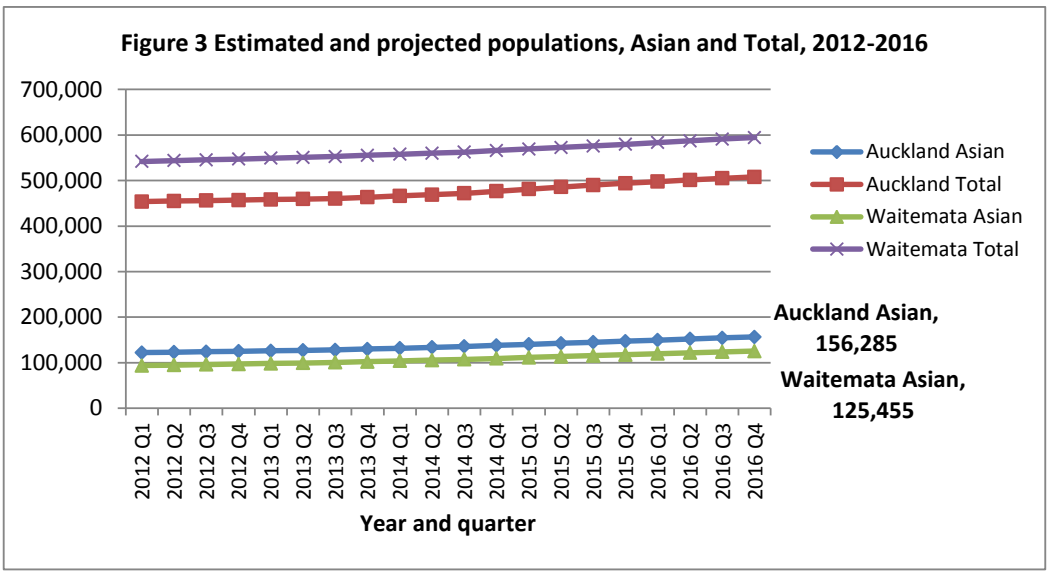


Figure 2 shows the number of PHO enrolees of Asian and total population for both DHBs between Q1 2012 and Q4 2016. There are 114,480 and 105,594 Asian PHO enrolees respectively in Auckland and Waitemata DHBs. The associated populations are shown in Figure 3.





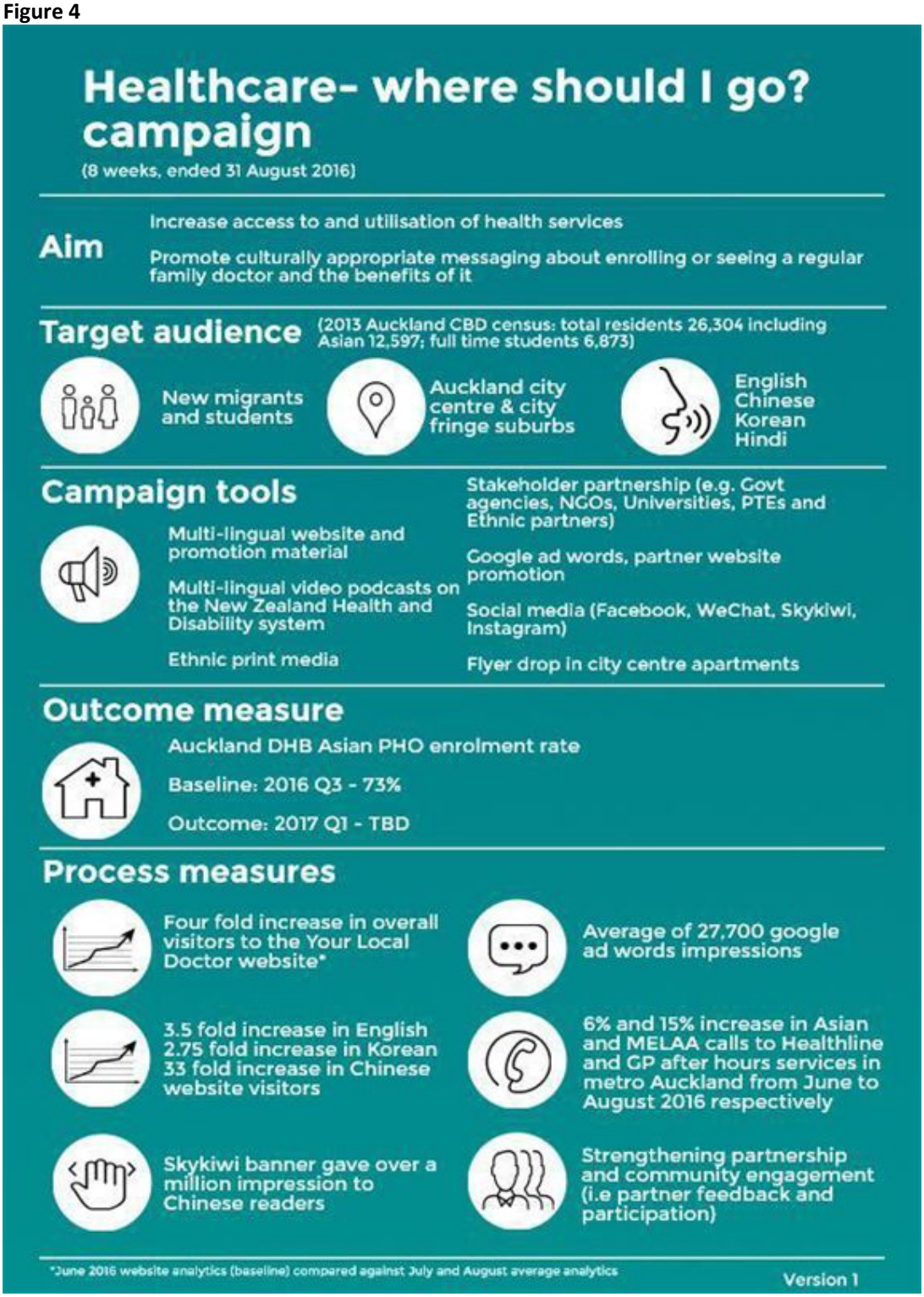
The lower Asian PHO enrolment rate for Auckland DHB cannot be simply explained by the increase of the Asian population, as Waitemata DHB has also had a significant increase between Q1 2013 and Q4 2016. It is thought a significant driver of the difference is the both the transient nature of the Asian population of Auckland DHB and the greater proportion of younger age-groups (20-24yrs, 25-29yrs) than that of Waitemata.

In response to the difference, we undertook a "*Healthcare – where should I go?*" campaign in Q3 2016 targeting Asian migrants and students of Auckland DHB living in the city centre and inner city fringe suburbs. Results to date are promising and are shown in Figure 4. There has been a positive increase in process measures however we won't know the impact on enrolment until Q1 2017.

Next Steps:

- Evaluation to date of the Phase 1 Healthcare- where should I go? campaign that rolled out in the Auckland CBD and inner city fringe suburbs is shown in figure 4.
- Explore the PHO enrolment data trends related to better understand any age and gender differences for both DHBs to inform further targeted key messages and campaigns. Phase 2 of a tailored and targeted Asian Healthcare- where should I go? campaign across Auckland and Waitemata DHBs is planned for roll out after Chinese New Year 2017 (Q1 2017).
- Phase 2 of a tailored and targeted Asian Healthcare- where should I go? campaign across Auckland and Waitemata DHBs is planned for roll out after Chinese New Year 2017 (Q1 2017)
- Inputs have been added to the development of a draft New Zealand International Student Wellbeing Strategy with a key focus on: 1) increasing awareness of the NZ health & disability system, and 2) access to, and utilisation of health services. As well as a Critical Response Workflow as part of membership with the Auckland Agency Group led by the Ministry of Education.
- A small working group led by Ailsa Claire (Chief Executive, Auckland DHB) has been established with membership by key DHBs across the country and MBIE is tasked to explore issues and costs related to over utilisation of health services by migrant communities. . We are working with MBIE's Chief Medical Officer on a project exploring PHO enrolment and visa type to understand visa type groups and enrolment behaviour to identify particular groups to target.

Figure 4


Healthcare- where should I go? campaign
(8 weeks, ended 31 August 2016)
Aim
Increase access to and utilisation of health services
Promote culturally appropriate messaging about enrolling or seeing a regular family doctor and the benefits of it
Target audience
(2013 Auckland CBD census: total residents 26,304 including Asian 12,597; full time students 6,873)
New migrants and students
Auckland city centre & city fringe suburbs
English
Chinese
Korean
Hindi
Campaign tools
Multi-lingual website and promotion material
Multi-lingual video podcasts on the New Zealand Health and Disability system
Ethnic print media
Stakeholder partnership (e.g. Govt agencies, NGOs, Universities, PTEs and Ethnic partners)
Google ad words, partner website promotion
Social media (Facebook, WeChat, Skykiwi, Instagram)
Flyer drop in city centre apartments
Outcome measure
Auckland DHB Asian PHO enrolment rate
Baseline: 2016 Q3 - 73%
Outcome: 2017 Q1 - TBD
Process measures
Four fold increase in overall visitors to the Your Local Doctor website*
Average of 27,700 google ad words impressions
3.5 fold increase in English
2.75 fold increase in Korean
33 fold increase in Chinese website visitors
6% and 15% increase in Asian and MELAA calls to Healthline and GP after hours services in metro Auckland from June to August 2016 respectively
Skykiwi banner gave over a million impression to Chinese readers
Strengthening partnership and community engagement (i.e partner feedback and participation)
*June 2016 website analytics (baseline) compared against July and August average analytics
Version 1

Strategic Initiatives – Youth Connections Pledge

Recommendation:

1. **That the Auckland District Health Board receives the report and recommendation from the Manawa Ora Committee**

2. **That the Board endorses the District Health Board becoming a Youth Employment Pledge Partner with Youth Connections.**

Prepared by: Aroha Haggie (Māori Health Gain Manager, Planning, Funding and Outcomes) and Vanessa Duthie (Māori Workforce Development Consultant)
Endorsed by:

Glossary

Auckland DHB	Auckland District Health Board
ATEED	Auckland Tourism, Events and Economic
DHBs	District Health Boards
NEET	Not involved in Education, Employment or Training
MALT	Māori Alliance Leadership Team
MOU	Memorandum of Understanding
Waitemata DHB	Waitemata District Health Board
Youth Connections	Auckland Council Youth Connections Team

1. Executive Summary

The aim of this paper is to attain Board approval for Auckland District Health Board to become a Youth Employment Pledge partner.

This report outlines the potential Youth Employment Pledge partnership between Youth Connections, Waitemata District Health Board, and Auckland District Health Boards, the steps involved in realising the commitment to the Pledge, and how being a Pledge partner will support the achievement of the Waitemata and Auckland DHBs existing Māori Health Workforce Development Strategy.

Youth Connections is an initiative championed by the Mayor and the Deputy Mayor of Auckland City Council. It is supported by Auckland Council, Tindall Foundation, Mayors Taskforce for Jobs, Hugh Green Foundation and Auckland Airport Community Trust. Youth Connections' vision is to have all young people either working and earning, or learning and training. The goal of Youth Connections is to ensure that every young person has a plan and a direction to help them reach their potential. Youth Connections provide leadership and solutions to local issues and encourage the business community to take a leading role for the future of their workforce.

Youth Connections has worked collaboratively with the metro-Auckland District Health Boards to identify and initiate activation of youth employment opportunities and to seek DHB support as Pledge partners through the development of a pledge partnership (CMDHB is also in the process of considering becoming a Pledge partner). The focus of the Pledge is to work together to grow the

Māori and Pasifika workforce with particular emphasis on building entry level opportunities for both academically and non-academically skilled youth.

On the 29th September 2016, the Māori Workforce Alliance Leadership Team (MALT) received a presentation from the Youth Connections team which discussed the challenges for youth employment locally, nationally and globally. This presentation included a proposal to become a Youth Employment Pledge Partners with Youth Connections. MALT subsequently discussed and endorsed the request for the Auckland and Waitemata DHBs to become a Pledge partner. This endorsement was presented to the Manawa Ora Committee on 5th October 2016.

Manawa Ora viewed the endorsement opportunity favourably and as such, this report recommends that the Auckland DHB Board move to become Youth Employment Pledge Partners with Waitemata DHB and Youth Connections.

2. Strategic Alignment

Community, whānau and patient centred model of care	Research shows that having a health workforce that better reflects the community we serve will support better health outcomes for our whole community.
Intelligence and insight	Canvassing issues and ensuring quality data are two areas of focus underpinning activity in workforce development.
Evidence informed decision making and practice	Research, data collection and evaluation of workforce development programmes.
Operational and financial sustainability	Includes contract management, and review of investment in programmes for workforce development.

3. Introduction/Background

The Auckland and Waitemata DHBs Māori Health Workforce Development Strategy 2014-2017 identified the need for a governance structure to oversee the achievement of a DHB workforce that reflects the ethnic make-up of the communities served. The Māori Alliance Leadership Team (MALT) was thus established in 2015 and has membership from both Auckland DHB/Waitemata DHB senior leadership Nursing, Human Resources and MOU partner representation from Te Runanga o Ngati Whatua and is Chaired by Waitemata DHB Chief Executive Officer Dr Dale Bramley.

An annual net target for Māori recruitment has been finalised and endorsed and articulated in Māori health plans for Auckland DHB/Waitemata DHB for 2016/17. The targets are aspirational, and achieving them requires the MALT to lead the implementation of a system-wide focus on increasing the proportion of Māori in the overall workforce and in eight priority professional groups.

Youth Connections is an initiative championed by the Auckland City Council Mayor and Deputy Mayor and is supported by Auckland Council, Tindall Foundation, Hugh Green Foundation and Auckland Airport Community Trust. Youth Connections works across the public and private sectors to collapse the space between work-ready young people and youth-ready employers. Youth Connections has a specific focus on Māori and Pasifika and their work complements the work of central government departments, such as the Ministry of Social Development and the Ministry of Education.

Auckland currently has around 23,000 young people who are not involved in education, employment or training (NEET). Unemployment levels in Auckland for youth between 15-24 years are at 22%. Combined with the fact there is a critical skills shortage in a number of sectors it is clear the region is facing a productivity crisis. This represents a substantial economic cost to society and an underutilised resource. It is vital that we address this issue for the future of Auckland's young people and for the social and economic development of the Auckland region.

Employers such as Auckland and Waitemata DHBs have entry-level opportunities available yet we experience challenges with finding enough suitable 'job-ready' candidates that meet our requirements.

4. Risks

These are the implications and risks associated with being Pledge partners, and how these can be mitigated/

Risk	Description	Mitigation
Pledge expectations.	Expectations created by Pledge not being achieved.	• Ensure that the Pledge is clear and aligned to current commitments and that DHB activities are appropriately resourced. • Communications strategy developed with Youth Connections to manage external communications.
Inability of DHB to influence other parts of the pipeline through Pledge partnership.	Pledge does not lead to increased influence of secondary and tertiary education providers and reflects negatively on DHB	• Continuous monitoring of data along the pipeline to the MALT. • 6 monthly reporting of activities to MALT.
Failure of whole of DHB system to demonstrate commitment to pledge	Increase in Māori workforce which is not able to be fully employed by Auckland and Waitemata DHBs.	• Ensure the sustainability of current DHB youth employment activities • Scope DHB roles identified as suitable for young people and monitor vacancies, applications and recruitment data for those

5. Approach, methodology and justification

5.1.1 Investigation

In a complex employment ecosystem businesses are lacking a centralised location that can facilitate the connection between unemployed youth and employer job positions the space is lacking an intentional employment matching service that communicates employer need and matches with employee skills. This means that silos are created in different sectors that are complex and fuel unintended competition and patch protection. Further to this DHB workforce development resources are diverted from achieving impact for young people and the DHB workforce to trying to understand and impact on a fragmented and complex system.

5.1.2 Research

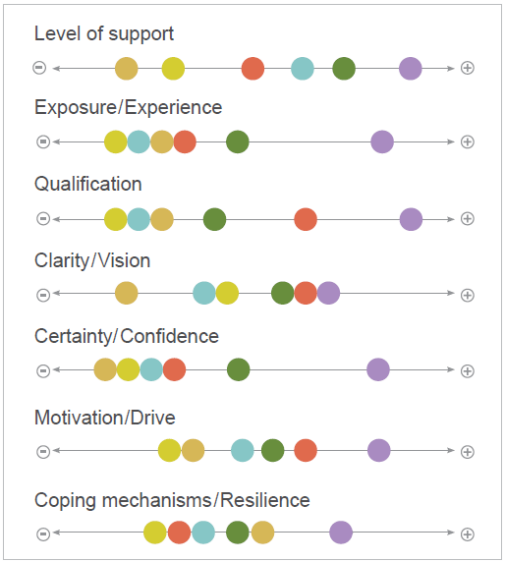
A recent literature review undertaken by Youth Connections which focused on understanding more about the world from an employer's perspective especially in relation to the pressures and experiences of hiring was informed by 20 empathy-based interviews across Auckland which varied in scale from small to large, and included both urban and rural businesses.

Employers Issues	**Observations**
Auckland Specific	• Māori and Pasifika have the highest rates of unemployment, particularly in Manukau and Papakura. • Restrictions such as not living locally can impact on an employer's decision to hire e.g. can this person easily get to and from work. • Auckland is home to more young people than any other city in New Zealand. • Almost half of all unemployed persons in Auckland are under 25 years of age.
Skills and experience	• Employers prefer experience over training when hiring young people • Young people are perceived to have a lack of experience. Employers find it hard to strong non-cognitive skills as well as technical expertise.
Education	• Business leaders are concerned that the education system is not providing the right set of skills, knowledge and attributes for young people to enter the workforce. • There is a mismatch between workforce demand and training. • Most education providers do not track what happens to students after they leave • Any qualifications must be credible to employers. • Young people can also be over-educated for employers.
Mentoring	• Taking on a new young employee can be costly, especially if it doesn't work out. • Church networks play an important role and often lead to 'first' opportunities • There is need and desire for more mentoring and support of youth.
Industry	• The fastest growing industry is construction. • Many of the youth-to-work initiatives currently in place and operating within communities are uncoordinated and share little to no best practice learning's. • More collaboration between industry and education is required to create career pathways.

5.1.3 Evidence

Further to this Youth Connections completed research with youth, the intent was to understand their current experiences when making the transition from school to employment. To do that effectively the researchers immersed themselves in understanding how young people make this transition, what if any support they may have, the tools they may have access to and how they are being utilised.

The collective insights across the youth research interviews were synthesised and distilled into 6 personas which best represented the key groups, particularly the research identified the variable experience of youth and indicate where further supports from employers may need to be built.



5.4 The Pledge

Signing up to this pledge means Auckland and Waitemata DHBs will work with Auckland Council and other organisations along the health workforce pipeline to build a strategic alliance and engagement with local boards, their Youth Connections teams and Auckland Tourism, Events and Economic Development (ATEED) to unblock the existing youth recruitment channels and identify ways to improve the supply chain by bringing business expertise and insight to the conversation.

All the benefits of being a pledge partner strongly align with the organisational goals of the DHB in relation to our Māori workforce development, including:

- A kite-mark that identifies you to council, government and other agencies/business as a pledge partner and a registered and quality youth employer
- Connections to ideas and information
- Celebration of DHB efforts and acknowledgement of DHB commitment at relevant ceremonies and events
- Partnerships with ATEED local offices, local boards and local Youth Connections teams to help DHBs navigate the landscape to find local opportunities in areas that matter to achieve DHB business
- Regional collaborations to resolve the hard problems by establishing government, business and community expert groups to design and develop initiatives with the Mayor's Youth Employment Traction Hub
- Connections, networks, government engagement through ATEED, the traction hub, Youth Connections networks and Auckland Council
- Insights and evidence to inform decision-making through research and evaluations gathered by Auckland Council, ATEED, Youth Connections and Youth Connections partners

6. Linkages/Impact

6.1 Strategic Context

The Northern Region Health Plan (NRHP) for 2016/17 has a range of activities to grow the capacity and capability of the DHBs Māori and Pacific Workforce. The overarching strategic approach is to

widen the pipeline and improve recruitment strategies and candidate support, areas which are expected to positively impact on the experience of young people applying for roles with DHBs.

Data provided by the Northern Regional Alliance confirms that:

- In the Auckland DHB catchment, the proportion of working-age Māori is **8%.**[1]
- In the Waitemata DHB catchment, the proportion of working age Māori is **9.4%.**

These percentages inform Māori staff recruitment targets over the next nine years, which all things being equal, will enable both DHBs workforce to reflect Māori working age population percentages by 2025.

Compared to resident populations of Auckland and Waitemata DHBs, Māori are critically under-represented in the DHB workforce. The variance or gaps shown below (Table 1) indicate that the current number of Māori employees would need to at least double to reflect the estimated population today.

Table 1: Ethnicity of DHB-employed workforce by headcount compared to population in June 2015

	Auckland DHB	**Waitemata DHB**
% of Māori in the workforce (Headcount)	3.9%	4.2%
% of Māori in the population	8%	9.4%
Variance	-4.1%	-5.2%

Table 2 demonstrates the slow progress that has been made to date to increase Māori in the workforce. For both DHBs the majority of Māori employed are in clinical roles or roles that have a direct relationship with Māori whānau, however since 2005 ADHBs Māori workforce has remained fairly static and WDHB has seen small but meaningful growth.

Table 2: Workforce Ethnicity Report, HWIP extracts to 30 June 2015.

	2011		**2015**		
Ethnicity	**HC**	**HC %**	**HC**	**HC %**	**Variation**
Auckland	373	3.9	343	3.9	-30
Waitemata	238	3.9	307	4.2	69
Total	611	3.9%	650	4%	39

The Māori Alliance Leadership Team (MALT) is the governance group overseeing the implementation of the Auckland DHB/Waitemata DHB Māori Health Workforce Development Action Plan 2016-2017. The Plan is designed to implement core workforce development strategic actions in the 2016-2017 fiscal year and it is aligned to the Māori Health Plans of both DHBs.

In seeking to respond and deliver against the Plan deliberate emphasis has been put into how the MALT not only work collaboratively to implement the actions across Auckland and Waitemata DHBs but also the northern region. With this in mind a set of prioritised activities have been developed by the MALT, these activities align to the areas for action in the Plan and expand on activities already occurring or where possible complement possible collaboration.

[1] The actual percentage is 7.8% however, we have rounded up this data for the purposes of this paper.

The MALT have identified that the Pledge Partnership with Youth Connections represents a key opportunity to promote and strengthen planned activities widely across sectors and communities.

As Pledge Partners the DHBs would access support, knowledge and leadership from Youth Connections to continue developing its overarching brand and communications by clustering engagement opportunities with stakeholders, sharing insights for tracking and managing relationships with stakeholders and youth, and convening strategic hui with tertiary education to enrol them in the cause. All these activities are in MALTs Action Plan for this financial year.

6.2 Impact on reducing inequalities and Māori Health Gain.

The New Zealand Public Health and Disability Act 2000 requires District Health Boards (DHBs) to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

Increasing Māori health workforce participation rates is fundamental to improving the quality and effectiveness of care as described in the DHBs Māori Health Plans (MHPs) which are fundamental planning, reporting and monitoring documents, underpinning the DHB's efforts to improve Māori health and reduce the disparities between Māori and non-Māori.

There exist longstanding issues such as low health qualification completion rates or for creating an organisational culture that will attract and retain Māori staff. Improvement in workforce disparities takes time, and requires leadership and commitment from a range of stakeholders. To achieve the desired level from 3-4% to 8-9% will require a whole-of-system approach to implementing the current workforce strategy, and will need systems, processes and policies for gathering intelligence and coordinating efforts.

The Waitemata-Auckland District Health Board's Māori Workforce Development strategy was commissioned by Te Rūnanga o Ngāti Whātua who have Treaty-based Memoranda of Understanding with Auckland and Waitemata District Health Boards. The Memoranda provide an opportunity to take a different approach to the way a strategy is developed; implemented and how funding decisions are made.

It is in this context that the establishment of an 'alliance leadership team' modelled on the DHB-PHO alliancing model is proposed. The Māori Alliance Leadership Team (MALT) oversees implementation of the workforce strategy and monitors performance. MALT is engaged in all Māori workforce planning and funding decisions that are 'best for whānau and best for system'.

The potential exists for Youth Connections and the DHBs to continue to work together using multi-sector (tertiary, secondary, health employers and community) forum to take words in strategies and have conversations about implementing them.

Therefore it is envisaged that one of the key outcomes of the Pledge Partnership will be to define and share what an 'exemplar' employer looks like – and encourage DHBs to stretch to be this.

7 Costs/Resources/Funding

It is important to note that there is no specific cost associated to becoming a pledge partner however it is expected that the DHBs and Youth Connections collectively work within current resources to deliver the actions outlined in the pledge.

8 Consultation/Engagement

8.1 Consultation already undertaken

A key approach has been to bring leaders and 'staff' that can implement strategy or provide solutions to strategies on the journey for change. An example of this is targeting the GMs Māori in DHBs with their voice and platform for change, and those who influence workforce development and Māori health outcomes.

The Pledge Partnership proposal has been presented to Tumu Whakarae the Māori DHB General Managers Forum, the Māori Alliance Leadership Team, the Manawa Ora Māori Health Gain Committee and all three representative groups have responded with positive endorsement for the opportunity.

Māori and Pasifika workforce development managers from across district health boards are also working through the respective processes to advance Pledge Partnerships for their DHBs.

9 Communications/Marketing

Harnessing the resources, networks and skills of the Youth Connections team to co-design communications strategies and implementation plans will enable sharing of messages to stakeholders around what the DHB activities are trying to prove or hoping to learn about responding to youth unemployment.

Internally, many different roles within the DHBs workforce hold the power and influence to make a change and contribute in a positive way to efforts to decrease/join the gaps between education, employment needs and whānau engagement, creating better alignment and smoother pathways. For example, a dynamic and multi-pronged communications implementation plan will ensure that Hiring Managers are aware of the value within the opportunity to hire young people, and the benefits, supports and enabling resources available to the organisation through the Pledge Partnership.

Externally, Youth Connections will contribute its employer and community insights to inform a DHBs communications implementation plan leveraging the established community of Pledge Partners across sectors. A communications strategy co-designed with Youth Connections will help ensure the DHBs aspirations and goals are enabled throughout the layers of the organisation and out into the communities we serve.

10 Implementation

10.1 Issues/considerations

Currently a range of workforce metrics are reported by the DHB Human Resources teams which provide information on workforce demographics, workforce indicators (employment status; role/ role category; turnover; length of service) and recruitment indicators (new job applications; applications reviewed; applicants interviewed; applicants hired including data on new graduate nurse applications via the Advanced Choice of Employment (ACE) scheme). There are however limitations to this data which means that we are not yet able to track a tauira (student) from the moment they touch our system, across their development pathway or understand their experiences and barriers.

10.2 Timelines

To become a pledge partner the DHB would be required to work with Youth Connections to undertake the following activities (the timeframe is indicative only):

Activity	Indicative timeframe
Seek endorsement from Auckland and Waitemata DHB Boards	December 2016
Develop and agree a set of principles and activities that make up the pledge	January 2017
Map work programmes for each partner, including: o Sharing lessons and insights gathered from other pledge partners o Developing a communications plan o Developing a DHB Champions to endorse and role model youth employment and growing the Māori workforce	February 2017
Create a joint reporting structure for the deliverables of the work	March 2017
A public event to complete sign-off of pledge between partners	April 2017
Six-monthly on-going reporting to Manawa Ora.	On-going

11 Conclusion

Young people are a critical source of labour, future skills, creativity and innovation and this proposal is an exciting opportunity for the DHBs to become Pledge Partners with Youth Connections in response to youth unemployment for Māori in Auckland.

Auckland unemployment for those aged 15-24 is 22% meaning 27, 200 Aucklanders aged 15-24 are not in education, employment or training. 27% of this group are Māori.

This issue represents economic as well as social risk to Auckland, and significant ongoing cost to Government in terms of tax loss and benefit spend at a macro-level. Locally, the Auckland DHB and Waitemata DHB have developed a joint Māori Workforce Development Strategy and related Action Plan with strong local regional and national alignment.

Youth Connections has already been working with the DHBs to align and promote the priorities within the Auckland and Waitemata DHB Māori Workforce Development Strategy and Action Plan with other organisations to promote a coordinated approach across sectors, and stakeholder groups.

There is no cost associated with becoming a Youth Employment Pledge Partner, but there is a structured approach to working in partnership with Youth Connections following the agreement to pledge. The activities to be undertaken as Pledge Partners are wholly aligned to the DHBs existing strategy and plan of activities for Māori workforce development in the 2016/17 financial year.

2017/18 Annual Plan Approach

Recommendation:

That the Board:

1. **Approve the approach to annual planning for 2017/18, including the timetable.**
2. **Note the national planning guidance, including updates and changes.**

Prepared by: Simon Bowen (Director – Health Outcomes), Wendy Bennett (Planning and Health Intelligence Manager)

Glossary:

DHB - District Health Board
MoH - Ministry of Health
SOI - Statement of Intent
SPE - Statement of Performance Expectation

1. Strategic Alignment

Community, whanau and patient centred model of care	Our Annual Plan demonstrates our commitment to our communities, patients and families through providing information on the priorities for the coming year and the associated activities to achieve these through improving health outcomes and enhancing patient experience.
Emphasis and investment on both treatment and keeping people healthy	Activities focused on both treatment and keeping people healthy are identified within the Annual Plan.
Consistent evidence informed decision making and practice	A range of indicators associated with the services and activities the DHB leads or is involved in are captured in the SPE and the MoH's reporting indicator section – along with targets for the coming year. Our Annual Plan demonstrates our commitment to achieving these.
Intelligence and insight	
Operational and financial sustainability	The Financial section of the Annual Plan lays out in detail the budget for the coming financial year. The Annual Plan also contains a variety of operational measures and targets we have committed to which will help us understand if we are delivering value and operating sustainably.

2. Executive Summary

DHBs are required to develop an Annual Plan each year.

As in previous years, the Ministry of Health has released an early draft of the 2017/18 DHB Annual Planning Package for consultation, before releasing a finalised version in December. The consultation draft indicates some significant changes in terms of content and format for 2017/18. A proposed approach and timeframes are included.

3. Draft Planning guidance – updates and changes

The Ministry of Health released the draft 2017/18 DHB Annual Planning Package – for consultation – in early November. Feedback is required by 30 November 2016.
The package proposes some significant changes to both content and format for 2017/18. These include:

- A reduction in length of the main body of the Plan to 30 pages
- The Statement of Performance Expectations, the Financial module and the DHB's System Level Measures Improvement Plan will now be included in the appendices
- The main section of the document – previously Module 2b which contains all of the DHB's deliverables and associated measures against each priority area – should be reduced to 10-12 pages (the equivalent section is approximately 30 pages in the 2016/17 Annual Plan) and must be included in the supplied template/table
- Additional priority sections: Disability Support Services, Pharmacy Action Plan, Delivery of Regional Service Plan
- Requirement for all DHBs to support the national roll-out of the bowel screening programme
- Removal of the requirement for a Maori Health Plan

Regional service plans will continue in their current form, but with an increased emphasis on the enablers.
Much of the guidance is still under development and performance measures and targets are still to be released.
The Minister will not be requesting that DHBs prepare SOIs in 2017/18. However, the integrated SOI and annual plan will be retained for every third year (or when requested by the Minister).

4. Proposed approach to Auckland Annual Planning

Given the review and feedback received on the 2016/17 Annual Plan and the 2015/16 Annual Report from AuditNZ, we would like to revisit the Auckland DHB SoI for 2017/18. It would clearly be advantageous to update the SoI to ensure that subsequent Annual Reports respond to the advice received as well as being acceptable to the Board and the public. We will therefore be requesting to make these amendments – which are mainly associated with language used and will not entail any wholesale changes.

The draft 2017/18 DHB Annual Planning Package has been disseminated to staff and other stakeholders to gather feedback and this will be collated for submission to the Ministry of Health within the consultation timeframes.

Although outside of the Ministry's official consultation timeframes, Board members are encouraged to provide any feedback they have on the draft 2017/18 DHB Annual Planning Package to the authors of this paper for late submission and consideration by the Ministry.

Given the very limited scope for input this year, we have elected not to organise a large scale planning day as was previously held early in the new year. However, given that ongoing discussions will be required throughout the process with PHOs, MoU partners and others to develop the priority area content, the planning team will facilitate and support smaller workshops as required.

A separate paper will be provided to the February FRAC meeting outlining the 2017/18 Annual Planning approach for the development of operational and capital expenditure budgets and Provider Arm volume contracts (Price Volume Schedules).

The timetable of key activities required to complete the plan is provisional as it has been developed based on the draft guidance provided by the Ministry of Health to date.

5. Sign Off Process and Timelines

Draft 1 of the Annual Plan will be presented to the February Board for consideration, with delegated approval sought for final sign off of the document via the March Finance, Risk and Assurance Committee (FRAC) meeting. The final draft will be presented for consideration in April, with sign-off of the final Annual Plan requested at the May Board meeting. Endorsement of the Annual Plan will also be sought at these critical stages from our MoU and other partners: Te Runanga o Ngati Whatua and designated primary care partners.

The final Annual Plan will require the signatures of the following:

- Board Chair
- One other Board member (for the Statement of Intent only)
- CEO
- The Chair of Te Runanga o Ngati Whatua

As in past years, it is proposed that any amendment or last minute changes to the Annual Plan, Statement of Performance Expectations and Statement of Intent be delegated to the Board Chair and the CEO. This provision allows flexibility to accommodate late information.

Regular oversight of the Annual Plan, the Statement of Performance Expectations and Statement of Intent while under development is the responsibility of the Director – Health Outcomes and the Director - Funding.

Provisional Timeframe

Note this timetable focuses on the non-financial elements of the planning process and does not include the budgeting process deadlines and milestones. Dates are provisional as 2017 Board and Committee meeting dates have not yet been finalised and no Ministry of Health timetable has yet been released.

Feb/March	Annual Plan content review and revisions continue
15 March	Auckland DHB FRAC meeting to review Auckland DHB 2017/18 Annual Plan – draft 1
29 March	Auckland DHB CPHAC meeting to approve Auckland DHB 2017/18 Annual Plan – draft 1
31 March	**2017/18 Annual Plans (including Statements of Intent) and Northern Region Health Plan submitted to the Ministry of Health as a draft for review**
Week beginning 1 May 2017	Ministry of Health provides feedback on draft Annual Plans
26 April	FRAC meeting: review of 2017/18 Auckland DHB Annual Plan (including Statement of Intent) draft 2 (including any changes made in response to MoH feedback)
17 May	Auckland DHB Board meeting: Final Annual Plan for approval
31 May	**Board-approved 2017/18 Annual Plans (including Statements of Intent) and**

	Northern Region Health Plan submitted to the Ministry of Health
From 13 June	Minister's letters to DHBs indicating approval or changes required for APs and RSPs
17 June	DHBs submit final AP with SOIs and SPEs, and RSPs to Minister for approval

6. Risks, Opportunities and Mitigations

Risk area	Specifically	Mitigation
Agreeing the right format, approach and content for the Annual Plan. Ensuring we retain focus on the right priorities for our population.	Given the significant changes proposed by the Ministry of Health for the Annual Plan, ensuring the right balance of government and local priority setting will be challenging.	Feedback to MoH re: over-prescriptiveness of guidance, need to allow for greater local priority setting and planning.
Active leadership of priority area content development. Adequately engaging with a wide range of stakeholders.	The increased prescriptiveness of the MoH guidance gives limited scope for input from stakeholders. However, there is still an expectation for DHBs to engage with relevant stakeholders, including their primary care partners, when developing their 2017/18 APs.	Early advice to staff and regular communication that keeps everyone up to date with planning expectations for 2017/18 throughout the process. Clear roles and responsibilities identified early in the process. Responsible authors identified at the start of the process and their role clear in December. Active support and facilitation of engagement opportunities.

7. Conclusion

2017/18 will present some challenges as we develop Annual Plans, Statements of Intent and Statements of Performance Expectations in line with the Ministry's significant proposed changes to the Annual Plan content and format. Key to our success is gaining endorsement from the Board for the proposed planning process. We will also need to make sure content development is appropriately assigned and led and that all key stakeholders are informed about the approach and have an opportunity to provide input into the planning process, given the changes to requirements and process.

Statement of Performance Expectations (SPE) Reporting

Recommendation:

That the Board:

1. **Reviews the proposed scorecard layout and content and provides feedback;**
2. **Reviews and approves the proposed reporting framework and frequency;**

Notes:

3. **That management will continue to work on the SPE scorecard (draft only included);**
4. **That management will develop a report to enable reporting against variance within the SPE scorecard**

Prepared by: Simon Bowen, (Director Health Outcomes) and Wendy Bennett (Manager Planning & Health Intelligence)

Glossary

AP - Annual Plan
CE Act - Crown Entities Act
DHB - District Health Board
MoH - Ministry of Health
SoI - Statement of Intent
SPE - Statement of Performance Expectations

1. Strategic Alignment

Community, whanau and patient centred model of care	SPE reporting demonstrates our commitment to our communities, patients and families through providing information on our services and progress made over the financial year in improving health outcomes and patient experience.
Emphasis and investment on both treatment and keeping people healthy	A range of indicators associated with the services and activities the DHB leads or is involved in are captured in the SPE – progress across the spectrum of care is measured and reported on
Consistent evidence informed decision making and practice	SPE reporting will monitor our achievement against the measures and targets we committed to in the Annual Plan/SoI to help us understand our progress and identify any gaps in performance.
Intelligence and insight	
Operational and financial sustainability	SPE reporting will reflect on our achievement against a variety of operational measures and targets we committed to in the Annual Plan to help us understand if we are delivering value and operating sustainably.

2. Executive Summary

The Board has requested regular reporting of the indicators in the Statement of Performance Expectations that makes up a key component of the Annual Plan. This paper outlines the proposed reporting structure and includes a draft (early version) of the proposed scorecard for review.

3. Background

Each DHB has a statutory responsibility to prepare:

- an Annual Plan for approval by the Minister of Health (Section 38 of the New Zealand Public Health and Disability Act 2000) – providing accountability to the Minister of Health
- a Statement of Performance Expectations (Section 149C of the Crown Entities Act 2004 as amended by the Crown Entities Amendment Act 2013) – providing financial accountability to Parliament and the public annually
- a Statement of Intent (Section 139 of the CE Act) – providing accountability to Parliament and the public at least triennially.

Measures within the Statement of Performance Expectations (Module 3 of the Annual Plan) represent the outputs/activities we deliver to meet our goals and objectives in the first two modules of the Annual Plan, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of cornerstone indicators. Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures is reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ.

Four Output Classes are used by all DHBs to reflect the nature of services provided. The Output Class categories are:

- Prevention
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support.

4. SPE reporting

Many of the indicators included in the SPE are currently reported via other scorecards/reports to Board and Board Committees. It is proposed that SPE reporting will be prepared quarterly for the Board and will include the SPE scorecard (see appendix 1) along with variance reporting against any indicators where performance is not tracking to target. Note that the scorecard will not include those indicators for which data is only available annually. Also the variance report will exclude where variance is reported elsewhere for those indicators included in other reports. The proposed scorecard and report are still under development and reporting mechanisms are still to be finalised.

5. Conclusion

The development of the SPE scorecard and associated report is underway and we ask that the Board consider the proposed scorecard and reporting framework format and content and provide feedback and endorsement.

Appendix 1:

Auckland DHB Performance Scorecard

Statement of Performance Expectations

Quarter 1

2016/17

Output Class 1: Prevention Services

	Actual	Target	Trend
Health Promotion			
Better help for smokers to quit - hospitalised	*95%*	*95%*	--
Better help for smokers - Primary Care	87%	90%	▼
Better help for smokers - Maternity	100%	90%	--
Raising Healthy kids	*74%*	*95%*	▲
Green Prescriptions - adults	1,439	1,538	▲
Health Protection (ARPHS - all northern region DHB results)			
Tobacco retailer compliance checks conducted (YTD)	0	0	▼
% of TB treatments with start date	100%	85%	--
Population based screening			
Breast screening coverage	63%	70%	▼
Newborn hearing - % babies offered screening within 1 month	96%	90%	▲
Referral rate to audiology	1.2%	<4%	▲
Audiology services by 6 month of age	100%	≥95%	--
Percentage of B4 School Checks completed (YTD)	24%	23%	▲

Output Class 2: Early Detection and Management

	Actual	Target	Trend
Primary health care			
Primary care enrolment	88%	95%	--
POAC Referrals YTD	1624	1750	▲
Increased immunisation (8-month old)	93%	95%	--
Cervical Screening	73%	80%	▼
Diabetes management	73%	61%	▲
CVD on Triple therapy	*53%*	*55%*	
% CVD risk assessed in last 5 years	92%	90%	▼
Community referred testing and diagnostics			
GP referred radiological tests (YTD)	6,550	5,704	▼
% CTs completed within 6 weeks	96%	95%	▼
% MRIs completed within 6 weeks	77%	85%	▼

Output Class 4: Rehabilitation and Support Services

	Actual	Target	Trend
Home-based support			
Long term support 65+ who have had interRAI	97%	100%	▼
% urgent InterRAI assessed in 5 working days	70%	90%	
% non-urgent InterRAI assessed in 15 working days	92%	90%	
Palliative Care			
Number of contacts (YTD)	2,469		
Proportion of hospice patient deaths that occur at home	25%		
Proportion of referrals that wait >48 hours for a hospice bed	5%		
Residential Care			
ARC providers with 4 year audit certification	31%		

Output Class 3: Intensive Assessment and Treatment

	Actual	Target	Trend
Acute services			
Number of ED attendances (YTD)	28,423		
Total acute WIES (DHB Provider - YTD)	25,604	25,682	▲
Shorter Waits in ED	95%	95%	--
Faster cancer treatment - within 62 days	79%	85%	▲
% of eligible stroke patients thrombolysed	*12%*	*6%*	▲
% of stroke patients admitted to stroke unit	*91%*	*80%*	▲
Coronary angiography in 3 days (ACS patients)	84%	70%	▼
Maternity			
Number of births in Auckland DHB hospitals (YTD)	1,872		
% primiparous vaginal births with 3rd/4th degree tears	5.9%	↓	
Elective (inpatient/outpatient)			
HT: elective surgical discharges	93%	100%	▼
Surgical intervention rates (SIR) - joints	*17.7*	*21*	▼
SIR - cataracts	*36.6*	*27*	▼
SIR - cardiac	*5.2*	*6.5*	▼
SIR - PCR	*11.2*	*12.5*	▼
SIR - angiogram	*30.8*	*34.7*	▼
% urgent diagnostic colonoscopy in 14 days	94%	85%	▼
% non-urgent diagnostic colonoscopy in 42 days	95%	70%	▲
% waiting > 4 months for their FSA (ESPI 2)	0.22%	0.40%	▼
% waiting > 4 months for their treatment (ESPI 5)	2.06%	1.00%	▼
Quality and patient safety (HQSC)			
Percentage of opportunities for hand hygiene taken	*84%*	*80%*	▲
Older patients assessed for risk of falling	*95%*	*90%*	▲
Hip & Knee operations with prophylactic antibiotic given	*94%*	*100%*	▼
Staph bacteraemia rate per 1,000 inpatient bed days	*0.0001*	*0.2*	▲
% of inpatients who rate care very good or excellent	85%	90%	▼
Mental health			
Mental health service access 0-19	*3.2%*	*3.0%*	▲
Mental health service access 20-64	*3.8%*	*3.7%*	▲
Mental health service access 65+	*3.1%*	*3.1%*	▲
0-19 Mental Health waiting within 3 weeks	*75%*	*80%*	▲
0-19 Mental Health waiting within 8 weeks	*89%*	*95%*	▼
0-19 Addictions waiting within 3 weeks	*96%*	*80%*	▲
0-19 Addictions waiting within 8 weeks	*100%*	*95%*	▲

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

ESPI traffic lights follow MoH criteria:

ESPI 2	ESPI 5
0	0
< 0.4%	< 1%
≥ 0.4%	≥ 1%

A Question?

9.2

2015/2016 Quality Account

Recommendation

That the 2015/2016 Quality Account report be approved.

Prepared by: Sue Waters, Chief Health Professions Officer & Dr Andrew Old, Chief of Strategy, Participation & Improvement
Endorsed by: Ailsa Claire (Chief Executive)

1. Introduction

This 2015/16 Quality Account has been produced in an A4 Portrait format, which is a companion format to this year's Annual Report. Note that photos and graphs herein are in low resolution to reduce file size (and some will appear slightly fuzzy). These will be corrected to high resolution print quality once approved by the Board for publication.

The content format follows the guidance provided to the sector by the HQSC:
http://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/QA-guidance-manual-May-2014.pdf

2. Acknowledgements

We would like to acknowledge the project team, led by Sue Waters, who developed this document:

- Dr Andrew Old, Chief of Strategy, Participation and Improvement
- Dr Andrew Jull, Nurse Advisor, Quality and Safety
- Dr Colin McArthur, Medical Advisor, Quality and Safety
- Leigh Manson, Project Director, Performance Improvement
- Jeremy Muirhead, Performance Management Officer
- Bruce Levi, General Manager Pacific Health, Waitemata DHB/Auckland DHB
- Dr Nelson Aguirre, Acting Quality Manager
- Verbena Miller-Whippy, Administration Support.

AUCKLAND DISTRICT HEALTH BOARD

Quality Account 2015/16

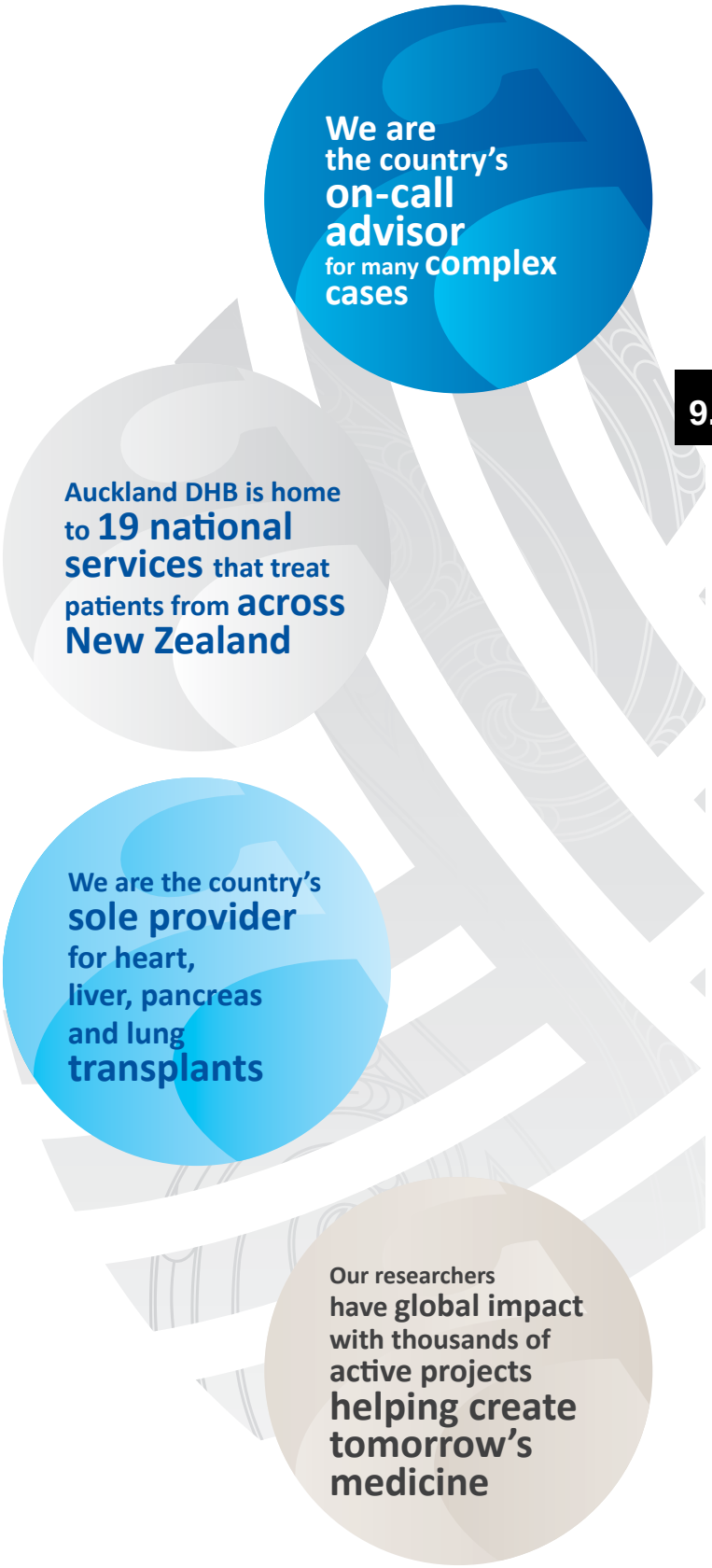
Welcome *Haere Mai* Respect *Manaaki* Together *Tūhono* Aim High *Angamua*

AUCKLAND DISTRICT HEALTH BOARD *Te Toka Tumai*

What we do

Auckland District Health Board is the government's funder and provider of health services to 510,000 residents living in the Auckland isthmus and the islands of the Hauraki Gulf. Our services are delivered from Auckland City Hospital, which is the country's largest public hospital, Greenlane Clinical Centre, and a number of specialist centres. There are approximately one million patient contacts each year, including hospital and outpatient services and we deliver these services with an annual budget of approximately $2.1 billion. We employ nearly 10,000 health and medical staff, or the equivalent of just over 8,000 full-time positions.

We provide a unique portfolio of services compared to other district health boards (DHBs) in New Zealand. Some of these services are provided solely by us for the country as a whole and a small subset of services are only offered by a few other DHBs. We are the "provider of last resort" for many conditions for many New Zealanders, as well as Pacific Island people for a number of services, and we play a significant role in the training of the New Zealand health workforce. Our DHB population grows by 40,000 people every five years and by 2026, it is estimated Auckland DHB will cater to an additional local population equivalent to Palmerston North.



9.3

We have the most **active clinical research** facility in New Zealand

Over **1,000** health professionals are training at Auckland DHB at any given time

We make **1 million** patient contacts each year

We provide New Zealand's **specialised paediatric services** and **high-risk obstetrics**

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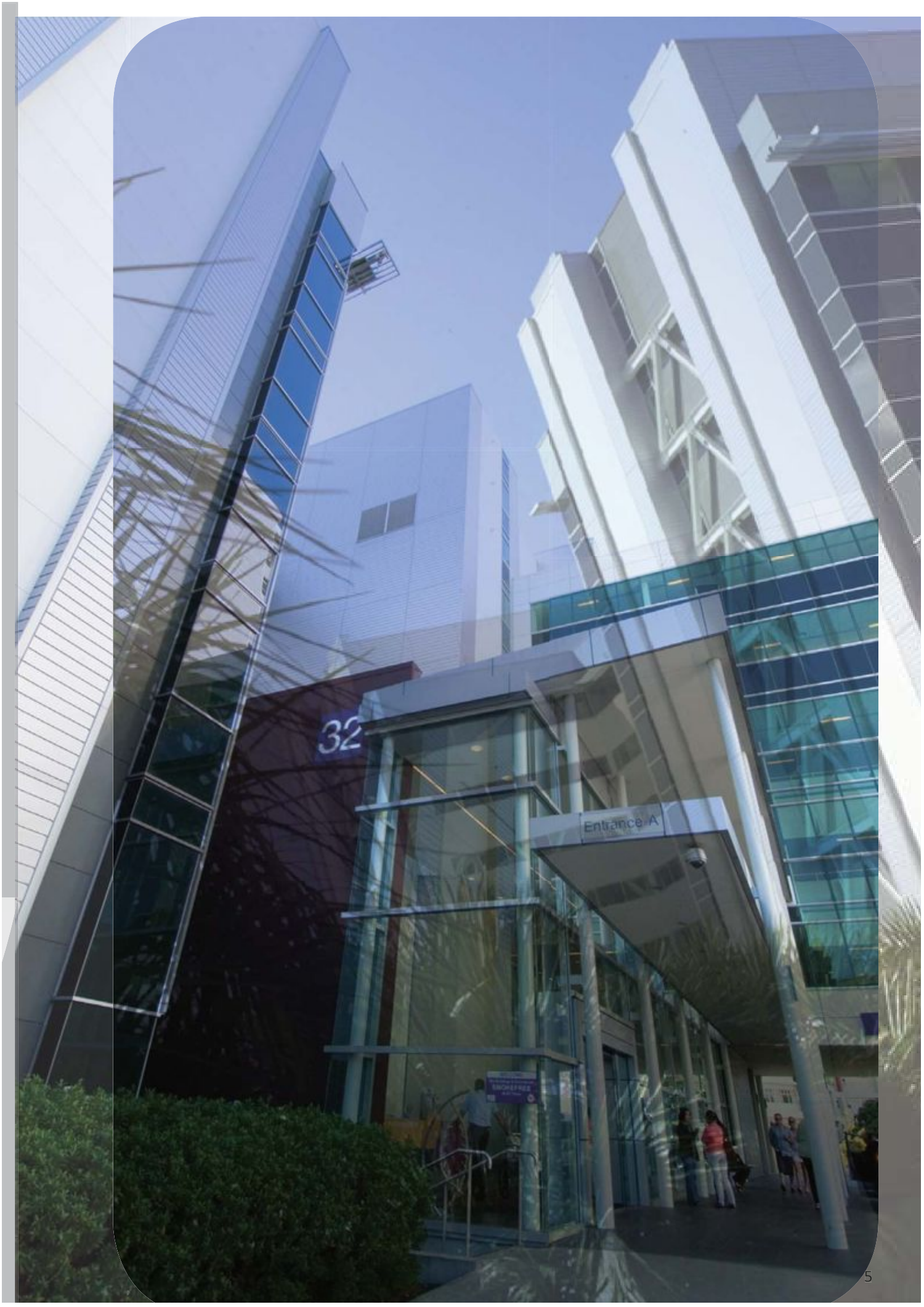
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Entrance A

Opening statements

Section 1

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

What quality means

At Auckland DHB we define quality as the provision of care that is safe, effective, efficient, equitable, all of which contribute to a positive patient experience.

Our Quality Account

The Board and Executive team of Auckland DHB have reviewed this Quality Account and are confident it provides an accurate overview of the quality improvement initiatives across the organisation. Quality and safety of care is a continuous journey and one that we are committed to for our patients, our staff, the wider DHB population and healthcare stakeholders.

What this report can tell you

This Quality Account describes the quality activities and performance of Auckland DHB for the financial year 1 July 2015 to 30 June 2016. It is split into three main sections: Opening statements, Performance review and Future focus.

In the Opening statements you can find a summary of our performance, both written and graphically. The Performance review section is split into two: Nationally consistent criteria and Our quality initiatives. In the former you can read about our performance against the national health targets and other markers consistent across DHBs throughout the country. We have used the quality initiatives section to personalise our quality story and illustrate the range of initiatives taking place across the organisation. Finally, in section three, we explain our priorities for improvement for the next financial year and beyond.

Quality Account team

A project team led by Sue Waters, our Chief Health Professions Officer, developed this document. Members of the team are:

Sue Waters, Chief Health Professions Officer; Dr Andrew Old, Chief of Strategy, Participation and Improvement; Dr Andrew Jull, Nurse Advisor, Quality and Safety; Dr Colin McArthur, Medical Advisor, Quality and Safety; Leigh Manson, Project Director, Performance Improvement; Jeremy Muirhead, Performance Management Officer; Bruce Levi, General Manager Pacific Health, Waitemata DHB/ Auckland DHB; Dr Nelson Aguirre, Acting Quality Manager; Verbena Miller-Whippy, Administration Support.

Digital version

A copy of our Quality Account is available in PDF format on the Publications page of our website.

What do you think?

We welcome feedback on the Quality Account from all our stakeholders, which we will take on board for future reports. Comments can be directed to:

QualityAccount@adhb.govt.nz or
Chief Executive Officer, Auckland District Health Board, Private Bag 92189, Auckland Mail Centre, Auckland 1142.

Foreword

Welcome to Auckland DHB's fourth Quality Account. This report tells the story of our key achievements and what we're doing to improve the quality, safety and experience of healthcare for all of our patients, whether in the hospital, or in Auckland, or further afield.

People often forget that we do much more than run hospitals. It's our role to lift the health of our community, at last count, 510,000 and steadily growing, and that means working alongside communities to keep people well.

Our job is to enable health and wellbeing through high-quality health and healthcare services, and a commitment to innovation, education and research. Our challenge is to have services in our hospitals and in the community so well coordinated that it feels like one single health system – Health Auckland. And our focus isn't only on the Auckland population. Half our patients come from outside the Auckland DHB region as many of our specialist services provide care and treatment for people living across the upper North Island and throughout the country.

This year we are pleased to report that we have met or exceeded three of the national health targets and made strong progress for the remainder, in the face of increasing demand for all our services this year. Fresh initiatives tell a story of further improvement across the Health Quality & Safety Commission's Quality Safety Markers.

We also want you to know about the many ways we're improving healthcare for our patients throughout our organisation. In our hospitals, we have significantly reduced the wait times for breast cancer patients. In the community we are working with a wide range of partners and Ngāti Whātua to bring healthcare and services closer to where people live in Tamaki. A community-led programme to immunise children against rotavirus has been followed by a significant drop in children with gastroenteritis requiring treatment in hospital and alongside that; reduced the stress on families of a very ill child. With Coeliac New Zealand, we have created support networks for children with coeliac disease to manage their illness with community support. This has worked so well that there's now almost a zero waiting time for hospital specialist appointments.

We want to make sure our communities and patients are part of how we plan and deliver healthcare. Co-design with patients and communities has been a core part of projects ranging from how we can offer reassurance and information in a child-centred way, to children who have broken a limb, to the design of universal translator cards for patients who have difficulty speaking or have English as a second language.

Our organisational strategy directly drives our work. We are evolving to a community, family/whānau and patient centric model of healthcare. The best investment we can make is in keeping people healthy and that investment must be based on the best evidence from good intelligence, and sharp insights, to ensure our resources are spent wisely and well.

There's always risk in healthcare. We don't and cannot always get it right for patients. But what's important is that we acknowledge this and do something about it. That's why we also report on adverse events publicly in our Quality Account. When something goes wrong and it results in an adverse event, which is a major loss of function or death; our obligation to the patient and their family and whānau is to investigate what happened. Thankfully, adverse events happen rarely compared to the number of patients we care for, but they have a big impact on the family and whānau, and our staff, who all deserve to know what we are doing to prevent it happening again.

We encourage you to continue reading our Quality Account and learn about the great work of our people, which pays many times over in health outcomes for our patients.

Dr Lester Levy, CNZM | Chair
Auckland District Health Board

Ailsa Claire, OBE | Chief Executive
Auckland District Health Board

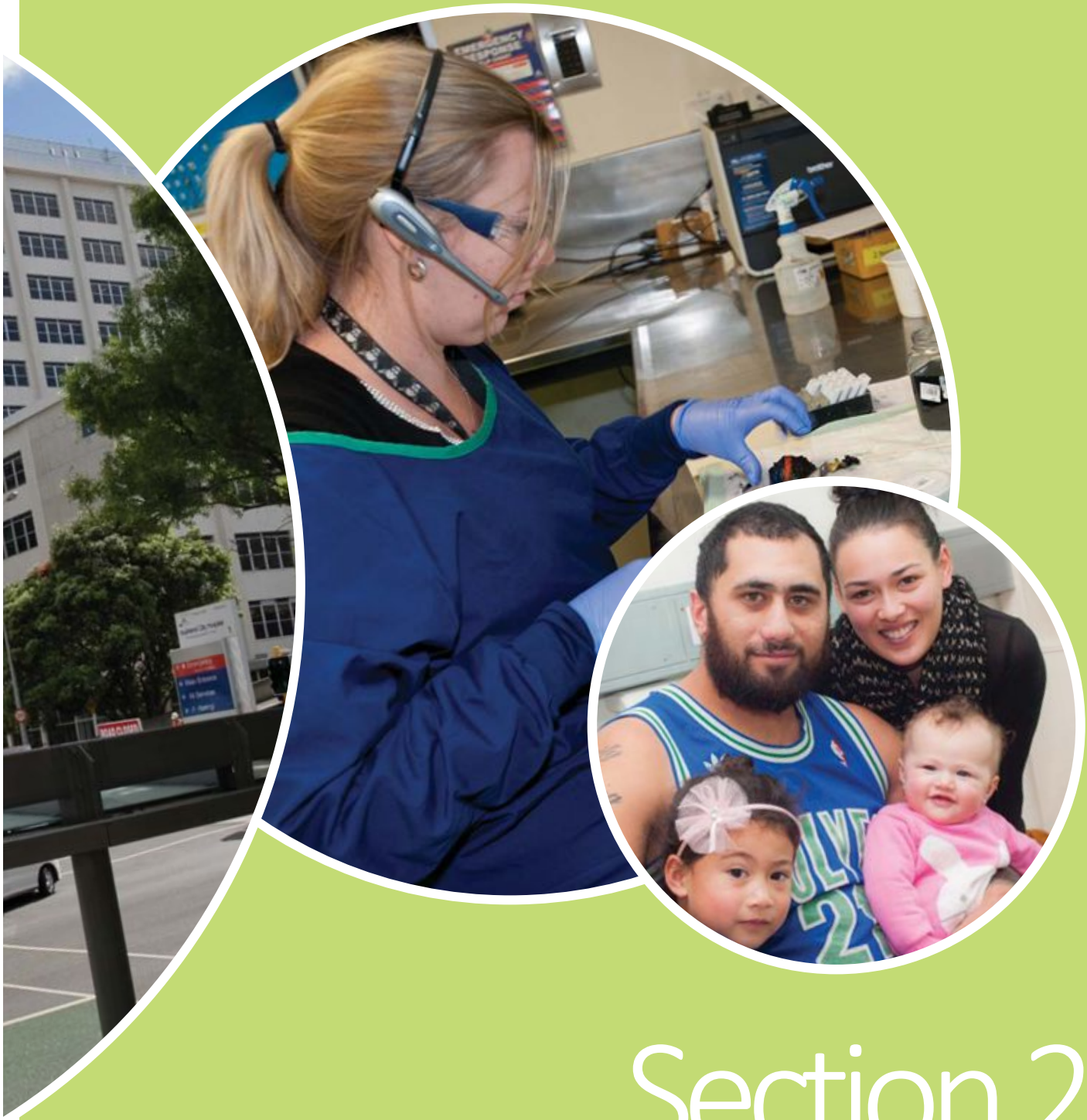
New Zealand Health Strategy – Five strategic themes

All DHBs make strong commitments to the government's New Zealand Health Strategy in their annual plans. The strategy has five guiding and interconnected themes. The links among them reflect the balance that everyone working in the system has to strike between what is best for people's health and wellbeing at individual and population levels, and what is affordable and possible.

Finding this balance involves choices. Sometimes there are trade-offs; for example, when someone can't get an appointment as soon as they want because the service is dealing with more urgent needs. A great system will find a balance that matches the most important needs with the best use of skills and resources. The aim is to have a more integrated and cohesive system that works in the best interests of New Zealanders.

9.3

Performance review



Section 2

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Health targets

There are six national health targets set by the Ministry of Health to track how well district health boards are providing services to their communities. The targets include both preventative health and hospital service measures and are publicly reported each quarter.

Auckland DHB has a number of programmes in place designed to help meet the targets. Improving our targets takes an all-of-health-sector approach and we have strong relationships with our primary and community based partners to ensure that people receive the services, check-ups and information they need to help them stay well.

9.3

2015/16 Health Targets

	Target	Q1	Q2	Q3	Q4	Achievement
Shorter stays in Emergency Departments 95% of patients admitted, discharged, or transferred from an Emergency Department (ED) within six hours.	**95%**	93%	95%	95%	95%	✓ Achieved
Improved access to elective surgery An increase in the volume of elective surgery by at least 4000 discharges per year.	**100%**	93%	98%	98%	101%	✓ Achieved
Faster cancer treatment 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer (HSC) and a need to be seen within 2 weeks.	**85%**	66%	70%	75%	77%	Good progress to target
Increased immunisation 95% of 8-month-olds have their primary course of immunisation at 6 weeks, 3 months and 5 months on time.	**95%**	95%	94%	94%	94%	Good progress to target
Better help for smokers to quit 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	**95%**	83%	85%	86%	88%	Good progress to target
90% of patients who smoke and are seen by a health practitioner in primary care are offered brief advice and support to quit smoking.	**90%**	85%	86%	88%	91%	✓ Achieved
More heart and diabetes checks 90% of the eligible population have had their cardiovascular risk assessed in the last 5 years.	**90%**	92%	92%	92%	92%	✓ Achieved

More information on health targets: www.health.govt.nz/new-zealand-health-system/health-targets

Health target

Shorter stays in Emergency Departments

"Overall, Auckland DHB has consistently met, or achieved higher than, the national health target for shorter stays in Emergency Departments over the past two years, which is a credit to all our teams."

Anil Nair, Clinical Director- Adult Emergency Department

✓ Target Achieved

Fast facts:

- ✓ Our EDs cared for nearly 100,000 patients (98,542) which was 5.6% more than last year
- ✓ 95% of patients are receiving their second observation within four hours of first being seen
- ✓ In the last three quarters of the year, 95% of patients were discharged, admitted or transferred from ED within six hours

Our Emergency Departments (Child and Adult EDs) took care of more people than ever; 98,542 patients, compared with approximately 93,300 the previous year. We met the target three out of the four quarters, with 95% of patients discharged, admitted or transferred from ED within six hours. The demand for our services keeps growing – a 50% increase in the number of patients presenting to the adult ED in the past seven years, from just over 43,000 in 2008/2009 to more than 66,500 in 2015/2016.

Adult ED ambulatory care

Each day 25 to 30 patients are treated for minor conditions in a new ambulatory care area within Adult ED, which opened in June 2016. This has reduced the waiting time for ED beds for our more serious patients.

Pharmacist trial in Adult ED

Following a successful trial, a pharmacist is now working alongside our medical teams in Adult ED and in the Assessment and Planning Unit (APU). The pharmacist's job is to reconcile patient medicines at admission ensuring improved quality, reduced medication errors and shorter wait times.

Children seen faster

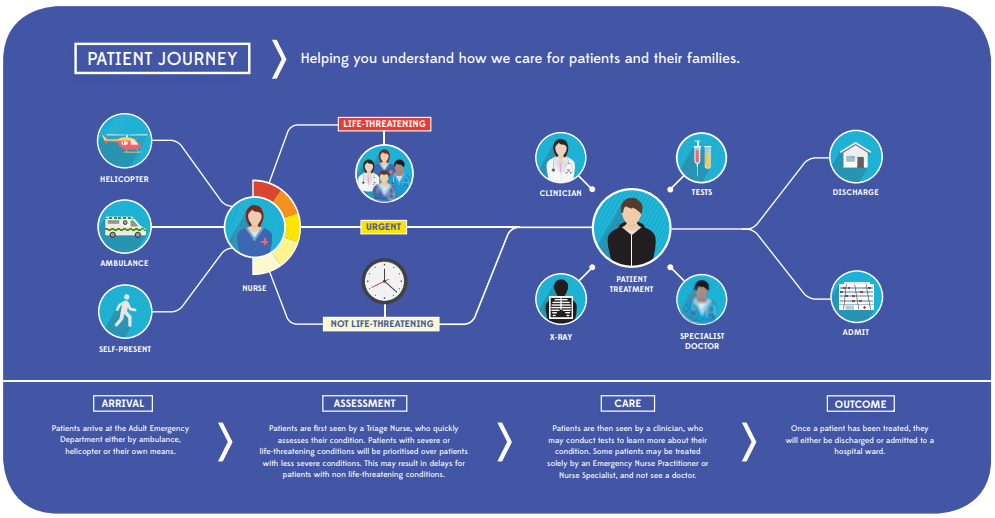
The waiting times to be seen and assessed in Starship Children's Hospital's ED have been reduced thanks to the hard work of our staff. In June 2016, the baseline average wait time was reduced by 30% – from 86 minutes to 60 minutes.

More support for older people

After a successful first year trial, we have extended the availability of a gerontology nurse specialist in the ED, increasing this to seven days a week for specialised care of older patients.

Journey through the Adult ED

We designed a patient journey map for our ED waiting room to explain to patients how the service works and where their care begins and ends, in very simple terms. The animation of this journey map has been translated into seven languages.



Health target

Improved access to elective surgery

> *Through systematically strengthening our planning approach we are proud to have exceeded our elective surgery health target of 16,700.*

Dr Wayne Jones, Director of Surgical Services.

✓ **Target achieved**

Fast facts:

- ✓ Elective surgical discharge target exceeded – 16,818 procedures performed
- ✓ 3000 more patients received elective procedures than last year
- ✓ Each day, 25 to 30 patients are treated for minor conditions in a new ambulatory care area within Adult ED

9.3

Auckland DHB achieved (and exceeded) its elective surgical discharge target for 2015/2016 of 16,700, performing 16,818 elective procedures, which was 3,000 more than the previous year.

Initiatives have included cross-functional forums, known as SCRUMs (Surgical Capacity Resource Utilisation Meetings), which included the refinement of our bed forecasting model. A weekly bed capacity forum now shows demand for the coming week with 90% accuracy. Our national elective surgery target was exceeded on top of the elective surgery we do for other DHBs, which is about half of all our elective work.

Patient and Operational Planning (POP) approach

Over the past four years we have set out to engage our clinicians in 'production planning' to support decisions that efficiently match our demand to our resource, while achieving our organisational goals. We have adapted the fundamentals of sales and operational planning from leading companies in other industries and applied them to health in a programme called Patient and Operational Planning (POP).

This approach aims to extend our planning horizons from simply reacting to situations to orchestrating them. Through joined-up planning across groups, we can optimise our resource use while providing quality healthcare.

Health target

Faster cancer treatment

> *Auckland DHB has effectively doubled the number of patients seen within 62 days. Women patients have benefitted enormously from a project designed to enable faster diagnosis and treatment of breast cancer.*

Dr Richard Sullivan, Deputy Chief Medical Officer and Director of Cancer and Blood.

✓ Good progress to target

Fast facts:

- ✓ While we didn't reach the overall target, we were the closest towards meeting it out of the northern region DHBs, achieving 77% in the fourth quarter
- ✓ We achieved the national target for women with a high suspicion of cancer (HSC), with 90% of women receiving treatment within 62 days
- ✓ We improved access to a First Specialist Appointment in medical oncology within two weeks – from 46% of patients in December 2015 to 76% at the end of June 2016

We have made good inroads towards the target, from 66% to 72% of the 85% target. Although Auckland DHB did not reach the target, we were the closest to achieving it out of all the DHBs in the northern region.

- In June 2015, our performance saw 66% of patients meeting the target
- In the fourth quarter (June 2016) this had climbed to 77% of patients
- While we are 8.3% below the national health target, Auckland DHB's progress in the last quarter of 2016 is higher than the national rate of 74%
- We saw a rise in patients on the cancer diagnosis and treatment pathway from 671 to 873, a 30% increase between the third and fourth quarters of 2016 by introducing better triage systems

We are improving equity of access to cancer treatment, which is a strategic mandatory set by our Board. Our focus will continue to be on the target, and in particular the equity gap with Māori and Pacific Island patients at 65% and 67%, compared to our Asian patients at 87% and European/Pākehā at 79%.

Tumour stream coordinators

We now have better visibility of patients with high suspicion of cancer (HSC) thanks to our team of tumour stream coordinators, which was established in November 2015. The team has enabled clinicians to see, at a glance, how individual patients are progressing from triage to first treatment. The coordinators source HSC data on patients and have put in place agreed ways to escalate when there is a potential breach of the target.

Faster diagnosis

By introducing HSC alerts in pathology and radiology systems, we have increased visibility of patients on the HSC pathway and improved diagnostic turnaround times. The status of patients' specimens in LabPLUS is now transparent via daily reports; similar reporting for Radiology is under development.

Medical oncology

We have improved access to a First Specialist Appointment in medical oncology within two weeks from 46% of patients in December 2015 to 76% at the end of June 2016. To meet the DHB strategic mandate for equity of access, the team wanted to ensure that by improving the pathway for patients with HSC, they did not unintentionally disadvantage other patients not on that pathway who still required medical oncology treatment.

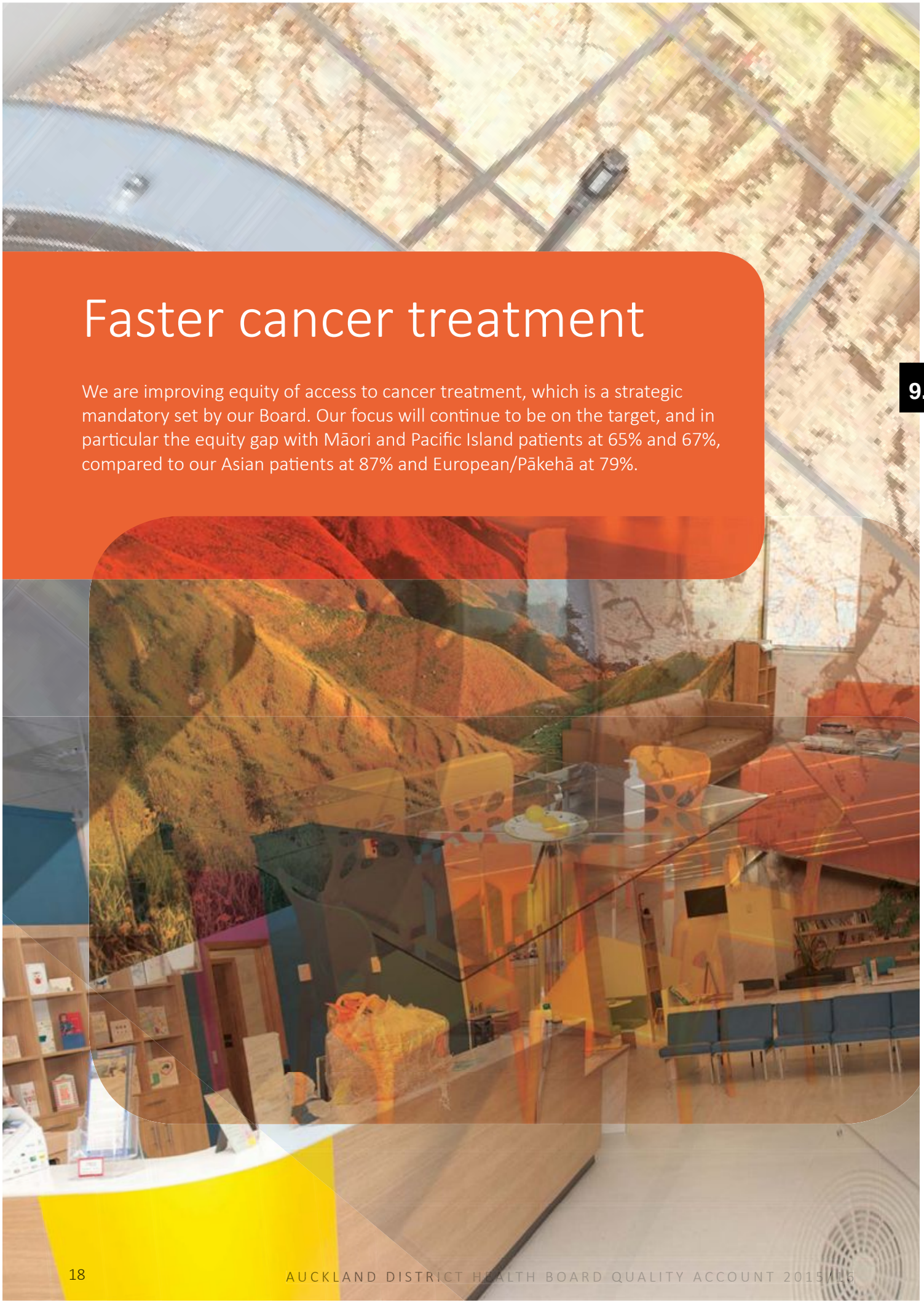
Better coordination in the northern region

Auckland DHB has worked closely with the northern region DHBs to improve cross-DHB referrals. A daily report provides greater visibility of HSC patients being referred. This increased visibility helps ensure that patients progress through their health journey at Auckland DHB in a manner that meets regional expectations for a 31-day diagnostic/31-day treatment timeline, to meet the 62-day target for treatment.

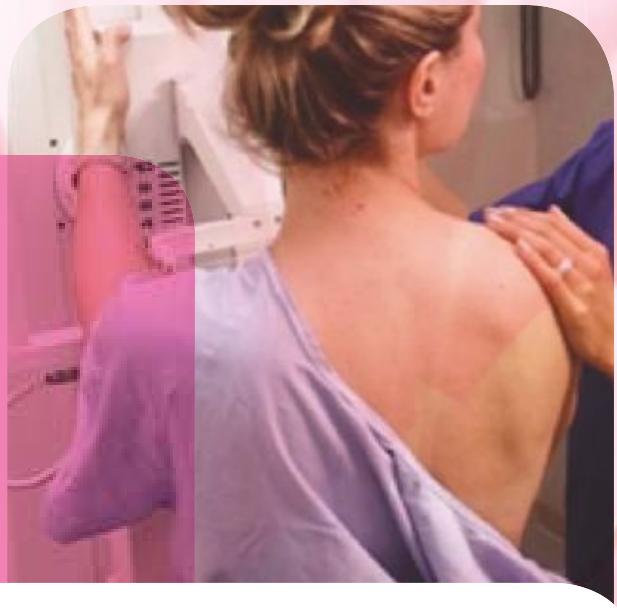
Faster cancer treatment

9.3

We are improving equity of access to cancer treatment, which is a strategic mandatory set by our Board. Our focus will continue to be on the target, and in particular the equity gap with Māori and Pacific Island patients at 65% and 67%, compared to our Asian patients at 87% and European/Pākehā at 79%.



Better outcomes for breast cancer patients



As of April 2016, 88% of women waiting for First Specialist Assessment were seen within 14 days, up from 25%. The average waiting time had reduced to nine days. Furthermore, Auckland DHB had achieved the national target for women with a high suspicion of cancer (HSC) with 90% of women receiving treatment within 62 days, in June 2016, a year in advance of the date to meet the challenge.

This is an immense achievement given the starting point. Between January 2014 and July 2015, 75% of patients referred to Auckland DHB with either a high suspicion of breast cancer or confirmed cancer waited longer than 14 days for First Specialist Assessment, and 29% of these waited longer than 62 days to receive treatment. Some waited longer than 100 days. Once a decision to treat had been made, 89% of patients were seen within the 31-day timeframe.

The project team developed an improved clinical pathway that is faster, more efficient and better for women with cancer or an HSC, while maintaining excellent and safe quality of care. The team began work with a commitment:

> *"If we do what is right by our patients and stay focused on that, then the target will take care of itself."*

The solution came in two phases. For Phase 1 implementation in April 2016, the improvements included:

- Moving to paperless referral and e-triage
- Implementing a daily triage roster so all referrals triaged in one business day
- Removing re-triaging at radiology
- Implementing a cover plan for leave

Between April and June 2016, 88% of women waiting for their First Specialist Assessment were seen within 14 days, with an average waiting time of nine days – reduced from 22 days.

Phase 2 from June 2016 has seen:

- A one-stop clinic for patients (full work-up and diagnosis)
- The electronic design and implementation of a new joint clinic template
- Appointments ring-fenced to ensure availability for cancer patients in under 14 days
- A redesigned pathway with the aim of being treated within 42 days in the future
- Redesigned reporting so the three indicators are visible in SCRUM (Surgical Capacity Resource Utilisation Meetings) and can be managed as urgent, where necessary

From June 2016, 90% of women were receiving treatment within 62 days, an increase from 71%.

This project was so successful that the lessons are being shared with other services, other DHBs and the Ministry of Health.

Health target

Increased immunisation

> *Immunisation uses the body's natural defence mechanism to build resistance to infections. It is one of the most effective and cost-efficient medical interventions to prevent disease.*

Dr Mike Shepherd, Director of Starship Child Health – Medical and Community

✓ **Good progress to target**

Fast facts:

- ✓ Although we did not reach the national target, we came close at 94% in the fourth quarter
- ✓ Immunisation rates for Māori and Pacific two-year-olds have reached between 97% and 98%
- ✓ Gastroenteritis presentations to Starship's ED have decreased by at least 50% this year

Our teams collaborate closely with nurses, doctors and communities across our region to work towards the national target.

- We continue to make progress towards meeting the overall target of 95% of eight-month-olds having their primary course of immunisation on time
- We have worked to close historic equity gaps, seeing immunisation rates for Māori and Pacific two-year-olds reach between 97% and 98%, compared to 95% overall

Rotavirus vaccine campaign

We have had success with our rotavirus vaccine campaign, introduced in July 2014. At the time, rotavirus infection was the leading cause of hospitalisation for children with gastroenteritis. Implementing the additional immunisation went smoothly in Auckland. Taking a collaborative approach across the sector we quickly achieved a high uptake. This year, children, parents and caregivers are reaping the rewards. Gastroenteritis presentations to Starship Emergency Department have decreased by at least 50%. That represents more than 200 Auckland children who stayed away from hospital this year, and countless more families and whānau who avoided a nasty bout of illness at home.

In 2012, the national immunisation target was for 95% of all two-year-olds to be fully immunised. While the target was achieved, it was recognised that many families were late in beginning the immunisation schedule for their babies, which left many unprotected at a time when they were particularly vulnerable.

As a consequence, the Ministry of Health changed the target to 95% fully immunised at eight months. Since December 2014, coverage rates have continued to be maintained at 94-95% for all eight-month-old infants. Although at times during the year we have been just short of the national target by 1%, we have consistently aimed for as many children as possible to be protected from once common infectious diseases.

Working with Primary Health Organisations (PHO) and nurses and doctors in the GP network across the district, we have maintained good results.

Key initiatives include:

- Taking a whole-of-health service approach to ensure families are reminded and babies are offered immunisations whenever they come into contact with any health services, including those admitted to Starship
- Maintaining an integrated National Immunisation Register/Outreach Immunisation Service across both Auckland and Waitemata DHBs
- Developing general practice resources and increasing knowledge and awareness of immunisation guidelines and timeframes; providing support and education for midwives, general practice staff and secondary care staff
- Developing robust referral processes to Outreach Immunisation Services (OIS); working with the National Immunisation Register team and PHOs to ensure all children are enrolled with a GP as soon as possible after birth to facilitate immunisations on time

Health target

Better help for smokers to quit

> *"For people residing in Auckland DHB's region, the prevalence of smoking is around 11% (11.2%), the lowest of any DHB."*
>
> **Simon Bowen,** Director of Health Outcomes.

✓ Primary care target achieved

✓ Hospital care target good progress made

Fast facts:

- ✓ Smoking kills around 5,000 New Zealanders each year
- ✓ However, 11.2% of those residing in Auckland DHB's catchment area are identifying as smokers, the lowest for any DHB
- ✓ Auckland DHB has met the National Health Target for 'Better help for smokers to quit' for the fourth year in a row

For the fourth year in a row, Auckland DHB has met the national health target for helping smokers in hospital to quit, and at local GP level there is similar success, with primary care-based interventions hitting the target for the third consecutive year.

Most smokers want to quit, but it's no easy mission. Our role lies in ensuring we provide consistent advice and support to quit across all parts of the health system i.e. local GPs, hospitals and other community health services.

Smoking-related diseases are a significant drain on health resources:

- In Auckland, smoking is estimated to result in 300 deaths a year and a large number of admissions to hospital
- In New Zealand, smoking kills more people each year than road crashes, alcohol, other drugs, suicide, murder and drowning

For patients enrolled with Primary Health Organisations (PHOs), the target is 90%. Our PHOs recorded 91.8% in the fourth quarter of the year, which represents 46,155 patients in primary care provided with advice to quit. In 2014/2015, Auckland DHB's result against the national target for hospitals was 95%.

The primary care health target was changed this year to include all smokers that are enrolled in a PHO (not just those that have seen their GP in the last year). This is a harder target to reach as it requires proactively making contact with patients.

The continued success is down to a true team effort involving PHOs and the leadership of the primary care support system. Auckland DHB acknowledges their commitment in providing support to general practices.

We provided advice and support via phone calls and text messages to patients trying to quit. The smoking cessation programme continued to be prioritised, with PHOs providing project team resources to support general practices. Many people who attempt to quit will experience a lapse. Behavioural support, such as a referral to 'quit smoking' services and pharmacological smoking cessation aids, will help prevent a lapse becoming a return to regular smoking. We have seen an increase in the proportion of smokers accessing primary care who are provided with smoking cessation support, a trend we want to see continue.

WERO competition

Due to the high rate of smoking by mental health and addiction service users, the DHB initiated a successful WERO stop smoking challenge, where teams of smokers competed over 12 weeks for prizes and the team that had the most verified non-smokers became the overall winner.

Health target

More heart and diabetes checks

> *More than 145,330 people in Auckland had their heart disease risk checked out of a total eligible population of 156,926.*
>
> **Dr Stuart Jenkins,** Clinical Director of Primary Care.

✓ Target Achieved

Fast facts:

- ✓ Heart disease and diabetes kill more than 6,000 New Zealanders each year and many of these deaths could be avoided
- ✓ There are over 240,000 people in New Zealand who have been diagnosed with diabetes (mostly type 2). It is thought there are another 100,000 people who have it but don't know
- ✓ Auckland DHB achieved the National Health Target for more health and diabetes checks, as the top performing DHB, with 93% of our eligible population risk assessed

This year Auckland DHB achieved the national target and was the top performing DHB, having risk assessed 93% of our eligible population. Between 1 July 2014 and 30 June 2016, more than 145,330 people across Auckland DHB had their heart disease risk assessed, out of a total eligible population of 156,926.

Diabetes, heart and blood vessel disease, stroke and smoking-related illness affect an increasing number of New Zealanders each year and have a significant impact on people's life expectancy and quality of life. We work together with our Primary Health Organisations (PHOs) to ensure eligible people are risk assessed and checks are carried out at a patient's general practice.

The work that has enabled us to exceed the target includes:

- Weekly reporting and monitoring of performance at PHO level
- Practices proactively identifying eligible patients for risk assessment
- Access to advanced IT tools to identify and assess eligible patients
- Increased support to practice teams from PHO support teams
- PHOs and general practices have worked hard to establish sustainable systems and processes to ensure eligible people are risk assessed for disease in a timely manner

The primary care team continues to meet with the PHOs monthly, or more frequently if needed, to discuss activities undertaken to maintain our achievement of the 90% target, with increasing coverage for Māori and Pacific populations and better management of cardiovascular disease being top priorities.

Quality and Safety Markers

The Health Quality and Safety Commission has developed Quality and Safety Markers (QSMs) in partnership with district health boards to drive improvements in key priority safety areas including falls, healthcare associated infections, perioperative harm and medication safety.

The markers are a mix of process and outcome measures that set expected levels of improvements; publicly report progress against thresholds and support greater accountability.

2015/16 Quality and Safety Markers

	Target	Q1	Q2	Q3	Q4	Achievement
Reducing harm from falls Percentage of patients aged 75 and over (Māori and Pacific Islanders 55 and over) that are given a falls risk assessment.	90%	91%	93%	94%	92%	✓Achieved
Preventing patient falls Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk.	90%	97%	95%	93%	93%	✓Achieved
Reducing surgical site infections Antibiotic given 0-60 minutes before "knife to skin".	100%	96%	95%	96%	95%	✓On track
Reducing surgical site infections Right antibiotic in the right dose – 2 grams or more cefazolin given or 1.5g or more of cefuroxime.	95%	100%	98%	95%	94%	✓On track
Reducing surgical site infections Appropriate skin antisepsis in surgery using alcohol/chlorhex or alcohol/providone iodine.	100%	100%	100%	99%	99%	✓On track
Improving hand hygiene Percentage of opportunities for hand hygiene for health professionals.	80%	79%	78%	81%	N/A*	✓Achieved
Medication safety Introduction of an electronic medication reconcilation system, (eMR).	N/A	Set to be implemented in late 2016				-
Safe surgery	90%	To be reported on from December 2016				-

More information on quality and safety markers:
www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers/

**Note: Hand hygiene compliance data is reported three times a year, therefore there is no data point specifically for Quarter 4*

Q&S Marker

Preventing harm from falls

> *Our work to prevent patients having falls has resulted in a 15% reduction in the number of falls causing serious harm over the previous year.*

Judith Catherwood, Director of Adult Community and Long Term Conditions.

Fast facts:

- ✓ We saw a 15% reduction in the number of falls causing serious harm
- ✓ The Adult Community and Long Term Conditions Directorate has had a 53% reduction in the number of falls per month since January 2016
- ✓ We have had a 60% reduction in patients falling over bed rails – a decrease from approximately 9 per month to 3.6 per month

A fall is a major source of harm to our patients. While our rate of falls recorded remains consistent, this is in the context of rising numbers of patients, therefore representing an overall decrease. However, we must continue to work hard to prevent harm from falls.

We continue to record about four falls per 1,000 bed days each year, a rate that remains stable as the number of patients we see has steadily increased. As an example, we saw 20% more patients for elective surgery this year than the 2014/15 year. However, our work to prevent patients having falls has resulted in a 15% reduction in the number of falls causing serious harm over the previous year.

Our programmes seek to prevent all falls, but our focus remains on falls that result in serious harm where the impact on a patient is most serious. These are a small number in relation to the number of patients seen by our services, but will mean patients who experience a fracture or laceration will require further investigations (such as x-rays) and procedures (such as extra operations to repair the fracture or suturing to close the laceration) and lengthen their stay in hospital.

In the 2013-14 Quality Account, we outlined the CONCEPT Ward, an initiative to test bed improvements in a ward that had a number of serious harm falls. The initiatives developed in the CONCEPT Ward have since been integrated into Auckland DHB's Accelerated Releasing Time to Care programme, which quadrupled the time nurses spend with patients in its pilot and is now being rolled out to all our wards. A key initiative we call the Falls Tool Shed has been rolled out into wards in the Adult Community and Long Term Conditions Directorate and the Adult Medical Directorate during 2015. We are starting to see the effects of these interventions. The Adult Community and Long Term Conditions Directorate has had a 53% reduction in the total number of falls per month since January 2016 from an average of 28 falls per month to an average of 15 falls per month.

Overall, we have had fewer serious harm falls in 2015-16 than the previous year.

- We reported 42 serious harm falls (1 death, 2 cranial injuries, 32 fractures, 6 lacerations, and 1 other injury), 15 fewer injuries than 2014-2015
- Patients in hospital had 35 serious harm falls (50 in the previous year) and patients attending outpatient services had seven serious harm falls (same as the previous year)

For each of these serious harm falls, a multidisciplinary team investigates and reports on their findings to a sub-committee of the Adverse Events Review Committee. While findings from each of these events is useful for the area involved, Auckland DHB has recognised that there needed to be a better process to extract initiatives for improvement from the reports. As a result, we have tested a new approach, with a large set of questions, to highlight contributing factors for the investigating team when they write their report. Initial testing has shown the investigating team values the new approach. As we accumulate these new reports, the answers to the large number of questions for each event will become the data for a network analysis to identify future priorities for improvement work at Auckland DHB.

We've exceeded the target on falls (The target is 90%)

Year	Patients risk assessed for falls	High risk patients provided care plan	Falls	Serious Harm falls
2015	93%	93%	1370	42
2014	93%	97%	1402	57

Falls over bed rails

We have had a 60% reduction in patients falling over bed rails – decreased from approximately 9 per month to 3.6 per month. Auckland DHB has agreed to make falls over bed rails a zero tolerance event so they will all be reviewed whether there is harm or no harm.

Q&S Marker

Healthcare associated infections

"Auckland DHB was one of the first DHBs to implement the National Surgical Site Infection programme and we have captured data on all patients undergoing hip and knee joint replacements since March 2013."

Dr Wayne Jones, Director of Surgical Services

Fast facts:

- ✓ At the start of the Surgical Site Infection Improvement (SSII) programme, about three in every 100 patients undergoing a hip or knee joint replacement developed an infection, now it's one patient per 100 procedures
- ✓ The combined CLAB rate for our ICU wards was 0.46/1000 catheter days to June 2016

9.3

Surgical site infections (SSIs)

Ensuring patients get the right drug, at the right dose, and at the right time before surgery has played a major part in reducing the number of patients getting infections.

- About 7-10% of patients admitted to hospital develop an infection of some kind, either during their time in hospital or shortly after being discharged. These infections, called healthcare-associated infections, result in longer lengths of stay or readmission to hospital
- Surgical site infections are associated with the wound made at the time of the operation. They are the second most common type of healthcare-associated infection and occur in about 2-5% of all patients undergoing surgery

The cost of these infections is significant, not only in managing care for the infection, but also in lost opportunities for other patients waiting for elective surgery.

Focusing on three interventions at the time of hip or knee joint replacement has led to better outcomes for patients, along with an extension of the regime across all orthopaedic procedures. These interventions are also being applied at the time of cardiac surgery; starting initially with adult patients and including children from early 2016.

As well as reducing the number of patients developing infections, the quality improvements to immediate care after surgery have flow-on effects. The goal is to get people home to their families sooner, which also helps to open up places for elective surgery.

The Health Quality & Safety Commission established the National Surgical Site Infection Improvement (SSII) programme to improve adherence nationally to a number of interventions known to reduce the risk of surgical site infections.

Auckland DHB was one of the first to implement the programme and we have captured data on all patients undergoing hip and knee joint replacements since March 2013. We followed patients for 90 days to see if they developed an infection in hospital, or in the community, and if they required readmission to hospital.

At the start of the SSII programme, about three of every 100 patients undergoing a hip or knee joint replacement developed an infection; now it's one patient per 100 procedures.

CLAB infections

Central line[1]-associated bloodstream or 'CLAB' infections account for about 30% of all healthcare-associated bloodstream infection events within our hospitals. At best they may result in an increased length of stay and at worst, patient harm and death.

Auckland DHB's three intensive care units – Paediatric ICU, Cardiothoracic and Vascular ICU and the Department of Critical Care Medicine – have been part of the national collaborative effort to reduce these infections and have considerably reduced our CLAB rate. The combined CLAB rate for our ICU wards was 0.46/1000 catheter days to June 2016.

Our ICUs achieved the national target of less than one infection per 1000 central venous line (CVC) days by mid-2012 and embedded the practice to support this as business as usual, as CLAB infections are no longer measured as a Quality and Safety Marker.

The three units at Auckland DHB report monthly compliance with the insertion bundle at over 85%.

Unit	CLAB rate (2015/16)
DCCM	0.29/1000
PICU	0.79/1000
CVICU	0.42/1000

[1] *A central line is an intravenous line that is inserted into a large vein, typically in the neck or near the heart, to administer medicines or fluids or withdraw blood.*

The monthly Auckland DHB ICU rate allows us to calculate an annual or average rate per 1,000 catheter days for each financial year.

Q&S Marker

Hand hygiene

> *Our hand hygiene success would not be possible without our Gold Champions, a team of more than 100 trained hand hygiene auditors who continue to monitor performance in their clinical areas.*

Sally Roberts, Clinical Head of Microbiology

The WHO Global Action Plan on Antimicrobial Resistance is a call to arms for all healthcare workers. The plan recommends measures to prevent resistant bacteria spreading between hospitalised patients.

One of the most important measures is hand hygiene, with a target of 80% for hand hygiene compliance across the DHB.

We reached a new high of 84% in May 2016, and in paediatric settings achieved 87%, a figure based on 1200 audited observations.

Our hand hygiene success would not be possible without our Gold Champions, a team of more than 100 trained hand hygiene auditors who continue to monitor performance in their clinical areas. Their data is collected and analysed by the Infection Control Team.

Auckland DHB continues to show leadership in this Quality and Safety Marker, with our DHB the source of almost 23% of the total number of 'moments' audited nationally.

Fast facts:

- ✓ We achieved a new high of 84% compliance for hand hygiene overall
- ✓ We achieved 87% for hand hygiene compliance in paediatric settings

Q&S Marker

Medication safety

> *We have a planned go-live date of late 2016 for an Electronic Medicines Reconciliation (EMR) system, which is the national medication safety Quality and Safety Marker.*

Ian Costello, Chief Pharmacist and Acting Director of Clinical Support Services.

Fast facts:

- ✓ 39% of adult patients routinely have medicines reconciliation completed
- ✓ Medicines reconciliation occurs for more than 50% of high risk patients
- ✓ Our Reduction In Dispensing Errors project has reduced dispensing errors by over 50%

Better governance

Auckland DHB has created a new governance model to lead, direct, develop and provide oversight of the quality and safety of medicine use across the organisation. The Medicines Governance Committee replaced the Medication Safety Committee in July 2015. The goal was to create a forum to drive innovation, improvement and efficiency.

Under the new model each DHB medical directorate has a specific medicines governance pharmacist working with them to review medicine incidents and implement system-based changes to reduce the potential for harm to our patients. A key focus of the new model has been 'walk-arounds' by a medicines governance team to prompt discussion and engagement about medication safety.

To date, the team has completed walk-arounds to more than 40 wards and departments. The team has worked with ward staff to review the corrective actions from surveillance audits and advise on the appropriate storage of medicines, as well as ensuring appropriate use of the green bag system - to store a patient's own medicines. The goal is to ensure each ward and department has a walk around at least once a year.

Designers and pharmacists collaborate on safer design

The Pharmacy team and Design for Health and Wellbeing (DHW) Laboratory have developed a new cap to reduce errors from anaesthetic liquids, and have produced a prototype via 3D printing.

Medicines reconciliation

Thirty-nine per cent of adult patients routinely have medicines reconciliation completed, with data showing that medicines reconciliation occurs for more than 50% of high risk patients. Electronic medicines reconciliation (the national medication safety QSM) has a planned go-live date for late 2016.

Reduction in Dispensing Errors (RIDE) project

A year-long project has reviewed the errors in the in-patient dispensary to find ways to reduce them. RIDE has reduced errors by over 50% and the number of near-misses reported is considerably less than predicted by international studies. The proportion of urgent items dispensed within our target time frame has increased from 44% to 59% and the average turnaround time has decreased by 16 minutes.

IMPACT (Inpatient Medical Pharmacist Admitting Collaborative Team) project

A clinical pharmacist has been working across Auckland City Hospital's Emergency Department and Admission Planning Unit (APU) alongside clinicians, taking medication histories from patients and updating the medication chart. As a result, there has been a reduction in medication-related discrepancies from 1.42 to 0.33 per patient. The pharmacist has reviewed over 700 patients and made 300 clinical interventions.

Ward-based technician service

A pilot project has placed two pharmacy technicians with four wards. The pilot sought to prevent patients missing doses, to ensure medicines were easily accessible to enable further treatment, and to free up nurses to focus directly on patient care. The pilot has delivered an integrated, multi-disciplinary approach to in-patient medication management and is delivering quality and efficiency benefits for patients, nursing staff and the pharmacy.

Q&S Marker

Safe surgery

> *"The focus of our work is on reducing the gap between best practice and the actual care the patient receives. Anaesthesia does not occur in isolation but within the work of a team."*
>
> **Dr Wayne Jones,** Director of Surgical Services.

Fast facts:

- ✓ In patient surveys, 95% of patients said their conversation with the anaesthetist was positive
- ✓ 98% also rated the care they received as positive

9.3

A new Quality and Safety Marker aimed at measuring levels of teamwork and communication was rolled out during 2015-16 financial year. The first public reporting will be in December 2016 on data for Quarter 3, 2016. However, we have been working towards this marker with the understanding it is coming into place.

It is inherently very safe to undergo anaesthesia for surgery in New Zealand. So the focus of our work is on reducing the gap between best practice and the actual care the individual patient receives. Anaesthesia does not occur in isolation but within the work of a team.

At Auckland DHB this has evolved to include the comprehensive perioperative care for each patient. Our goal is to continue to develop a more post-operative care and monitoring process as improvements in this area will lift the long-term outcomes for our patients.

We listen carefully to patient feedback and experience. What they tell us helps us improve what we do and how we do it. In patient surveys, 95% of patients said their conversations with the anaesthetist was positive and 98% rated the care they received as positive.

Our work towards Safe Surgery includes the following initiatives:

- We have introduced venous thrombosis risk assessment and follow up preventive action for every surgical patient and expect results from an audit tool in the next reporting period
- Anaesthesia-specific perioperative score cards have been developed, and work is under way to improve the data and the reporting of that data to our teams
- Quality committees for each theatre group meet monthly to identify and mitigate or eliminate risks to patients and the organisation
- A hospital-wide revision of the antibiotic prophylaxis guidelines has been completed
- We are developing a confidential tool for individual anaesthetists to assess their personal performance
- Patient satisfaction with anaesthesia is being assessed allowing minor cases of dissatisfaction to be followed up and corrected, avoiding repeat incidences

Serious adverse events: Making healthcare safer

Serious adverse events: Making healthcare safer

> *When a serious adverse event happens, a team of experts go through a formal and structured review to identify the underlying causes and see what needs to change in our systems to prevent such harm from occurring in the future.*

Sue Waters, Chief Health Professions Officer.

Fast facts:

- In the year to June 2016, we reported 80 serious adverse events, compared to 98 in the previous year
- This was a 20% reduction from 1.22 to 0.88 events per 1,000 bed days
- The most significant reduction was the number of falls causing harm (57 reduced to 42)

For most of us, receiving healthcare is a smooth process. But there is always some risk and occasionally consumers are harmed in the course of their treatment. When something does go wrong, we are committed to being honest and open so that patients and family/whānau know exactly what happened, and we have a strong duty to figure out why and how it happened so we can improve our systems to reduce the chance of similar events happening again.

The first step in this process is to ensure that adverse events, including 'near misses' when an error or process failure does not cause harm, are promptly reported and reviewed. We encourage a no-blame approach, recognising that although our staff are highly trained professionals, people do make mistakes, and we need to build our systems to prevent errors from causing harm.

Most of these incidents were of a minor nature, but a small number did cause significant harm to consumers. When a serious adverse event happens, a team of experts go through a formal and structured review to identify the underlying causes and see what we need to change in our systems to prevent such harm from occurring in the future. These events, and what we have learned, are also shared nationally through the Health Quality and Safety Commission, along with similar reports from DHBs, and increasingly from private hospitals, ambulance services and other primary care providers.

- Although the overall number of reported events has been steadily rising, in line with an increased number of patients and a growing reporting culture, the number of serious adverse events reported has started to reduce
- In the year to June 2016, we reported 80 serious adverse events, compared to 98 in the previous year, a 28% reduction from 1.22 to 0.88 events per 1,000 bed-days (Figure 2.)
- The most significant reduction was in the number of patient falls causing harm (57 vs 42), an area in which a range of improvements have been put in place in recent years

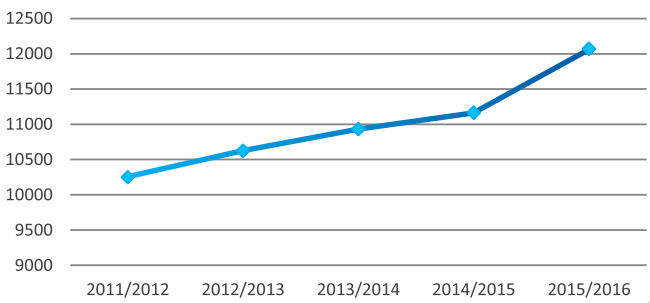


Figure 1.

Incident reporting over five years at Auckland DHB

Over the past five years we have seen a steady rise in reports of incidents (Figure 1.) where our systems did not function as expected. This shows that we have a strong reporting culture.

Often the weaknesses in our processes illustrated by one event are also present in other services and providers; wider sharing of what happened and how the risk of similar future events can be reduced is important, both locally and nationally. In the past year, we have contributed to several of the Health Quality and Safety Commission's "Open Book" publications to promote safety messages arising from serious adverse events to a national audience.

The reviews of these events are presented to the Adverse Events Review Committee, a group of senior medical, nursing and allied health leaders, to ensure the quality of the review, the robustness of the recommendations, and the communication of the findings back to the patient and family/whānau, the services involved, and more widely across the organisation.

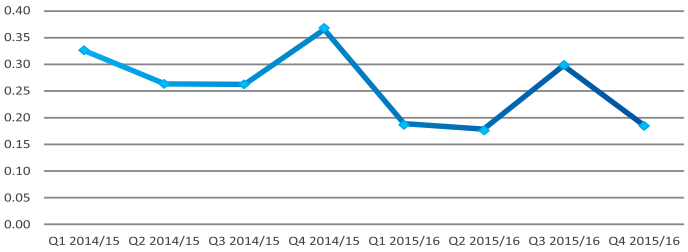


Figure 2.

Rate of reported serious adverse events per 1000 bed days at Auckland DHB

"Auckland DHB perceives an increase in incident reporting as having a positive effect on patient safety. We have been working to not only make positive changes in patient care, but changes in the attitudes of our staff around the reporting of incidents."

Dr Nelson Aguirre, Acting Quality Manager

Pressure injuries

Auckland DHB has had a sustained focus on reducing hospital-acquired pressure injuries since 2011, working in conjunction with the Northern region 'First Do No Harm' programme.

Pressure injuries are caused by immobility, which can occur when patients have an operation that makes moving in bed difficult or have a disease that reduces their ability to reposition themselves.

Since February 2012, we have conducted a monthly random audit of approximately 20% of hospital patients, with results fed back to wards. We identify both pressure injuries and care processes associated with pressure injuries. The prevalence of pressure injuries has fallen from a baseline four years ago of 8.4% of hospitalised patients of all ages to 4.0% in 2014/2015. Almost all these pressure injuries are stage I (reddened skin) and stage II (broken skin) pressure injuries.

Auckland DHB has proactively declared that serious harm pressure injuries should be a "never event". We use a case finding approach because self-reporting is inaccurate. We are among the few DHBs that report serious pressure injuries in our annual Serious Adverse Events Report. Previous Quality Accounts have addressed our ongoing improvement activities in pressure injuries.

Recent reviews have led to the introduction of high specification foam mattresses for children's cots, low air loss mattresses for extremely unwell children, a standardised care plan incorporating a bundle of care for children, revision of the assessment and care planning forms in adult services, and development of a care bundle specific to adults on extracorporeal membrane oxygenation.

We are currently working with a CONCEPT Ward in an adult area to test other pressure injury prevention initiatives including improved heel lifts, turning schedules, seating solutions, and pressure injury alerts.

Our quality initiatives

Quality, safety and experience of care

Improving the quality and safety of the care we provide is a continuous journey and we aim to do better year after year. In this section we tell the story of the recent quality improvement initiatives we have taken. They fall under three categories:

- Quality, safety and experience of care
- Health and equity for the population
- Value for public health system resources

Rapid Response service begins next phase

The nurse-led Rapid Response Team was first launched in June 2015 to respond to referrals from within the hospital for patients who were discharged, but needed follow up in the community to stay well at home. From May, 2016 the Rapid Response Team began to extend its service to patients in aged residential care facilities, GP practices and the St John service. "Community facilities and GPs can call the Rapid Response Team for help to enable a patient to safely remain where they are living," says Sam Abbott, Team Leader.

The service bridges the gap between hospital and home by providing in-home care and support for adult patients for up to five days upon returning from hospital. It interacts across all community services to ensure patients receive wrap-around care and aims to support safe and earlier discharge from hospital and reduce readmission.

Patients have welcomed the service. As one wrote:

"It was a real comfort to know that professional staff were coming to visit over the critical days following my father's discharge. Long may the Rapid Response Team continue!"

The Rapid Response Team receives between 50-60 new referrals from Auckland City Hospital each month and undertakes approximately 670 follow-ups a month.

Micronutrients for patients with chronic kidney disease

Patients with chronic kidney disease are now taking a specifically formulated, Pharmac funded multivitamin and mineral supplement called Renal Vit.

Kidney disease changes the biochemistry, metabolism and nutrient requirements of many vitamins and trace minerals. At the same time, patients with kidney disease are being treated with a combination of dietary restrictions, medicines, and sometimes dialysis. This leaves them more vulnerable to vitamin and mineral deficiency. Off-the-shelf vitamin and mineral supplements may contain elements that can harm patients with chronic kidney disease if taken in the incorrect dosage.

While specific micronutrient supplements are available overseas for patients with chronic kidney disease, they were not available in New Zealand. Urologists, nephrologists and dietitians worked to find a local solution that could be supported by Pharmac to ensure wide access, especially for patients from low socio-economic areas.

By working with a local supplements company, a multi-disciplinary team developed a renal-specific micronutrient supplement, Renal Vit. The supplement provides the unique combination of beneficial micronutrients at the right dose for people with kidney disease and does not contain vitamins and other compounds that may be harmful.

Pharmac funded Renal Vit in August, 2015 for dialysis patients and late stage patients with chronic kidney disease.

Better screening
for newborn babies

All newborn babies should be offered a test from the Newborn Metabolic Screening Programme (NMSP) to screen for a number of congenital disorders e.g. PKU (phenylketonuria), cystic fibrosis, hypothyroidism. These disorders can cause significant health issues but can be prevented by early detection and treatment. The Ministry of Health National Screening Unit (NSU) is responsible for the national screening programme and contracts Auckland DHB to provide the laboratory testing, which is done at LabPLUS.

It was recently picked up that the results of a screen on a newborn baby in our birthing service did not appear to belong to that particular baby and that there had been a laboratory or labeling error. However, it was quickly determined that no error had occurred and that the baby correctly had an abnormal result, and treatment then began.

Our investigation raised questions as to whether there were gaps in the screening pathway that needed to be addressed. A retrospective audit of babies born in 2014 suggested that 47 babies may have missed metabolic screening. More detailed analysis accounted for nine cases where screening was declined, two where testing had not occurred and four where it was unclear whether testing had occurred. For the remaining babies it appeared that the test had been taken but the sample had not reached the laboratory.

In 2015, a project group was established to proactively identify any babies that may have missed being screened. The group was chaired by the Director of Midwifery and included representation from the National Screening Unit and LabPLUS.

A better monitoring process was established where all babies born at Auckland City Hospital were matched with the screening test received by the laboratory. When a baby could not be matched to a test result, the caregivers were contacted to ensure the test was offered, and if the test had been ordered, to locate the sample.

This approach was successful in significantly improving the screening coverage. An audit of outcomes for 2015 found that of the 7,026 babies born at Auckland City Hospital, a screening outcome was known for all but two babies – highlighting that our babies are given maximum opportunity for early detection and treatment of congenital metabolic disorders, and better health outcomes.

our voice | Advance Care Planning
to tātou reo

Encouraging
Conversations that Count

Auckland DHB staff have continued to contribute leadership to regional and national work to ensure more people know about Advance Care Planning (ACP).

ACP encourages people to have conversations with their family, friends and clinicians about their preferences for future and end-of-life care, and is one of the actions outlined in the Ministry of Health's Health Strategy Road Map.

International evidence shows that when ACP has been undertaken, there is less depression and anxiety in bereaved families and the healthcare system is also able to better target need.

Auckland DHB has exceeded the 2015/16 regional target of a 20% increase in year-on-year documented conversations. The Quarter 4 total of 2034 documented conversations was the largest single quarter to date.

On 16 April 2016, we marked Conversations that Count Day, a national day to raise public awareness of ACP, which was promoted with a campaign by the Health Quality and Safety Commission. Conversations that Count morning teas were offered in Auckland City Hospital's main public space and in wards and clinics across the DHB. A Conversations that Count team gave 40 presentations to over 1,000 members of the public in rest homes, libraries and primary care organisations.

Auckland DHB has had a national leadership role for ACP. Further work this year included:

- Reviewing and refreshing the ACP plan and guide with three national surveys, multiple focus groups, and two co-design workshops held in Christchurch
- Korean translation of the ACP plan and guide, through working with the Korean Hanurai community group
- Developing a one-day ACP training course for clinicians, with a focus on the legal framework and documentation of conversation

As a result, all 80 members of the Korean Hanurai group have completed ACP plans. There has been a 95% attendance rate at the one-day training course, with 106 participants trained since May, 2016.

Clinician feedback on the training has been positive:

"It covered issues that were not dealt with before. It helped me to clear the doubts about the legal framework and clinical dilemmas. Also, the information obtained gave me confidence to think and initiate ACP for my family members and clients."

"It was great to have nurses/participants from secondary care, hospice and other allied professionals to share information and get new perspectives."

Enhancing our care of critically ill patients

We have invested in staff and equipment to build a better Department of Critical Care Medicine (DCCM).

This year we added 11 nurse FTE (fulltime equivalent positions) to the staff, an increase of more than 18%, and now have two doctors (Resident Medical Officers) on-site 24 hours a day. Critical care patients require a dedicated nurse to undertake the close monitoring required and without the extra nursing staff, we would not have been able to build the capacity of our DCCM to care for more of our most vulnerable patients.

The rapidly rising population in Auckland has seen an accompanying increase in the need for critical care services. Auckland City Hospital is also the major transplant centre for the northern region, so patients who have had kidney and liver transplants are cared for in the DCCM after surgery. The number of patients having transplant procedures for kidneys, in particular, has risen. The increase in patients has not seen any decline in the quality of care, with the DCCM matching the standardised mortality rates for tertiary critical care services in New Zealand and Australia.

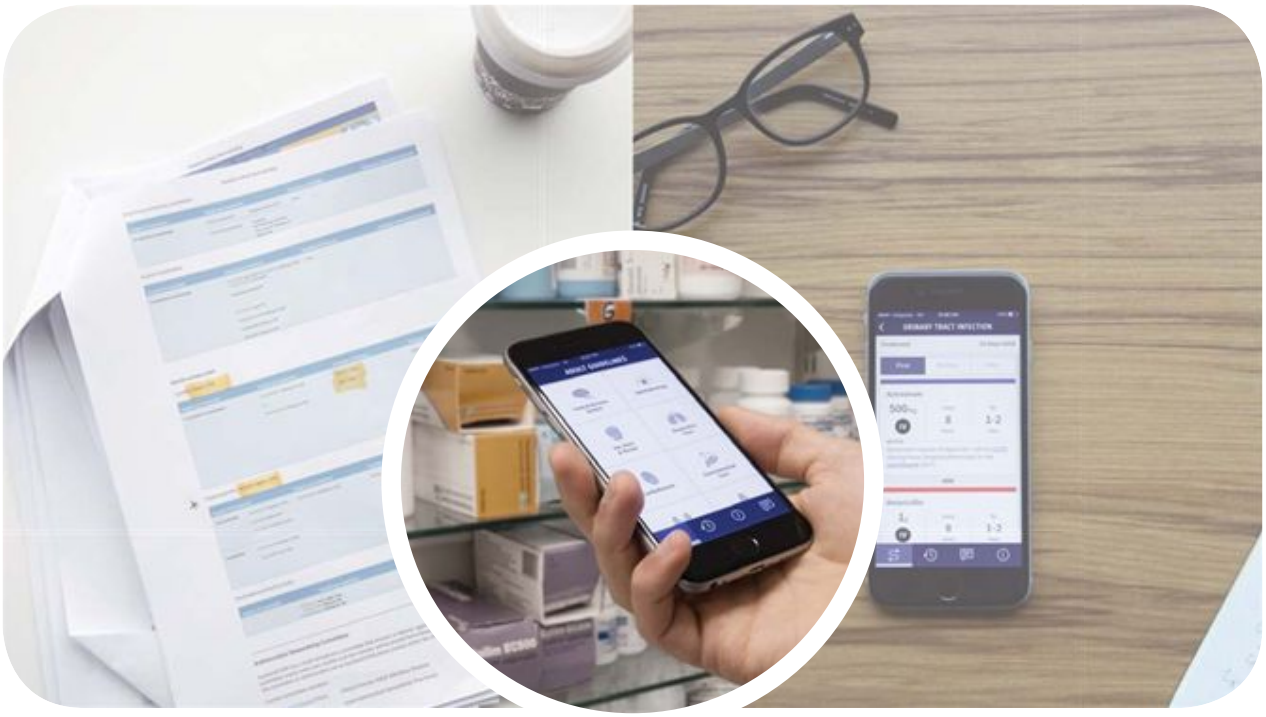
Staff from the DCCM are also working on the key programme 'Best practice for deteriorating patients' (see Future Focus, pg. 51). As part of their critical care outreach work, we are working with clinical staff throughout our wards to intervene earlier and ensure patients at risk of deteriorating have the advice and care they need to remain stable and improve.

Feedback from patients and their families is positive. Patient surveys regularly record between 88% and 100% agreement to 12 standard questions about the specifics of their experience and care at the DCCM.

Compliments include:

"The care is excellent. The staff listen to our remarks and questions and follow up!"

"I think that the staff did an excellent job of preserving patient dignity especially during washing and changing. Because the patient is non-verbal, the staff took the time to find out how she communicates so that they could communicate with her and find out her needs and how she is feeling. This ward works extremely well as a team."



Simple access to antibiotic guidelines with *Script* phone app

Auckland DHB's Design for Health and Wellbeing (DHW) Laboratory has worked with pharmacists, clinicians and researchers from both the DHB and the University of Auckland to develop a smartphone app called Script, which allows clinicians to gain quick and easy access to antibiotic guidelines.

In the community, and in hospitals, antibiotic resistance has become a significant problem and threat to global public health. Incorrect and over-prescription leads to antibiotics becoming ineffective in treating infectious bacteria and disease. Though evidence-based antibiotic guidelines are available online, access can be slow and difficult in a clinical setting.

The app:

- Enables doctors to enter patient signs and symptoms, and then formulates the recommended antibiotic treatment plan. Any drug reactions or conflicts a patient may have are immediately highlighted to minimise the risk of prescription errors
- Supports continued learning of the evidence-based antibiotic guidelines, and helps increase clinician confidence when prescribing antibiotics

App concepts and prototypes were tested with medical students and clinicians to ensure the functionality met their needs.

As there is limited research evaluating the use of smartphone apps to deliver antibiotic guidelines, a clinical trial is being conducted, using a beta version of the Script app to assess the effectiveness and clinical accuracy of this approach. Depending on the outcome of the trial, the Script app may become a valuable tool in increasing the rate of correct prescribing.

Better pathway for children with coeliac disease

Starship Children's Hospital has worked with community health organisation Coeliac New Zealand to create a new outpatient pathway for children with coeliac disease in the northern DHB region.

The new pathway has received great feedback from parents and whānau and the waiting time for hospital appointments has been reduced to almost zero.

Previously, children throughout the region were referred to hospital for diagnosis. After a positive diagnosis, follow-up tended to vary, with families often unsure how to manage their child's disease.

The new pathway saw Auckland DHB fund Coeliac New Zealand to provide support and advice to families of children with coeliac disease. The DHB project team mapped out an approach for patients in primary care that is focused on education and self-management.

Key improvements include an electronic clinical pathway for GPs in the wider Auckland region and a GP e-referral service direct to the Starship Children's Hospital's paediatric gastroenterology service.

Dr Helen Evans, a consultant in the Paediatric Gastroenterology team says the goal was to ensure patients received the right care, follow-up and support in the community.

"By working with Coeliac New Zealand, we know that there will be more timely and relevant advice and support provided in a peer-to-peer way."

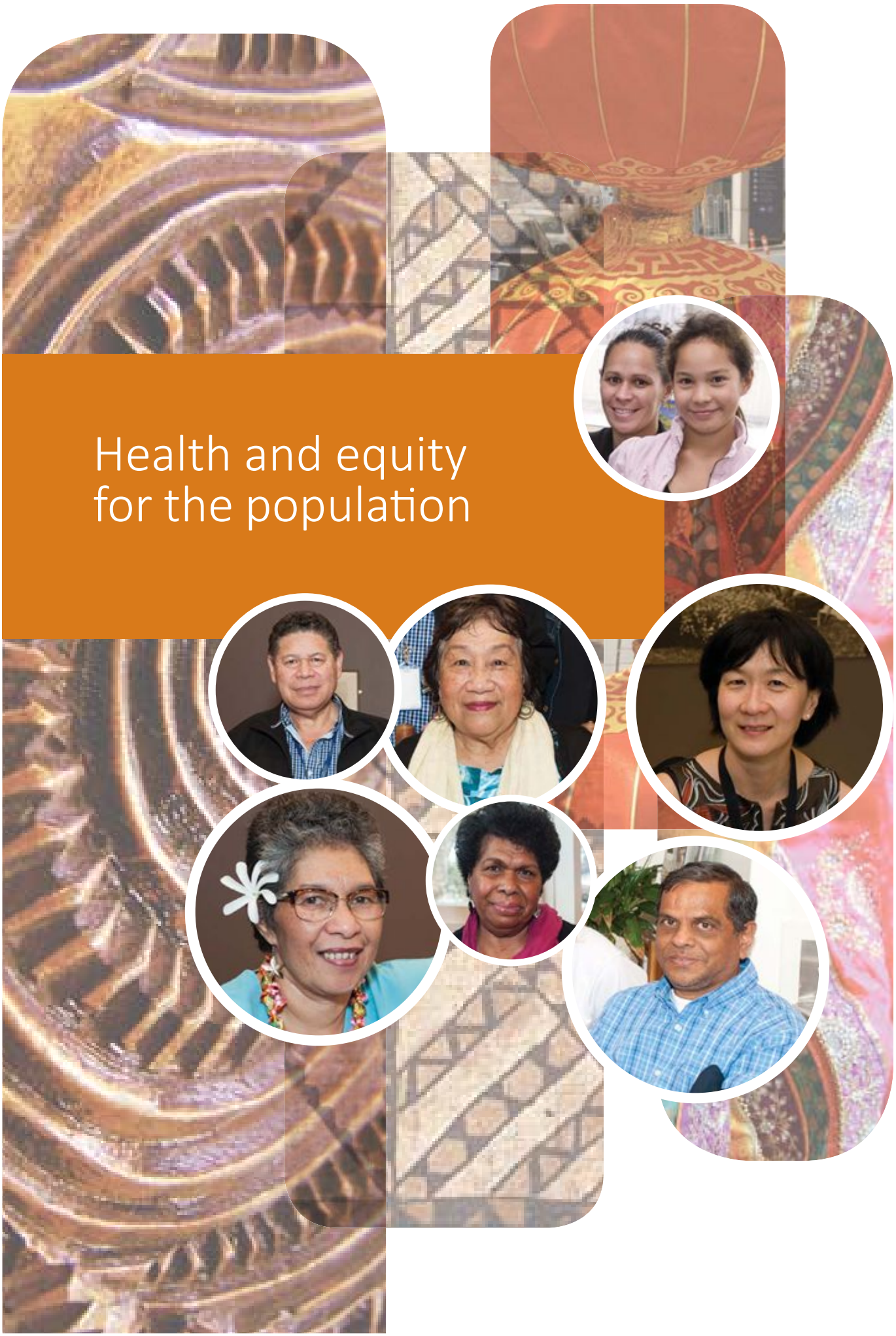
Whole blood **transfusions at scene** for critically ill patients

Auckland DHB has worked with the Auckland Helicopter – Emergency Medical Service (HEMS), the New Zealand Blood Service and the Auckland Rescue Helicopter Trust, to enable a doctor and paramedic emergency team to transfuse whole blood to critically ill patients before they are transported to hospital.

More than 12 patients have benefitted from this initiative which has been made possible by close partnership across multiple services, to ensure there are robust systems for refrigeration of whole blood outside the Blood Service.

The project helped foster change at Auckland City Hospital in the development of the Trauma Code Crimson pathway to form a vital link in the 'chain of survival' for critically ill patients arriving at hospital.

Health and equity for the population



Health and equity for the population

Communication is key

Auckland District Health Board undertakes regular surveys to ask patients what they value, and what we are most often told is that they value good communication with our staff. We are committed to improving how we listen to patients, family/whānau and our many and diverse communities.

Māori midwifery team based in community

As a step towards reducing inequities in access to healthcare and health outcomes, Auckland DHB established a Māori midwifery team in 2015. This year, through partnering with Orakei Health Services at Ngāti Whātua's Glen Innes facility, the Māori midwifery team has developed and formalised a new model of care for the delivery of ante and postnatal services in the community. Three Māori midwives and a newly-appointed Māori obstetrician and gynaecologist work alongside Māori social workers to support Māori women close to where they live. The first clinic took place in May 2016.

Choirs tackle rheumatic fever

A novel approach to health messaging has leveraged the power of Pacific choirs to showcase ways to prevent rheumatic fever.

The Choir Sing Off, a joint initiative between Auckland and Waitemata DHBs and the Healthy Village Action Zone (HVAZ) of Auckland, invited church leaders to partake in workshops to learn about key ways to prevent rheumatic fever. They then returned to their communities to lead church choirs to showcase prevention messages through song.

More than 2000 people attended the sing-off and more than 700 of these participants responded to surveys which highlighted their increased understanding of rheumatic fever prevention.

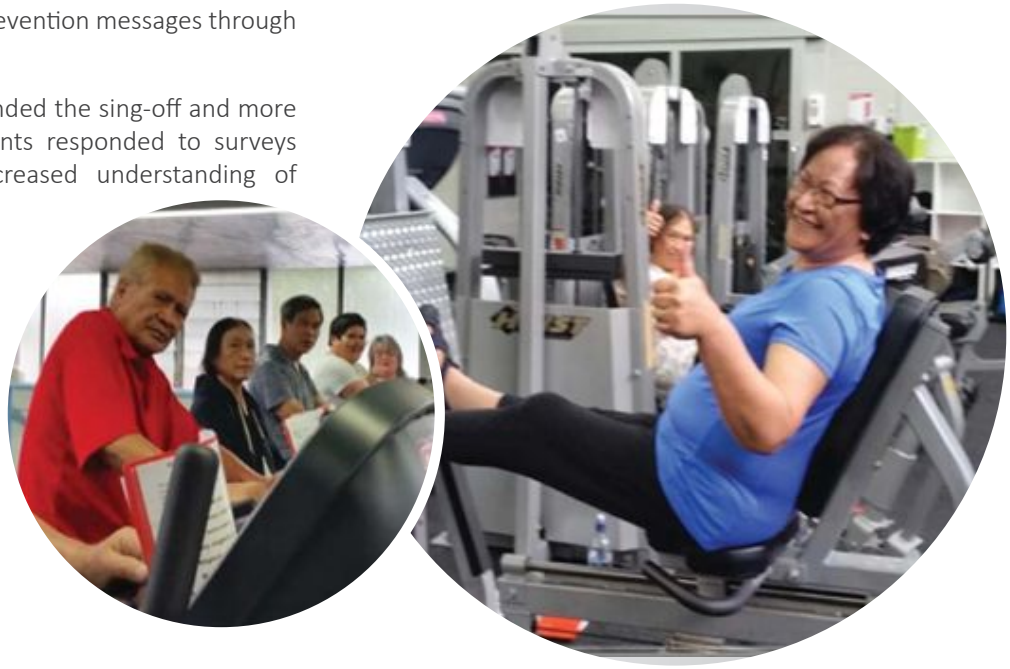
Whānau ora approach lifts take-up of cardiac rehabilitation

Auckland DHB's cardiac rehabilitation team has partnered with local Whānau ora provider, Te Hononga O Tāmaki Me Hoturoa, to enable better rehabilitation for Māori and Pacific Island patients with heart disease.

After a cardiac event, it is best practice for patients to start a regular, guided exercise programme. However, uptake of this programme was low nationwide, with Māori and Pacific Island patients most at risk of not participating.

To help improve this rate, over the past year Auckland DHB's cardiac rehabilitation team has worked with Te Hononga O Tāmaki Me Hoturoa to form a multidisciplinary team to support Māori and Pacific Island heart patients to stay well.

A community based exercise programme, supervised by Te Hononga and Auckland DHB staff, now runs twice a week, with 12 Māori and Pacific Island patients per session. Each patient receives an individual programme based on best practice guidelines. After the eight-week programme has been completed, the patients move on to a public gym, with continuing support. The Auckland DHB/Te Te Hononga O Tāmaki Me Hoturoa partnership also works with patients who are not engaging with outpatient clinics, to provide more individualised support to improve access to a wider suite of health services.



Case study: **Supporting people to stay well**

A 53-year-old Māori man with type 2 diabetes, hypertension, metabolic syndrome and a current smoker had a heart attack. Hospital treatment, including a stent, enabled him to return home.

However, he was not taking his medication and failed to attend most of his cardiac rehabilitation sessions. The cardiac rehabilitation team asked Te Hononga O Tāmaki Me Hoturoa to work with the patient.

When nurses and life coaches visited, they found that the patient and his wife were primary caregivers of young grandchildren and that his wife had also had a heart attack.

The household faced financial problems and lived on a poor diet.

The couple continued to smoke and neither were taking their preventative medications.

Te Hononga O Tāmaki Me Hoturoa staff worked with the family to change their lifestyle in a positive way. The whānau have improved their diet and have started a home vegetable garden. The patient and his wife are now taking their medication, have lost weight and have enrolled in a Wero programme to support them in their journey to quitting smoking.

Increased awareness of health services for new New Zealanders

The Auckland DHB region has experienced record net migration recently, including a significant increase in migration of people from Asian countries such as India, the Philippines and China.

Figures from a wider piece of work showed that ED utilisation rates for new and long-term migrants from Asia were almost the lowest of all ethnic groups. In addition, a survey of 318 international students in the Auckland CBD indicated the students tended to have lower level of understanding of the New Zealand health and disability systems and were less likely to have a regular GP clinic.

The findings supported work that was being undertaken to strengthen student and migrant awareness about the New Zealand health and disability system, but also identified the need to increase our focus in the CBD area.

Key messages were developed and tested on students and the Health Literacy North team. They were then expanded into an online media campaign which was rolled out in June 2016 and was directed at Chinese, Indian and Korean first language speakers in the Auckland CBD and CBD fringe suburbs. It was supported by key stakeholders such as universities, private training establishments and Auckland Tourism.

The aim was to help migrants to:

- Identify the appropriate healthcare options around where to go for less serious health concerns, and when to go to the hospital ED
- Recognise the benefits of enrolling with a local family doctor, or seeing one regular doctor (for those who are not eligible or entitled to enrol)
- Know where to locate information i.e. your local doctor's website to find health services

Podcast videos about the New Zealand public health system were also created in Mandarin, Hindi and English.

Bringing the consumer voice to Women's Health

The Women's Health Directorate is working with community and consumer organisations to establish a diverse and multicultural working group for regular discussion of ideas and issues, to improve maternity health services for women. With the assistance of representatives of the Women's Health Action Trust, a plan is under way to embed the voice of consumers at key forums.

The project team has engaged with a range of community organisations and NGOs to seek nominations for consumer representatives that reflect the diverse makeup of our patients and staff. We have partnered with Ngāti Whātua and Asian health non-government organisations (NGOs), teen parent groups and maternal mental health consumers.

The goal is for the consumer governance group to develop a set of consumer-focused outcomes, measures and targets and to work with Auckland DHB's Patient Experience and Performance Improvement teams on ways to innovate and improve how we engage with diverse maternity consumers. An induction and training manual for maternity consumer representatives is being finalised.

Picture book reassures child patients

Hospitals can be scary places, especially for children. Our Design for Health and Wellbeing (DHW) Laboratory worked with staff and children to create a set of interactive picture books to help ease children into the hospital environment. They tell the story of a little girl called Lin and her experience of visiting the outpatients' department at Starship Children's Hospital after breaking her arm.

The goal is to relieve any fears children might have and engage them in treatment by giving them honest information in a fun and friendly format.

Value for public health system resources

Better patient pathways

Auckland DHB's Pathways Programme aims to make the journey through our health services a better experience for our patients and to increase efficiency and reduce waste in the health system.

We use the Lean Six Sigma methodology to understand what we do and how we do it, so our pathways teams can easily identify where we can do better. This includes working with patient partners to find out what patients, feel would add value to their journey through the system.

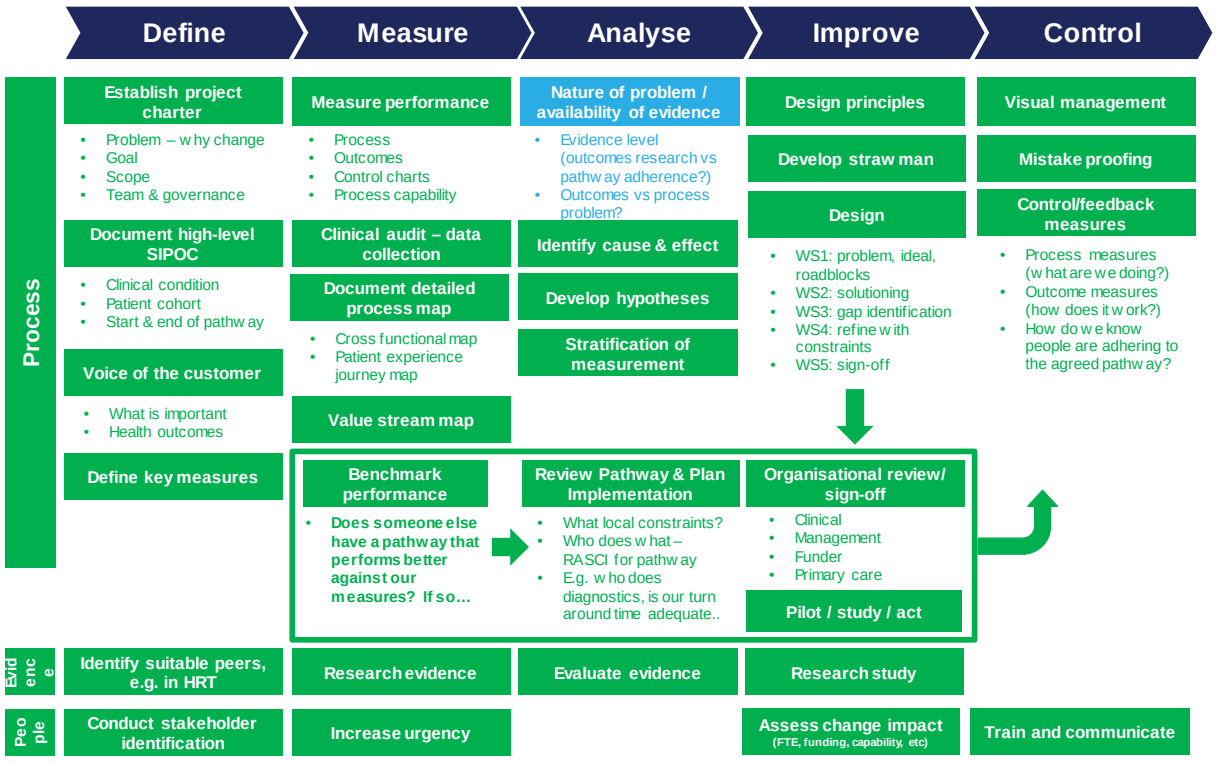
The programme focuses on specific diseases such as recurrent kidney stones, stroke rehabilitation and diseases related to the Faster Cancer Treatment National Health Target. We have also focused on the pathways where we have a higher volume of patients throughout the whole northern DHB region, including lung, melanoma, genitourinary, gynaecology, colorectal and breast cancers.

One key area of improvement over the past year is the identification of patients who have a High Suspicion of Cancer (HSC) at referral assessment. Compared to the previous year, we have seen a steady increase in identifying patients who need to be on a tumour stream pathway. Prompt identification means we are then able to track progress through the pathway and ensure timely appointments and treatment.

Quality and experience improvements include:

- The establishment of one-stop clinics to reduce the number of patient visits and speed up treatment
- Improving hand-over practices between services
- Improving disease-specific information for patients
- Reducing any repeated processes, where possible
- Improving the referral assessment processes to increase access

Pathway Programme Toolkit



Improved access to radiology services

Our radiology service provides diagnostic imaging and interventional radiology to patients across the Auckland region and nationally.

A multi-faceted approach has improved the processes and systems within our radiology service to help us get closer to meeting the Ministry of Health indicators for community and outpatients receiving their Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans within six weeks of referral. Previously, we were not sustainably meeting these and it was taking several months before an appointment for a scan became available.

We are now meeting or exceeding the indicators for CT and ultrasound scans and have made a significant improvement towards meeting the waiting time indicator for MRI scans.

Quarter on quarter comparison of number of patients waiting less than six weeks for imaging:

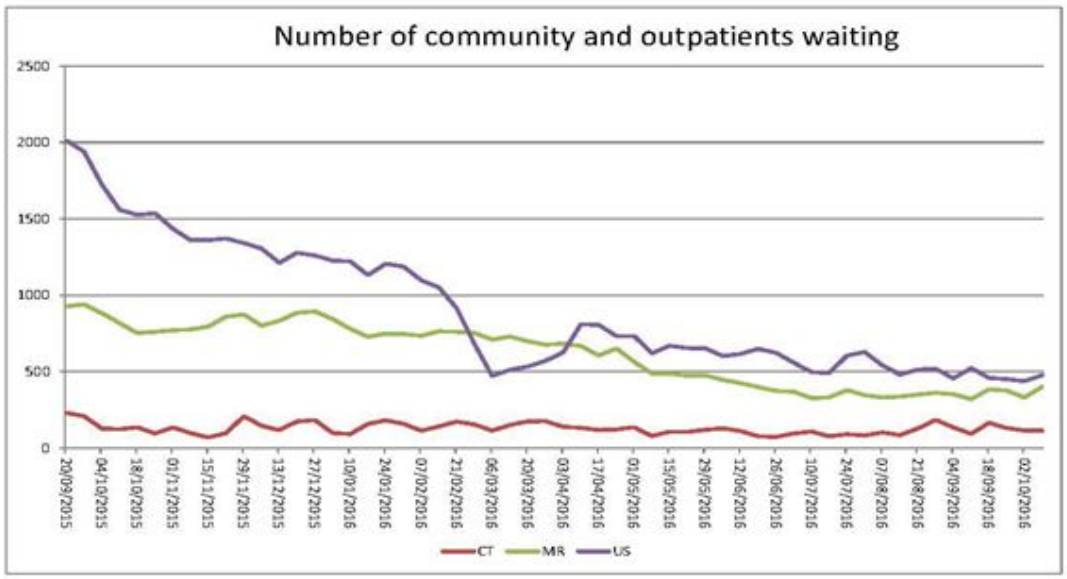
Quarter on quarter comparison			
	Q4 14/15	**Q4 15/16**	**% Improvement**
CT	**78%**	**93%**	**20%**
MR	**48%**	**66%**	**38%**
US	**43%**	**80%**	**85%**

We worked through a major change programme with four key work streams:

- Demand management
- Improving acute diagnostic flow
- Imaging throughput/patient flow improvement
- Improved reporting and visibility of performance

It was important that patients were engaged at an early stage and were partners throughout the process. For example, referrers and patients were included in the design process to create a better after-hours ultrasound service.

By improving our radiology service, most patients are receiving their scans faster, which means clinicians can make decisions to treat earlier. This work has helped Auckland DHB in its progress in meeting the Faster Cancer Treatment target and improving patient pathways for elective surgery. This has also meant we have improved patient experience by reducing some of the anxiety for patients waiting for a diagnosis.



9.3

Patient-centred booking improves clinical attendance

The diabetes outpatient clinic at Greenlane Clinical Centre had an issue with patients not turning up to appointments. Known as DNAs, (Did Not Attends), this is particularly common with diabetes patients. Twenty five percent of patients were failing to turn up overall, and for Māori and Pacific patients, the figure was around 40%.

To combat this, the diabetes clinic trialled patient-centred booking. Rather than sending a letter with an appointment time as they had done previously, they began asking patients when an appointment was convenient for them and matching that with their service.

The trial found that 20% of the patients who were called to schedule their appointments weren't at home during the day, so the DHB's call centre staff were then trained to call and book appointments for patients in the evenings when they were more likely to be in.

In May 2016, the clinic recorded its lowest number of patients not attending appointments in two years.

- The DNA rate of 30% in August 2015 had dropped to 20% in May 2016
- In March, 2016, the percentage of Pacific patients who failed to arrive at appointments had dropped from 41% to 30%

Although there is still more work to be done to trial the impact, if the evidence stacks up and the results continue, patient-centred booking will be rolled out to outpatient clinics throughout Auckland DHB.

Better use of blood product in cardiac surgery

In consultation with Auckland DHB's cardiovascular directorate, a transfusion algorithm was developed and piloted for blood transfusions to help avoid wastage of blood product and increase efficiency.

About 50% of patients having cardiac surgery will require a blood transfusion due to bleeding. Not only is blood product a scare resource, the use of blood transfusion is clearly associated with greater risks for the patient and higher costs for surgery.

A survey of cardiac anaesthetists at Auckland City Hospital showed variation in behaviour between anaesthetists despite appropriate access to coagulation testing in the operating theatre suite. They suggested the need for a patient-centred approach that would align blood product transfusion practice with international guidelines and a base of the best evidence.

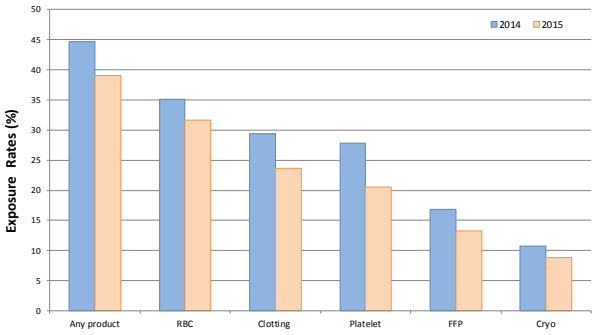
To create the transfusion algorithm, blood product use was audited for one year prior to introduction of the guidelines and one year after its introduction following a 'bedding in' period.

A significant reduction in blood product use was seen following introduction of the algorithm (See graph).

- A 5.7 % absolute reduction in patient exposure to all blood products
- A 3.7% absolute reduction in patient exposure to fresh frozen plasma
- A 7.3% absolute reduction in patient exposure to platelets (clot-producing cells)

At the same time, there was no increase in bleeding rate among patients and no increase in the need for re-operation.

Exposure rates per year

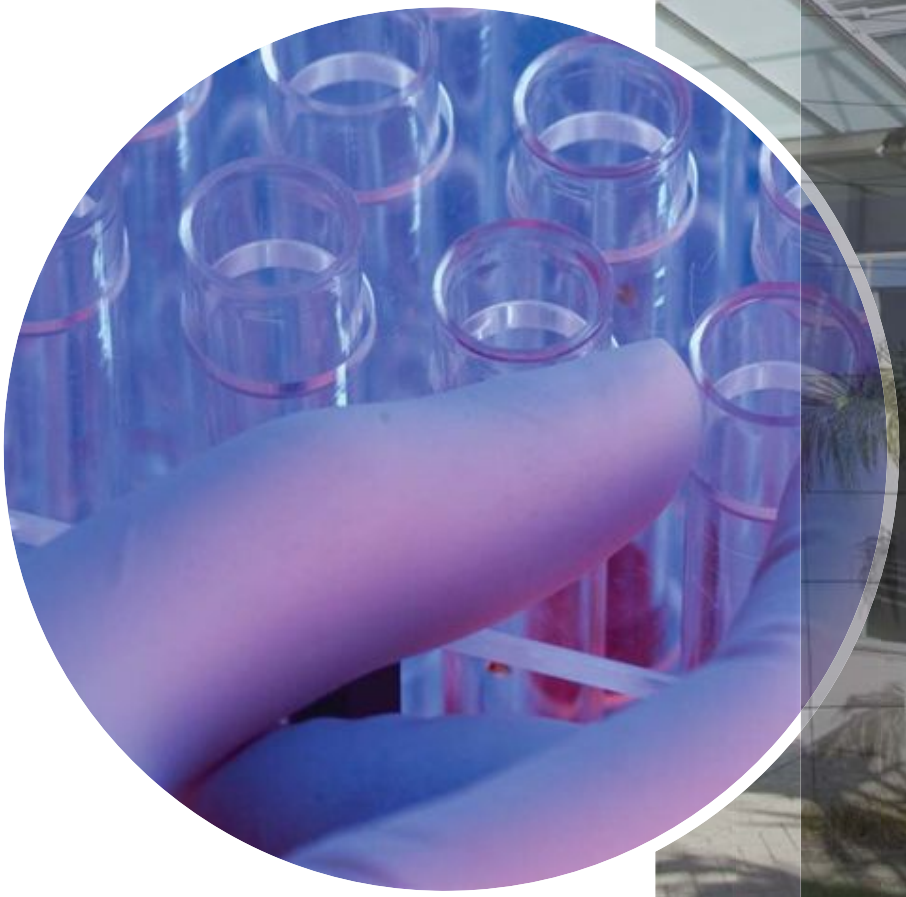


Where clotting = any blood product except red blood cells (RBC). Exposure rate is the percentage of patients exposed to this blood product during their postoperative recovery. The reduction is statistically significant.

Turnaround for biopsy reporting times

An improvement project has reduced the turnaround time for histology results by 40%, or about three days on average.

- Histology, where tissue samples are checked for signs of disease, is one of the key moments in our patients' journey. Accurate and speedier diagnosis is essential to improving patient outcomes, allowing them to begin treatment sooner. Faster turnaround times also reduce anxiety for patients while they wait for their results
- The project has involved training scientists to support fine needle aspiration diagnostic procedures, in order to complete more complex cases, remove bottlenecks in laboratory processes and enhance and more closely monitor the tracking of samples
- LabPLUS manager Dr Joe McDermott says both patients and staff have benefitted. For patients, there are fewer stays and potentially better outcomes, for staff the improvements have created a better working environment where pathologists are able to spend more time on their core role



9.3

Upskilling our people: Nurse endoscopists

Two Auckland City Hospital nurses are among the first four in New Zealand to be undertaking endoscopies, where a long flexible tube with a camera is used to examine a patient experiencing health problems with their stomach, intestines or bowels.

The creation of the nurse endoscopist role is part of a movement to collectively build the skills and experience of our health professionals to enable the delivery of the National Bowel Screening programme, which the Government announced in the 2016 Budget.

The specialist nurses are taking part in the Nurse Endoscopy Training and Credentialing Programme which launched in February 2016, and includes two postgraduate papers at the University of Auckland's School of Nursing, and practical experience at Auckland City Hospital.

They are part of a multi-disciplinary team that looks after patients with inflammatory bowel disease, dyspepsia and rectal bleeding.

9.3

Future focus

Section 3

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Future focus

Priorities for improvement

We have identified a number of strategic programmes to deliver improvement over the next one to three years.

We have chosen to highlight three of these:

Daily hospital functioning

Improving patient safety

Primary and community initiatives

Auckland DHB Strategy to **2020**

Our **strategic themes**

- Community, family/whānau and patient-centric model of healthcare
- Emphasis and investment on treatment and keeping people healthy
- Service integration and/or consolidation
- Intelligence and insight
- Consistent evidence informed decision making practice
- Outward focus and flexible service orientation
- Emphasis on operational and financial sustainability

Daily hospital functioning

Running our hospitals and clinics smarter

Introduced this year, the daily hospital functioning programme encompasses initiatives to put in place best-practice models for how we run our hospitals and outpatient clinics.

Best practice evidence supports the creation of an integrated operations centre that co-locates key operational staff and provides them with a timely view of past and predicted operational performance, with escalation plans for the whole organisation. The goal is to build a comprehensive understanding of how our patients arrive and move through our services and back to the community and home.

This year our work will focus on:

- Improving our operational intelligence and forecasting
- Developing an integrated operations centre
- Developing our Transition Hub to ease patients into being admitted to, and leaving, hospital

We are also working on variance response management as part of a Care Capacity Demand Management where Auckland DHB is partnering with the New Zealand Nurses Organisation, the New Zealand Public Service Association and the Safe Staffing Healthy Workplaces Unit on steps to better balance demand on our services with the capacity of our staff.

The success of this work will be demonstrated by:

- Organisation-wide visibility and understanding of the journey patients take through our services, whether inpatients or outpatients
- Routinely meeting the Shorter Stays in Emergency Departments National Health Targets in the face of our growing population and demand
- Our integrated operation centre monitoring our daily planning and using timely and accurate data

Keeping our patients safe after hours

Internationally, patient safety has been identified as more at risk after hours – 5pm to 8am weekdays and throughout the weekend.

Auckland DHB manages large and complex inpatient hospitals, offering a full range of services across 24 hours of operation. Our goal is to ensure that patient safety after hours is equivalent to daytime safety and that we have a sustainable after hours staffing model across all our wards and theatres.

Work has begun to design and put in place robust and reliable after hours safety systems and processes to keep inpatients safe across all our directorates.

This work is tied to our programme on best practice for deteriorating patients and improving how we run our hospitals and clinics.

For the 2016/17 year we will be:

- Mapping after hours staffing in all areas, and developing an online tool for staff working after hours to easily find the information they need to deliver safe after hours care
- Looking at ways to strengthen staffing models across our administration, nursing and medical teams and to enhance cover for operating theatres and anaesthesia after hours

As part of the work, we want to introduce a consistent, cross-directorate handover process based on models already working well in our hospitals.

Best care for deteriorating patients

We want to ensure we identify deteriorating patients as early as possible across our wards and put in place the right treatment and care. By doing this well, we can prevent their decline and keep them stable and well.

As a complex and large organisation, Auckland DHB has a range of diverse ways to manage this class of patient. We will be working on a project to develop a consistent approach to improve the care of medically unstable patients throughout the hospital, aligning with international best practice and the Health Quality and Safety Commission's national deteriorating patient programme.

A workshop involving staff from across the DHB has developed a high-level vision for this priority: "Auckland DHB inpatients will have excellent, comprehensive, integrated, seamless care that identifies and manages physiologically unstable patients."

Work that commenced in the 2015/16 year included:

- The audit and review of our two current warning systems, the Early Warning Score, (EWS) for adults and the Paediatric Early Warning Score (PEWS) for children
- Analysing options and measures for how best to care for and treat deteriorating patients
- Developing a seven days a week, 24 hours a day model of care for deteriorating patients

Health where people live – Our Tāmaki Mental Health and Wellbeing Initiative

The Tāmaki Mental Health and Wellbeing Initiative was launched in 2013 to help create a new experience of mental health and wellbeing support in Tāmaki.

The initiative team wanted to understand how they could better service the people of Tāmaki so in August and September 2016, they held a series of workshops to find out how people in Tāmaki want to experience mental health, addiction and wellbeing support in their community.

A clear theme emerged that called for a personalised service, which can be accessed in the right way, at the right place and with the right people. More specifically, the community wanted support that was easily accessible, that comes in a variety of different ways and helps them to reach identified goals.

The themes were then translated into possible solutions. The initiative team worked closely with community based support services - Mind and Body, Affinity Services and Pathways – to put together a prototype support service that provides flexible, non-medical, mobile support that is driven by what matters to the person. Support workers will help the person to plan for their wellness and will provide practical help until they are able to get back on track to live the life that they want.

This service is being trialled through Panmure Medical Centre and East Tāmaki Healthcare over the next six months. The trial will be a great opportunity to learn and to adapt the service into one that is person-centred and reflective of what the user wants.

Capability development

At Auckland DHB we invest in our people and systems to ensure we create an environment that is safe, sustainable, and where staff are encouraged to reach their potential. Here we outline organisation-wide programmes that support this approach.

Coaching Conversations

Coaching Conversations is a course that teaches leaders how to coach in a practical and pragmatic way.

Initially the programme was offered to support clinicians in new leadership roles and while clinicians remain the priority, the programme has since been opened up to all leading teams.

Coaching Conversations comprises four full-day sessions of cumulative skill building and practice. To date, we have run five cohorts, with about 60 people going through the programme.

Feedback from those undertaking the course has been positive. For example, one attendee made comment:

> *"Just a note to express my sincere thanks for such well-organised and extremely important subject matter, especially to me as a relatively new (second year) line manager with my own clinical team. I enjoyed every session and have learned so much – I am recommending these sessions to all of my senior colleagues as not just essential for coaching conversations but critical to a better understanding of team dynamics."*

Leadership Development Programme

The Leadership Development Programme was co-designed with clinician leaders and external partner JumpShift. The programme is highly engaging and involves peer networks across directorates, with managers and teams active in supporting participants' development.

It is a four to five month programme of six half-day structured sessions that include sharing and reflection on roles and responsibilities, a 360-degree development survey, developing a personal leadership development plan, access to the best practice lecture series from the American Centre for Creative Leadership, and asynchronous earning delivered via Jump Shift's technology platform.

Our pilot programme finished in May and three programme cohorts commenced in early June. By the end of FY16/17 we aim to have had approximately 150 staff complete the programme.

Developing our culture

We are taking a multi-pronged approach to developing a safety culture. Over the past two years, we have moved from defining our values to embedding them. The annual focus has been as follows:

2014 Build the Values **2015 Lead** the Values **2016 Live** the Values

Behaviours

We are focusing our people on the behaviours needed to ensure reliable quality and safety at all times, where the patient is at the centre of all decisions, and where staff speak up to improve safety.

Speak Up programme

The F16/17 plan will see a Speak Up programme to raise awareness of bullying and other inappropriate behaviours, options for resolution, and consequences for conscious or persistent disregard of our values, including the promotion of our independent employee whistle-blower policy.

Leadership development programme

Our Leadership development programme is specifically designed to enable our clinician leaders to lead culture change, to create an engaging environment where our teams feel valued and supported to be at their best, enabling patients to feel safe.

People strategy

We are finalising a three-year people strategy to facilitate the development of a workforce culture that delivers quality outcomes. The strategy aims to ensure our staff are a shining example of a happy, healthy, high performing community, which in turn delivers the culture necessary for optimal patient safety.

Improvement training

We are continuously focusing on improving the capability of our staff as improvement needs to be a constant work-in-progress.

Two training programmes have been developed to help build the improvement mindset and capability of our staff – Improvement Fundamentals and Improvement Practitioner.

Improvement Fundamentals is a two-day programme that introduces participants to key improvement tools. The course enables participants to lead small improvement activities or to be active participants in GreenBelt projects, which are run by the Lean Six Sigma methodology. This methodology relies on a collaborative team effort to improve performance by systematically removing waste. The Improvement Fundamentals course is a prerequisite for the Improvement Practitioner course.

Health and safety

Strengthening health and safety

The new Health and Safety at Work Act 2015 (HSWA) became law in April 2016. In preparation, and under the strong leadership of the Board, we:

- Commissioned an external audit of health and safety management systems and identified all of the actions required to upgrade them to meet the requirements
- Reviewed all health and safety related policies, systems and training
- Provided information to the DHB's management teams on their new roles and responsibilities

In addition, a suite of health and safety training courses is set to increase the capability of the DHB to prevent risk and manage incidents at all levels in the organisation.

Over the next year we will continue to embed the new systems and strengthen the health and safety culture across the organisation.

9.3

Health and safety representative training

Auckland DHB's Health and Safety team has worked hard to qualify about 60% of the DHB's 275 Health and Safety Representatives (HSRs) under the new training legislation (Health and Safety at Work Act 2015).

This legislation requires a higher level of training for HSRs than what they were receiving under the 2002 amendment to Health and Safety in Employment Act 1992 (HSE).

WorkSafe allowed for all staff who were qualified as HSRs under the legislation as of 30 March 2016 to take transition training that would qualify them as HSRs under the new legislation. This transition training needed to be completed by 30 June 2016.

A two-day training course will be provided during the 2016/17 financial year for the remaining HSRs who did not undertake the transition training.

What our patients say

"On the day of the day surgery procedure, the duty anaesthetist spotted that I had a heart murmur. This had been missed in pre-admission. I knew I had one but the questionnaire only asked about heart surgery and pacemakers. The anaesthetist gave careful consideration as to whether it was safe to proceed. In preparation for the upcoming big surgery I have now had an echocardiogram done thanks to her picking this up."

"My pre-op meeting was relaxed and informative. I was told that they thought I could manage without a pre-op drug that would make recovery time longer but the decision was mine. I chose to take their advice and in fact had no nervousness (that I felt) when I was taken to the theatre."

"In comparison with an operation 25 years ago where it took weeks to recover from the anaesthetic, I woke up with the very mildest nausea and no vomiting at all. The anaesthetist who interviewed me at the pre-med was terrific and the one in theatre was funny and friendly. Wow!"

"He was a cool guy, very informative and explained everything well – he was kind and explained everything perfectly. He deserves 10/10 for bedside manner!"

9.3

AUCKLAND DISTRICT HEALTH BOARD

Quality Account

2015/16

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Conflict of Interest Policy Approval

Recommendation

That the Board:

1. **Approves the updated Conflict of Interest Policy for staff.**
2. **Notes that:**
   a. **The Auckland DHB Conflict of Interest Policy has been reviewed as per audit and accounting standard requirements.**
   b. **This Policy has been reviewed and updated to reflect changes to ensure alignment where necessary with the Waitemata DHB (WDHB) Conflict of Interest Policy.**
   c. **The policy has been considered and endorsed by the Executive Leadership Team.**

Prepared by: Marlene Skelton (Corporate Business Manager)
Endorsed by: Rosalie Percival (Chief Financial Officer)
Endorsed by Executive Leadership Team: Yes: Date: Tuesday, 15 November 2016

Glossary

PBE	Public Benefit Entities
IPSAS	International Public Sector Accounting Standard

1. Executive Summary

This paper is to request the Board to consider and endorse the updated Auckland DHB Conflict of Interest Policy and approve the recommendations noted above.

The policy has been revised to ensure currency and to incorporate the PBE IPSAS 20 Related Parties Accounting Standard. Various improvements have also been made including clarification of scope, and the inclusion of fuller detail and instruction on disclosure and documentation and determining the existence of conflicts.

The policy has been considered and endorsed by the Executive Leadership Team. It is recommended that the Board approve the revised Conflict of Interest Policy.

2. Introduction/Background

An Audit undertaken in 2015 identified and recommended that the guidance for Board members and key management personnel be updated to ensure full awareness of interest disclosure requirements to enable full compliance with the new PBE IPSAS 20 Related Parties Accounting Standard.

The previous Conflict of Interest Policy did not specify that the procedures that Board and Committee members follow differ, nor where this information could be found. This has been addressed in the updated policy.

3. Analysis

The reviewed policy is applicable to DHB employees. The procedures by which Board and Committee members identify, declare and manage conflicts of interest are set out in the Auckland DHB Governance Manual.

Changes have been made to reflect the requirement to disclose related party interests as per PBE IPSAS 20 Related Parties Accounting Standard. Additional text has been included to more explicitly describe disclosure criteria, frequency and documentation.

The revised policy was sent out for consultation by seeking input from Legal, Finance, Procurement, and Human Resources. Revisions based on comments received during consultation were included and all parties have confirmed they are supportive of the proposed revised policy being submitted as final for approval by the Board.

5. Conclusion

The Conflict of Interest policy has been reviewed and revised to ensure currency and incorporate the PBE IPSAS 20 Related Parties Accounting Standard. A range of improvements have also been made. It is recommended that the Board approve the revised policy for adoption.

CONFLICT OF INTEREST

Overview

This Document

This document outlines the policy to ensure decisions made by our District Health Board are not influenced by the personal interests of its employees. The District Health Board acknowledges that conflicts do exist from time to time; with openness and transparency, these can be managed positively.

Topic	See Page

CONFLICT OF INTEREST

Introduction

Purpose

Our District Health Board is committed to providing a fair, ethical and accountable environment for the conduct of health system operations. All employees are expected to perform duties in a fair and unbiased way and not to make decisions which are affected by private interests or personal gain. The integrity and fairness of the decisions and actions taken by employees could be undermined if, when performing their duties, a conflict between the District Health Board and private interests exists or appear to exist.

To protect the integrity of the District Health Board and its employees, conflicts of interest need to be properly managed. Employees have an ongoing obligation to disclose any conflict of interest.

Conflicts of interest must be as transparent as possible. The generally accepted view is that where conflict between the organisation's duty, requirements and private interest exists, matters must be resolved in the organisation's interest.

Scope

This policy applies to all District Health Board employees. It includes commercial transactions and recruitment of employees, any person seconded or contracted to the Auckland DHB and students training in DHB premises, as well as clinical research and related activities such as funding and research grants.

Employees must disclose all interests, regardless of whether they consider they may or may be in conflict with Auckland DHB.

The procedures by which Board members and members of committees identify, declare and manage conflicts of interest are set out in:

- The Auckland DHB Governance Manual
- Part 2 of the Crown Entities Act 2004
- Schedule 3 of the New Zealand Public Health and Disability Act 2000

CONFLICT OF INTEREST

Associated Documents

The table below indicates other documents associated with this policy.

Type	Document Titles
NZ Legislation	• Crown Entities Act 2004 • NZ Public Health and Disability Act 2000 • Employment Relations Act 2000
Board Policies	• Conduct - Standards • Discipline & Dismissal • Sponsorship, Donations, Gifts and Corporate Hospitality Policy • Delegated Authority Policy
Other	• Auckland DHB Governance Manual • Staff Interests Register • Managing Conflicts of Interest – Good Practice Guide (2007) – Office of the Auditor-General • PBE IPSAS 20 Related Parties Accounting Standard • Conflict of Interest Guidelines for DHBs – Ministry of Health

Policy Statements

Policy Statements

Where an employee or their related party has an interest (or potential interest) in a transaction – financial, professional or personal –or could be influenced or perceived as being influenced by a personal or private influence which may potentially conflict with their obligations to the District Health Board, they must declare that interest to the appropriate Manager or Clinical Head.

Continued on next page

CONFLICT OF INTEREST

Where an employee or their related party has a (potential) conflict of interest, this must be discussed with the appropriate Manager/ Clinical Head, and they are to decide whether any change to the employee's activities is required to mitigate any conflict.

Employees have an ongoing obligation to disclose actual, potential or perceived conflicts of interest. They should err on the side of caution; if they are unsure whether they have a conflict of interest in a particular situation they should discuss the matter with their manager or professional lead.

Where an employee or their related party has a conflict of interest and has knowingly withheld this information, and/or acted to their own advantage, the employee may be subject to disciplinary action up to and including dismissal.

Conflicts of interest must be either eliminated or managed in the best interest of the DHB

Key Words

Key words to be recorded for Intranet search functions related to this topic are as follows:

- Transaction
- Interest in a transaction
- Conflict of Interest
- Related party
- Gifts
- Sponsorship
- Donation
- Corporate Hospitality

CONFLICT OF INTEREST

Conflict of Interest

The Meaning of Conflict of Interest

Conflict of interest exists when it is likely that an employee could be influenced or could be perceived to be influenced by a personal or private interest **in any transaction** whilst carrying out their responsibilities for the District Health Board.

Transaction means:

- The exercise or performance of a function, duty, or power of the District Health Board; or
- An arrangement, agreement, or contract to which the DHB is a party; or
- A proposal that the District Health Board enter into an arrangement, agreement, or contract.

The functions the relevant individual performs, and delegated authorities that employee holds at the District Health Board, will need to be considered to determine how a conflict of interest may arise.

A personal or private interest are those interests that can bring benefit or disadvantage to an employee as an individual, or to others whom the employee may wish to benefit or disadvantage.

Related party means:

- A friend
- A relative or close member of the family
- An associate

Close members of the family of an individual are those family members who may be expected to influence, or be influenced by, that person in their dealings with the entity and include:

a) That persons children and spouse or domestic partner
b) Children of that persons spouse or domestic partner; and
c) Dependants of that person or that persons spouse or domestic partner

An Interest in a transaction, that can lead to a conflict of interest, may exist where an employee:

- Will derive financial benefit from the transaction
- Has financial interest in another party to a transaction
-

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CONFLICT OF INTEREST

Conflict of Interest, Continued

- Is a director, officer or trustee of another party to the transaction, or is a person who will or may derive a material financial benefit from the transaction
- Has an interest in another party tendering for work which the District Health Board is contesting
- Is a shareholder of another party to the transaction
- Is the parent, child, or spouse of another party to the transaction, or a person who will or may derive a financial benefit from the transaction.

Examples of interests employees should consider are:

- Shares they own
- Their having made or received a donation or gift
- Their being an adviser, employee, trustee or director of another business or organisation
- Their being a member of a professional body
- Their family affiliations
- Any business proposals they are developing

See Appendix 1 for a list of situations where conflicts of interest may potentially occur. Be aware that these are examples only and that the list is not exhaustive.

Perceived and Potential Conflicts of Interest

Conflicts of interest can be actual, perceived or potential.

An actual conflict of interest involves a direct conflict between an employee's current duties and responsibilities and existing private interests.

A perceived or apparent conflict of interest can exist where it could be perceived, or appears, that an employee's private interests could improperly influence the performance of their duties, whether or not this is the case.

A potential conflict of interest arises where an employee has private interests that could conflict with other official duties in the future.

For advice, please contact the head of the decision making group to which you belong or your relevant manager.

Continued on next page

CONFLICT OF INTEREST

Conflict of Interest, Continued

Competing Interests or Conflict of Duties

Conflicts of interest can also arise where an individual has official roles in more than one public organisation. In these situations, it may be difficult for a public official to keep the roles separate and this can lead to poor performance of one of the roles, at least, and unlawful or improper decision making at worst, or improper use of information to give advantage to the second organisation, etc**.**

These types of conflict are not always recognised because no private interest is involved or apparent. These situations are usually described as one of competing interests or a conflict of duty, and are best managed on the same basis as conflict of interest.

Deciding if a Conflict of Interest Exists

Employees should ask themselves the following questions to help decide if a conflict of interest exists or could be perceived by any person to exist:

- Do I, a relative, friend or associate stand to gain/lose financially from the District Health Boards decision or action on this matter?
- Do I, a relative, friend or associate stand to gain/lose in any way from the District Health Board s decision/action?
- Am I in a position to influence decision making about a matter related to a potential personal or professional interest?
- Have I made any promises or commitments in relation to this matter?
- Have I received a benefit or hospitality from someone who stands to lose or gain from the District Health Boards decision/action?
- Am I a member of an association, club or professional organisation, or do I have particular ties or affiliations with organisations or individuals, who stand to lose or gain from the District Health Boards consideration of the matter?
- Could there be benefits for me in the future that could cast doubt on my objectivity?
- If I do participate in assessment or decision-making, would I be happy for my colleagues and the public to be aware of any association or connection?

Continued on next page

CONFLICT OF INTEREST

Conflict of Interest, Continued

- Would a fair and reasonable person perceive that I was influenced by personal interest in performing my public duty?
- Do I need to seek advice or discuss the matter with an objective party?
- Am I confident of my ability to act impartially and in the public interest?
- Do I need to declare the matter to my manager or to the relevant decision making group?
- Might I be perceived as favouring a particular person or firm because of a longstanding association?
- Am I in a position to influence development of a particular strategy or policy that will guide future decisions from which I may benefit personally?
- When I am making a presentation or recommendation to the Board or other decision making group, are they aware of my interests (including private practice commitments) which might be perceived as influencing the advice I am giving?

Disclosure and Documentation

Disclosure of Conflict of Interest

After determining that a conflict of interest may exist in a particular situation, the individual employee must disclose any actual or potential interest they have (whether pecuniary or non-pecuniary).

Disclosures should be made at the earliest opportunity on the declaration of interests form and documented in the interests register.

The employee should disclose to their manager and/or any relevant decision making group, or the responsible decision making person, his or her conflict of interest at the first available opportunity, for a decision as to what action should be taken to avoid or deal with the conflict. Disclosures are to be treated as confidential if appropriate. A disclosure should provide relevant information such that management can make an informed decision about how best to manage the actual or potential conflict of interest.

CONFLICT OF INTEREST

Disclosure, Continued

Specific information disclosed must include:

- The position at issue (the role) and its functions and duties specifically in relation to the transaction
- The potential value (direct and indirect) of the transaction
- The way in which the interest or conflict will or may impact on the performance of the employees role
- An explanation of any personal benefit – perceived, actual or potential, direct or indirect, financial or otherwise – resulting from the transaction
- Possible future involvements and benefits

Disclosures should be made verbally and in writing. An employee who has a conflict of interest must ensure that the interest is reported to the Corporate Business Manager for recording in the Staff Interests Register.

If an employee, their manager or professional lead is uncertain whether a particular situation constitutes a conflict of interest they should err on the side of caution and arrange for the interest to be declared and recorded in the interests register. If further advice is needed on whether or not the particular situation constitutes a conflict of interest, the matter can be referred to the Corporate Business Manager for guidance.

Documentation

Employees are to complete the Declaration of Interests form and provide it to their manager who will manage the potential conflict of interest. The manager will provide the form to the Corporate Business Manager for recording in the Staff Interests Register.

The existence of a conflict of interest by a member of staff must be documented in an Interests Register.

This documentation should note:

- The name of the employee
- The nature of their interest in the transaction, and
- What role they had in the transaction e.g. No role, only involved in the discussion but not the decision, full involvement.

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CONFLICT OF INTEREST

Disclosure and Documentation, Continued

Interests Register

An Interests Register is to be maintained by the Corporate Business Manager to record all interests (actual or potential).

The Register is to incorporate as a minimum the following information:

- Name of the person declaring the interest
- Name of the person the interest was declared to
- Date of declaration
- Organisation or individual involved
- Brief description of matter
- Action taken/comments and how the conflict of interest will be managed/mitigated

Options and Appeals

Options for Dealing with a Conflict of Interest

Generally, if a pecuniary interest is disclosed, the individual with the interest must not be involved in consideration or discussion of the matter in which he or she has the interest and must not vote on any question relating to the matter.

In rare situations this may not be possible, for example, if a conflict of interest is identified at or near the conclusion of a process. Appointing an independent person to be involved in decision-making would minimise the actual or perceived influence or involvement of the person with the actual or reasonably perceived conflict.

However, a broader range of options exists for dealing with conflicts of interest that do not have a pecuniary component. Choosing the right option to deal with the situation will depend on the circumstances and an objective assessment of it.

Continued on next page

CONFLICT OF INTEREST

Options can include:

- Take no action because the conflict is assessed as being minor in nature or is eliminated by disclosure or effective supervision
- Allow limited involvement (e.g. Participate in discussion, but not in decision making)
- Prohibit any involvement
- Request the individual concerned relinquish or divest the personal interest which creates the conflict
- Appoint an independent person to manage the process to provide assurances of fairness and equity in the matter

Appeals Process

If an employee and their manager disagree with respect to any Conflict of Interest issue, an appeal may be made for a review to the Chief Human Resources Officer, or the Chief Medical Officer, or through other options available to the employee.

CONFLICT OF INTEREST

Appendix 1: Conflict of Interest Examples and Recommended Actions

Listed below, under various classifications, are situations where conflicts of interest may potentially occur and a recommended action to avoid or deal with the conflict.

Purchasing of Goods and Services or Letting of Contracts

Situation	Recommended Action
Accepting gifts or benefits from suppliers, or other individuals, involved in the provision of goods and/or services could present a conflict of interest or obligation and be perceived as encouraging or obliging the employee to favour that supplier. Gifts and benefits can take many forms e.g. Lucky door prizes, raffles, travel, meals. It also includes opportunities to attend educational conferences or meetings and attendance at or participation in sports events.	Refer to your policy on Sponsorship, Donations, Gifts and Corporate Hospitality. Best practice is to accept the gift on behalf of the unit for which you work. , Report that you received the gift to your manager to record the details appropriately. Complete the Sponsorship, Donations, Gifts and Corporate Hospitality Declaration form. Note that there are limits placed on the value of gifts that can be received. *Relevant register: Gifts Register*
Selection of Tenders/Appointment of contractors: Preferring tenderers or prospective contractors with whom there is a private relationship	Where there is a private interest with any Tenderer or contractor, the employee must declare their conflict of interest and withdraw from the selection process.

Recruitment

Situation	Recommended Action
Sitting as a member on selection panels where applicants for the position are known to the member personally, as family, friend or close associate, to an extent that could be considered to be a conflict of interest.	Declare the interest and withdraw from any part of the recruitment process is the preferred option; however in some situations it may be necessary to include the person with the conflict on the panel (for example in cases where they have specific expertise that is required). In these cases it may be an option to include an independent person in the recruitment process. *Relevant register: Staff Interests Register*

CONFLICT OF INTEREST

Situation	Recommended Action
Being in a position to **influence the selectio**n, or non-selection, of an applicant for a position where the applicant is known personally and involvement could be perceived to be a conflict of interest.	Declare the interest. Other choices as noted above. *Relevant register: Staff Interests Register*

Staff Administration

Situation	Recommended Action
Having a **close personal and/or family relationship** with another employee over whom control is exercised.	All employees are to be treated equally and fairly and any relationships that could be perceived to be of possible concern should be brought to the attention of the appropriate senior employee. If it appears that employees are being given preferential treatment, these concerns should be addressed through the disciplinary process. *Relevant register: Staff Interests Register*

Presentations to the Board or Other Decision Makers

Situation	Recommended Action
Making a written or oral presentation to the Board (or to another Auckland DHB decision making body) about equipment, facilities or services when the presenter has, or is contemplating, private sector involvement in a similar service.	At the start of the presentation the presented is expected to explicitly declare their private practice involvement. The Board or other decision making body then as an opportunity to ask questions about this interest. When arrangements are being made for a staff member to make a presentation to the Board, the staff member will be reminded of the expectation to declare private practice commitments. *Relevant register: Staff Interests Register*

Improper Actions

Promoting friends or relatives where other employees are more deserving.

Preferentially rostering staff to the advantage of particular individuals due to personal association with those persons. This can have financial (penalty rates, etc.) advantage to the favoured individuals to the disadvantage of other employees.

CONFLICT OF INTEREST

Allocation of overtime regularly to particular individuals to the disadvantage of other persons equally entitled and equally efficient.

Assessment and/or inappropriate recommendation of particular individuals over others because of personal associations, for such things as:

- Training courses
- Attending conferences
- Job or advancement opportunities

Recommending incremental progression, or non-progression, of particular employees due to personal interests, or attitudes, that are not aligned to the work situation.

Giving preference for the taking of leave by individuals to the detriment of others due to personal association.

Not applying the same rules equally to all employees because of personal association, e.g. Failure to address issues of late attendance, non-performance, etc.

Continued on next page

CONFLICT OF INTEREST

Appendix 1: Conflict of Interest Examples and Recommended Actions, Continued

Client/Patient Relationship

Situation	Recommended Action
Providing information or making recommendations to client/patient regarding service providers where one of the service providers is a **close friend/relative**, etc. Providing information or making recommendations to patients by recommending yourself in a private capacity.	Staff are not to give preferential treatment to personal associates at the expense of others. (Wherever practicable, staff are not to recommend any one service provider or firm. They should provide "lists" of available service providers/firms.) If a staff member is found to have received a financial return for recommending one service provider, or firm, or oneself, disciplinary action taken may include dismissal. *Relevant register: Staff Interests Register*

Membership of Associations or Clubs, Professional Organisations, Political Parties

Situation	Recommended Action
Being involved in decision-making processes of the District Health Board or a professional body, association, etc. that could have an effect on the method of operation of the District Health Board or that association, club, professional organisation, etc. that the employee is a member of, or has an interest in.	Declare the interest and allow management to determine the extent of involvement. If an employee is found to have made or influenced a decision to the District Health Board's detriment, then that employee could be subject to disciplinary action and possible dismissal depending on the circumstances. *Relevant register: Staff Interests Register*

Clinicians and Other Health Professionals

Health professionals encounter a variety of circumstances in their day-to-day work which could give rise to potential conflicts of interest.

Situation	Recommended Action
Establishing a relationship with a **pharmaceutical company or medical equipment supplier** where it could be perceived that preference was given to that particular company during a procurement/ tendering process.	Declare any potential conflict of interest to the Chief Executive Officer (CE) or authorised delegate(s) e.g. Your manager *Relevant register: Staff Interests Register*

Continued on next page

CONFLICT OF INTEREST

Appendix 1: Conflict of Interest Examples and Recommended Actions, Continued

Situation	Recommended Action
Accepting **travel and accommodation fees** to present research findings.	Obtain approval from CE or authorised delegate(s) for accepting travel and accommodation fees and releasing of possible confidential information. *Relevant register: Gifts Register*
Accepting **payment of fees** and/or honorariums for sitting on committees	If a fee-for-service is received and the service is provided **during working hours**, then the income must be declared and provided to the organisation. (Also refer to Secondary/Additional Employment Policy) *Relevant register: Gifts Register*
Participating on **professional boards, committees, societie**s, etc. Which could constitute a conflict of interest with position held in health organisation.	Obtain approval from CE or authorised delegate(s) to participate in external boards, etc. where there is any or could be a perception of a conflict with the duties or functions performed in the health organisation. *Relevant register: Staff Interests Register*
Having **directorships** and **share holdings** in private companies, associations, etc. which deal with the health organisation.	Declare the interest to the CE or authorised delegate(s) who would then decide whether a conflict of interest existed and possibly restrict the person's involvement in the District Health Board s processes or request resignation from external involvement. *Relevant register: Staff Interests Register*
Evaluating new **products / drugs** where decisions may be influenced by personal associations/offers of samples or equipment, whether to the individual or the organisation	Declare any potential conflict of interest to the CE or authorised delegate(s). *Relevant register: Staff Interests Register*
Evaluating new **products / techniques devices** developed by employees also involved in clinical trials of same; or when a company licensed to use an employee's invention is sponsoring trial to be undertaken with the District Health Board	This must be approved by the Clinical Review Board and the Research Review Committee, who will decide on how to manage the conflict and legal responsibilities. *Relevant register: Staff Interests Register*

CONFLICT OF INTEREST

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Strategic Relationship between the District Health Boards and the Accident Compensation Corporation

Recommendation

That the Auckland District Health Board gives approval for the Auckland DHB Chief Executive Officer to sign the Memorandum of Understanding with the Accident Compensation Corporation.

Prepared by: Sharon McCook (Executive Business Manager)
Endorsed by: Ailsa Claire (Chief Executive Officer

Glossary

ACC	Accident Compensation Corporation
MOU	Memorandum of Understanding

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	The proposed MOU specifically focuses on developing a coordinated, integrated approach to patient-centred service delivery between ACC and the DHBs. A key focus is identifying outcomes that matter to patients, communities and whānau
Emphasis/investment on both treatment and keeping people healthy	Key areas of joint interest include community prevention and home- based support
Service integration and/or consolidation	The DHBs and ACC will work together to coordinate activities to increase the overall capability of all parties. The MOU will build upon existing joint processes.
Intelligence and insight	Information will be freely shared between ACC and the DHBs on areas of common interest.
Evidence informed decision making and practice	Initial strategic priorities will focus on what existing evidence tells us works.
Outward focus and flexible service orientation	To ensure that the ACC and the DHBs fund and deliver quality services, our relationship and work programme will respond as appropriate to the constantly changing health service delivery environment.
Operational and financial sustainability	A key focus for the MOU is determining an approach that is sustainable for providers and funders.

2. Executive Summary

This paper provides an update on a proposed Memorandum of Understanding (MOU) between the District Health Boards and the Accident Compensation Corporation (ACC). The purpose of the MOU is to set out how the DHBs and ACC will work together to deliver further progress on improved outcomes for our shared patients. The MOU will also enable the DHBs and ACC to enhance the constructive relationships that are in place and coordinate activities to help drive action on shared priorities.

A programme of work that sets out the range of strategic priority areas is currently under development and is expected to be confirmed shortly. A Steering Group has also been established

to oversee the operation of the MOU and the delivery of strategic projects. Membership of the Steering Group includes 3 DHB Chief Executives, representing all twenty DHBs, and ACC's Chief Operating Officer. Other designated representatives include ACC's Head of Provider Services and Manager for Treatment Injury Prevention.

The MOU has been revised and refined following several rounds of consultation with ACC's Legal representatives and the Chief Executive for every DHB in New Zealand. Current feedback has indicated that the MOU can now be prepared for signing. It should be noted that the MOU is a relationship agreement and is not intended to be legally binding.

It is recommended that the ADHB Board approves the Auckland DHB Chief Executive to sign the MOU (attached in the resource centre).

3. Background: Strategic Relationship between ACC and the DHBs

In 2007, the DHBs developed a Charter of Collaboration with ACC. This Charter was facilitated through the DHB CEO Group and DHBNZ and was designed to support a senior management level relationship between the agencies. It was anticipated that such a relationship would support both the DHBs and ACC to carry out their respective legislative and accountability obligations and focus on areas of mutual interest.

Since the Charter of Collaboration ended in 2010, the parties have signalled their desire to renew the commitment to work together collaboratively. Currently, individual DHBs have a range of relationships and alliances with ACC many of which focus on common priorities such as work to reduce falls. Others also have a wider strategic brief involving other organisations (e.g., the Health Quality and Safety Commission). It is expected that a new collaborative agreement and an updated work programme will provide a framework to support both current and future activities.

Implementation at Auckland DHB

It is expected that the MOU and a well-executed strategic work programme will facilitate Auckland DHB efforts to lead change, achieve expected outcomes and realise a number of benefits as outlined in the proposed MOU. In particular the MOU acknowledges that the DHBs and ACC are both purchasers of health and disability services. DHBs are also providers of certain health and disability services that are funded by ACC.

In addition, in some cases, DHBs and ACC fund similar services, deal with the same providers and provide services to the same patients. In light of this, the initiatives of one agency can have impacts on another agency and affect service delivery to and outcomes for patients.

4. Memorandum of Understanding

The proposed MOU recognises the existing joint processes and mechanisms that DHBs and ACC have for working together on areas of common interest. It is anticipated that this MOU will build on but not replace any of these existing process and mechanisms. Under the MOU the DHBs and ACC will:

- Work together to consider and agree projects intended to deliver against the agencies' shared priorities,

- Respect each other's roles and responsibilities in the health sector as described in legislation, and the right of the agencies to express clear and independent positions on issues as appropriate,
- Ensure early engagement with each other on any work or initiatives that affect or involve the other agencies, and take an early warning/no surprises approach where possible,
- Ensure open, timely and honest communication on joint initiatives and areas of common interest where possible,
- Work together to coordinate activities to increase overall capability of all parties, while taking care to treat all information and intellectual property with respect, maintaining its security, ownership and confidentiality including complying with all relevant law,
- Keep the processes for engagement as simple as possible to minimise time and resources needed,
- Improve understanding of each other's business, including priority areas, constraints and differences,
- Make reasonable efforts to inform each other before making public comment in areas of common interest, and
- Keep strictly confidential all confidential information provided to it by the other parties or which comes into any party's possession. These confidentiality arrangements will extend beyond the duration of this MOU.

5. Risk assessment

The MOU clearly outlines the commitment of the parties to the strategic relationship. It should be noted that Ailsa Claire is also the lead DHB Chief Executive for managing the strategic relationship with ACC.

It does not appear that the proposed relationship will place an undue burden on Auckland DHB. It is anticipated that the strategic relationship will support the delivery or person-centred service delivery between the partners, facilitate outcome-focused interventions and improve outcomes for patients.

Importantly, the strategic relationship represents a multidisciplinary and integrated approach where the agencies work together to ensure optimum care and coordinated access to services for patients.

MEMORANDUM OF UNDERSTANDING

Between the District Health Boards (DHBs) and the Accident Compensation Corporation (ACC)

1. Parties

The parties to this Memorandum of Understanding are:

Accident Compensation Corporation – a statutory corporation continued by the Accident Compensation Act 2001 ("ACC")

The District Health Boards – the District Health Boards which are signatories to this Memorandum of Understanding (DHBs)

together called "the agencies"

2. Purpose

The purpose of this Memorandum (MOU) is to set out how the District Health Boards (DHBs) and the Accident Compensation Corporation (ACC) will work together to deliver further progress on improved outcomes for our shared patients/clients.

The MOU will enable DHBs and ACC to enhance the constructive relationships that are in place and coordinate their activities to help drive action on shared priorities through jointly agreed projects.

It is not intended to be legally binding.

3. Context

DHBs and ACC are both purchasers of health and disability services. DHBs are also providers of certain health and disability services that are funded by ACC.

In addition, in some cases, DHBs and ACC fund similar services, deal with the same providers and provide services to the same patients/clients.

Therefore, the initiatives of one agency can have impacts on another agency and affect service delivery to and outcomes for patients/clients.

The MOU does not replace any existing joint processes and mechanisms DHBs and ACC have for working together on areas of common interest.

4. Agreement

DHBs and ACC agree to:

- Work together to consider and agree projects intended to deliver against the agencies' shared priorities

- Respect each other's roles and responsibilities in the health sector as described in legislation, and the right of the agencies to express clear and independent positions on issues as appropriate
- Ensure early engagement with each other on any work or initiatives that affect or involve the other agencies, and take an early warning/no surprises approach where possible
- Ensure open, timely and honest communication on joint initiatives and areas of common interest where possible
- Work together to coordinate activities to increase overall capability of all parties, while taking care to treat all information and intellectual property with respect, maintaining its security, ownership and confidentiality including complying with all relevant law
- Keep the processes for engagement as simple as possible to minimise time and resources needed
- Build on existing processes and mechanisms for engagement between the agencies
- Improve understanding of each other's business, including priority areas, constraints and differences
- Make reasonable efforts to inform each other before making public comment in areas of common interest
- Keep strictly confidential all confidential Information provided to it by the other parties or which comes into any party's possession. These confidentiality arrangements will extend beyond the duration of this MOU.

Further information about functions, roles, delegations, and work protocols associated with this MOU is set out in the Terms of Reference in Appendix 1.

5. Principles underpinning joint initatives

In undertaking joint projects between ACC and one or more DHBs, the agencies will be guided by the following service design and delivery principles. Services will be:

- Person-centred – patients/clients are integral in design
- Outcome focused – interventions add value and improve outcomes for patients/clients
- Evidence-based – focus on what research indicates will work
- Multidisciplinary – agencies work together to ensure the optimum care and outcomes for the patients/clients
- Integrated - agencies work together to ensure patients have easy access to services and supports
- Sustainable for the agencies and providers

6. Roles

6.1 Steering Group

A Steering Group will oversee the operation of this MOU and the projects sitting under it. The Steering Group will comprise:

- DHBs' representative Chief Executives
- ACC's Chief Operating Officer

or their delegates.

The Steering Group will oversee the administration of the MOU and joint work programme.

6.2 Relationship managers

Relationship managers appointed by each agency will identify issues and work relevant to, and be responsible for the administration of, this MOU. They will escalate issues to their senior management and/or the Steering Group as appropriate.

Agencies can change their relationship manager at any time by sending notice by email to the Steering Group secretariat without the need for a formal variation of this MOU.

7. Joint initiatives

The parties will agree on a joint initiatives work plan on an annual basis.**8. Issue resolution**

Any issues regarding this MOU will be resolved quickly at the lowest appropriate level, and notified to the relevant agencies' relationship managers.

Where resolution cannot be reached, the issue will firstly be escalated to the relevant agencies' relationship managers, and if required to the ACC's Chief Operating Officer and either the Chief Executive representing the DHBs collectively or the relevant DHB's Chief Executive, whichever is more appropriate in the circumstances.

9. Term of the memorandum of understanding

This MOU comes into effect on the day it is signed by all parties.

Any agency may terminate their participation in this MOU by giving notice in writing at any time.

SIGNED

_____

Chief Executive

Accident Compensation Corporation

Date

_____

Chief Executive

Counties Manukau DHB

Date

_____

Chief Executive

Northland DHB

Date

_____

Chief Executive

Waikato DHB

Date

_____

Chief Executive

Waitemata DHB

Date

_____

Chief Executive

Lakes DHB

Date

_____

Chief Executive

Auckland DHB

Date

_____

Chief Executive

Bay of Plenty DHB

Date

_____

Chief Executive

Tairawhiti DHB

Date

_____

Chief Executive

Taranaki DHB

Date

_____

Chief Executive

Capital and Coast DHB

Date

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Chief Executive

Hawke's Bay DHB

Date

_____

Chief Executive

Wairarapa DHB

Date

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Chief Executive

Whanganui DHB

Date

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Chief Executive

Nelson Marlborough DHB

Date

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Chief Executive

MidCentral DHB

Date

_____

Chief Executive

West Coast DHB

Date

_____

Chief Executive

Hutt Valley DHB

Date

_____

Chief Executive

Canterbury DHB

Date

_____

Chief Executive

South Canterbury DHB

Date

_____

Chief Executive

Southern DHB

Date

(together called "the DHBs")

Appendix 1

Draft Terms of Reference for the Accident Compensation Corporation and District Health Boards Steering Group

1 Introduction

The strategic relationship between the Accident Compensation Corporation (ACC) and the District Health Boards (the DHBs) represents a key opportunity to work together to ensure further progress on improving outcomes for shared patients/clients. It is anticipated that this joint approach will support the agencies to enhance the constructive relationships that are in place and coordinate their activities to help drive action on shared priorities through jointly agreed projects.

The jointly agreed projects will be overseen by a Steering Group that will include representation from the agencies and other designated representatives as jointly agreed by the agencies.

2 The Steering Group

The Steering Group will be established by and is accountable to the agencies. The Steering Group will be responsible for the operation of the MOU and the jointly agreed projects. Where required, this may include determining the feasibility of the projects, implementation plans and agreed outputs.

Membership of the Steering Group will be agreed by the agencies, who will appoint the members. The Steering Group membership will be fixed and include appropriate representation of the agencies. The Steering Group will be able to co-opt further people to attend meetings when appropriate, by mutual agreement of the agencies.

The chairperson for the Steering Group is Ailsa Claire. Quorum for the Steering Group will be half of the members plus one. Steering Group members will be appointed for a period of one year initially.

The Steering Group may have regular teleconferences/meetings in the initial development stages of the programme. After this, teleconferences/meetings may be held frequently, or according to necessity defined by key milestones. Meetings will generally be between 1 – 1.5 hours.

The Steering Group will attempt to resolve any disputes by discussion and consensus. In situations where consensus cannot be reached, the issues will be escalated as per the process outlined in the MOU between the agencies.

3 Role and responsibilities of Steering Group members

The members of the Steering Group will have the following roles and responsibilities:

- Understanding the strategic implications and outcomes of the projects which fall under the remit of the Steering Group (as these are pursued through outputs and recommendations);
- Ensuring that the projects align with the requirements of ACC and the DHBs and addressing any issue that has major implications for the projects;
- Ensuring that effort and expenditure (where applicable) are appropriate to ACC and DHB expectations;
- Ensuring that the range of projects enhance but do not duplicate any existing collaborative activity;
- Being an advocate for projects and their outcomes within their respective organisation;
- Maximising the potential for further strategic relationships through the development of links with other stakeholders;
- Appreciating the significance of the joint projects for some or all major stakeholders and taking a broad, strategic view of the needs of these stakeholders, without undue influence from interested parties.

In practice this means:

- Setting the priorities for the jointly agreed projects, with reference to existing priorities developed by the parties, and work done by their advisory groups;
- Developing projects in support of the strategic relationship, articulating the core themes and ensuring the work programme is documented;
- Helping to balance conflicting resources and priorities and keeping the projects on track if emergent issues force changes to be considered;
- Monitoring the progress of the planning and implementation of the projects against predetermined objectives, timelines and standards of best practice;
- Regularly reporting on the progress of projects to ACC and to DHB Chief Executives;
- Consulting with stakeholders (where appropriate) when providing advice and guidance, and seeking additional expertise in any areas not covered by the Steering Group membership;
- Declaring conflicts of interest should they occur and disclosing conflicts of interest that may become apparent in the future, as they arise and during the lifetime of the strategic relationship;
- Attending Steering Group meetings, or if unable to attend arranging to forward input on all agenda items. Where possible, at least two weeks' notice should be given if there is an inability to attend the meeting;
- Replying promptly to requests for comments on draft documents.

3.1 Role and responsibilities of Steering Group Chair

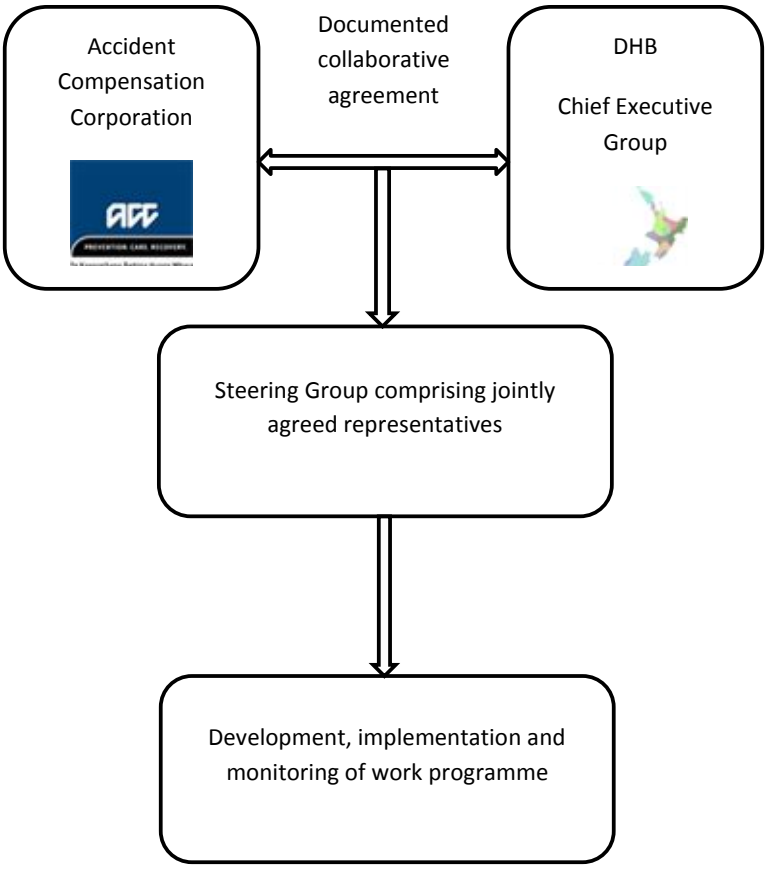
The Chair of the Group will have the responsibilities detailed above and will be additionally responsible for:

- Chairing the meetings;

- Managing the process of conflict resolution including escalating matters as per the processes outlined in the MOU between the agencies
- Monitoring attendance and ensuring that members respond to requests for input within the given time frame;
- Supervising the implementation of Steering Group decisions; and
- Dealing with correspondence relating to the Steering Group.

The diagram below outlines the relationship between the parties and the role of the Steering Group.

Diagram 1: Relationship between the parties and the role of the Steering Group



3.2 Role and responsibilities of the secretariat

Auckland DHB and ACC will provide secretariat support to the Steering Group and will have the following responsibilities:

- Ensuring that administrative support is provided to the Steering Group including organising teleconferences/meetings;
- Taking the minutes of the meeting, specifically the Steering Group recommendations, and distributing a draft copy to the Chair and Group members within two weeks of the meeting date;
- Preparing the agenda for meetings, including discussing agenda items with the Chair, and ensuring that the agenda is sent out at least one week in advance, where meeting times permit;
- Working with sub-groups to implement the jointly agreed processes for planning and running the conference in a manner that is consistent with the parties processes and policies;
- Forwarding final recommendations from the Steering Group to ACC and the DHB Chief Executive Meeting as required and ensuring coordinated feedback is provided to the Group;
- Dealing with correspondence on behalf of the Chair; and
- Providing Steering Group members with all relevant information and regular updates on issues relating to the work of the Group as appropriate.

3.3 Conflict of Interest

All members must agree to disclose any perceived or actual conflict of interest. This applies to any and all existing and potential conflicts of interest.

3.4 Official Information

The provisions of the Official Information Act 1982 apply to the activities of the Steering Group. The Chair of the Group is responsible for ensuring that members are aware of the provisions of the Act and the extent to which written material of meetings is potentially able to be disclosed under the Act.

4 Scheduled meetings

It is anticipated that the Steering Group meetings will be held via teleconference. It is anticipated that meetings will be held on monthly basis as determined by key milestones/necessity.

5 Timeline for commencement of the Steering Group work and meetings

A provisional timeline for the work is given below. This timeline is indicative, and will be subject pending the establishment of the Steering Group.

Date	Activity
TBC DATE	Steering Group meeting

Establishment of Executive Committee of the Board

Recommendation

1. **That the Board approve the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/ New Year Board recess.**
2. **That membership of the Committee is to comprise the Board Chair, the Deputy Board Chair, Lee Mathias, Gwen Tepania-Palmer Jo Agnew and Judith Bassett, with a quorum of three members (the Chair needs to be one of the three members).**
3. **That the Executive Committee be given delegated authority to make decisions on the Board's behalf relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from a Committee or the Chief Executive (same arrangements as last year).**
4. **That all decisions made by the Executive Committee be reported back to the Board at its meeting on 22 February 2017.**
5. **That the Executive Committee be dissolved as at 22 February 2017.**

Prepared by: Marlene Skelton (Corporate Business Manager) for Dr Lester Levy (Board Chairman)

Glossary

NZPH&D Act - New Zealand Public Health and Disability Act 2000

1. Purpose

To seek the Board's approval to establish a committee to conduct pressing Board business during the Christmas/New Year recess.

2. Background

The final normal scheduled meeting of the Board for the year is on 7 December 2016. The next meeting is on 22 February 2017. There might be some items of business requiring approval at Board level that need to be processed during this period.

Under the NZPH&D Act (Schedule 3 Clause 38) there is provision for the Board to establish one or more committees for a particular purpose or purposes.

3. Proposal

As in recent years, it is proposed that the Executive Committee should have a relatively small membership so that it can be convened at short notice, should this be necessary. The proposed membership is the Board Chair, the Deputy Board Chair, Lee Mathias, Gwen Tepania-Palmer Jo Agnew and Judith Bassett, with a quorum of three (the Chair needs to be one of the three members).

It is expected that, by their nature, any items referred to this Committee are likely to need to be taken in public excluded session. The date and agenda items of any meeting(s) would, as soon as confirmed, be advised to all Board members and meeting(s) publicly notified if they involve any open meeting agenda reports.

A Value of Care approach at Auckland District Health Board - A Discussion Document.

Recommendation:

That the Board hold a workshop in February 2017 to discuss the value of care approach.

Prepared by: Dr Karen Bartholomew (Clinical Director, Health Gain Team, Planning, Funding and Outcomes); Dr Sue Fleming (Director Women's Health), Abbas Al-Murrani (Health Economist, Health Gain Team, Planning, Funding and Outcomes).
Endorsed By: Dr Debbie Holdsworth, Director Funding, Executive leadership team

Glossary

COAD	- Chronic Obtrusive Pulmonary Disease
COPD	- Chronic Obstructive Pulmonary Disease
DHB	- District Health Board
DRGs	- Diagnosis Related Group
ICHOM	- International Consortium of Health Outcomes Measurement
IPUs	- Integrated Practice Units
NHS	- National Health Service
PROMs	- Patient Reported Outcome Measures
STAR	- Socio-Technical Allocation of Resources
UK	- United Kingdom
US	- United States
VBHC	- Value Based Healthcare

1. Executive Summary

Value of Care is a concept which in being investigated at Auckland District Health Board (DHB). It is a way to link health outcomes with costs in order to deliver better care, better patient experience and better outcomes more transparently and intentionally. Value of Care is a cost-conscious, data driven approach that centres on outcomes that matter for patients. Ultimately this approach will facilitate Board decisions on resource allocation. This paper provides an introduction to the concept for discussion and a proposed approach to further development work.

2. Strategic Alignment

Community, whānau and patient centred model of care	Outcomes that matter for patients are a core driver for this concept.
Emphasis and investment on both treatment and keeping people healthy	Value of care can be applied to population segments and interventions as well as treatment services.
Service integration and/or consolidation	Value of care includes a view on allocation of the right mix of services as well as what services provide the most value.
Intelligence and insight	Value of Care requires systematic collection, use and

	improvement of health outcomes. More transparent view of currently collected data including costs.
Evidence informed decision making and practice	Evidence-based interventions for part of the base of the Value model, reducing 'low value' interventions aligns well with the Choosing Wisely approach.
Outward focus and flexible, service orientation	Outcome measurement includes both community and hospital provided services and generic measures can be used to compare value across.
Operational and financial sustainability	Resource constraint is one of the drivers of Value of Care, where improving outcomes and reducing costs are incorporated.

3. Introduction/Background

Value is a concept that has multiple meanings. Economic value is about the benefit of something (usually expressed in monetary terms), based on someone's preferences. Value-Based Healthcare (VBHC) or Value of Care are concepts introduced in the early 2000s by Sir Muir Gray in the United Kingdom National Health Service (NHS) and by Michael Porter at Harvard Business School in the United States.

The two models or approaches to Value of Care have some similarities however the US model developed out of the Managed Care movement and challenges to the Fee for Service payment model in the US healthcare system. The NHS approach to Value of Care has included population health, individual/personalised value and improvements to care pathways in what is known as the Tripe Value Model. The elements of both models are briefly described below. Both models use technology and information (actionable data) in order to improve care, outcomes and enhancing patient experience. Reducing variation, improving quality and disinvesting in low value care also means there are potential cost savings in a Value of Care approach.

4. Triple Value model or Value Based Healthcare (UK)

The NHS model was developed as an approach to managing rising need, demand and costs and is based on systems thinking, populations and the desire to move from institutions to networks of providers. Sir Muir Gray identified the following key drivers for the new paradigm:

- Unknown and unwarranted variation.
- Patient harm, from over diagnosis and over treatment, even when the quality is high.
- Inequity, from underuse of high value healthcare services by some groups.
- Waste, defined as anything that does not add value to the outcome for patients or uses resources that could give greater value if used for another group of patients.
- Failure to prevent the diseases that healthcare can prevent (e.g. stroke in atrial fibrillation).

Sir Muir proposes that in addition to usual healthcare approaches more needs to be done to:

- Empower patients with knowledge – ensuring that every individual receives full information about the risks and benefits of the intervention being offered, to ensure high personal value.
- Shifting resources at multiple levels – reducing unwarranted variation, disinvestment/transfer where there is evidence of lower value or overuse to higher value or underuse in order to provide a better service mix (allocation).

- Appropriate service access – ensuring that those people in the population who will derive most value from a service reach that service. This minimises overuse, underuse and inequity, and increases technical value (efficiency) of the healthcare system.

The Triple Value Model has the following elements (see Figure 1):

1. **Allocative value** – determined by how services are allocated to different subgroups of the population.
2. **Technical value** – determined by how well resources are used for each subgroup.
3. **Personal value** – the delivery of services informed by what matters to the individual.

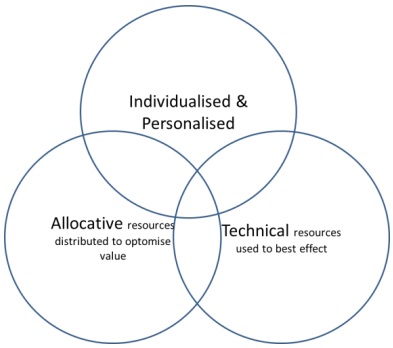


Figure 1. Triple Value Model (Sir Muir Gray, Better Value Healthcare)[1]

Allocative value

There are three levels of decision making about how to distribute resources when allocative value is considered:

- Between programmes, for example between cancer and mental health, or vice versa,
- Between systems within a programme, for example between asthma, COPD, sleep apnoea and breathlessness within the respiratory program.
- Within systems, for example within the resources available for COPD.

Technical value

Technical value is not the same as quality. Quality improvement is about doing things right, but technical (efficiency) improvements include doing the right things by identifying and discontinuing lower value activities (e.g. Choosing Wisely). Evidence based decision making is important, but technical value also include the balance of benefit to harms in an intervention/service.

Personal value

Personalised or personal value is the delivery of services informed by what matters to the individual, what they personally value and what is important to them in their life. This may include approaches to genomic data, personalised medicine and tailored individual approaches to care.

[1] For further information see http://www.bettervaluehealthcare.net/

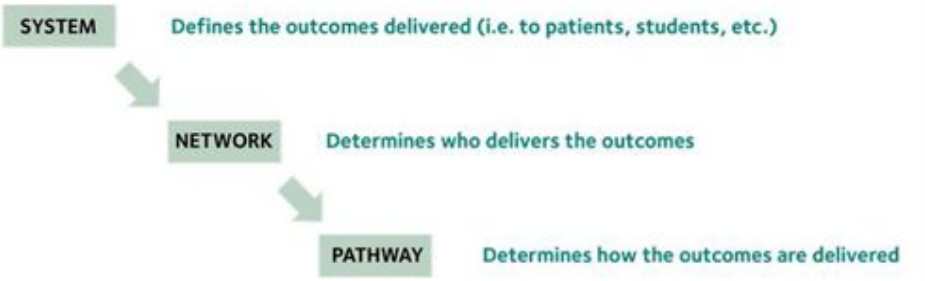


Figure 2. Population Systems (systems thinking) in the Value of Care Model

Better Value Healthcare (Sir Muir Gray is the Director) has proposed a set of approximately 30-40 'big systems' within which there are sets of programmes delivered by networks of providers. A set of system outcomes measures are defined and selected. Populations in the systems and programmes are defined by a common symptom, condition or characteristic, for example breathlessness, arthritis, or multiple morbidities. The focus is not on institutions or specialties. A VBHC approach seeks to optimise the outcomes which maximise value for those populations and the individuals within them.

5. Porter Value of Care Model (US)

Michael Porter wrote a seminal article on Value of Care in the New England Journal of Medicine in 2010,[2] and summarised this in the Harvard Business Review. This model is more aligned to the technical value component of the Triple Value model, and is focused mainly on technical or efficiency improvements in pathways of care or around specific interventions. This work includes reducing unwarranted variation, quality improvement, better care coordination and integration, clinician use of data, understanding costs across a whole pathway of care (not just hospital visits). The model is more condition/disease specific than the Triple Value model and doesn't address multi-morbidity or frailty particularly well, and is more institution focused than the UK model.

Figure 3. Value of Care "Value Equation"

There model has evolved from a healthcare Value Equation model (Value = Health Outcomes divided by Cost) to a more nuanced approach which has seven components (some which include similarities to the allocative value approach in the Triple Value model).

[2] Porter ME. What Is Value in Health Care? New England Journal of Medicine. 2010;363(26):2477-81. http://www.nejm.org/doi/full/10.1056/NEJMp1011024#t=article .

1. Integrated Practice Units (IPUs) – medical conditions or segments of the population, team based integrated services, full cycle of outpatient and inpatient care, measure outcomes and costs.
2. Measure outcomes for every patient (risk adjusted).
3. Measure costs – map pathways, time driven activity based costing, examination of actual expense a full cycle of care in a medical condition. Opportunity to identify quality improvement and cost savings.
4. Bundled prices – reimburse for 'cycle of care' with patient choice among approved providers.
5. System integration – move non-acute care out of heavily resourced hospital to a network of facilities based on medical condition. Examine economies of scale, offer some services only at specific facilities, clinical integration for pathways across units/facilities.
6. Geographic expansion – integration with community providers, affiliate with excellent providers, grow areas of excellence (hub and spoke, satellites, pre/post acute centres), widen service lines in specific localities.
7. Build enabling IT - full cycle of care measurement, common outcomes, combines all data, structured, interoperable systems.

6. Health outcomes measurement

Both the US and UK models are data-driven approaches that centralise what patients value and patient experience. Few health systems systematically define, measure or utilise actionable health outcomes data. Both Value of Care models have defined population groups/segments of interest, and have defined health outcomes indicators (and other pathway indicators) of interest within these. For example in the Porter model the collaborative work of Harvard University, the Karolinska Institute and the Boston Consulting Group have developed the International Consortium of Health Outcomes Measurement (ICHOM)[3] 'standard set' of outcome measures. These measures include clinical measures, functional/recovery measures, quality of life measures, Patient Reported Outcome Measures (PROMs) and more work is going into patient experience measures.

Measuring health outcomes is challenging, outcomes need to be clinically valid, comparable between providers and reliable. Different scores need to be based on differences in quality, not on bias, problems in measurement or issues with risk-adjustment. This requires more precise and more complete data capture, and analysis of patient-level data. Linking different data sources, and collecting data from patients electronically, can reduce the data burden significantly and allow rapid 'actionable' use and feedback to clinicians (and where useful, to patients), as well as services and health systems.

7. Value of Care health system examples

A. Porter approach: University of Utah Hospital - *Perfect care* [4]

This healthcare system developed a value-driven outcomes tool using the Porter definition of value: health outcomes achieved per dollar spent. They invested significantly in developing a robust costing

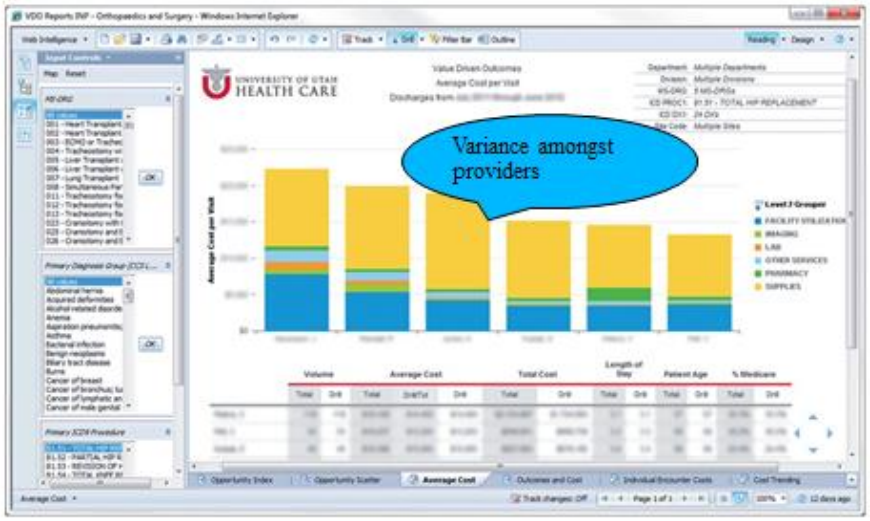
[3] For further information see: http://www.ichom.org/medical-conditions/

[4] V.S. Lee et al. Implementation of a Value-Driven Outcomes Program to Identify High Variability in Clinical Costs and Outcomes and Association with Reduced Cost and Improved Quality. JAMA 2016, 316(10) 1061-1072.

system that captured real costs attributable to direct patient care. A single binary outcome measure, *perfect care*, was defined for a small number of DRG's. The inputs into this measure came from key quality and outcome variables that included: risk-adjusted mortality, patient safety measures such as hospital-acquired infections, clinical process measures, unplanned hospital readmissions or emergency department visits, Patient satisfaction data and patient-reported outcomes (including physical and emotional functioning).

Clinical teams then were enabled to view and monitor care costs and quality metrics using a web-based value-driven outcomes visualisation tools (example of dashboard-Figure 4). The data was available on an individual patient basis or aggregated at the clinician or service-line level to facilitate broader understanding of variations in cost and quality. Initial trials were conducted in three areas: total joint replacements, laboratory utilization and sepsis value improvement.

Orthopaedic supported by a process engineer developed a consensus clinical pathway for patients undergoing hip and knee joint replacement. The multidisciplinary team defined a perfect care index for joint replacement comprising six nationally and locally defined quality indicators. Over the course of three years using an iterative re-design approach a significant increase in "perfect care" was accompanied by a decline in costs Figure 5).



Kensaku Kawamoto et al. J Am Med Inform Assoc 2015;22:223-235

Figure 4. Physician Dashboard

Figure 5. Impact on outcomes and costs

B. Muir Gray approach- NHS STAR methodology

The Health Foundation, a leading UK health think-tank worked with the London School of economics to develop a toolkit to enable the assessment of current and future health interventions in terms of their health benefit and value for money. This tool known as STAR (Socio-Technical Allocation of Resources) has now been used to design a number of successful health interventions. Using a combination of robust local data, evidence from the literature and perspectives and value based on benefits from providers and consumer's interventions that could potentially form part of a care pathway are evaluated and 'value triangles" created. Pathways are then built using the interventions with the most favourable value triangles first to build a high value care pathway (Figure 6)

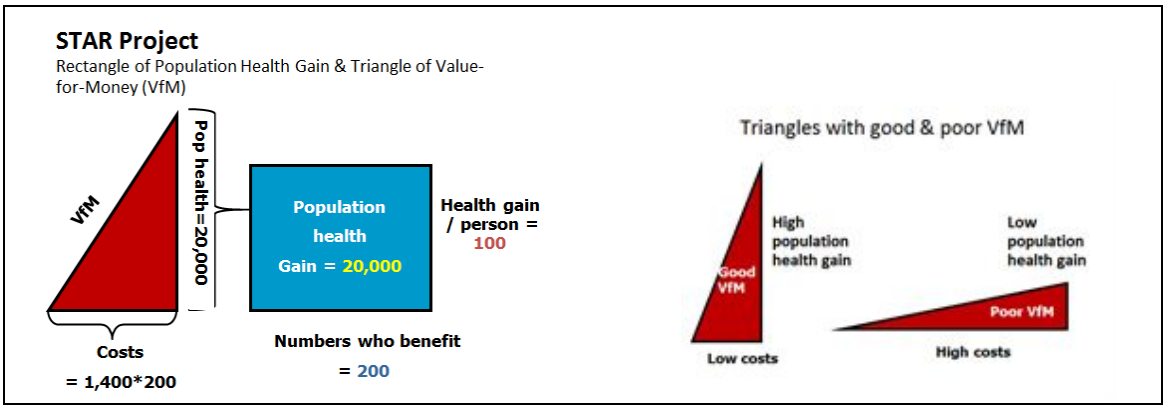


Figure 6. STAR methodology for building value-for-money triangles

This approach has been used to help design several successful interventions.

IMPRESS- a joint initiative between two leading respiratory clinical societies in the UK used STAR to develop a guide for commissioning authorities on chronic obstructive airway disease. The work involved analysing the relative value of interventions for a COAD population. This is reported to have resulted in a 50% reduction in emergency asthma admissions by investing in improving patients' inhaler technique in the Isle of White[5].

SyMPOSE- Pathway redesign by NHS Sheffield changed its approach to eating disorders by building a pathway using value for money triangles. This is reported to have improved patient experience, improved system coordination and reduced costs by 15% (Figure 7)[5].

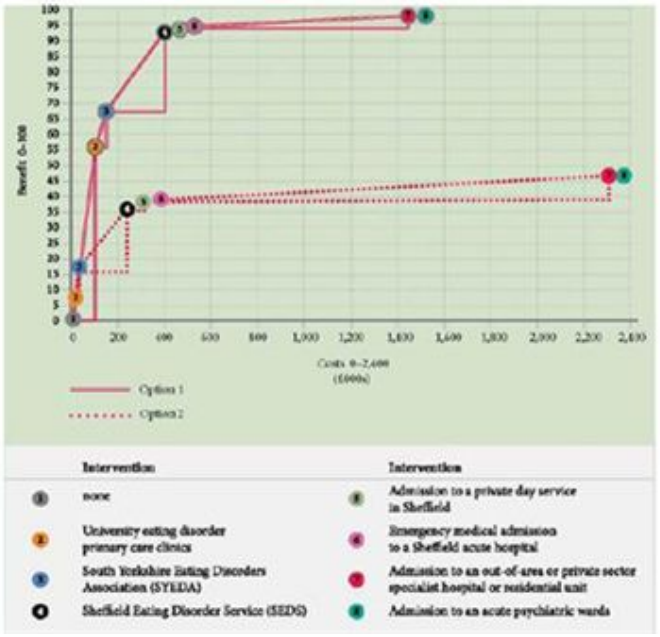


Figure 7. Sheffield Eating Disorders Value for Money Pathway

C. Tang Tock Seng Hospital- Singapore- Better people, better care

TTS Hospital, a large (1544 beds, 8000 staff)tertiary hospital in Singapore, has taken a value-based approach to delivering healthcare to their population with a focus on their staff being the critical determinant to driving value for their patients. The combination of determining what staff value, what patients' value and measuring the costs of care is enabling this institution to moderate increasing demand on the healthcare system (figure 8).

[5] The London School of Economics and Political Science. Research impact: making a difference. Ise.ac.uk/researchAndExpertise/researchimpact/PDFs/nhs-deliver-better-care-less-money.pdf

Figure 8. Tang Tock Seng Hospitals Value-Driven Strategy

10.1

8. Alignments

A Value of Care approach aligns with Auckland DHB vision, strategic themes and mandatories (particularly intelligence and insight and patient and whānau centred care) and areas of focus, as well as our articulated future direction. Using the Hospital Wisely, innovation and quality improvement, the DHB values development (and valuing of our staff), care redesign, care coordination, patient self-management, whole-of-system management. There are also opportunities in this work for further development of academic partnerships and research for example on the applicability of international tools for priority population groups such as Māori, Pacific, people with English as a second language and people with low health literacy.

9. Proposed Next Steps

It is proposed that the Planning, Funding and Outcomes Health Gain Team will work collaboratively with key interested clinicians and managers to further investigate different approaches and learnings related to Value of Care. We have begun exploring this with colleagues locally in Counties Manukau and in Australia and the UK. We have also adapted a matrix[6] for assessing 'readiness' for Value of Care that has been used as an inter-country comparison tool, to a local context where we can assess Auckland DHB 'readiness' to undertake this work at a range of levels within the DHB. Further exploratory work will understanding the national and regional health outcomes measurement direction, the resource and IT requirements, the potential outcome datasets, tools and areas (services/diseases) of interest for further discussion. It is likely that an approach is a selected set of pathways, services or conditions would be pragmatic, understanding the work in practice. The team also propose to hold a Board discussion workshop in early February 2017.

[6] The Maturity Assessment Matrix. Used for a 12 country comparison (including New Zealand) https://www.bcgperspectives.com/content/articles/health_care_public_sector_progress_toward_value_based_health_care/?chapter=3#chapter3

10. Conclusion

A Value of Care approach is a systematic way to examine health outcomes and costs for population groups within our services, that can be used for quality improvement, reducing costs and to more intentionally and transparently decide about the right mix of services and programmes for our population based on what they value and the benefit our services can generate for them. This is a data-driven approach and we do not currently collect health outcomes data in a systematic or accessible way. As investment in this approach would be required we have proposed further exploration in order to inform investment parameters and future direction.

Auckland DHB Programme Management: Update on EPMO Development, Programme Identification and Definition

Recommendation

That the Board:

1. **Receives the Auckland DHB Programme Management Update on EPMO Development, Programme Identification and Definition report.**
2. **Notes the progress and status of the Portfolio, Programme and Project Management approach for Auckland DHB.**

Prepared by:	Jeremy Muirhead (PMO Officer)
Endorsed by:	Andrew Old (Chief of Strategy, Participation and Improvement), Ailsa Claire (Chief Executive)
Attachments:	Appendix A: Programme Lifecycle Overview Appendix B: 90 Day Plan

Glossary

P3M3	Portfolio, Programme, Project Management Maturity Model
ICR	Investor Confidence Rating
EPMO	Enterprise Programme Management Office

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	Establishment of a clear Portfolio, Programme and Project management framework, with associated systems, processes and assurance, will allow us to prioritise, monitor and evaluate our activity ensuring alignment with relevant objectives and strategic themes.
Emphasis/investment on both treatment and keeping people healthy	
Service integration and/or consolidation	
Intelligence and insight	
Evidence informed decision making and practice	
Outward focus and flexible service orientation	
Operational and financial sustainability	

1. Executive Summary

This paper provides an overview of the work undertaken to date to support the development of the Auckland DHB Programme Management Framework, an Enterprise Programme Management Office (EPMO) and a set of strategic programmes to deliver the Board's strategy.

Through a process with the Senior Leadership Team, a list of potential programmes were shortlisted, and mapped to the organisation strategy. Each programme was appointed a member of the Executive Leadership Team as Executive Sponsor, who will retain ultimate accountability for the programme.

In October 2016, Executive Sponsors and Programme Leads were asked to describe the aims and objectives of their programmes, and the suite of projects that would deliver them. This has proved to be a considerable undertaking, given the limited availability of people familiar with programme management and the variation in maturity/development of the programmes themselves. It will be completed over the next few weeks.

The development of programme management is part of a wider piece of work to address portfolio, programme and project management across the DHB. Key outputs of this work will further enable the strategic programmes, particularly the development of the enterprise portfolio and the EPMO.

2. Introduction

The development of programme management, and strategic programmes began in 2016 to address the recommendations arising from the Board and the Treasury's Investor Confidence Rating (ICR) assessment process.

The selection of programmes and the development of a programme management approach is part of a larger piece of work to create a framework for portfolio, programme and project management, to be deployed across the entire organisation. These frameworks are being designed to work together to ensure consistency in application, and to ensure we meet the requirements of the ICR, as well as enhance our ability to deliver the objectives of each programme.

i. Definition of a programme

A programme is a temporary organisation, created to deliver outcomes and benefits, via a group of related projects managed in a coordinated way. The Managing Successful Programmes methodology defines a programme as a *'temporary, flexible organisation, create to coordinate, direct and oversee the implementation of a set of related projects and activities to deliver outcomes and benefits related to the organisation's strategic objectives.'*

This paper refers to 'strategic programmes' – these are the shortlisted programmes selected by the Senior Leadership Team. The proposed programme management framework, once finalised, will apply to any future Auckland DHB programme.

3. Strategic programmes identification and definition

i. Selection of the potential strategic programmes

The Senior Leadership team ran a process to establish and refine a set of strategic programmes for the organisation and map these to our organisational strategy. Each programme has as a member of the Executive Leadership Team as an Executive Sponsor.

ii. Definition, Clarification and Planning

Executive Sponsors and Programme Leads have been tasked with the further definition, clarification and planning of their programme(s), and to ensure several key activities and documents are completed.

Fig 1: Proposed Auckland DHB Programme Management Lifecycle

This activity represents the *Identification* and *Definition* phases of the Auckland DHB programme lifecycle, an overview of which is included as Appendix A. The *identification phase* is undertaken to consider the strategic fit, vision, time scale, and costs of the proposed programme at a high level. The *definition phase* comprises an exploration of the options for delivering the required outcomes and benefits together with robust and detailed planning for delivery. It culminates in the presentation of a Programme Charter, which proposes a clear future state and a business case. The process, key steps and assurance gates have been defined for the identification and definition phases of the programme life cycle, in line with P3M3 requirements.

A programme is a major undertaking, with potentially significant capital and operational funding, and substantial, transformative change. As such, the *identification* and *definition* phases of the programme lifecycle require input from a range of stakeholders, and can be resource intensive. This process has been difficult for some programmes, given in part to the varying degree of development of the programmes, and the maturity of the work-streams and initiatives already underway within them. The concepts involved are new to many – thus, the appropriate internal resource is constrained.

The current focus is on assisting all programmes in the identification phase, and completing the programme briefs. This will enable the Executive Leadership Team to make further decisions regarding resource and prioritisation. It may also help to illuminate where a programme management approach is not appropriate (for example, where a shortlisted 'programme' is more akin to a sub-portfolio).

iii. Proposed Programme Management Framework

Prior to the development of this framework, the DHB did not have a standard Programme Management methodology, which was identified as a risk by an independent, external

assessor. Application of this framework will ensure that programmes are undertaken in a more standardised way:

- through the establishing of a common approach;
- providing standardised roles and overarching governance structures; and
- providing standard programme controls and strategies.

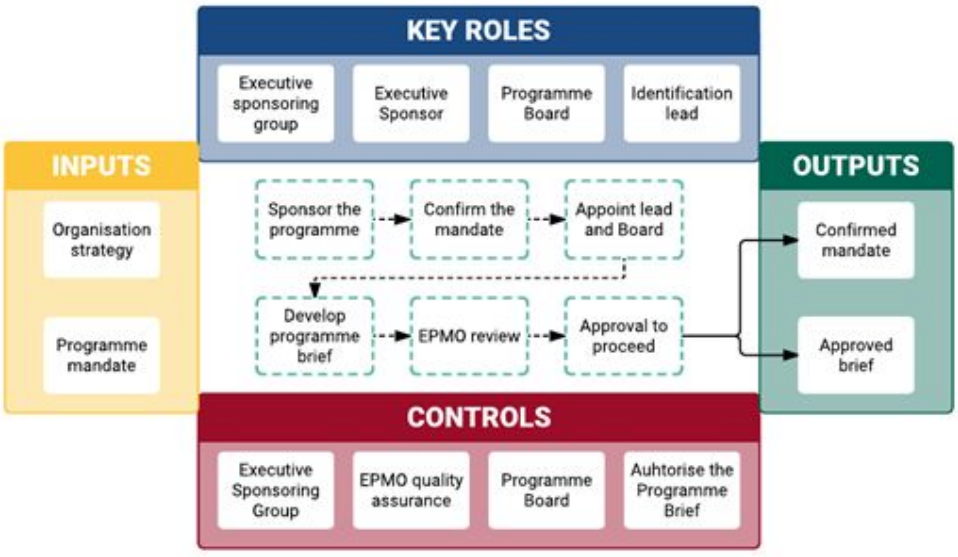
The proposed framework is based on the *Managing Successful Programmes* (MSP) methodology. MSP was developed by the Office of Government Commerce (United Kingdom), and is now owned by Axelos. Axelos likewise owns P3M3, the framework under which Auckland DHB was assessed for portfolio, programme and project management maturity, and are naturally aligned.

The Framework has been customised for use at Auckland DHB, and our unique circumstances and organisational context. We will continue to contextualize the framework for our organisation and our policy, and thread it through with the other P3M3 elements in development. The Auckland DHB Project Management Framework is currently being redeveloped alongside the Programme Management Framework to ensure consistency in approach. We are being supported by an external assurer through this process to ensure any changes retain the integrity of the process for future accreditation.

iv. Programme assurance

An assurance framework is currently being developed, and is one of the highest priorities of the P3M Improvement Project (detailed in the next section). This framework will set out how and when programme assurance will take place, as well as template assurance plans for projects within those programmes.

Fig 2: Proposed framework for Auckland DHB Programme Identification showing assurance and controls



4. Portfolio, programme and project management development project

The development of the strategic programmes, and the programme management approach and framework, is part of a larger piece of work designed to improve the maturity of our project, programme and portfolio management. A project group has been formed to undertake this improvement work.

In addition to the development of frameworks, process and tools, the development of the EPMO and the enterprise portfolio management approach will be closely tied with the strategic programmes.

i. Portfolios and the enterprise portfolio

As noted in the P3M3 assessment, we do not currently have a true, enterprise-wide portfolio. Although projects are undertaken collaboratively, portfolio management is largely siloed in functional business units. At present the DHB does not have formal portfolio management, and lacks, at the enterprise level: an enterprise wide project repository, prioritisation process, or enterprise portfolio reporting.

As a first step, work is currently underway to build a single repository of all project information, and to put in processes to ensure this information is collected regularly. The flow of information to and from the programmes to the enterprise portfolio will be a vital to both.

ii. EPMO development

Both our P3M3 assessor, and a previous consultant, recommended the implementation of an enterprise portfolio management office (EPMO). Enterprise-wide portfolio functions cannot be executed within existing Business/Functional units, or governance groups – and particularly when considering sub-portfolios which may not presently have P3M expertise.

The proposed EPMO will also serve as a programme management office for the strategic programmes. Services offered will gradually ramp up, but for the immediate term, it will be focussed on the strategic programmes, and creating and maintaining an accurate picture of the entire portfolio.

The 90 day road map for this work is included as Appendix B.

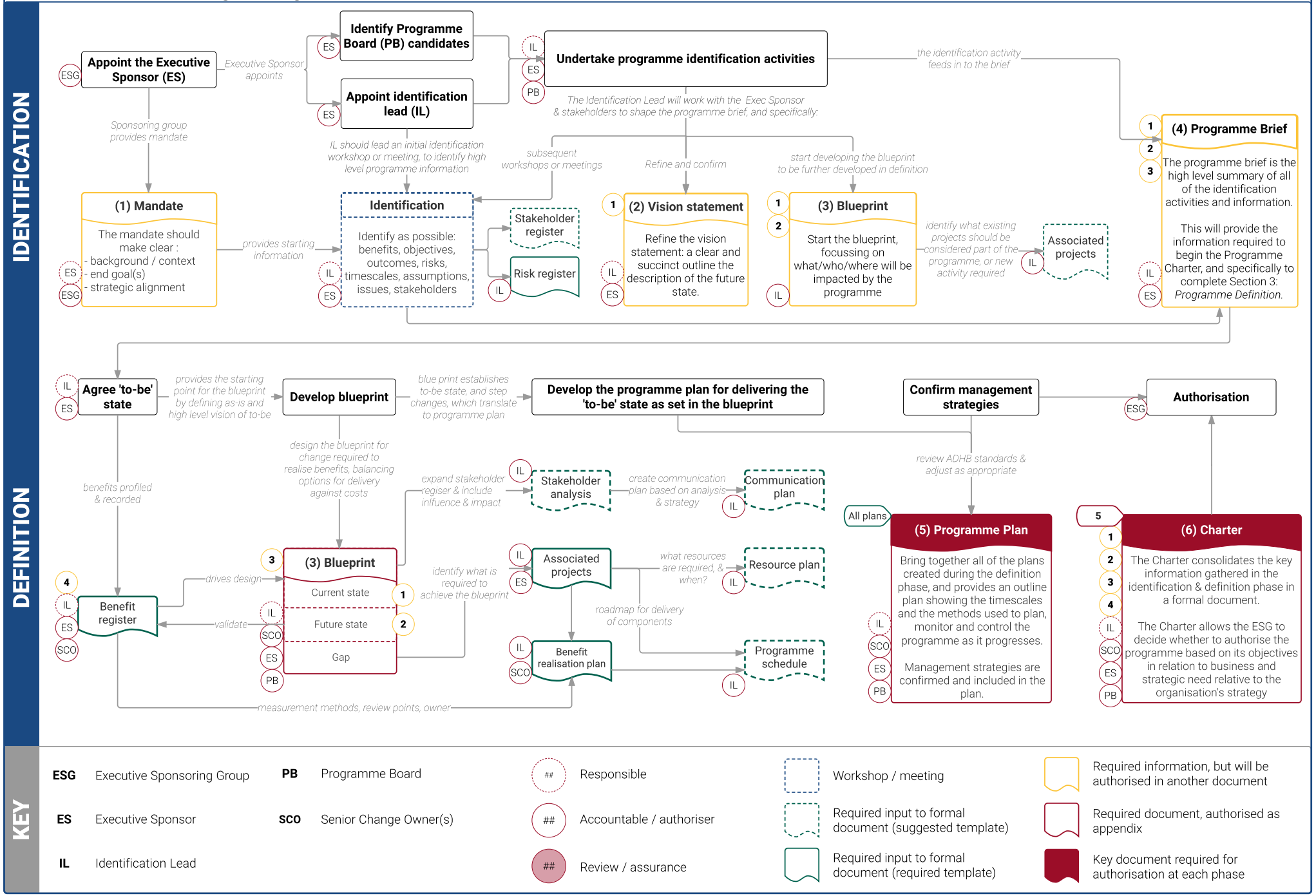
5. Conclusion

Development of the programmes is progressing, with tailored support being provided where required.

Work underway within the broader P3M project will enable the programmes development, and will define the assurance framework to be executed.

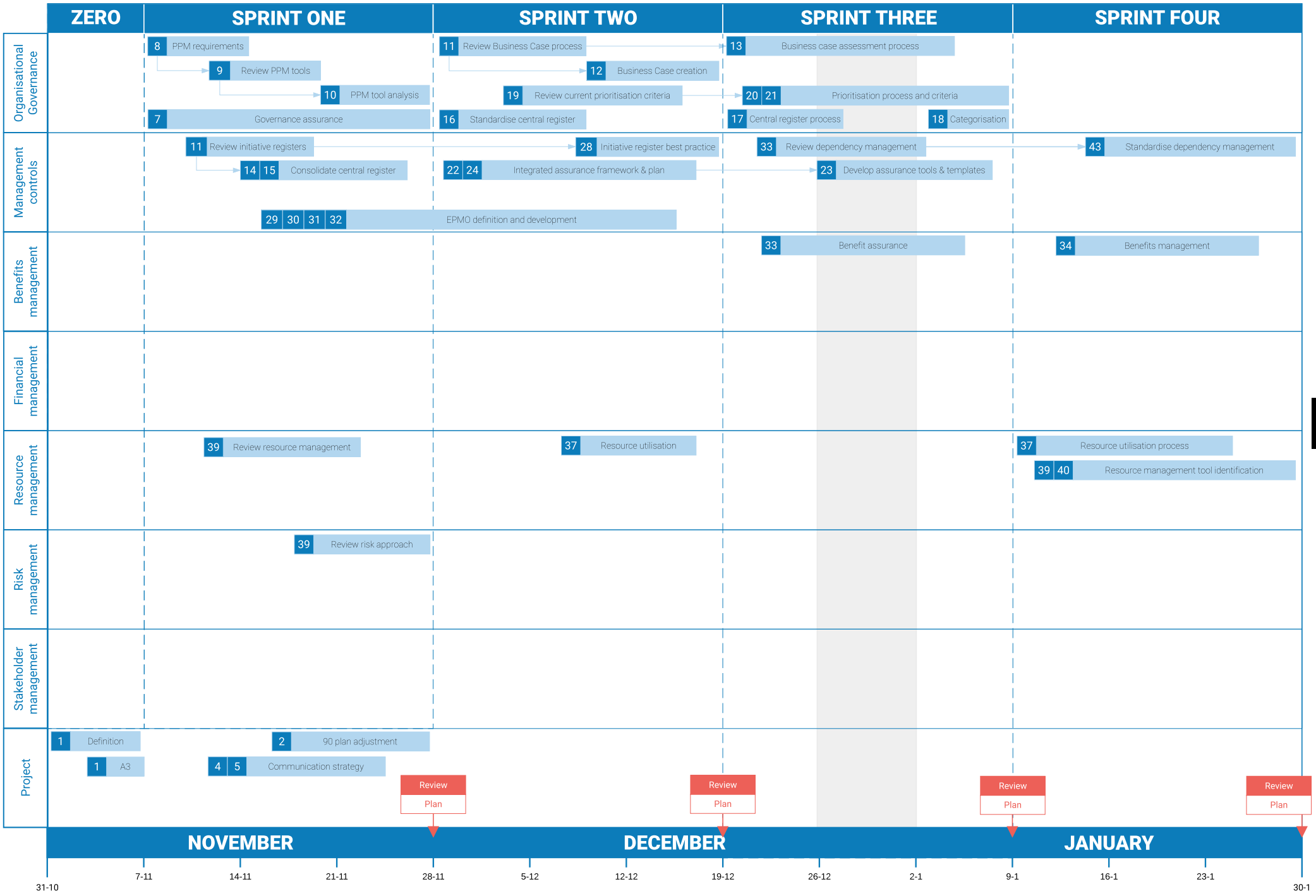
Auckland DHB Strategic Programme Identification & Definition

September 2016



ADHB P3M PROJECT **90 DAY PLAN**

Jeremy Muirhead **31-10-16**



10.2

Auckland Water Supply

Recommendation:

That the Board:

1. **Receive the Auckland Water Supply report.**
2. **Note the nature of Auckland's reticulated drinking water supply (as delivered by Watercare Services Limited), including the infrastructure, the monitoring and treatment undertaken, and procedures developed to respond to a contamination incident.**
3. **Note that the level of risk inherent in Havelock North's drinking water supply does not exist in Auckland's reticulated drinking water supply due to the treatment of all raw water, including chlorination.**
4. **Note that if contamination of a water source occurs, Watercare has the ability to isolate the affected source(s) supplying the metropolitan area, and redistribute clean water from other parts of the network.**

Prepared by: Jane McEntee (General Manager ARPHS), Sunil Kushor (Manager Health Protection), Dr David Sinclair (Medical Officer of Health), Andrew Phillips (Senior Policy Analyst), Ken Zhu (Drinking Water Assessor, ARPHS) and Leslie Breach (Drinking Water Assessor, ARPHS)
Endorsed by: Simon Bowen (Director Health Outcomes)

Glossary

ARPHS	-	Auckland Regional Public Health Service
CCO	-	Council Controlled Organisation
DWAU	-	Drinking Water Assessment Unit (Auckland)
DWSNZ	-	Drinking Water Standards for New Zealand
DZ	-	Distribution zone
FAC	-	Free Available Chlorine
WTP	-	Water treatment plant
WSP	-	Water safety plan
WINZ	-	Water Information for New Zealand

1. Executive Summary

The Waitemata DHB Chief Executive requested this paper for the Northern DHBs as lead for public health in order to:

- Review the state and security of the current water supply in Auckland.
- Learn any potential lessons from the Havelock North incident.
- Increase visibility to the boards of public health protection activities delivered by ARPHS.
- Watercare Services Limited (Watercare) is responsible for the collection, treatment and distribution of reticulated potable water in the Auckland region. All water distributed via Watercare's reticulated network undergoes treatment, including

chlorination. A fully automated control system allows Watercare to monitor the performance of its water treatment plants in real-time.

Watercare is required to prepare Water Safety Plans (WSPs) for all of its water treatment plants, as well as undertake regular monitoring to ensure compliance with the Drinking Water Standards for New Zealand (DWSNZ). Contingency procedures and incident management responses have been developed to manage threats to the water supply.

Havelock North recently experienced a large scale public health incident after campylobacter contaminated the town's water supply. A similar level of risk does not exist for Auckland's reticulated drinking water system, as all raw water is chlorinated.

2. Background

Approximately 95% of the population of the region covered by the three Auckland DHBs are on a Watercare reticulated (piped) supply. This covers the majority of metropolitan Auckland, and all the satellite towns. The other 5% have individual rainwater supplies, or small borewater or surface water supplies.

Watercare is a Council Controlled Organisation (CCO) and wholly owned by Auckland Council. From 1 November 2010, Watercare took over ownership and management of all the water and wastewater assets within the Auckland Council region.

Watercare provides drinking (potable) water to both metropolitan and non-metropolitan areas throughout the region. Watercare operates 15 water treatment plants (WTPs), and all the water collected from eleven dams, seven bores and springs, and four river sources is treated (see Appendix 1 for a summary of the type of treatment provided at each of Watercare's WTPs). The treated water is then distributed through over 9,000 kilometres of water pipes, 149 reservoirs, and 108 pump stations, to 450,000 households. Watercare's interconnected network allows it to move water from any one of its WTPs to anywhere within the metropolitan Auckland system.

Watercare has a monitoring programme in place to monitor water quality compliance with the Drinking Water Standards for New Zealand (DWSNZ). Monitoring of parameters is undertaken at various stages throughout the treatment process and transmission and distribution network. The monitoring parameters include: Free Available Chlorine (FAC), pH, *E.coli*, and turbidity. From the Annual Drinking Water Survey conducted by Auckland Regional Public Health Service (ARPHS) Drinking Water Assessment Unit (DWAU), for the period July 2015 to June 2016, water treated at all of the WTPs, both metropolitan and non-metropolitan, fully complied with the DWSNZ in terms of microbiological and chemical compliance.

The WTPs utilise a fully automated control system that allows a WTP to be either controlled at multiple locations onsite, via the central Control Room in Newmarket, or remotely, through secure networked computers assigned to a Watercare On Call Controller.

The control system continuously monitors the performance of the plant and processes. The control system will raise a general alarm when equipment faults or process variables fall outside of pre-set limits. For example, the alarm is raised if the FAC in treated water falls below the DWSNZ standard. As critical alarms are monitored 24 hours a day, a rapid

response can be implemented to investigate the cause of an alarm, and appropriate action can be undertaken.

Under the Health (Drinking Water) Amendment Act 2007, Watercare is required to prepare a Water Safety Plan (WSP) for each of its WTPs. All Watercare's WSPs have been approved by ARPHS's DWAU as it is the only drinking water assessment unit in the Auckland region designated by the Ministry of Health. The WSPs are required to include controls, compliance monitoring, an improvement plan and corrective actions undertaken by the water suppliers.

The WSP for each WTP contains contingency procedures for the following:

- actions for filtration failure
- actions for incorrect coagulation pH
- actions for insufficient FAC
- actions for positive *E.coli* results in treated water
- plant shutdown and start up

In addition to the WSPs, Watercare has an Incident Management Plan to provide a generic process for the management of threats to the water supply. Watercare utilises the services of an international drinking water expert, Professor Colin Flicker Ph.D. of CRF Consulting Ltd (Microbiological Testing, Research and Consulting), United Kingdom, as its consultant to review plans and processes for Auckland's drinking water supply. The Standard Operating Procedure for any incident is to:

- **Isolate** the cause
- **Investigate** to identify the cause of the problem
- **Remedy** the identified problem
- **Notify** the Ministry of Health (via ARPHS), and implement a communication plan for Watercare customers

3. Public Health Unit's Role

ARPHS's DWAU assesses water supply compliance with the Health Act 1956 and DWSNZ. The DWAU carries out WSP assessments, provides advice and information on drinking water supplies, investigates public health problems arising from drinking water, responds to drinking water transgressions, maintains a drinking water monitoring and surveillance system (Water Information for New Zealand, (WINZ)) and promotes public knowledge on drinking water safety and quality.

As part of Watercare's Incident Management Plan, ARPHS is notified of any transgressions (including *E.coli* and chemical transgressions) under the DWSNZ, as well as other incidents that may pose a significant public health risk. If ARPHS establishes that an event may pose a public health risk, it would work closely with Watercare in managing the incident, including advising if a boil water notice should be issued, and recommending appropriate channels to reach all of the affected population.

Pursuant to section 69ZZH of the Health (Drinking Water) Amendment Act 2007, a Medical Officer of Health has the ability to serve a compliance order to prevent, remedy or mitigate

any risk to public health arising from the drinking water supply. However, from ARPHS's previous experience, Watercare has been quick to act once a transgression is detected, and notify ARPHS as soon as possible.

4. Comparisons with Havelock North

In August 2016 the Havelock North water supply became contaminated with *Campylobacter*, resulting in approximately 5,200 of the town's 13,000 residents developing gastroenteritis. Impacts were extensive, including closure of schools for several days, markedly reduced commercial activity in the town and impacts on employment. Several rest homes were badly affected. Patient load for primary care and community nursing services substantially exceeded normal capacity for over a week, but capacity was reduced as many staff were also off ill. Emergency Department assessments and hospital admission for Hawkes Bay Hospital in Hastings exceeded capacity for several days, although most admissions were short (mainly for rehydration). There were several admissions to ICU (<10) and one death likely related to campylobacter (a rest home resident).

The Havelock North municipal water supply came from three relatively shallow bores extracting water from a shallow aquifer near the town. The supply was not treated prior to distribution (e.g. by chlorination or UV), but did have regular microbiology testing.

While the exact source of contamination is still under investigation a number of factors are likely to have contributed. Firstly, the layer of clay overlying and protecting the aquifer was shallow, irregular and thin (often less than one metre thick). This layer had been damaged by earthworks at a facility adjacent to one of the three bores in 2015, resulting in water contamination. This bore was taken out of service in October 2015. Second, there are a significant number of private water bores in the area, leading to potential damage to the protecting layer. One of these old bores was found to be uncovered and unused, so potentially able to be contaminated from the surface. Third, the contamination followed a heavy rain storm which may have washed animal faeces into the aquifer or bore through damage to the clay layer or an old bore. Electricity for the water pumps was also disrupted by the storm. All bores have been closed, with water supplied now from Hastings with chlorination and UV treatment.

Central government has initiated an inquiry to investigate how the Havelock North water supply became contaminated, how this was subsequently addressed, and how local and central government agencies responded to the public health threat that occurred as a result of the contamination. Once this inquiry is completed, ARPHS will consider the findings within the context of Auckland's reticulated drinking water system.

Questions have been raised about the 'secure status'[1] of Havelock North's bores that are used to supply the town's drinking water, as well as the lack of routine treatment.

An important distinction between Havelock North and Auckland is that in Auckland, Watercare, as a CCO of Auckland Council, is the only reticulated water supplier. All water sourced from Auckland's bores undergoes treatment (including UV, filtration and/or

[1] 'Secure bore water' definition in *Drinking-water Standards for New Zealand 2005 (Revised 2008)* - water that is free from surface influences and free from contamination by harmful micro-organisms. It must be abstracted via a bore head demonstrated to provide protection from contamination. Water from springs and unconfined aquifers with bore intakes less than 10 m deep are excluded.

disinfection with chlorine to provide a FAC residual in the drinking water (see Appendix 2)) Treatment is provided in Auckland regardless of whether the bore has obtained secure status or not.

5. Non-reticulated areas

Non-reticulated domestic water supplies in the Auckland region include self-supplies (roof water and bore water), rural schools and marae, and water carriers.

In New Zealand, statutory control of an individual water supply (i.e. self-supplier) falls under the Health Act 1956 and the Building Act 2004. The Building Act requires premises to be provided with potable water for consumption, oral hygiene, utensil washing and food preparation. Local authorities have obligations under the Building Act and Health Act to ensure that water being supplied to buildings is potable, and that buildings may not be leased unless they have a potable supply of water. A self-supply could not create an incident such as at Havelock North, as only a small number of people would access a self-supply.

ARPHS regularly receives enquiries from people on roofwater tanks about the likely quality of their drinking water. For the most basic installations, the only 'treament' is sedimentation with the settled sludge liable to re-suspension upon disturbance by heavy rain. Additional precautions are possible at the choice of the supply owner eg by regular tank and gutter cleaning; multi-stage filtration (to 0.5 micron) and UV 'polishing' - which can collectively provide bacterial water quality very close to the best municipal supply. ARPHS freely distributes, on request, the Ministry booklet "Household Water Supplies" which provides excellent, practical advice about tank supplies and dilution calculations for people needing chlorine disinfection. This booklet and two others with related information is available on the Ministry of Health website[2].

Water carriers have to be registered with the Ministry of Health, and meet the Health Act and DWSNZ requirements, including having an approved Water Safety Plan. Apart from Waiheke Island and Great Barrier Island, most water carriers in Auckland source drinking water from Watercare filling stations. ARPHS annually reviews all water carriers, including those on the islands to ensure compliance with DWSNZ. Under the Health Act, each application for registration must be accompanied by a DWA's Certificate of Water Carrier Compliance. If there are concerns, the options include that the DWA continues to work with the water carrier to resolve the issue, or the water carrier be referred to a designated officer to address non-compliances that pose a significant immediate public health risk. Rural marae and school water supplies are generally registered for DWSNZ requirements.

6. Conclusion

The recent contamination of Havelock North's water supply has led to a central government inquiry into the incident. The level of risk inherent in Havelock North's drinking water supply does not exist in Auckland's reticulated drinking water system due to the treatment of all raw water (not just bore water), including chlorination.

[2] http://www.health.govt.nz/your-health/healthy-living/drinking-water/household-water-supplies

Appendix 1 – Summary of Watercare's water treatment plants

Water Treatment Plant (Source)	Max Flow (M^3/day)?	Manning Normal Hours?	WSP Approved?	Treatment?
Ardmore (Hunua Ranges)	350,000	Manned &Control	Yes	Conventional treatment and chlorination
Waikato (Waikato River)	150,000	Manned &Control	Yes	Conventional, membrane and sand filtration and chlorination
Huia (Waitakere Ranges)	126,000	Manned &Control	Yes	Conventional treatment and chlorination
Onehunga (Groundwater)	25,000	Remote control from Huia	Yes	Conventional treatment and chlorination
Waitakere (Waitakere Ranges)	21,000	Manned &Control	Yes	Filtration and Chlorination
Huia Village (Waitakere Ranges)	250	Remote control from Huia	Yes	Conventional treatment and chlorination
Muriwai (Spring)	480	Remote control from Waitakere	Yes	UV and chlorination
Snells/Algies (Groundwater)	1,800	Remote control from Warkworth	Yes	Filtration and chlorination
Wellsford (River water)	1,440	Remote control from Warkworth	Yes	Conventional treatment, UV and chlorination
Warkworth (River water)	1,600	Manned &Control	Yes	Conventional treatment, UV and chlorination
Helensville (Stream water)	1,000	Manned &Control	Yes	Conventional treatment and chlorination
Waiuku Road, Waiuku (Groundwater)	1,200	Remote control from Ardmore	Yes	UV and chlorination
Victoria Ave, Waiuku (Groundwater)	1,000	Remote control from Ardmore	Yes	UV and chlorination
Cornwall Road, Waiuku (Groundwater)	1,300	Remote control from Ardmore	Yes	UV and chlorination

Bombay (Groundwater)	157	Remote control from Ardmore	Yes	Filtration, UV and chlorination

Appendix 2 - Summary of Bore Security Status for Watercare Water Supplies

Water Supply and WINZ Code	Bore Details	Bore Security Status	Due for 5 yearly assessment	Population served	WSP Approval	Treatment
Waiuku – WAI214	• Waiuku Road, Waiuku Bore G01471 • Cornwall Road, Waiuku Bore G00081 • Victoria Bore, Waiuku G00080	Re-approved 20/07/2016 Re-approved 20/07/2016 Non Secure Bore *	20/07/2021 20/07/2021 N/A	8697	Yes	UV and Chlorination for all three bores
Snells/Algies – SNE002	• Hamilton Road TP Bore 1 G00005 • Hamilton Road TP Bore 2 G02135	Re -approved Nov 2013 Under review	Nov 2018 N/A	4664	Yes	Sand filtration and chlorination for both bores
Onehunga-AUC003ON	• Onehunga Town Bore G00001 • Rowe St Bores, Onehunga G00233	Non secure bore* Non Secure bore*	N/A	27,101	Yes	Conventional treatment and Chlorination for both bores

*Non Secure bore status as they would not meet the Drinking Water Standard requirements. Therefore, treatment and monitoring is in place at all the times.

INTERNATIONAL BENCHMARKING OF ASIAN HEALTH OUTCOMES FOR WAITEMATA AND AUCKLAND DHBS

Recommendation:

That the International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs report be received.

Prepared by: Samantha Bennett (Asian, Migrant & Refugee Health Gain Manager), Dr Lifeng Zhou (Senior Epidemiologist & Asian Health Advisor
Endorsed by: Dr Debbie Holdsworth, Director Funding; Simon Bowen, Director Health Outcomes

Glossary

CVD - Cardiovascular Disease
DHB - District Health Board
HNA - Health Needs Assessment
YLL - Years of Life Lost

1. Executive Summary

The purpose of this adapted Health Needs Assessment (HNA) is to profile and assess the health of Waitemata and Auckland districts' Asian population in an international context – considering their health status against our high level outcomes to maximise life expectancy and reduce inequalities in health outcomes. A benchmarking process was used to apply metrics and compare best practice approaches to comparator countries in order to determine who has the very best key health outcomes and health areas, who sets the standard and what that standard is compared to New Zealand at a country level and at a district level for Waitemata and Auckland District Health Boards (DHB).

Overall, the findings of this report highlight the two DHBs are national and international leaders in Asian health, with Asian peoples experiencing excellent health outcomes and health status compared to the rest of the population and when benchmarked internationally. This includes high life expectancy at birth, lower rates of infant mortality, lowest rate of Years of Life Lost (YLLs) from Cardiovascular Disease (CVD) and lowest rate of YLLs from Cancer. The impact from Diabetes for both DHBs was also low when considered internationally. The report also identifies that migrants in New Zealand experience the most equitable entitlement (Migrant Integration Policy Index report 2014) when compared with comparator countries. Asian peoples in both DHBs are highly educated with the proportion of the population having a bachelor degree/level 7 qualification or above, higher than the New Zealand average.

Disparities highlighted in this report specific to Asian 'high-risk' ethnic subgroups include a greater risk of CVD for our South Asian population, and the higher Chinese risk of diabetes, youth mental health and childhood obesity.

The findings of the report should provide the foundation for future Asian population-based planning for annual plans, regional service plans and other strategic and operational plans. A set of focus areas have been included in the report aimed at improving, maintaining or accelerating Asian health status. Recommendations or next steps address the disparities within Asian 'high-risk' subgroups associated with access to, and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective 'healthy migrant effect'.

2. Strategic Alignment

Community, whanau and patient centred model of care	Identifying the variations in Asian subgroup health outcome areas is imperative in order to plan solutions to improve health disparities and issues of access and utilisation of services for high-risk groups.
Emphasis and investment on both treatment and keeping people healthy	Preventative healthcare needs will not be met if certain segments of the population are not enrolled with a General Practice, use Primary Care services ad hoc or have poor lifestyle related behaviours.
Intelligence and insight	Key findings of the report will guide future Asian population-based planning for annual plans, regional service plans and other strategic and operational plans.
Evidence informed decision making and practice	Undertaken an adapted HNA and benchmarking process to identify health outcomes, important risk factors, health service use, and policy frameworks to inform decisions

3. Background

Traditionally, a HNA is an analysis of a population's demand and need for health services, (Ministry of Health, 2000a), it can help to create a picture of the health status of a DHB population at a given time. Benchmarking Asian subgroups within the two DHBs and at a country level to international comparator countries, established a platform to better understand potential future demands on services for identified subgroups and unmet need to close the health inequalities gap experienced by targeted Asian ethnic groups.

The report covers:

1. Headline qualitative findings from an international health literature analysis, comparing best practice approaches and benchmarked performance of New Zealand compared with reference countries in the following areas:
    - Monitoring Asian and migrant health
    - Policy and legal frameworks affecting Asian and migrant health
    - Asian and migrant sensitive health systems including service access and utilisation, and the health workforce
    - Networks, partnerships and multi-country frameworks on Asian and migrant health
2. Population profile of Asian in Waitemata and Auckland DHBs, and other countries
3. Key health outcomes, health risk factors and prevention and health service use
4. Patient experience and community engagement/participation

5. Opportunity including social progress index indicators
6. Key findings

4. Findings

In Auckland DHB there are 154,370 Asian peoples living in the district which is 31% of the total population. There are 123,750 living in Waitemata DHB, 21% of the total population. 40% of our Asian population is Chinese. Our Asian peoples enjoy high life expectancy at birth, lower rates of infant mortality, lowest rate of YLLs from CVD and lowest rates of YLLs from Cancer. The impact of Diabetes for both DHBs was also low when considered internationally. The report also identifies migrants in New Zealand experience the most equitable entitlement when compared to the comparator countries.

There are disparities for Asian 'high-risk' subgroups such as access to health services including General Practice and timely access to mental health services, as well as greater risk of CVD for our South Asian population, Chinese risk of diabetes, youth mental health, and childhood obesity.

5. Conclusion

Overall the health outcomes of the Waitemata and Auckland DHBs' Asian population - when compared to New Zealand and overseas - are very good. However, the results of the benchmarking process have identified emerging areas to monitor. These include the future burden of lifestyle-associated risk factors such as smoking and obesity and the ability of the Asian population to access and utilise culturally appropriate health services. If we are to maintain or accelerate Asian health status we must address the disparities within Asian 'high-risk' subgroups. This is significant as these have the potential to impact on the future health needs and demand for services for segments of the Asian population. Overseas evidence suggests that the 'healthy migrant effect' wanes among migrants with additional years in the new 'host' country (Singh G. H., 2006) (Arcia, 2001) (Singh G. K., 2009). Our focus should be on action now for issues related to CVD for our South Asian population, and the higher Chinese risk of diabetes, youth mental health and childhood obesity, as well as protecting and sustaining the excellent health outcomes that the Asian population experience.

A formal Launch of this Asian international benchmarking report is planned for February 2017 to coincide with Chinese New Year celebrations.

International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs

November, 2016

Dr Lifeng Zhou, Samantha Bennett
Planning, Funding and Outcomes Unit, Waitemata and Auckland DHBs

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Waitemata District Health Board
Best Care for Everyone

Disclaimer

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Foreword

Auckland's population is growing and changing incredibly rapidly. The cultural and ethnic diversity of our people has enriched our city in a myriad of ways, creating a working and living environment unlike any other in New Zealand. We have more than 180 different ethnicities living in the city, and almost 40% of Aucklanders were not born in New Zealand.

In the last 15 years the greatest increase of any ethnic group has been in those of Asian origin, principally from China, India and Korea. In 1991, 5.5% of Auckland's population identified themselves as Asian. By 2001 this had risen to 14% and in 2016 it has reached 25%.

The overall health outcomes of our Asian populations are very good. This report highlights that the two DHBs are national and international leaders in Asian health with Asian peoples experiencing excellent health outcomes and health status compared to the rest of the population and when benchmarked internationally. Our Asian peoples enjoy high life expectancy at birth, lower rates of infant mortality and lower mortality from cardiovascular disease, diabetes and cancer.

Importantly, migrants are less likely to experience barriers to social integration in New Zealand. We score very highly in terms of personal rights, personal freedom and choice, tolerance and inclusion. The Asian population in both DHBs are also highly educated with the proportion of the population having a bachelor degree/level 7 qualification or above higher than the New Zealand average.

Our challenge is to maintain these outstanding results and to address those areas where issues are emerging particularly for some Asian sub groups. While many Asian migrants enjoy good health, we need to be mindful that the 'healthy migrant effect' will diminish over time and the rapidly growing population will create unique challenges for maximising health outcomes into the future.

This report identifies specific points of focus and outlines some recommendations that will help us maintain world class health status for our Asian population. These include the future burden of lifestyle-associated risk factors such as smoking and obesity, and the ability of the Asian population to get information on the health & disability system, and access and utilise culturally appropriate health services in a timely manner.

We are highly committed to achieving and maintaining equitable health outcomes for the multiple, varied population groups in Auckland and look forward to working with our many partners who are passionate about Asian health and wellbeing in this city.

Dr Dale Bramley,

Chief Executive Officer

Waitemata District Health Board

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List of Abbreviations

ARR	Annualised Rate of Reduction
ATEED	Auckland Tourism, Events and Economic Development
AUT	Auckland University of Technology
BMI	Body Mass Index
CALD	Culturally and Linguistically Diverse
CBD	Central Business District
CHAG	CALD Health Reference Group
CI	Confidence Interval
CME	Continuing Medical Education
CNE	Continuing Nursing Education
CVD	Cardiovascular Disease
DAA	Direct acting-antivirals
DALYs	Disability-adjusted Life Years
DHB	District Health Board
ECHO	Ending Childhood Obesity
ED	Emergency Department
GBD	Global Burden of Disease
GP	General Practitioner
HNA	Health Needs Assessment
HoP	Health of Older People
ICD	International Classification of Disease
IGME	Inter-agency Group for Child Mortality Estimation
IHME	Institute for Health Metrics and Evaluation
INFoRM	Inter-Agency Network for Refugees and Migrants
INZ	Immigration New Zealand
MDG 5	The Fifth Millennium Development Goal
MELAA	Middle Eastern, Latin American and African
MIPEX	Migrant Integration Policy Index
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MOPS	Maintenance of Professional Standards
NGO	Non-Government Organisation
NHS	National Health System
NRRS	National Refugee Resettlement Strategy
NSW	New South Wales
NZ	New Zealand
NZHS	New Zealand Health Survey
OECD	Organisation for Economic Co-operation and Development
OR	Odds Ratio
PBU	Primary Birthing Unit
PHO	Primary Health Organisation
PTE	Private Training Establishment
RSSG	Regional Settlement Steering Group
SDGs	Sustainable Development Goals
SRR	Standardised (mortality) Rate Ratio
TANI	The Asian Network Inc.
UI	Uncertainty Interval
UK	United Kingdom
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UoA	University of Auckland
US	United States of America
WHO	World Health Organisation
YLD	Years Lived with Disability
YLL	Years of Life Lost

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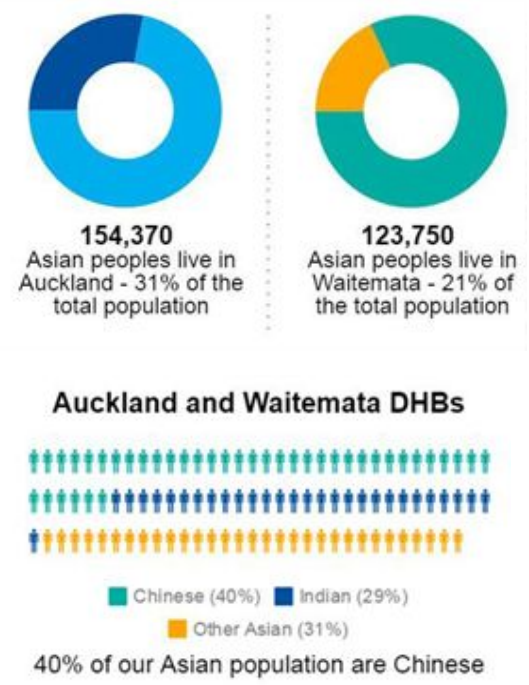
Executive summary

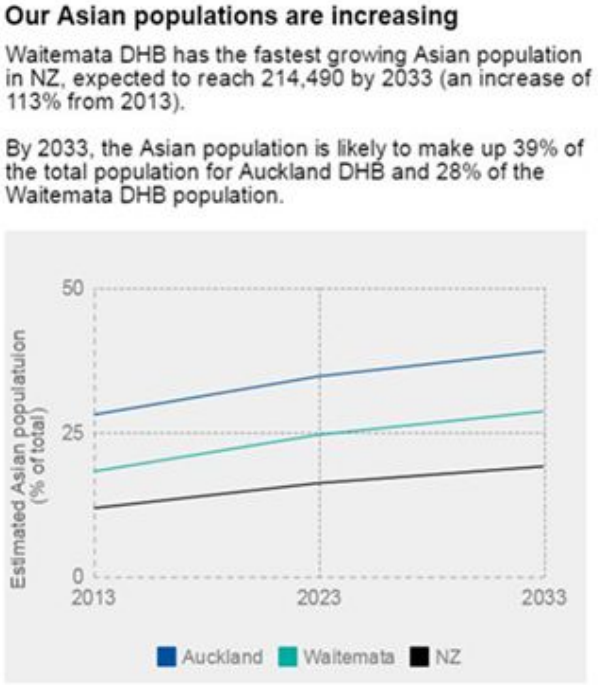
This benchmarking report has been developed to profile and assess the health of Waitemata and Auckland districts' Asian population in an international context – considering their health status against our high level outcomes to maximise life expectancy and reduce inequalities in health outcomes. It is important to note that the Asian population is made up of many individual population groups and each of these groups has differing and specific health needs. Where possible, these differences are explored further in this report. The report has been developed alongside a supplementary Asian Health Benchmarking Technical Report.

Population profile

New Zealand, and particularly the Auckland region, are becoming more diverse in ethnicity and culture. The 2013 census estimated that there are 127,980 (28% of the total) Asians residing in Auckland District Health Board (DHB) and 100,550 (18% of the total) in the Waitemata DHB. When compared nationally, Waitemata and Auckland DHBs have higher proportions of their population identifying as Asian (Asians accounted for 12% of the total nationwide).

By 2033, the Asian population will likely make up between 28% to 39% of the total population for Waitemata and Auckland DHBs. Nationwide, Asian populations are growing the fastest and will account for 19% (slightly more than 1 million in size) of the total by 2033. New immigrants make up a large proportion of the New Zealand Asian population. In the Auckland region, approximately 78% of the Asian population were born overseas, and nearly half of this overseas-born population are new settlers who have been residing in New Zealand for less than 10 years. This high volume of migrants creates unique challenges for maximising health outcomes.





Overall, the findings of this report highlight that the two DHBs are national and international leaders in Asian health with Asian peoples experiencing excellent health outcomes and health status compared to the rest of the population and when benchmarked internationally. This includes high life expectancy at birth, lower rates of infant mortality, lowest rate of years of life lost (YLLs) from cardiovascular disease (CVD) and lowest rate of YLLs from cancer[1]. The impact from diabetes for both DHBs was also low when considered internationally. These results are consistent with the well-established phenomenon of the 'healthy migrant effect' (Appendix 1).

The report also identifies that migrants in New Zealand experience the most equitable entitlement (Migrant Integration Policy Index report 2014) when compared to the comparator countries[2]. Asian peoples in both DHBs are highly educated with the proportion of the population having a bachelor degree/level 7 qualification or above higher than the New Zealand average.

Health Outcomes		
Life expectancy	• Both DHBs experience a higher life expectancy at birth (90 years, Waitemata; 89 years, Auckland; 92.9 years for Chinese in Waitemata) when compared to the comparator countries and to the Asian population of New Zealand.	
Cardiovascular diseases	• Both DHBs had the lowest rate of years of life lost (per 100, 000 population) from cardiovascular disease (Waitemata women 897, men 1,147; Auckland women 894, men 1,617).	
Cancer	• Both DHBs had among the lowest rates of years of life lost from cancer (Waitemata women 1,330, men 2,265; Auckland women 1,633, men 2,020).	
Mental health	• Both DHBs had lower overall years of life lost than the total population of New Zealand (Waitemata women 120 per 100,000 Waitemata, men 401 per 100,000, Auckland women 208 per 100,000, men 264 per 100,000).	
Diabetes	• Both DHBs had the lowest rates of years of life lost from diabetes (Waitemata women 154, men 204; Auckland women 174, men 212).	
Infant health	• Both DHBs had a combined infant mortality rate was amongst the lowest (2.2 per 1,000 live births).	
Risk Factors & Prevention		
Tobacco smoking	• Both DHBs had slightly lower smoking prevalence among the Asian population (9.9%, Waitemata; 9.8%, Auckland) than the New Zealand average (10%) • The prevalence in Chinese men is among the highest in the Asian sub-groups (15.2%, Waitemata; 13.8%, Auckland) and higher than the New Zealand average • There is a large inequality in smoking prevalence between sexes,	

[1] In this document we have used the term 'cancer' to refer to all neoplasms that may be benign (not cancer), or malignant (cancer)

[2] These are: Australia, being a neighbouring country of New Zealand and with a high immigrant population; Canada, the UK and Singapore who all have high immigrant populations and China, Korea and India where the highest volumes of Asian immigrants originate from.

	with Asian males having a smoking prevalence five to seven times higher than females.	
Obesity	• The rates of obesity in both DHBs (14.1%, Waitemata; 11.6%, Auckland) are lower than New Zealand as a whole • The DHBs' obesity rates are higher than many of the comparative Asian countries • New Zealand had the highest all-cause mortality rate (49.1 per 100,000 population) attributable to high Body Mass Index (BMI).	
Physical activity	• Both DHBs had a lower prevalence for adults meeting the New Zealand guidelines for physical activity (30.5%, Waitemata; 45.2%, Auckland) than the New Zealand average (54.0%) • Both DHBs had the lowest prevalence of sufficient physical activity when compared to the comparator countries.	
Health service use	**Immunisation** • Both 8-month and 2 year old immunisation rates are above the 95% coverage target. Rates are similar to the best performing comparator country (China). **Cancer screening** • The cervical screening coverage rates for Asian women of both DHBs (52.9%, Waitemata; 52.4%, Auckland) were lower that the New Zealand average (76.7%) • Asian breast screening rate was lower in Waitemata (66%) than the New Zealand average (71.4%) and lower when compared to the comparator countries. **Health service utilisation** • Asian adults in New Zealand were less likely to have a usual health practitioner or service to visit when unwell (<90%) than other ethnicities • Primary Health Organisation (PHO) enrolment rates among the Asian population remain well below that of other ethnicities of both DHBs (82%, Waitemata; 74%, Auckland).	
Social Progress		
Social progress index & opportunity	• Higher proportions (>95%) of Asian peoples aged 25+ years in both DHBs had a bachelor degree/level 7 qualification or above than the New Zealand average (89%) • New Zealand had the highest overall social progress index score (87.1) among the comparator countries (2015) • Migrants in New Zealand experience the most equitable entitlement (Migrant Integration Policy Index report 2014) when compared to the comparator countries.	

Comparison of health indicators between Waitemata, Auckland, New Zealand and comparator country best

Summary of key highlights comparing DHBs' Asian population with comparator countries (Appendix 2 and the supplementary technical report).

Table 1 Comparison of health outcomes between Waitemata, Auckland, New Zealand and comparator country best

		Waitemata Asian	Auckland Asian	New Zealand	Comparator country Best	
Life expectancy (years)	Overall	90	89	82#	83# (Singapore)	
Cardiovascular disease (YLL per 100,000 population)	Female	897	894	1,691*	1,326* (Australia)	
	Male	1,147	1,617	2,991*	2,301* (Australia)	
Cancer (YLL per 100,000 population)	Female	1,330	1,633	2,803*	1,907* (India	
	Male	2,265	2,020	3,406*	2,129* (India)	
Diabetes (YLL per 100,000 population)	Female	154	174	137*	71* (UK)	
	Male	204	212	233*	106* (UK)	
Alzheimer's & other dementia (YLL per 100,000 population)	Female	118	103	283*	30* (Singapore)	
	Male	129	103	305*	41* (Singapore)	
Intentional Injuries (YLL per 100,000 population)	Female	120	208	302*	151* (the UK)	
	Male	401	264	908*	467* (China)	
Maternal and infant health	Low birth weight rate	6.5%	8.3%	5.7%$	2.4%$ (China)	
	Infant mortality	2.2 per 1,000 live births		5$	2.0$ (Singapore)	
Smoking	Current smoking rate	9.9%	8.8%	17.6%#	12.4%# (India)	
Obesity	High BMI rate	14.1%	11.6%	29.2%#	4.9%# (India)	
Physical activity	Physical activity rate	30.5%	45.2%	60.2%#	86.6%#	
Immunisation	Coverage rate (8 months)	98%	97%	92.7%	-	

*Global Burden of Disease Study 2010; # Estimates by World Health Organisation; $ Estimates by World Bank or the UN

Overall the health outcomes of the Waitemata and Auckland DHBs' Asian population - when compared to New Zealand and overseas - are very good and in many areas Asian health status within the two DHBs would make us an international leader in achieving excellent health outcomes. However, the results of the benchmarking process have identified emerging areas to monitor. These include the future burden of lifestyle-associated risk factors such as smoking and obesity, and the ability of the Asian population to access and utilise culturally appropriate health services. This is significant as these have the potential to impact on the future health needs and demand for services for segments of the Asian population. Overseas evidence suggests that the 'healthy migrant effect' wanes among migrants with additional years in the new 'host' country (Singh G. H., 2006) (Arcia, 2001) (Singh G. K., 2009). Our focus should be on action now, protecting and sustaining the excellent health outcomes that the Asian population experience.

Patient experience and community engagement/participation

Enhanced patient experience is a strategic priority and long-term outcome for the DHBs with the intent to engage patients and communities in the care they receive. Improving experiences of health care services is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes.

Patient experience of care	
Values	The top four values Asians placed on their experiences and expectations of Auckland DHB health services were: 1. Excellence and professionalism 2. A professional connection with clinicians 3. Confidence about the level of care 4. Efficiency, productivity, and good processes.
Experience of healthcare services	• Asian patients of Auckland DHB are less likely to rate their overall care and treatment as 'very good to excellent' (81%), compared to non-Asians (NZ European 84%, Māori 84% and Pacific 84%) • 58.7% of Chinese patients of Waitemata DHB were 'extremely likely' to 'recommend our ward to friends and family if they need similar care or treatment', compared to non-Asians (NZ European 70%, Māori 69.2%, Samoan 65.2% and Tongan 58.8%).
Access to healthcare services	• Chinese of Auckland DHB Local Boards were more likely to rate their access to health care as 'low', compared to New Zealand Europeans • Factors attributing to a 'low' self-rating relate to 'cost' of services and quality issues such as 'availability/waiting times' at general practice.
International students	International students tended to: • have a lower level of understanding of New Zealand health and disability systems • be less likely to have a family doctor or General Practitioner (GP) clinic to go to • have accessed Emergency Departments (ED) at public hospitals significantly less, after adjusting for the effects of ethnicity.

Overall, Asian patients had the greatest tendency to rate their overall care/treatment or recommend similar care/treatment lower as compared to other ethnic groups across the two DHBs. This may be attributed to the high values they place on receiving timely access to care, how services address language and cultural barriers, and the provision of high quality, professional culturally appropriate treatment. Engagement with key segments of the population i.e. students across the localities such as the Auckland CBD or at a Local Board level are key to understanding the attitudes, experiences, barriers and enablers to uptake of health services, and can guide future opportunities for targeted community engagement/participation and co-design work with Asian ethnic consumers.

Where to next?

The overall findings within this report show that the Asian populations of Waitemata and Auckland DHBs experience excellent health outcomes and health status compared to the rest of the New Zealand population and when benchmarked internationally. If we are to maintain or improve Asian health status we must address the disparities within Asian 'high-risk' subgroups associated with access to, and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective 'healthy migrant effect'. Disparities highlighted in this report include a greater risk of CVD for our South Asian population, and the higher Chinese risk of diabetes, youth mental health and childhood obesity.

The next steps will include progressing a set of recommendations to maintain, improve or accelerate (if possible) health status where there are variations in health outcomes with an overarching focus on the following areas:

Areas for focus

The key recommendations are focused on the need to maintain and improve further the health outcomes our Asian populations already experience. Key areas for focus include:

Maintain health status

Health Outcomes

- Continue to monitor and maintain where health outcomes are excellent, such as life expectancy and lower mortality rates from CVD and cancer.

Children get the best possible start in life

- Increase the proportion of Asian newborn infants enrolled with a PHO and other health services by three months of age.

Monitoring Asian & migrant health

- Monitor separately the health of South Asian, Chinese and Other Asian populations in national and regional surveys.

Policy & legal frameworks

- Ensure alignment of efforts to national strategies:
  - New Zealand Health Strategy: Future direction
  - New Zealand Migrant Settlement and Integration Strategy's - Outcome 5: Health & Wellbeing
  - New Zealand International Student Wellbeing Strategy Outcomes Framework - Outcome 3: Health & Wellbeing
  - New Zealand Refugee Resettlement Strategy - Health & Wellbeing Outcome.

Networks & partnerships

- Asian consumer voices are included in service co-design planning cycles.

Improve or accelerate health status

Asian & migrant sensitive health systems

- Increase Asian PHO enrolment rates, with the commensurate benefits of seeing one regular family doctor (GP)
- Support the People Strategy (Auckland DHB) to increase promotion of the culturally and linguistically diverse (CALD) cultural competency courses.

Reduce premature mortality from cardiovascular disease

The lowest premature mortality from cancer

- Increase culturally appropriate messaging to South Asian and other targeted ethnic groups about CVD and diabetes risk assessments and healthy lifestyle behaviours.

Achieve a smokefree Waitemata and Auckland by 2025 (<5%)

- Promote culturally appropriate smokefree information and messages to male Chinese and Other Asian communities to achieve the Smokefree Aotearoa 2025 goal.

Reduce childhood obesity

- Work in partnership with Healthy Families Waitakere, the Healthy Babies Healthy Futures (HBHF) programme and other partners.

Children get the best possible start in life

- Promote awareness of the prevalence of measles and uptake of the 4-year immunisations in Asian communities.

Reduce morbidity and mortality for people with mental illness

- Work with Asian Mental Health Services (Auckland and Waitemata DHBs) to provide culturally appropriate support for Asian clients and their families.

Older people experience independence and quality of life

- Progress the roll out of the Cognitive Impairment Pathway and support the review of Day Programmes for older adults.

Patient experience

- At least 5% of Asian representatives join Reo Ora (Auckland and Waitemata DHBs).

Strategic approach

The Asian and Middle Eastern, Latin American and African (MELAA) Health Action Plan (Auckland and Waitemata DHBs) will be updated to address the areas of focus set out in this health needs assessment. This action plan will be overseen by the Asian & MELAA Health Governance Group (Auckland and Waitemata DHBs). Successful implementation of the action plan will require collaboration across the health sector.

Background and scope

Traditionally, a health needs assessment is an analysis of a population's demand and need for health services - it can help to create a picture of the health status of a DHB population at a given time. It provides the foundation for the Annual Plan, Regional Service Plan, and other strategic and operational plans. Previous health needs assessments have highlighted the mainly excellent health outcomes of Asian populations across our districts. The purpose of this adapted health needs assessment therefore was to compare health outcomes of Asian populations in Waitemata and Auckland DHBs with Asians internationally to highlight what action could be taken locally to further improve health outcomes for Asians in our districts.

New Zealand, and particularly the Auckland region is becoming more diverse in ethnicity and culture. The Asian population share significantly contributes to the total population in Waitemata and Auckland DHBs and New Zealand. There were estimated 127,980 (28% of the total) and 100,550 (18% of the total) Asians residing in the catchment areas of Auckland and Waitemata DHBs, respectively (Asians accounted for 12% of the total nationwide), based on Census 2013. By 2033, the Asian population will likely make up 28% to 39% of the total population for Waitemata and Auckland DHBs. Nationwide, Asian populations are growing the fastest and will account for 19% (slightly more than 1 million in size) of the total by 2033. New immigrants make up a large proportion of the New Zealand Asian population. In the Auckland region, about 78% of the Asian population were born overseas, and nearly half of this overseas-born population are new settlers who have been residing in New Zealand for under 10 years (Walker, 2014).

Despite the common tendency to cluster all Asian peoples into one single category, it is important to note that the term 'Asian' as used in New Zealand refers to very diverse communities with origins in the Asian continent, from Afghanistan in the west to Japan in the east, and from China in the north to Indonesia in the south (Ho, 2015). Moreover, some Asian ethnic groups living in New Zealand may have arrived on these shores as a new migrant by 'choice', whereas others such as refugees (and their families), and asylum seekers have come to this country asking for protection for fear of being mistreated or are in danger. They are from countries including Burma, Bangladesh, Bhutan, Cambodia, China, India, Laos, Nepal, Pakistan, Sri Lanka and Vietnam. New Zealand is unique in that it reserves its quota placements for the most needy cases such as medically disabled, women-at-risk and protection cases as identified by the United Nations High Commissioner for Refugees (UNHCR) (The Ministry of Health, 2016).

Asian populations are performing well in many health areas in Waitemata and Auckland DHBs, perhaps partially due to the protective 'healthy migrant effect', enjoying higher than average life expectancy at birth, and generally better health outcomes compared to other ethnic groups nationally. However there are significant variations experienced within and across Asian subgroups and unmet needs for 'high-risk' groups such as former refugees. Other than ethnic origins, the people grouped under the generic label of Asian are very diverse in health status, health beliefs and practices, housing, geographical distribution, migration history, English language proficiency and socio-economic status; all of these factors can influence how they engage with health services (Bedford & Ho, 2008) (Frieson, 2005) (Ho & Bedford, 2006) (Horner & Ameratunga, 2012). Furthermore, there is evidence of their underutilisation of health and social services compared to other ethnic groups (Mehta, 2012).

"New Zealand's health system needs to do better for the population groups that do not enjoy the same health as New Zealanders as a whole. These groups include Māori and Pacific peoples, some Asian subgroups, refugees, migrants and people with disabilities."

- *Minister of Health. 2016.* ***New Zealand Health Strategy: Future direction****. Wellington: Ministry of Health.*

A benchmarking process was used as the method to apply metrics and compare best practice approaches in order to determine who has the very best key health outcomes and health areas, who sets the standard and what that standard is, compared to New Zealand at a country level and at a district level for Waitemata and Auckland DHBs. The results of undertaking such a process allows funders and planners to identify the gaps and areas of high performance for Asian subgroups locally, looking at their health outcomes compared internationally, with broader consideration to international social progress indices, broader policy and legal frameworks, and culturally appropriate services, programmes and partnerships. Benchmarking Asian subgroups within the two DHBs and at a country level to international comparator countries, establishes a platform to better understand potential future demands on services for identified subgroups and unmet need to close the health inequalities gap experienced by targeted Asian ethnic groups.

The report covers the following sections:

1. Headline qualitative findings from an international health literature analysis, comparing best practice approaches and benchmarked performance of New Zealand compared with comparator countries in the following areas:
   - Monitoring Asian and migrant health
   - Policy and legal frameworks affecting Asian and migrant health
   - Asian and migrant sensitive health systems including service access and utilisation, and the health workforce
   - Networks, partnerships and multi-country frameworks on Asian and migrant health
2. Population profile of Asian in Waitemata and Auckland DHBs, and other countries
3. Key health outcomes, health risk factors and prevention, and health service use
4. Patient experience and community engagement/participation
5. Opportunity including social progress index indicators
6. Key findings
7. Reflections and next steps.

Most countries in Europe do not routinely collect health data by migrant status, in contrast to the practice in Australia, Canada, New Zealand and the United States (US) (WHO, 2011). Singapore, Australia, Canada and the UK have higher migrant populations or a higher share of migrants in their total populations according to the Migration Policy Institute. In addition, China, India and South Korea ('South Korea' and 'Republic of Korea' are used interchangeably in this report) will also be included as they are the major origin countries of the Asian peoples in Waitemata and Auckland DHBs and in New Zealand.

Table 2 Countries included in the report

Country	Reason for inclusion as a comparator	Income level	Migrant status, ethnicity data or proxy	Population group to be used for comparison
Australia	Neighbouring country of New Zealand and with higher immigration population	High income	Available	National data, Asian data when available
Canada	Higher immigration population	High income	Available	National data, Asian data when available
The UK	Higher immigration population	High income	Available	National data, Asian data when available
Singapore	Higher immigration population	High income	Mainly Chinese and Indian	National data
Korea	Korean, origin country	High income	Korean	National data
China	Chinese, origin country	Developing country	Chinese	National data
India	Indian, origin country	Developing country	Indian	National data

Methods

Literature sources

The literature review focused on studies of Asian and migrant health from a series of comparable countries (Australia, Canada, China, India, Korea, New Zealand, Singapore, UK and US). Searches for relevant articles were conducted on Medline, PubMed, Scopus, Grey Literature, Web of Science and Google Scholar between November 2015 and February 2016. In addition, the websites of the World Health Organization (WHO) and MIPEX were searched. The following combinations of keywords were used to identify relevant articles:

- [(Specific Country, e.g. Australia) AND (monitor OR Surveillance OR trends OR ethnicity data OR health status)] AND (Migrant OR Asian)
- [(Specific Country) AND (policy OR entitlement OR legal framework OR law OR regulation)] AND (Migrant OR Asian)
- [(Specific Country) AND (culturally competent OR work force OR access OR responsive OR cultural support OR diversity)] AND (Migrant OR Asian).

Strategic and Outcome frameworks

This benchmarking report is informed by the Boards' Strategic Themes for both Waitemata and Auckland DHBs.

Community, whānau and patient-centred model of care	**Emphasis/investment on both treatment and keeping people healthy**
Service integration and/or consolidation	**Intelligence and insight**
Evidence informed decision making and practice	**Outward focus and flexible, service orientation**
Operational and financial sustainability	

Outcome and intervention logic frameworks have been included in the 2016/17 annual plans for both Waitemata and Auckland DHBs (Appendix 3 and 4). At a high level, the health outcomes of both DHBs are: 1) increase in life expectancy at birth, and 2) reduce the ethnic gap in life expectancy at birth. To achieve the high level outcomes, the two DHBs measure their performance against a range of outcome and impact measures to understand how to address inequalities in life expectancy. Both DHBs have established key long-term outcomes made up of three main areas: 1) risk factors/prevention or healthy communities; 2) reducing mortality rates from conditions considered amenable, and 3) improving patient experience of health services. This benchmarking analysis follows the order of the high level and then long-term outcomes.

Disease burden metrics

The World Bank commissioned the first Global Burden of Disease (GBD) study for its World Development Report 1993, in collaboration with the Harvard School of Public Health and WHO. The Bill & Melinda Gates Foundation provided funding for a new GBD 2010 study in 2007, led by the Institute for Health Metrics and Evaluation at the University of Washington, in collaboration with WHO, Harvard University, Johns Hopkins University, and the University of Queensland (WHO, 2013). Most recently, papers were published in the Lancet, based on the new round of study – GBD 2013 (Murray, 2015) (Global Burden of Disease Study 2013 Collaborators, 2015) (GBD 2013 Risk Factors Collaborators, 2015). New Zealand and Australia have also produced burden of disease reports (The Ministry of Health, 2012) (AIHW, 2015).

There were substantial differences in some areas between the GBD 2010 and the WHO/UN Interagency groups, but in many other areas the results were quite similar. However, when the WHO report was released in November 2013, it did not endorse the GBD 2010 results before they had the opportunity to review and assess the reasons for differences, pending the availability of more detailed information on the data. It is also not known whether WHO will endorse the results of GBD 2013, which includes changes and improvements since GBD 2010. However, the concepts of disease burden are the same between the two sets of methods.

Disability-adjusted life year (DALY) is a summary measure combining time lost through premature death and time lived in states of less than optimal health, referred to as 'disability'. One DALY can be thought of as one lost year of 'healthy' life and the measured disease burden is the gap between a population's health status and that of a normative reference population (WHO, 2013). DALYs for a cause is calculated as the sum of the YLLs from that cause and the YLDs for people living in states of less than good health resulting from the specific cause:

DALY = YLL + YLD for a specific cause or all causes.

Box 1 Key terms used in burden of disease studies (AIHW, 2015)

Attributable burden: The disease burden attributed to a particular risk factor. It is the reduction in burden that would have occurred if exposure to the risk factor had been avoided.

Disability-adjusted life year: One (1) year of healthy life lost, either through premature death or, equivalently, through living with ill health due to illness or injury.

Incidence: The number of new cases (of an illness or event) occurring during a given period.

Prevalence: The number of cases of a disease or injury in a population at a given time.

Years lived with disability: A measure of the years of what could have been a healthy life that were instead spent in states of less than full health. YLD represents non-fatal burden.

Years of life lost: Years of life lost due to premature death. YLL represents fatal burden interchangeably termed 'fatal health loss'.

WHO adopted the simplified calculation methods for DALYs in late 2012 as described below (WHO, 2013):

- Use of a new normative standard life table for the loss function used to compute YLLs
- Calculation of YLDs simply as the prevalence of each sequela multiplied by the relevant disability weight

- Adjustment for comorbidity in the calculation of YLDs
- No discounting for time or unequal age weights.

The report adopted the WHO methods for calculating mortality and YLL rates for Waitemata and Auckland DHBs and New Zealand, using the WHO standard life table (standard loss functions), WHO World standard population (2000-2025) for age standardisation, WHO/GHE cause categories and ICD 10 codes, the WHO method of redistribution of garbage disease cause codes and adjustment for incompleteness of death registrations.

DALYs and YLDs were not included in the comparison/ranking at DHB level due to the necessary epidemiological data not being available for Asians and their sub-groups in both DHBs and the potentially large discrepancy between data sources.

At country level, the disease burden metrics were extracted for the year 2010 (termed as 'GBD 2010' in this report) from the Viz Hub of the IHME (IHME, 2016). Acknowledging the potential differences of the methods for mortality and YLL rates between the WHO and the IHME (GBD 2010 and 2013), we used the New Zealand average for adjusting the discrepancy when comparing the health outcomes of Asians in the two DHBs with the metrics at country level. There may still be residual biases, but the comparisons aimed to look at the rank rather than the absolute values and are thus thought to be relatively robust.

Maternal health

Maternal mortality ratio (MMR) measures the number of maternal deaths per 100,000 live births. The fifth Millennium Development Goal (MDG 5) aims for a 75% reduction in MMR between 1990 and 2015. The GBD 2013 study used their cause of death database (1980-2013) to estimate MMR (Kassebaum, 2014). Direct and indirect deaths during pregnancy and within 6 weeks of delivery, plus late maternal deaths up to 1 year after delivery and the fraction of HIV-related deaths aggravated by pregnancy were included in the calculation of MMR in GBD 2013.

The Perinatal and Maternal Mortality Review Committee (PMMRC) of New Zealand defines a maternal related death as 'death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes', based on the WHO definitions from the International Classification of Diseases (10th edition) (PMMRC, 2015). In addition, the PMMRC also defines MMR as the number of maternal related deaths per 100,000 maternities, and maternities are defined here as 'all births at 20 weeks or beyond or weighing 400g or more if gestation was unknown'. Because of the different definitions of MMR between PMMRC and the GBD 2013 study, direct comparisons would be hard. No calculations were made for MMR by ethnicity at DHB level due to very small numbers.

Low birth weight is defined as a weight of less than 2500g (up to and including 2499g) irrespective of the gestational age and the measurement should be taken within the first hours of life, before significant postnatal weight loss has occurred (The Ministry of Health, 2015). Child mortality is a core indicator of child health and well-being. The MDG4 target was to reduce the under-five mortality rate by two thirds between 1990 and 2015.

An infant death is a live-born infant dying before the first year of life is completed according to WHO (UN IGME, 2015). Infant deaths comprise early neonatal deaths, late neonatal deaths and post-neonatal deaths. Infant death rate is the number of infant deaths per 1000 live births over a particular time period (usually annually).

Risk factors

GBD 2013 estimates the burden of disease attributable to risk factors in three categories at Level 1: 1) behavioural, 2) environmental, and 3) metabolic. At its level 2, the risk factors are as follows:

Table 3 Risk factors included in GBD study

Low glomerular filtration rate	Air pollution
Low bone mineral density	Unsafe sex
High total cholesterol	Tobacco smoke
High systolic blood pressure	Sexual abuse and violence
High fasting plasma glucose	Low physical activity
High body mass index	Dietary risks
Unsafe water, sanitation, and hand washing	Child and maternal malnutrition
Other environmental risks	Alcohol and drug use
Occupational risks	

WHO reported four metrics of smoking, which are defined below (WHO, 2015).

Table 4 Definitions of smoking used by WHO

Current Tobacco Smoking	'Current' means smoking at the time of the survey, including daily and non-daily smoking. 'Tobacco smoking' means smoking any form of tobacco, including cigarettes, cigars, pipes, hookah, shisha, water-pipe, etc. and excluding smokeless tobacco.
Daily Tobacco Smoking	'Daily' means smoking every day at the time of the survey. 'Tobacco smoking' means smoking any form of tobacco, including cigarettes, cigars, pipes, hookah, shisha, water-pipe, etc. and excluding smokeless tobacco.
Current Cigarette Smoking	'Current' means smoking at the time of the survey, including daily and non-daily smoking. 'Cigarette smoking' means smoking any form of cigarette, including manufactured and roll-your-own.
Daily Cigarette Smoking	'Daily' means smoking every day at the time of the survey. 'Cigarette smoking' means smoking any form of cigarette, including manufactured and roll-your-own.

The smoking rates based on Census 2013 are used in this report so that the rates by Asian subgroup can be calculated. The definitions related to smoking in Census 2013 are listed below:

- Regular smoker – Someone who actively smokes one or more manufactured or hand-rolled tobacco cigarettes per day
- Never smoked – Someone who never actively smoked manufactured or hand-rolled tobacco cigarettes at all or never actively smoked one or more per day
- Ex-smoker – Someone who is not a regular smoker now but had been a regular smoker of one or more cigarettes in the past.

'Regular smoker' in Census 2013 is very close to the definition of 'daily smoking' in the New Zealand Health Survey (NZHS).

Overweight and obesity, modifiable risk factors for health are defined as 'abnormal or excessive fat accumulation that may impair health' according to WHO (WHO, 2016). Obesity is defined as a person's BMI of 30 kg/m^2 or higher for an adult. Obesity rate is the percentage of a defined population with BMI of 30 kg/m^2 or higher. The WHO's definition of overweight is a person's BMI greater than or equal to 25 but less than 30 kg/m^2 for an adult.

Social Progress Index

The Social Progress Index offers a 'rich framework for measuring the multiple dimensions of social progress, benchmarking success, and catalysing greater human wellbeing' (Social Progress Imperative, 2016). The index is designed based on four principles, namely exclusively social and environmental indicators, outcomes rather than inputs, holistic and relevant to all countries, and actionable. There are three dimensions of social progress included at country level in the Social Progress Index Framework (Appendix 5), which are: 1) basic human needs, 2) foundations of wellbeing, and 3) opportunity, so that these three questions can be answered properly:

- Does a country provide for its people's most essential needs?
- Are the building blocks in place for individuals and communities to enhance and sustain wellbeing?
- Is there opportunity for all individuals to reach their full potential?

There are four components for each dimension of the framework and for each component there are three-five specific outcome indicators. The overall Social Progress Index score is a simple average of the three dimensions, and each dimension is the simple average of its four components. 'Principal component analysis' is used to identify the components using the outcome indicators within each component of the Social Progress Index framework.

It is particularly important for migrants to live in a harmonious and inclusive social and political environment, in addition to enjoying good general physical and mental health. In the framework, the last but not least dimension, opportunity, 'measures the degree to which a country's citizens have personal rights and freedoms and are able to make their own personal decisions as well as whether prejudices or hostilities within a society prohibit individuals from reaching their potential'. Access to advanced education is essential for migrants and creates abundant opportunities for individual and social development.

Social Progress Index scores at the overall level, dimension level, and component level are all based on a 0-100 scale.

Definitions

Table 5 Definitions used in the report

Term	Definition
Asian	People originating from Asian countries including countries in West Asia (Afghanistan and Nepal), South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong, Japan), and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Cambodia). This definition is commonly used within the health sector and is the basis of the Statistics New Zealand Asian ethnicity categories
Cancer	In this document we have used the term 'cancer' to refer to all neoplasms that may be benign (not cancer), or malignant (cancer)
CALD populations	Culturally and linguistically diverse populations from Asian, Middle Eastern, Latin American and African backgrounds
Fatal health loss	Fatal health loss refers to the measure of YLLs
Health loss	Health loss refers to the measure of DALYs
MELAA	Middle Eastern, Latin American and African groups
Migrants	People who were born overseas who settle in New Zealand (also known as immigrants)
Refugees	Any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country[3]. Refugees arrive in New Zealand under one of three categories: ▪ Quota refugees ▪ Family reunification members ▪ Asylum seekers
Total dependency ratio	The total dependency ratio estimates the burden of the dependent populations (the number of children (0-14 years old) and older persons (65 years or over)) by the working-age population (15-64 years old)[4], which is related to social and economic development, and has implications for social support needs and use of health care services.

[3] United Nations Convention Relating to the Status of Refugees (1951). United Nations Conference on the Status of Refugees and Stateless Persons, Article 1. Geneva.
[4] Dependency ratio. http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/demographics/dependency_ratio.pdf, accessed 12 April 2016

Legend used for interpretation and reflection

To reflect on the 'learnings' from the benchmarked findings and areas for further work, a section on 'Interpretation and reflection' has been added after each health outcome area for the main headings: 1) Life expectancy at birth, 2) Major cause group and leading causes of disease burden, 3) Risk factors & prevention, and 4) Long-term outcomes. The legend is as follows:

Indicates where our result is better than that being compared to

Indicates where our result is similar to that being compared to

Indicates where our result is not as good as that being compared to

Caveats and limitations

Literature review

1. The Asian cohort is often described as a subset of the country's migrant population or ethnic minorities, instead of being categorised as its own separate entity. As a result, the qualitative literature resources on Asian health in the comparable countries were limited. A second search round with inclusion of 'migrant' as a search word was incorporated into the method, in order to expand the scope of the search and draw comparable findings from the literature.
2. Apart from the comparator countries (Australia, Canada, UK and US), there were difficulties in finding literature from China, India, Korea and Singapore. These difficulties include language differences and literature from these countries not being readily published on the search databases accessed.
3. The majority of the literature sourced focused on pilot studies on a specific disease outcome. This had limitations in terms of generalisability or transferability at a national, regional or sub-regional level for a targeted Asian ethnic group, though the findings were interesting to note for identified Asian ethnic groups.

Analysis of health outcomes

The report uses a wide range of data sources and the data may come from different years for the same indicator. For the health outcomes and all cause disease burdens attributed by the health risk factors, the data of the four metrics namely; mortality rate, DALYs rate, YLL rate and YLD rate, were mainly extracted from the GBD study and Global Health Estimates/WHO, at country level. At DHB

level and by ethnicity, only mortality rate and YLL rate were estimated based on robust mortality data, using the WHO methodology. There are differences to some degree in cause definition by ICD codes, standard life table, World standard population and redistribution of 'garbage codes' between the GBD study and the WHO method in calculating mortality and YLL rates. In addition, there are many data gaps particularly for Asians residing in the migrant countries Australia, Canada and the UK as ethnicity has not been systematically collected and reported in their national systems, such as birth or death registrations.

Nevertheless, the report attempts to provide an international context for the performance of Asian health in Waitemata and Auckland DHBs, to identify the areas of high and low performance, issues, unmet need, and experiences and expectations of Asian health service users.

Literature review

This section of the report summarises recent international and national literature on Asian and migrant health monitoring, policy, programmes and partnerships for benchmarking purposes in the following areas:

- Monitoring Asian and migrant health
- Policy and legal frameworks affecting Asian and migrant health
- Asian and migrant sensitive health systems including service access and utilisation, and the health workforce
- Networks, partnerships and multi-country frameworks on Asian and migrant health.

Monitoring Asian and migrant health

New Zealand's approach to monitoring Asian and migrant health data is comparable with the comparator countries in terms of the methodology used for health data surveillance. Similar to the comparator countries, New Zealand has faced many systematic issues with migrant and ethnicity coding with regards to disaggregation of migrant (into migrant variables) and ethnicity (into Asian subgroups) health data. A recent significant shift has been the updating of the Ministry of Health (MoH) Ethnicity Data Protocols for the Health and Disability Sector (2004) recommendations. Refreshed protocols support a transition from the previous minimum requirements of collecting up to three ethnicities at Level 2 classification, to collecting up to six ethnicities at Level 4 classification. This reflects the requirement for information systems to capture the greater population diversity and improved granularity of information to plan, fund and monitor health services. These changes represent a significant move forward in terms of ethnicity data collection and will make a valuable contribution to health planning. The changes will apply to the whole of the health and disability sector from July 2017.

Communicable disease monitoring

Global public health agencies have shifted focus to improving the collection of ethno-cultural data to assist with communicable disease prevention and control (Gushulak, 2010). Historically, there has been an association of labelling communicable disease risk attributed to targeted ethnic groups risk during periods of outbreak e.g. measles and tuberculosis. Consistently, New Zealand and the US experience a common trend, whereby the collection of ethno-cultural data and inclusion of the migrant variables used in Australia have been traditionally linked to communicable disease surveillance, and not transferred over to non-communicable disease monitoring routines.

Policy and legal frameworks affecting Asian and migrant health

MIPEX

The MIPEX (Wong, Mortensen, Lim, & Abbott, 2015) is a unique tool which measures policies to integrate migrants in 38 countries. MIPEX is the most reliable and cited index of integration and citizenship policies, widely used by both qualitative and quantitative researchers globally. It

examines the following dimensions with a comparison to what an ideal healthcare system would look like for migrants, including:

- All residents having the same healthcare coverage as domestic nationals in law and in practice
- Access to entitlements, in which all residents can access information in various languages, and through various methods, including cultural mediators
- Healthcare providers informed of these entitlements and equipped to meet their needs, through training, interpretation methods, adapted diagnostic methods and including diversity in staff.
- Health policies support these changes and are equipped to respond to the needs of an increasingly CALD society.

Data from the MIPEX report (2014) was analysed based on the health policy criteria above. New Zealand was ranked the highest ahead of every country listed in the MIPEX report, as well as when benchmarked against the comparator countries in this benchmarking report. The findings demonstrate that migrants in New Zealand receive the most equitable entitlement as compared to our comparator countries both in terms of policy and in practice. There are local policies implemented to cater for the migrant population where there is a high migrant population density. These policies make New Zealand one of the most progressive countries as benchmarked against the countries in this report, but also in the OECD.

Drivers of change

Globally, there is competition to attract, recruit and retain talent to drive the national business growth agenda. New Zealand is right in the mix of this competitive drive for migrant talent. Canada recognises the advantage of highly skilled migrants and international students filling the labour shortage in highly skilled areas, growing the economy and nation building. New immigration policies and programmes have been specifically created to make it easier for international students to study, work, and become permanent residents in Canada, especially for graduate students (Gopal, 2014). New Zealand's new immigration approaches are similar to Canada's in terms of purpose and intention. The result has seen unprecedented net migration of permanent and temporary individuals from Asian countries such as India (21%), China (19%) and the Philippines (9%) who choose to live, work and study in New Zealand (MBIE, Auckland's Migration Statistics and Trends, 2016). However, current policies shaping migrants lives through rules around time limits, work rights and the possibility of gaining permanent residence creates situations where some temporary migrants experience increased vulnerability including limited access to services and unmet need (Collins, 2016). National drivers include:

- New Zealand's immigration policy has progressively shifted from an emphasis on permanent settlement towards an increasing focus on temporary migration (Collins, 2016). Research indicates that 36.1% of temporary migrants to New Zealand live in the Auckland CBD (Collins, 2016)
- The internationalisation and commodification of education is another component of change impacting migration in New Zealand (Collins, 2016). Growth in the export value of international education is a significant contributor to the country's Business Growth Agenda

Auckland hosts a large proportion of international students - close to 63% - which represents a contribution to the Auckland economy of $1.6 billion (MBIE, Auckland's Migration Statistics and Trends, 2016). A key policy encouraging international students to study in New Zealand, in particular in the Auckland district, is driven by targets set by the Auckland Tourism, Events and Economic Development (ATEED) Agency (92,000 by 2025, currently at 70,000 in 2015) (ATEED, 2016)

- Retention policies to encourage international students holding New Zealand degrees to stay post study and work in high value sectors. New Zealand offers work search visas under two categories – Open and Employer Assisted. The Open visa is for 12 months; the Employer assisted visa is for between 2 to 3 years. Students who stay on after they graduate are more likely to stay permanently (MBIE, Auckland's Migration Statistics and Trends, 2016). ATEED has set a target of 25,000 international education jobs within the Auckland region by 2025 (currently 15,000 in 2015).

Asian and migrant sensitive health systems including service access and utilisation, and the health workforce

CALD cultural competency training

Waitemata eCALD® services are a world leader in the development of CALD cultural competency training for the health workforce.

A comprehensive and quality range of CALD online and face-to-face courses and resources for the New Zealand health workforce has been developed by Waitemata DHB's eCALD® Services (WDHB, eCALD, 2016) with the aim of:

- Improving the quality of engagement of health practitioners and CALD clients/patients
- Improving cross-cultural communication and interactions between employers and employees, as well as employees-to-employees working in a culturally diverse workplace.

New Zealand health bodies have endorsed eCALD® courses and resources for their members, for example, the Royal New Zealand College of General Practitioners and the Health Regulatory Authorities of NZ (HRANZ) which includes: the Dental Council of NZ, Dietitians Board, Medical Council of NZ, Midwifery Council of New Zealand, Medical Radiation Technical Board, Medical Sciences Council, NZ Chiropractor Board, NZ Psychologists Board, Nursing Council of NZ, Occupational Therapy Board of NZ, Pharmacy council of NZ, Physiotherapy Board of NZ, Podiatrists Board of NZ, Psychotherapists Board of Aotearoa NZ and the Optometrists & Dispensing Opticians Board.

National primary care and non-governmental organisations such as Plunket NZ, Family Works, and Metlifecare are working with eCALD® to roll out courses to their employees. There is strong interest from the University of Auckland, School of Population Health and the New Zealand Police to adopt/adapt the eCALD® courses. There is also international interest from Denmark, Australia and the US to review/adapt/adopt some of the eCALD® courses and resources.

Diverse workforce

Health organisations recognise that recruiting a diverse health workforce is advantageous to ensuring that the diverse cultural, linguistic and religious needs of their patients are met with the delivery of culturally appropriate and responsive services. In the UK, there is increasing pressure to use migrant labour, largely driven by cost and availability (Wong, Mortensen, Lim, & Abbott, 2015). There are policies in the US to encourage racial and ethnic diversity in the health workforce, but they are not migrant specific (Wong, Mortensen, Lim, & Abbott, 2015). In Australia and Canada, there are very limited measures that encourage the participation of migrants into the health workforce (Wong, Mortensen, Lim, & Abbott, 2015).

In New Zealand, diversity is encouraged in the workforce; however the policies often prioritise Māori and Pacific, aimed at engagement, and access to and through health care for prioritised populations, enabling and creating a sustainable health workforce (The Ministry of Health, 2016). The rapid net migration of new migrants from CALD Asian backgrounds in both Waitemata and Auckland DHBs warrants targeted workforce development strategies that include growing and sustaining a diverse, culturally competent workforce that provides 'cultural intelligence' in the health sector. This within key high use settings such as primary health, secondary care and mental health to best reflect the needs of the communities they serve now and in the future.

Digital health tools

Australia has best practice examples of two applications or online tools available to support those with CALD Australian and refugee backgrounds:

- The Cancer Council Victoria provides a multilingual printable appointment card to help CALD Australians more easily access healthcare appointments (Cancer Council Victoria, 2016)
- New South Wales (NSW) Refugee Health Service's online Appointment Reminder Translation Tool allows the Service to generate translated appointment details into the client's preferred language (NSW Refugee Health Service, 2016).

In New Zealand, Waitemata DHB has developed the 'Listen Please' clinical translation application for patients to communicate with nurses, doctors and allied health personnel, and vice versa. It is aimed at patients who cannot speak at all (e.g. breathing tube in their airway) but can communicate non-verbally, or patients who cannot speak English but can speak Mandarin/Cantonese Chinese, Korean, Samoan or Tongan.

Language support

Research shows that language barriers have a negative effect on access to care and prevention services, adherence to treatment plans, timely follow-up, and appropriate use of emergency department services (Gushulak, 2010). Language interpretation is free and generally available to health patients in Australia, New Zealand, UK and in a few states in the US. In Canada, free services are not readily available, with the patient required to pay for service (Wong, Mortensen, Lim, & Abbott, 2015). In New Zealand, every individual has the legal right to an interpreter when dealing with the law, with health service providers or during elections, in keeping with Article 21 of the Universal Declaration of Human Rights (UN, 2016). Health interpreting services are free for patients

who are eligible and entitled to publicly funded health and disability services living in the metropolitan Auckland DHBs with the aim of (a) ensuring health services are accessible, (b) improving communication, and (c) improving and maintaining clinical safety (WDHB, Asian Health Services, 2016). In 2015/16, the top three languages requested by non-English speaking or limited English speaking clients and hearing impaired peoples when accessing primary health interpreting for services such as general practice in both Waitemata and Auckland DHBs were (NRA, Metro Auckland Primary Health Interpreting Report, 2016):

Waitemata DHB

1. Mandarin
2. Korean
3. Sign language

Auckland DHB

1. Mandarin
2. Vietnamese
3. Cantonese

In 2015-16, Immigration New Zealand undertook cross-government work to review and address the language barriers experienced in accessing services provided or funded by government agencies in the six resettlement regions in New Zealand. The Interpreter Services Project focused on available language assistance services for those who are not proficient in English, including the provision and use of interpreters by mainstream agencies, services and programmes (MBIE, Interpreter Services Project - Summary of National Themes from Service Provider Consultation, 2016)

Networks, partnerships and multi-country frameworks on Asian and migrant health

The literature indicates that the historical purpose of international collaboration and partnerships was to prevent potential cross-border spread of communicable disease, and this still is the primary focus for most countries.

A notable partnership between Auckland, Waitemata and Counties Manukau DHBs has been working in partnership with New Zealand Red Cross volunteers and the Mangere Refugee Resettlement Centre. Both have played pivotal roles in promoting the Refugee Primary Care Wrap Around Service (funded by the three metro Auckland DHBs) to their settling quota refugee (including Burmese, Kachin, Chin, Karen and Kayar) and asylum seeker communities aimed improving enrolment rates with a family doctor (GP) for access to universal healthcare.

In New Zealand, there are a number of key stakeholder networks established at the national, regional or sub-regional levels, led by Central Government Ministries, DHBs or other agencies across health, settlement support agencies, Non-Government Organisations (NGO) providers, academia, immigration networks and community. The priority population foci includes Asians, migrants, and/or refugee populations where health is either the core focus or included in discussions as part of the Terms of Reference. The key networks (though not exhaustive) include: New Zealand Refugee Resettlement Strategy Implementation Auckland/Wellington Key Stakeholders Reference Group,

Auckland Health National Refugee Resettlement Strategy (NRRS) Working Group, Auckland Agency Group, Auckland Regional Asian & MELAA Primary Care Working Group, Asian & MELAA Health Governance Group (Waitemata and Auckland DHBs), Asian Mental Health & Addiction Governance Group (Waitemata DHB), Asian Mental Health & Addiction Governance Group (Counties Manukau DHB), Asian Clinical Governance Group Committee -Mental Health (Counties Manukau DHB), Pan-Asian Health Interest Group (Counties Manukau DHB), Multi-Ethnic Health Network (Waitemata and Auckland DHBs), The Asian Network Inc.(TANI) General Network Meeting, regional and/or local settlement networks, and ethnic specific groups. There are many other intersectoral ethnic advisory and interest groups established such as the Ethnic Peoples Advisory Panel (Auckland Council) and Asian Advisory Board (New Zealand Police).

In the South Island of New Zealand, there are dedicated groups addressing refugee and migrant health in the Canterbury region, which are: Inter-Agency Network for Refugees and Migrants (INFoRM), Health and Wellbeing Network, Elder Canterbury's Elder Refugee and Migrant Group, and CALD Health Reference Group (CHAG).

Population profile

Asian populations in Waitemata and Auckland DHBs, New Zealand

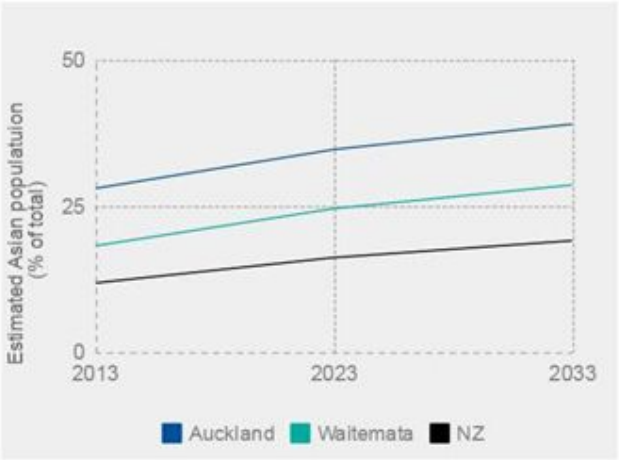
154,370
Asian peoples live in Auckland - 31% of the total population

123,750
Asian peoples live in Waitemata - 21% of the total population

Our Asian populations are increasing

Waitemata DHB has the fastest growing Asian population in NZ, expected to reach 214,490 by 2033 (an increase of 113% from 2013).

By 2033, the Asian population is likely to make up 39% of the total population for Auckland DHB and 28% of the Waitemata DHB population.



Auckland and Waitemata DHBs

Chinese (40.31%) Indian (28.68%)
Other Asian (31.01%)

40% of our Asian population are Chinese

There are more females than males in our Chinese and Other Asian populations, and more Indian males than females, especially in Auckland DHB.

The Asian population is relatively young.
More than 50% of our Asian peoples are aged between 15 and 44.

9% of our Chinese population are aged 65+.

A higher proportion of Asian peoples aged 20-24 live in Auckland DHB than Waitemata. This is thought to be due to students attending Auckland universities and Private Training Establishments (PTEs)

For relatively smaller Asian sub-groups, only the Census Usually Resident (CUR) figures were available for use and the ethnicity was Total Response (i.e. one individual can belong to more than one self-identified ethnic group). We cannot make direct comparisons between the CUR population and the estimated population. There was a large Korean population followed by Filipino and Japanese in Waitemata DHB. In Auckland DHB, Filipino almost matched the Korean population, followed by Sri Lankan and Japanese.

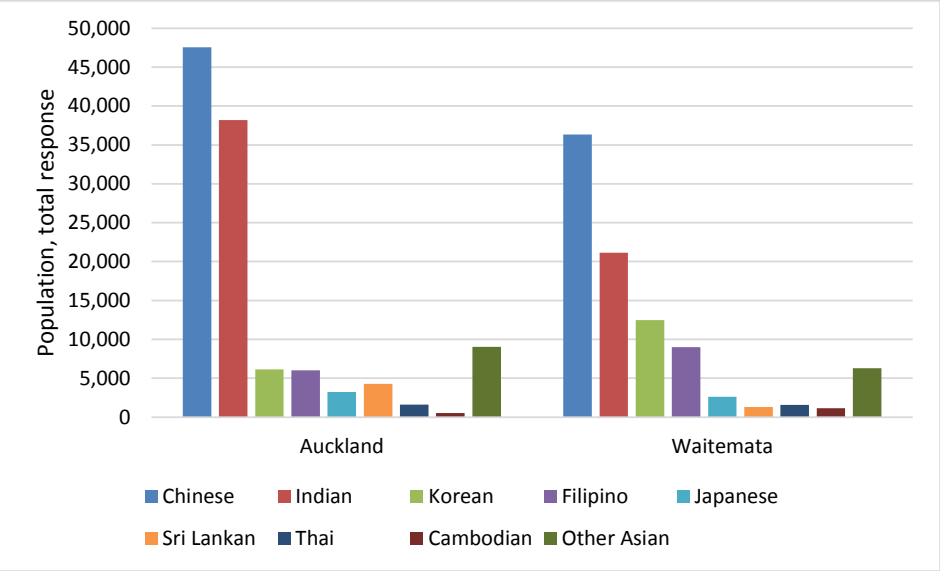


Figure 1 Asian sub-groups, Waitemata and Auckland DHBs, total response, CUR 2013

Other countries

The table below summarises the size of the Asian population and its contribution to the total population of that country.

Table 6 Size and proportion of Asian population by country

Country	Asian population (in thousands)	Proportion of the total population (%)	Year	Data source and comments
China	1,393,337	100%	2013	Global health observatory, WHO
India	1,252,140	100%	2013	Global health observatory, WHO
Republic of Korea	49,263	100%	2013	Global health observatory, WHO
Singapore	5,412	100%	2013	Global health observatory, WHO
Australia	1,538	6.5%	2015	Based on the top 10 countries of birth
Canada	4,279	13.0%	2011	Visible minority populations of South Asian, Chinese, Filipino, Southeast Asian, West Asian, Korean and Japanese
The UK	4,214	7.5%	2011	England and Wales, Census 2011
New Zealand	521	11.7%	2013	Estimated population

Australia

Australia does not collect ethnicity information in the social and health sector in a systematic way as New Zealand does. Country of birth is now used as a proxy for ethnicity, but probably omits the people born in Australia who are self-identified as Asian or Asian sub-groups.

Persons born in the UK were the largest group of overseas-born residents, accounting for 5.1% of Australia's total population, followed by people born in New Zealand (2.6%), China (2.0%), India (1.8%) and the Philippines and Vietnam (both 1.0%) (ABS, 2016).

Table 7 Top ten countries of birth estimated resident population, Australia, as at 30 June 2015 *(a)(b)(c)*

Country of birth	Population	% of Australian population
United Kingdom *(d)*	1,207,000	5.1
New Zealand	611,400	2.6
China *(e)*	481,800	2.0
India	432,700	1.8
Philippines	236,400	1.0
Vietnam	230,200	1.0
Italy	198,200	0.8
South Africa	178,700	0.8
Malaysia	156,500	0.7
Germany	125,900	0.5

Notes (a) Estimates are preliminary. (b) Top 10 countries of birth excluding Australia. (c) All population figures presented in this table are rounded. Estimates of the proportion of the Australian population are based on unrounded numbers. (d) United Kingdom, Channel Islands and Isle of Man. (e) Excludes Special Administrative Regions and Taiwan.

Source: Australian Bureau of Statistics. http://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/3FA175EA6651F2CACA25776E00178CAA?opendocument, accessed 27 April 2016.

Canada

In Canada, 'visible minorities' are used in accordance with the Employment Equity Act of Canada. The Act defines 'visible minorities' as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour' (Statistics Canada, 2016), with the aim of promoting equal opportunity in employment.

When the concept of visible minority was applied, South Asian and Chinese accounted for 4.8% and 4.0% respectively of the total population in 2011, with Korean accounting for 0.5%. When single and multiple responses of self-identified ethnic origin were both counted in Census 2011 of Canada, Chinese took 4.5% with a population of 1,487,580, with 3.6% for East Indian (1,165,145).

Table 8 Visible and non-visible minority populations by group, 1996–2011, Canada

Group	1996[2,3]		2001[4]		2006[5]		2011[1]	
	Population	%	Population	%	Population	%	Population	%
South Asian	670,590	2.4%	917,075	3.1%	1,262,865	4.0%	1,567,400	4.8%
Chinese	860,150	3.0%	1,029,395	3.5%	1,216,565	3.9%	1,324,750	4.0%
Filipino	234,195	0.8%	308,575	1.0%	410,695	1.3%	619,310	1.9%
Southeast Asian	172,765	0.6%	198,880	0.7%	239,935	0.8%	312,075	0.9%
West Asian			109,285	0.4%	156,700	0.5%	206,840	0.6%
Korean	64,835	0.2%	100,660	0.3%	141,890	0.5%	161,130	0.5%
Japanese	68,135	0.2%	73,315	0.2%	81,300	0.3%	87,270	0.3%
Visible minority, n.i.e.	69,745	0.2%	98,915	0.3%	71,420	0.2%	106,475	0.3%
Multiple visible minorities	61,575	0.2%	73,875	0.2%	133,120	0.4%	171,935	0.5%
Not a visible minority	25,330,645	88.8%	25,655,185	86.6%	26,172,935	83.8%	26,587,575	80.9%
Total population in private households	28,528,125	100.0%	29,639,030	100.0%	31,241,030	100.0%	32,852,320	100.0%

Notes: 1. Statistics Canada, NHS Profile, Canada, 2011; 2. Statistics Canada, Population by Aboriginal Groups and Sex, Showing Age Groups, for Canada, 1996 Census (20% Sample Data); 3. Statistics Canada, Total Population by Visible Minority Population, for Canada, 1996 Census (20% Sample Data); 4. Statistics Canada, Community Highlights for Canada; 5. Statistics Canada, 2006 Community Profiles: Canada (Country)

Source: https://en.wikipedia.org/wiki/Demographics_of_Canada, accessed 2 April 2016.

The three Asian sub-groups, South Asian, Chinese and Korean, were generally younger than the total population of Canada in Census 2006. South Asian had a higher proportion of children aged less than 14 years (24.2% vs. 17.9% of the total population), with Korean having a relatively large proportion of its population aged 15-24 years (20.4% vs. 13.5% of the total population). 10.7% of Chinese were aged more than 65 years, close to 13.0% of the total Canadian population but it was only 6-7% for South Asian and Korean in 2006.

The UK

There were 4.2 million Asian/Asian British residing in England and Wales, based on Census 2011, accounting for approximately 7.5% of the total population. In addition, there were 341,000, classified as 'White and Asian' in the mixed/multiple ethnic group (0.6% of the total). Within Asian/Asian British, Indian accounted for 33.5%, followed by Pakistani (27%), then Bangladeshi (11%) and Chinese (9%).

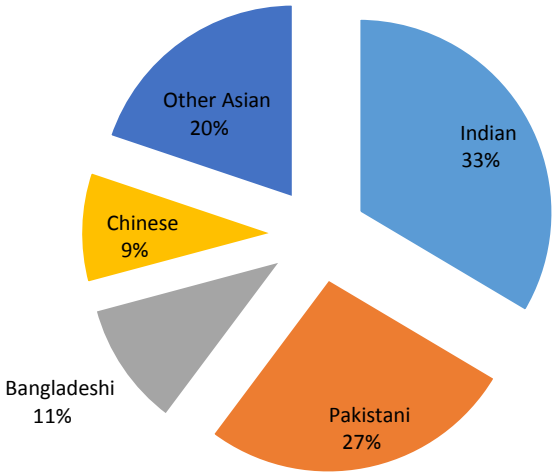


Figure 2 Asian make-up of usual resident population of England and Wales, Census 2011, the UK

Asian British, in general, had a higher proportion of children (23.2% vs. 17.6% for total population) in Census 2011, which is particularly true for Bangladeshi and Pakistani but not for Chinese. Chinese had the highest proportion of working age (15-64 years) population at 83.2% relative to 65.9% of the total population and 65.6% of the White total. The Asian British were generally younger than the total population of England and Wales; Indian had the highest proportion of 65+ years of all the Asian sub-groups (8.1%), which was less than half of the proportion for the total population (16.4%).

Asian countries

China and India have the largest populations in the world and in this comparison as well. India had a higher proportion of children aged less than 15 years (29%), 9% higher than that of New Zealand. India and China had lower populations over 60 years as well. The median age of New Zealanders is comparable to that of China and Australia, older than that of India, but younger than Canada, the UK, Korea and Singapore.

There were more males than females in China and India (by 6.3% for China and 7.6% for India), whereas in other countries including New Zealand there are more females. New Zealand had the lowest sex ratio of the total population; there were only 96 males per 100 females in New Zealand. New Zealand had a higher total dependency ratio than most other countries except for the UK in 2015. China, Korea and Singapore had comparable ratios, sitting at around 37%. The old age dependency ratio for New Zealand was 23% in 2015, similar to that of Australia, Canada and the UK, but much higher than India and China.

Table 9 Population size and age structure by country (2013)

Country	Population (in thousands) total	Population proportion under 15 (%)	Population proportion over 60 (%)	Population median age (years)	Population living in urban areas (%)
China	1,393,337	18	14	37	53
India	1,252,140	29	8	26	32
Republic of Korea	49,263	15	17	39	82
Singapore	5,412	16	16	38	100
Australia	23,343	19	20	37	89
Canada	35,182	16	21	40	82
United Kingdom	63,136	18	23	40	82
New Zealand	4,506	20	19	37	86

Source: http://apps.who.int/gho/data/view.main.POP2040ALL?lang=en, accessed 10 February 2016.

11.2

Life expectancy at birth

Internationally	• New Zealand had similar life expectancies to other high income countries	
	• Asians of both DHBs, in particular Waitemata, had the highest life expectancy, compared to the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had higher life expectancy than New Zealand	
	• The Chinese population of Waitemata had the highest life expectancy within Auckland and Waitemata	

Life expectancy at birth reflects the overall mortality level of a population, estimating the average number of years that a new-born is expected to live if current mortality rates hold true.

At country level, New Zealand had comparable life expectancies to other high income countries according to the Global Health Observatory of the WHO. Singaporeans enjoyed the highest life expectancies for females and males (just one year higher than those of New Zealanders), whereas India's life expectancies at birth were the lowest (less than 70 years).

Asians in Waitemata and Auckland DHBs had higher life expectancies than their European/Other counterparts, for both females and males; the life expectancies for Asians residing in Waitemata DHB were the highest. By Asian sub-group, Chinese in Waitemata DHB had the highest life expectancy at birth followed by Indian and Other Asians (including Korean and South-East Asians).

The graph below attempts to compare and rank Asian life expectancy at birth between Waitemata and Auckland DHBs and people of other countries of interest. It should be noted though, that the potential discrepancy between data sources (deaths and population), different years of the data, and different calculation methods (e.g. whether or not using hierarchical Bayesian models for dealing with random variation of death rates (Statistics New Zealand, 2015)). Asian of both DHBs had higher life expectancy at birth than that of the total population of the countries on the list (Asian population of New Zealand: 86 years at birth).

There is generally a lack of vital statistics for Asian in Australia, Canada and the UK, preventing life expectancy being calculated in the usual way. In 2001, Indian and Chinese females had higher life expectancy at birth (82.6 years and 81.6 years respectively), compared to the White Total or the total female population in the UK, and Indian (76.0 years) and Chinese (75.4 years) men had comparable figures to White men. Bangladeshi and Pakistani had slightly lower life expectancy at birth for both women and men. These numbers, although indicative, are however out of date, so cannot be directly compared to the numbers in Figure 3.

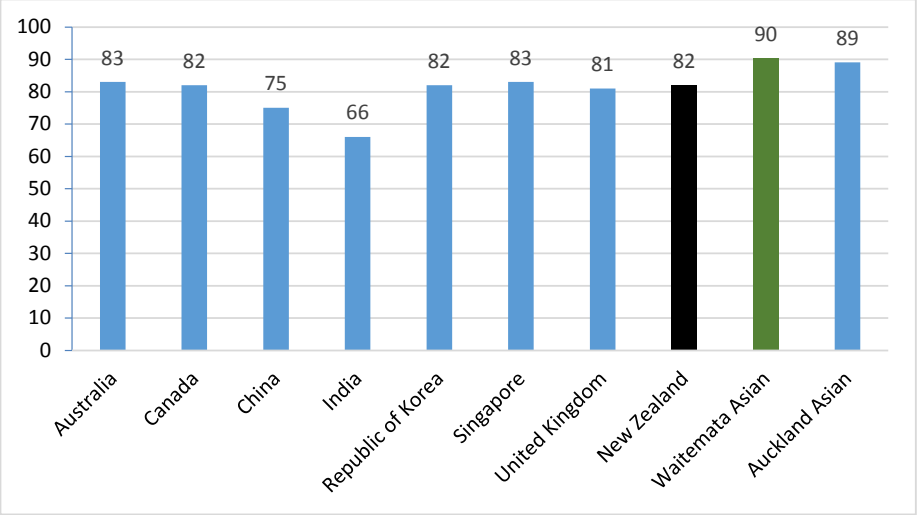


Figure 3 Life expectancy at birth (years), female and male combined, DHBs and countries, 2010-12 and 2013

Interpretation and reflection

Compared to the total population of the comparator countries, Asian of both DHBs performed better and the Chinese in Waitemata DHB is doing the best compared to other ethnic groups in both DHBs. The life expectancy used in this analysis is a period measure assuming the population born now will follow the age specific mortality rate of the present population at various age groups. This assumption holds true to a large degree for a stable population; however, it is likely to be an over-estimate for a migrant population such as Asian, as immigrants are usually screened or selected to be eligible for migration to New Zealand, the so called 'healthy migrant effect'. Nevertheless, as a cross-sectional summary measure of fatal burden on the population, the higher life expectancy of the Asian population needs to be maintained.

There are many factors associated with mortality/life expectancy covering social determinants, up-stream risk and protective factors of disease and injuries, and use of primary/community and secondary services including preventive programmes such as immunisation and screening services. We will need to address the whole spectrum of imperatives presented in the DHBs' Outcomes Frameworks to maintain our top performance in life expectancy across both DHBs. Moreover, it is important to understand the values that drive Asian help-seeking and health-seeking behaviour. In 2014, the top four values Asians placed on their experiences and expectations of Auckland DHB health services were:

1. Excellence and professionalism
2. A professional connection with clinicians
3. Confidence about the level of care
4. Efficiency, productivity, and good processes.

Major cause group and leading causes of disease burden

Internationally	• New Zealand had lower rates of health loss due to communicable diseases as well as maternal, perinatal or nutritional conditions	
	• New Zealand had higher rates of health loss due to mental health and substance use	
	• Asians of both DHBs, in particular Waitemata, had the lowest overall rates of fatal loss compared to the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had lower overall fatal health loss than the total population of New Zealand	

Similar to most high income countries, non-communicable diseases accounted for more than 80% of the fatal health loss in New Zealand. Communicable, maternal, perinatal and nutritional conditions still played an important role in the fatal loss in India (42% of total years of life lost), while injuries accounted for 20% of total YLLs in the Republic of Korea.

New Zealand had the lowest rate of DALYs for communicable, maternal, perinatal and nutritional conditions, a comparable rate for non-communicable diseases, but with a relatively higher injury rate of DALYs (still lower than the three main origin Asian countries of the Asian migrants living in New Zealand, namely China, India and Korea).

Table 10 Age standardised rate of DALYs by major cause group, 2012, GHE/WHO

Country	All Causes	Communicable, maternal, perinatal and nutritional conditions	Non-communicable diseases	Injuries
Australia	17,696	1,161	14,458	2,076
Canada	18,838	1,311	15,725	1,802
China	24,811	3,282	18,748	2,781
India	47,950	15,840	26,503	5,607
New Zealand	**18,742**	**1,157**	**15,164**	**2,420**
Republic of Korea	17,921	1,452	13,824	2,646
Singapore	14,354	1,641	11,555	1,159
UK	20,376	1,394	17,157	1,825

New Zealand had a similar ranking in age standardised mortality rates in 2010 of the GBD study led by IHME, compared to the WHO's estimates. For age standardised DALYs, New Zealand ranked fourth in the WHO estimates, but ranked fifth in the GBD 2010 study, both data sources supporting that New Zealand did better than the UK, China and India. India's DALYs rate was more than double that of New Zealand's in both sources. The rank for YLLs is the same as for mortality rate according to GBD 2010, with India having the highest rate of YLLs (36k per 100,000) followed by China (16k per 100,000) and Korea (but it is still less than 10k per 100,000 as for other high income countries).

Table 11 Age standardised YLLs, all causes, by sex, GBD 2010

Country	Female			Male		
	Rate	95% UI		Rate	95% UI	
Australia	6486.3	6386.0	6594.7	10603.6	10482.9	10729.7
Canada	7268.7	7161.1	7370.5	11352	11223.8	11471.1
China	11795.4	11167.5	12503.7	19775.1	18523.6	20997.5
India	31937.2	28896.0	34975.2	40055.9	35687.8	44841.0
New Zealand	**7832.9**	**7637.0**	**8027.0**	**11833.7**	**11589.0**	**12076.1**
Singapore	6338.8	6187.1	6508.0	10386.5	10188.4	10589.8
Republic of Korea	6917.4	6821.9	7023.8	13625.2	13465.0	13771.9
United Kingdom	7986.5	7905.0	8073.5	12196.5	12098.3	12293.7

As for YLDs, the rank by country is very different from those for mortality rates or YLLs. New Zealand had a similar rate to the UK. Australia and India had the highest rate for YLDs, and China and Singapore were the best performers on the list. It is however unlikely that this means the non-fatal health burden was comparable between Australia and India or between China and Singapore; it is likely that the burden of health loss varies by cause, age group and sex between these countries.

At DHB level, the Asians in Waitemata DHB had roughly 40% of the YLL rate of all the residents of New Zealand (rate ratio: 41% for women and 40% for men). If these rate ratios can be applied to the GBD 2010 rates, we would have 3,188 years of life lost per 100,000 for women and 4,735 per 100,000 for men. Similar to mortality, these rates are clearly the lowest of all the countries on the list, even when uncertainty level or confidence level is taken into account. There were variations within Asian sub-groups.

In Auckland DHB, the rate ratios of YLLs were 52% for women and 50% for men relative to the rate for all New Zealand residents. Again, if we apply these ratios to the New Zealand rate in GBD 2010, we will have 4,096 YLLs per 100,000 for females and 5,921 per 100,000 for males. Just like the Asians in Waitemata DHB, these rates are also the lowest at country level. Again, there were variations by Asian sub-group. Chinese men and women did the best in both DHBs.

As for the Asians living in Australia, the age standardised mortality ratios were both 0.64 for female and male Asia born Australians relative to those born in Australia (AIHW, 2014). If we apply these ratios to the mortality rates in 2010 by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) and compare the adjusted rates with the ones of Asian in Waitemata and Auckland DHBs (2010-12), the Asian in Waitemata seemed to have a lower mortality rate than the Asia born Australians both female and male; the Asians in Auckland DHB were roughly comparable to the Australians born in Asia (Figure 4). Caution needs to be exercised when interpreting the graph as the data were drawn from different years and residual confounding and biases may still exist.

In a nationally representative Canadian cohort study (Wilkins, 2008) among the adult population of Canada who completed the 1991 census long-form questionnaire, East Asian had a 34%-37% lower mortality rate than the non-visible minority population in Canada over the 10 years and it was 20%-42% lower for South Asian. The standardised mortality rate ratios (SRR) for Asian in Canada were generally comparable to the mortality rate ratios for Asians of both Waitemata and Auckland DHBs

(all ages), though they were slightly higher than the ones of the two DHBs (reference: SRR=0.53 for women and 0.47 for men in Waitemata DHB; 0.61 for women and 0.56 for men in Auckland DHB).

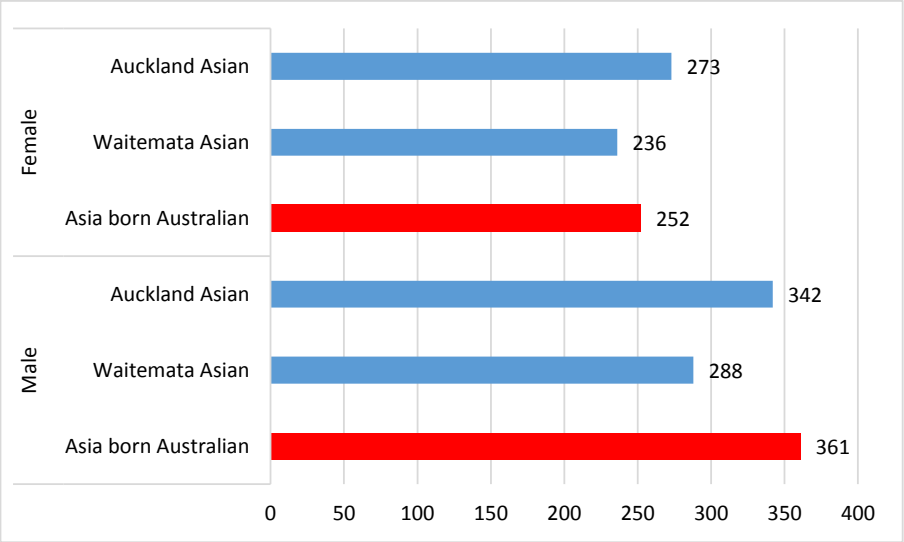


Figure 4 Adjusted mortality rate of Asians in New Zealand and Australians born in Asian countries

The table below shows DALYs ranked by the leading causes (top 21), of the countries on the list. Cardiovascular diseases and cancers were the top two causes of disease burden measured by DALYs in most countries, but mental health and substance use was ranked the first in Australia and second in New Zealand while musculoskeletal disorders ranked in second place for the UK and Canada.

Table 12 Rank of causes by age standardised DALYs, all countries, both sexes, GBD 2010

Both sexes, Age-standardized, 2010, DALYs per 100,000

	China	S Korea	Singapore	Australia	New Zealand	UK	Canada	India
Cardiovascular diseases	1	3	1	4	4	3	4	1
Neoplasms	2	1	2	2	1	1	1	10
Musculoskeletal disorders	3	2	5	3	3	2	2	11
Other non-communicable	4	5	6	5	5	5	5	5
Mental & substance use	5	4	3	1	2	4	3	9
Chronic respiratory	6	10	8	8	8	8	8	4
Diabetes/urog/blood/endo	7	6	4	7	6	7	7	8
Unintentional inj	8	9	11	9	9	9	9	6
Transport injuries	9	12	13	11	10	16	12	14
Neonatal disorders	10	14	14	12	12	11	11	3
Neurological disorders	11	7	9	6	7	6	6	13
Diarrhea/LRI/other	12	15	7	15	15	10	13	2
Nutritional deficiencies	13	11	10	13	13	13	14	12
Self-harm & violence	14	8	12	10	11	14	10	15
Digestive diseases	15	16	15	14	14	12	15	16
Cirrhosis	16	13	17	16	16	15	16	18
NTDs & malaria	17	18	19	20	20	20	20	17
HIV/AIDS & tuberculosis	18	17	16	18	18	18	18	7
Other group I	19	19	18	17	17	17	17	19
War & disaster	20	21	21	21	21	21	21	21
Maternal disorders	21	20	20	19	19	19	19	20

Interpretation and reflection

At country level, New Zealand had lower DALYs rates due to communicable/maternal/perinatal or nutritional conditions compared to all other countries on the list. A recent report by the MoH suggested that New Zealand has come very far along this 'epidemiological transition' i.e. the change from a usually communicable disease dominated health loss pattern to one dominated by long-term conditions (The Ministry of Health, 2016). Communicable diseases are more likely to affect children, whereas long-term conditions more so affect adults. However, this is not the case for India (and China to some degree) as communicable diseases still had significant effects on health loss in DALYs. China and India still had a higher health burden due to non-communicable diseases.

For New Zealand, the health loss due to mental health and substance use requires targeted effort, together with musculoskeletal disorders. Whilst, the degree of health loss for cancers and cardiovascular diseases are already well known to us.

At the districts level, the Asians of both DHBs halved the total YLL rate of the New Zealand average for men and women, which is consistent with the findings for mortality rate. Again, the low YLL rate can be partially explained by the 'healthy migrant effect'. The lack of robust data on duration of stay for Asians in New Zealand and lack of ethnicity data in other migration countries such as Australia, Canada and the UK, has made direct 'Asian to Asian' and confounding-controlled comparisons challenging. YLLs and mortality as measures of fatal health loss are certainly important however equally will need to look at the prevalence of risk factors and health conditions, health service use, and patient experience of care for segments of the Asian population - as it takes at least 10-15 years for the healthy migrant effects to wane and many years for the end outcome 'death' to happen. It will be too late to act once we see a substantial increase in YLLs or mortality rates decades later. The YLD rate would be useful to measure the non-fatal burden of disease on the Asian population, but the analysis is not feasible due to lack of robust epidemiological data such as prevalence of health states. It is also still subject to the influence of the 'healthy migrant effect'.

Long-term outcomes

Reducing mortality rates from conditions considered amenable by curing ill health is a key long-term outcome of both Waitemata and Auckland DHBs. In this section, both non-communicable and communicable diseases are included, together with injuries, maternal and infant/child health.

Cardiovascular diseases

Internationally	• New Zealand had similar rates of health loss due to cardiovascular diseases compared to many of the comparator countries	
	• Asians of both DHBs, in particular Waitemata, had the lowest rate of fatal health loss from CVD compared to the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had half the rate of fatal health loss from CVD compared to that of New Zealand	
	• The Indian population of Waitemata and Auckland had higher rates of fatal health loss from CVD compared with other Asian ethnicities	

At country level, Australia and Canada ranked better in mortality rates than New Zealand which had a similar rate to the UK and Singapore. India and China are outliers with higher cardiovascular mortality rates. New Zealand ranked in fourth place in DALYs rate, better than the UK and Singapore and much better than India and China. For YLL rate, New Zealand was in the same place as for DALYs. The YLD rate distribution by country shows a very different picture from that of mortality or DALYs. New Zealand had the lowest rate of cardiovascular YLDs followed by China, Australia and India. Rheumatic heart disease accounted for a good proportion of the non-fatal health loss due to cardiovascular disease in India (44 YLDs per 100,000; 95% UI: 30, 62), which was very different from other countries.

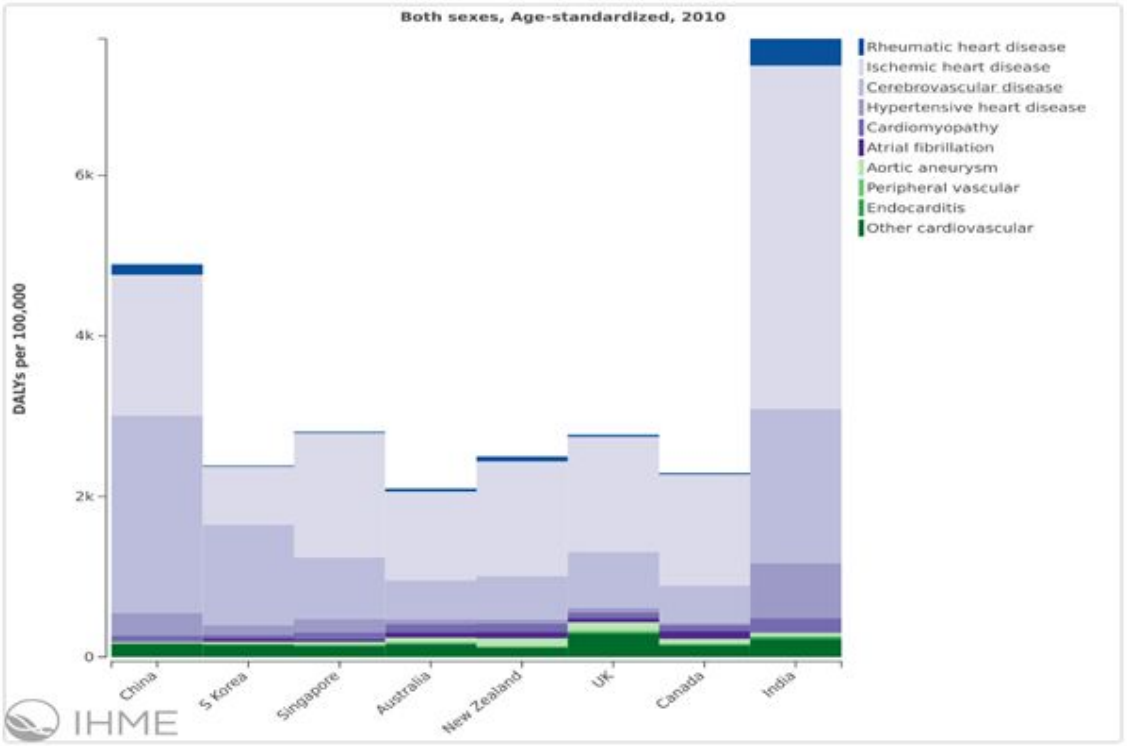


Figure 5 Age standardised DALYs for cardiovascular diseases, both sexes, GBD 2010

At DHB level, Waitemata Asians had 40%-55% of the YLL rate of all the residents of New Zealand (rate ratio: 55% for women and 41% for men). When the rate ratios are applied to the GBD 2010 rates, there are 937 YLLs per 100,000 women and 1,216 per 100,000 men. These rates are clearly the lowest of all the countries on the list, particularly for men. Within Asian sub-groups, Chinese residents had the lowest rate of mortality compared with the other two Asian sub-groups regardless of sex.

In Auckland DHB, the rate ratios were 55% for women and 57% for men relative to the rate for all New Zealand residents. When these ratios are applied to the New Zealand rate in GBD 2010, we will have 934 years of life lost per 100,000 women and 1,714 per 100,000 men. Just like the Asians in Waitemata DHB, these rates are still the lowest at country level. Women of Other Asian ethnicities had the highest rate of lost life years and for men, Indian people had the highest rate; those of Chinese ethnicity did the best for both females and males.

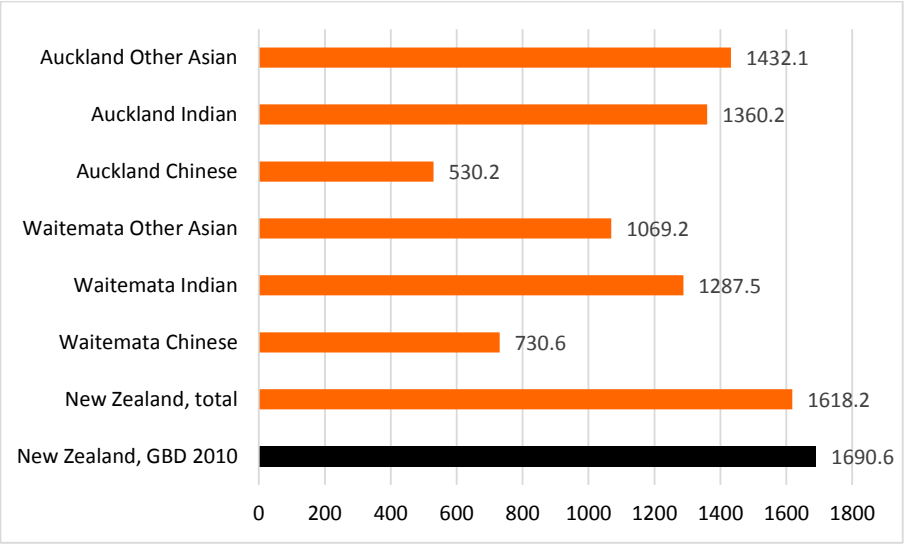


Figure 6 Age standardised YLLs, cardiovascular disease, Asian-subgroups, female

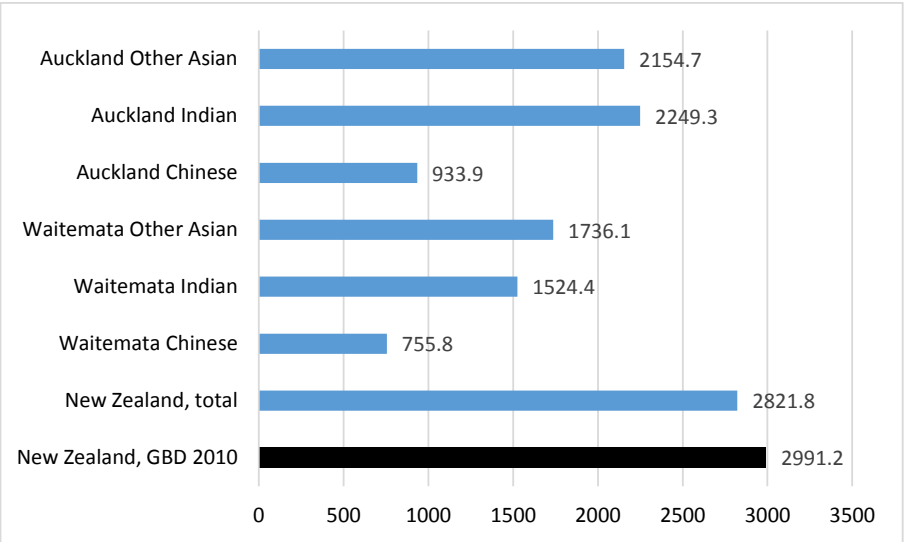


Figure 7 Age standardised YLLs, cardiovascular disease, Asian-subgroups, male

Interpretation and reflection

At country level, New Zealand had the lowest rate of cardiovascular YLDs and performed quite well in the cardiovascular DALYs rate. Cardiovascular diseases were the fourth leading cause of DALYs rate in New Zealand. There is still room for the cardiovascular mortality rate to be reduced, including: 1) reducing prevalence of obesity, hypertension and diabetes/pre-diabetes, and improving physical activity levels, and 2) increasing CVD risk assessment rates and the proportion of patients with CVD or diabetes on proper medication/treatment to reduce premature mortality from CVD.

Although the Asians of both DHBs did very well in the fatal health loss due to CVD, compared to the New Zealand average or the total population of other countries on the list, there were ethnic variations in the cardiovascular YLL rate – Indian and Other Asians had higher rates than Chinese. The DHBs must work to reduce premature mortality from cardiovascular disease and maintain the

lowest premature mortality rates from cancer. To achieve this, it is imperative to understand the barriers that prevent high-risk groups such as South Asians and Chinese from accessing and utilising general practice (Appendix 6).

A Community Health Survey aimed at community members (n=2313) was conducted in October 2012 across the Auckland DHB Local Boards. It cited 'cost' and 'affordability' as barriers in accessing general practice, as well as 'availability' of appointments and 'transport'. Moreover, a study on 'Utilisation of Primary Health Care services: The perceptions and experiences of South Asian immigrations in Auckland, New Zealand found that: 1) South Asians would prefer a family doctor (GP) act as a facilitator rather than a gatekeeper, and 2) health professionals should acknowledge that South Asians are equipped with the right skills to maintain health and wellbeing – they just require opportunities to work in partnership with their family doctor (GP) using a patient centred, culturally appropriate approach (Tamanam, 2016).

To increase 'More heart and diabetes checks', the structural issues of 'cost' and 'transport' should be addressed as part of cross-sectorial and system level upstream measures as well as engaging high-risk groups in the 'co-design' of localities and setting-based interventions in partnership with groups such as Healthy Families Waitakere. Other strategies include culturally appropriate campaigns to increase PHO enrolment, and the benefits of seeing one regular family doctor (GP), delivery of a suite of culturally appropriate self-management interventions and lifestyle messaging on healthy eating and physical activity, and up-skilling of cultural competency in the primary health workforce as part of Waitemata DHB's eCALD® services (WDHB, eCALD, 2016).

Cancer

Internationally	• New Zealand had simliar rates of health loss due to cancer compared with the comparator countries	
	• Asians of both DHBs had the lowest rates of fatal health loss due to cancer compared to the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had half the rate of fatal health loss due to cancer compared with New Zealand	

China had the highest rate of DALYs, while India did the best and Singapore did the second best. The DALYs rates for cancer were comparable between New Zealand, Australia, Canada, the UK and the Republic of Korea, though Australia did marginally better (ranked third). The distribution of YLL rates by country was the same as that for DALYs. The YLDs pattern was very different from the aforementioned three metrics of burden of diseases: all of the Asian countries led by India and China had lower rates than the other countries on the list; New Zealand had the highest YLD rate, although it was statistically comparable to other countries except for India and China. There may be many factors behind this, better health care and survival rates from cancers in the non-Asian countries might be contributory, which needs to be confirmed. The proportion of YLDs of the total DALYs indicated that the Asian countries had lower YLD contributions (China and India less than 3%, Korea 3.5% and Singapore 4.5%).

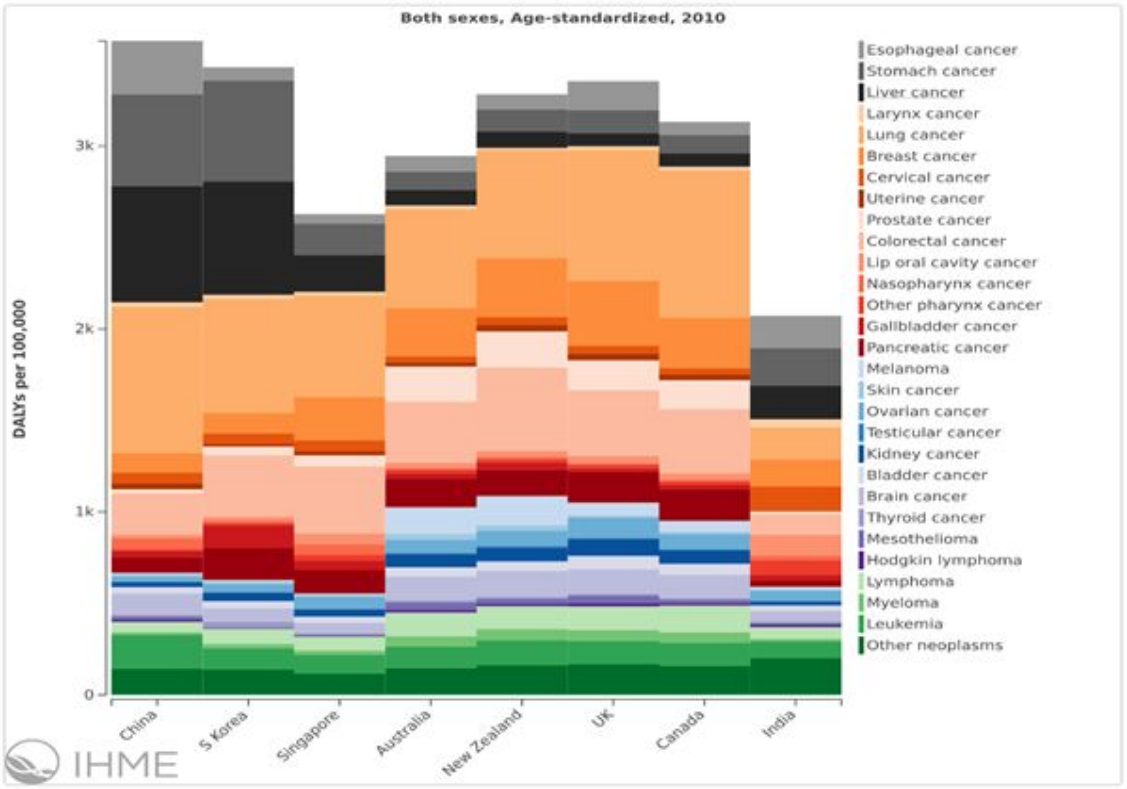


Figure 8 Age standardised DALYs for cancer, both sexes, GBD 2010

At DHB level, Waitemata Asians had 40%-60% of the YLL rate of all the residents of New Zealand (rate ratio: 40% for women and 57% for men). When the rate ratios are applied to the GBD 2010 YLL rates, this gives us 1,134 YLLs per 100,000 women and 1,937 per 100,000 men, the lowest of all the countries on the list. Indian and Other Asian women did better than Chinese women; for men, Chinese performed better than Indian followed by Other Asian.

In Auckland DHB, the rate ratios were roughly 50% for both women and men relative to the rate for all New Zealand residents. This is 1,392 years of life lost per 100,000 women and 1,728 per 100,000 men, when these ratios are applied to the New Zealand rate in GBD 2010. These rates are the lowest at country level. Within Asian sub-groups, Other Asian women did the best followed by Indian women; Indian men halved the rate for Chinese which still performed better than Other Asian men.

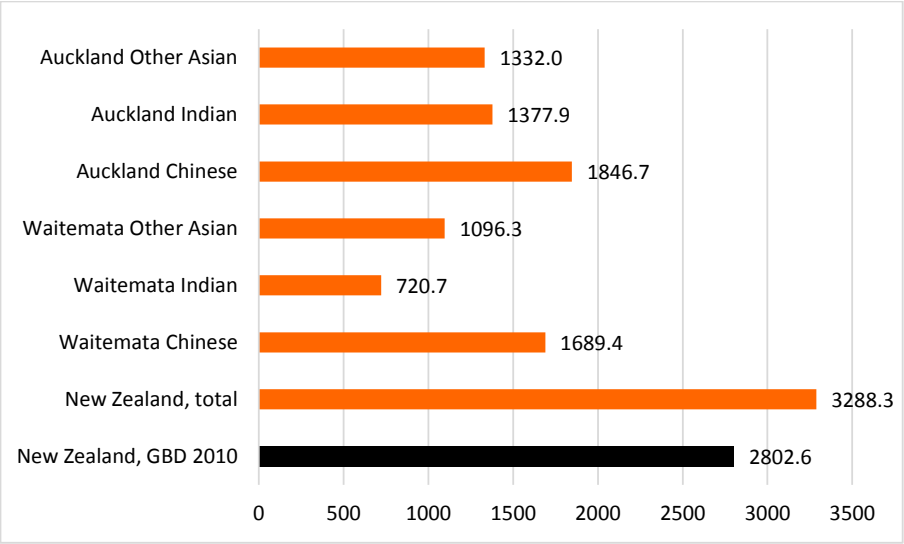


Figure 9 Age standardised YLLs, cancer, Asian-subgroups, female

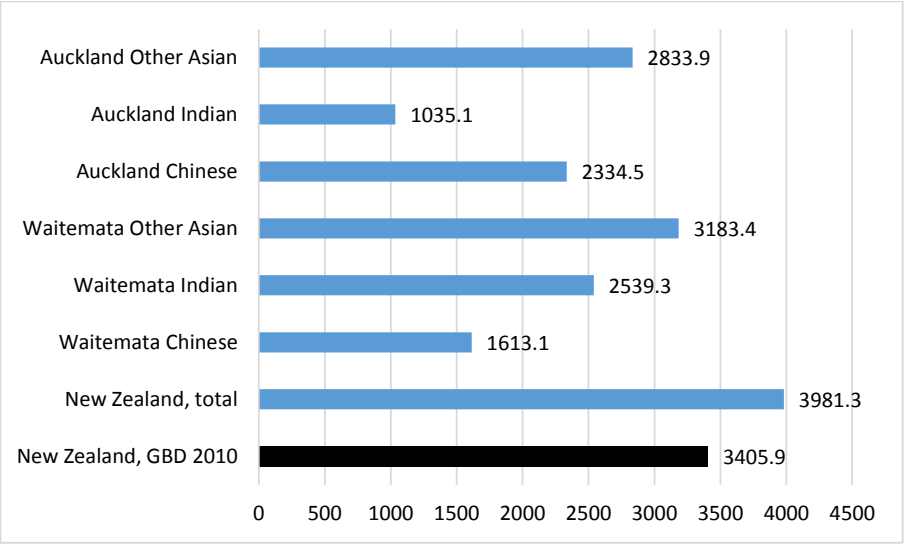


Figure 10 Age standardised YLLs, cancer, Asian-subgroups, male

Among people aged 20-69 years in England and Wales (1999-2003), people born in Asian countries such as India, Pakistan, Bangladesh and Sri Lanka all had lower than average mortality rates from cancer. A direct comparison of these mortality rates with the Asians of both DHBs is difficult due to the difference in time period, amongst other issues.

Interpretation and reflection

India had the lowest cancer DALYs, YLL and YLD rates of all the countries compared. It is not known whether the lower cancer rates for India could be at least partially explained by the higher 'competing risk' of other conditions such as communicable and cardiovascular diseases. In other words, the 'epidemiological transition' for India has not progressed to the extent of developed countries on the list including New Zealand. The lower contribution of cancer YLDs to the total cancer DALYs for Asian countries indicates that the 'disability transition' for cancers has not really taken place. The 'disability transition' is the change of a population's health loss from a fatal dominated pattern to one dominated by non-fatal outcomes (The Ministry of Health, 2016).

Asians of both DHBs did much better in YLL rates than the New Zealand average or compared to the total populations of other countries on the list. The two DHBs will need to continue to work on decreasing mortality rates from conditions considered amenable, as cancers were the top leading cause of DALYs for New Zealand. The key focus areas for interventions include awareness raising and linking in with school-based programmes to promote HPV vaccination coverage, lifestyle programmes (smoke free/cessation, diet, and physical activity), cancer screening programmes (cervical, breast and bowel), ongoing schemes to offer free screening for eligible populations, and progress against the faster cancer treatment health target - 85% of patients have their first cancer treatment or other management within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

We hope the incidence rate of cancers can be reduced, and early detection/early treatment proportions and survival rates can be improved with the aforementioned comprehensive measures in place. We also need to ensure that already vulnerable cancer patients have positive patient experiences of care when accessing and navigating the health system, and DHBs meet the 'Faster cancer treatment' health target. A key limitation currently for Asian monitoring is the lack of ethnic specific data reporting for the cancer health target.

Diabetes mellitus

Internationally	• New Zealand had lower rates of health loss due to diabetes compared with the majority of the comparator countries	
	• Asians of both DHBs had among the lowest rates of fatal health loss due to diabetes compared to the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs among the lowest rates of fatal health loss due to diabetes than New Zealand	
	• The Indian population of Waitemata and Auckland had higher rates of fatal health loss from diabetes compared with other Asian ethnicities	

India and the Republic of Korea had the highest mortality rate from diabetes mellitus. New Zealand had a rate comparable to China, Singapore and Australia, while the UK did the best. The distribution of YLLs followed a similar pattern to the mortality rate. For DALYs, India had the highest rate followed by Singapore and the Republic of Korea (the latter two countries were not statistically higher than New Zealand) and the UK still did the best though not significantly better than New Zealand. In terms of YLDs, Singapore and China had the highest rate and Australia had the lowest rate but the differences were not significantly different from that of New Zealand.

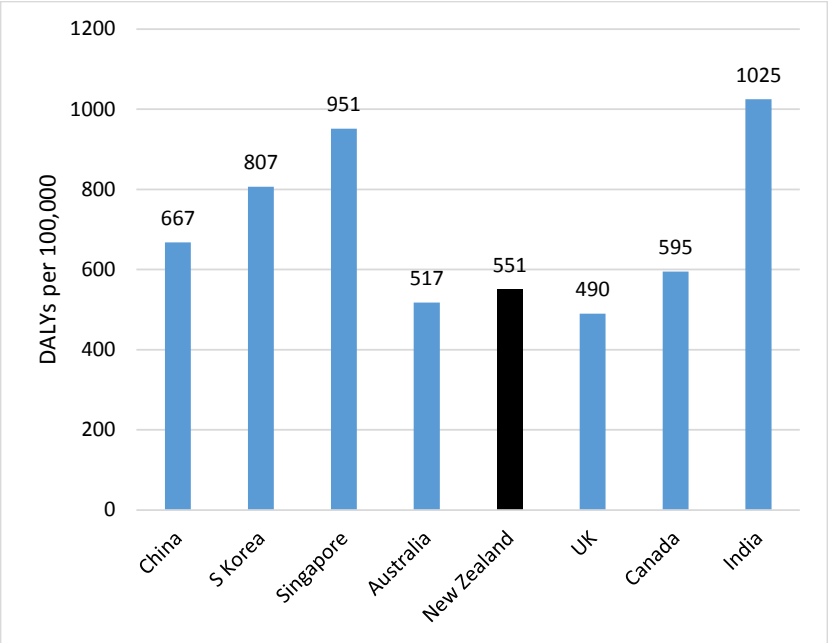


Figure 11 Age standardised DALYs for diabetes, both sexes, GBD 2010

At DHB level, the rescaled YLL rates were 108 per 100,000 for women and 159 per 100,000 for men in Waitemata DHB, which makes Waitemata Asian the second best after the UK for women and men. However, Indian women and men and Other Asian men followed India and Korea closely at the country level, while Chinese women and men scored the best against the UK.

Asians in Auckland DHB had the rescaled rates of 122 per 100,000 for women and 165 per 100,000 for men. The variations within Asian sub-groups in Auckland were very close to the pattern in Waitemata.

Table 13 Age standardised YLLs, diabetes, by sex, Asian sub-groups, Waitemata and Auckland DHBs, 2010-12

DHB	Asian sub-group	Female			Male		
		Rate	95% CI		Rate	95% CI	
Waitemata	Chinese	67.9	65.1	70.7	50.0	46.6	53.3
	Indian	481.6	466.5	496.6	494.7	479.6	509.7
	Other Asian	89.3	84.2	94.3	433.1	419.9	446.4
Auckland	Chinese	126.3	123.7	128.8	63.4	61.4	65.3
	Indian	297.6	290.0	305.1	570.7	559.4	582.1
	Other Asian	149.1	139.8	158.3	*	*	*

* data not to be used due to small number of events

Female Australians born in Asia had a slightly increased death rate from diabetes, in comparison to those born in Australia (SRR=1.12) (AIHW, 2014).

Interpretation and reflection

India had the highest DALYs, YLL and mortality rates but not the YLD rate, for diabetes of all the countries on the list. The UK had the lowest YLLs, mortality and DALYs rates but a slightly higher YLD rate than other 'Western' countries. This suggested a higher contribution of the non-fatal health loss to the total health loss due to diabetes. In fact, there needs to be further research to understand the survival factors in the UK and the health services treating diabetics.

Indians of both DHBs had relatively higher YLL rates at the country level. On one hand, the DHBs need to continue to promote healthy lifestyle messaging such as healthy diet and regular physical activity; on the other hand, early detection and good management can reduce premature mortality and improve quality of life. We need to work to address the barriers to Heart and Diabetes Checks (Appendix 6), review the suite of self-management programmes available in the community as part of the deliverables of the Diabetes Service Level Alliance, and ensure Asian and in particular Indians and Chinese are 'living well with diabetes' and receiving high quality and timely care.

Alzheimer's disease and other dementias

Internationally	• New Zealand had simliar rates of health loss due to Alzheimer's and other dementias compared with the majority of the comparator countries	
	• Asians of both DHBs lower rates of fatal health loss from Alzheimer's than the majority of the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had lower rates of fatal health loss from Alzheimer's disease than New Zealand	

The Asian countries led by Singapore and the Republic of Korea had much lower mortality rates from Alzheimer's disease and other dementias, whereas the 'Western countries' had very similar rates including New Zealand, Australia, the UK and Canada. The distributions of DALYs and YLLs by country were very similar to that of the mortality rate. Regarding YLDs, Singapore, China and India had a similarly lower rate. New Zealand's rate was comparable to Australia, Canada, the UK and the Republic of Korea. The burden of disability on the health and social sector warrants further work, with New Zealand being one of the countries with the highest YLDs.

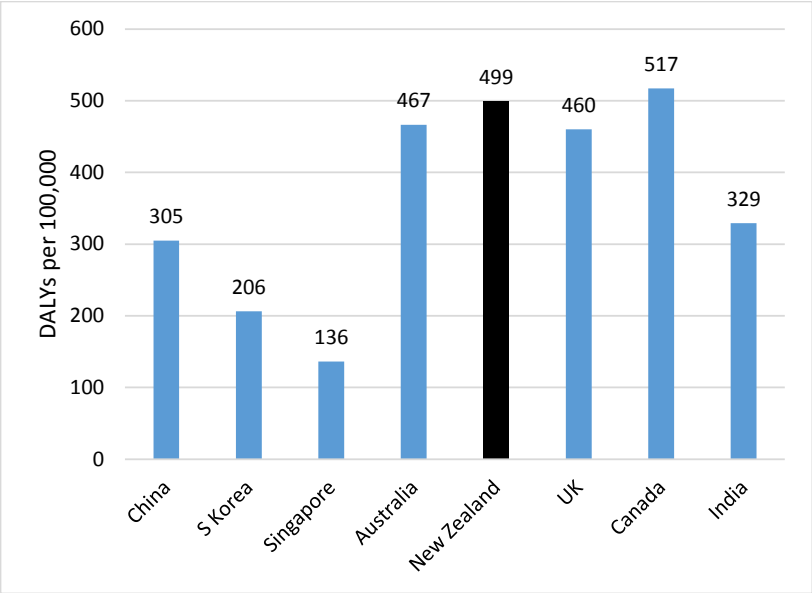


Figure 12 Age standardised DALYs for Alzheimer's disease, both sexes, GBD 2010

The rescaled Asian YLL rates for Alzheimer's disease were 167 per 100,000 women and 198 per 100,000 men in Waitemata DHB, which placed Asian women and men close to China and India but behind Singapore and the Republic of Korea, just like the mortality rate pattern. Other Asian men had a quite high rate of years of life lost, which is not likely to be fully explained by random variation. In Auckland DHB, the rescaled years of life lost rates were 145 and 158 per 100,000 for women and men respectively, placing Auckland Asian residents similar to Waitemata at the country level.

In Australia, it was also found that Asian born in Asian countries had a 40% lower mortality rate of dementia and Alzheimer's diseases, compared to people born in Australia (AIHW, 2014), which is similar to the rate ratios for Asians of both DHBs.

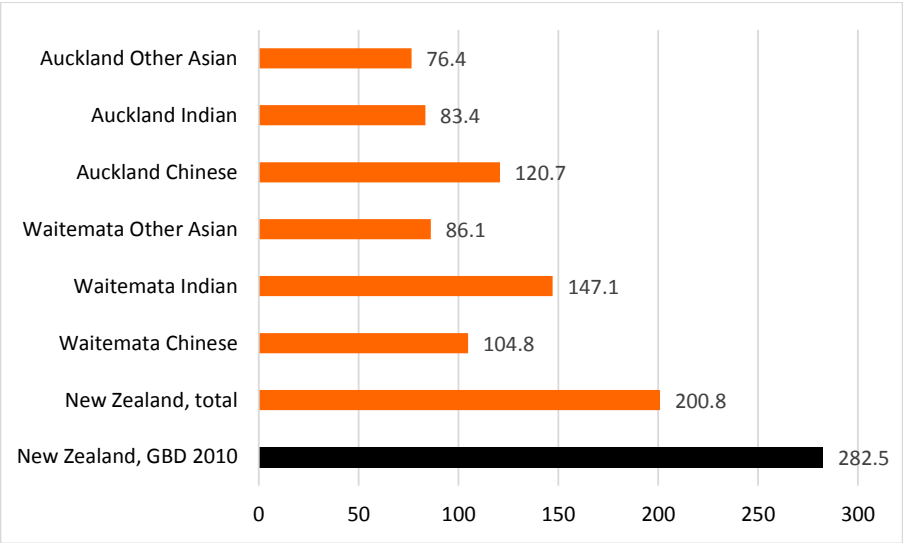


Figure 13 Age standardised YLLs, Alzheimer's diseases, Asian-subgroups, female

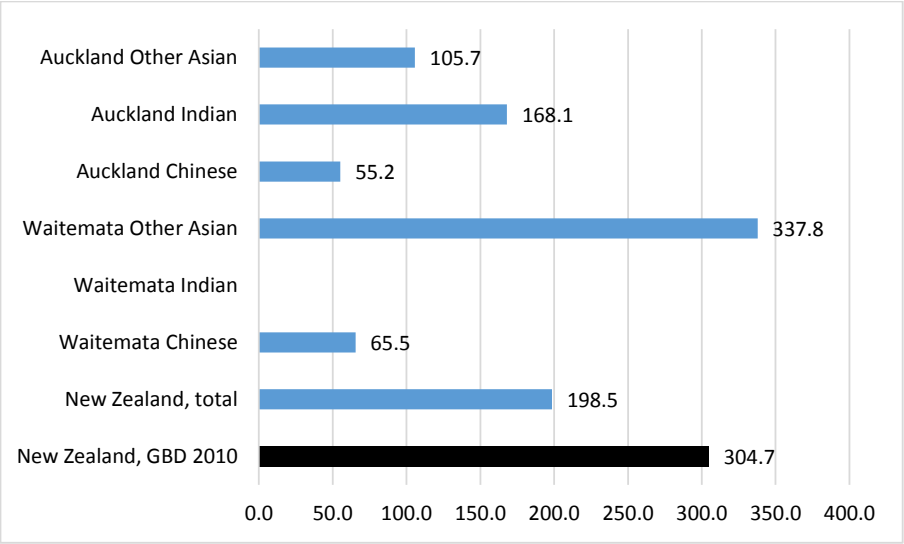


Figure 14 Age standardised YLLs, Alzheimer's diseases, Asian-subgroups, male

Interpretation and reflection

New Zealand had comparable dementia mortality rates, YLLs, YLDs and DALYs compared to other 'Western countries' on the list, while the Asian countries had lower rates for these measures. It is not known whether the lesser health loss due to dementia among Asian countries is related to under-identification/under-reporting, residual confounding due to age, genetic or cultural factors, or health and social services available to people living with dementia.

Asian peoples of both DHBs had a lower YLL rate in general, close to the Asian countries on the list. There needs to be further work on the relatively higher YLL rate for Other Asian in Waitemata DHB as it looks quite different from the general Asian pattern. The Other Asian group here was not homogenous as it contained 'South-east Asian' and 'Other Asian' at level 2 ethnicity.

The prevalence of dementia is closely related to age. With the ageing of the population including Asians, the concept of 'Healthy Ageing' and 'Ageing in Place' is particularly important. A high proportion of older Asian peoples, particularly Chinese and Koreans, do not have competent language capabilities, may not be enrolled with a family doctor (GP), are not familiar with the New Zealand health and disability system, availability of aged care support services, and may not adopt cultural beliefs and values that involve concepts of 'filial piety' - to be cared for by loved ones at home. The DHBs' aim is to ensure older people experience independence and quality of life reflected in the delivery of quality services (including assessment) that are culturally responsive and appropriate to key segments of the Asian population who are living with dementia. This will involve working with the HoP and Primary Care teams (Auckland and Waitemata DHBs) to progress the roll-out of the Cognitive Impairment Pathway and supporting the HoP team (Auckland and Waitemata DHBs) in the review of Dementia Day Programmes for older adults. It may also include ensuring the availability of multilingual resources accessible in preferred languages.

To increase the cultural competency of the HoP workforce in Aged Residential Care a resource was developed by the University of Auckland "CALD Guidelines for Dementia Patients in Aged Residential Care" to complement their "CALD Older People Resource for Health Providers" available at Waitemata DHB's eCALD® services at www.eCALD.com (WDHB, eCALD, 2016).

Hepatitis and Tuberculosis

Internationally	• New Zealand had among the the lowest rates of health loss due to hepatitis and tuberculosis than the comparator countries	
	• Asians of both DHBs had lower rates of fatal health loss from hepatitis and tuberculosis than the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had lower rates of fatal health loss from hepatitis and tuberculosis than New Zealand	

These are two important communicable diseases internationally. Asian women in both DHBs had comparable hepatitis YLL rates to the other high income countries except for Australia (which was relatively high in comparison to other high income countries). Asian men in both DHBs would still be among the best at country level, if years of life lost were shared between Waitemata and Auckland Asian men to minimise the effects of random variation. Other Asian residents tended to have a higher rate of YLLs.

The Asians in Waitemata and Auckland DHBs had close to a zero tuberculosis mortality rate or YLL rate regardless of sex, which would rank them the first place at country level.

Interpretation and reflection

India and China had higher rates of fatal health loss due to hepatitis and India also had a much higher rate of fatal and non-fatal health loss due to tuberculosis, compared to other comparator countries. Asians of both DHBs had very low YLL rates due to hepatitis or tuberculosis partially attributable to the health check included in the immigration process. Vaccines are recommended where appropriate, particularly when travelling to overseas destination with a high prevalence of hepatitis. There are various types of hepatitis and their risk factors vary. Progressive work is currently being undertaken in New Zealand to reduce prevalence and burden of disease associated with hepatitis C including treatment using direct acting-antivirals (DAA) which have a cure rate of 90+ per cent and have few side effects. The Hepatitis Foundation of New Zealand is a key partner in the support of follow-up programmes and management for people with chronic hepatitis B and C to improve health outcomes for Asian populations.

Self-harm and interpersonal violence

Internationally	• New Zealand had higher rates of health loss due to intentional injury compared with the many of the comparator countries, but was much lower than South Korea and India which had the highest rates	☹
	• Asians of both DHBs had lower rates of fatal health loss from intentional injury than the majority of the comparator countries	☺
Nationally	• Asians of Waitemata and Auckland DHBs had lower rates of fatal health loss from intentional injury than New Zealand	☺

India and the Republic of Korea had the highest mortality rate from intentional injuries. New Zealand did equally well as other countries except for the UK, which had the lowest rate. However, New Zealand had a higher burden of total fatal and non-fatal health loss than China, Singapore and the UK. India and the Republic of Korea had the highest DALYs rate. The YLL rate followed a similar distribution by country to the DALYs. Canada surpassed India in the burden of YLDs with all other countries relatively close to each other. The higher rates of interpersonal violence contributed significantly to the heavy burden of the two countries, namely Canada (interpersonal violence: 16 per 100,000, 95% UI: 11, 21) and India (interpersonal violence: 16 per 100,000, 95% UI: 12, 21).

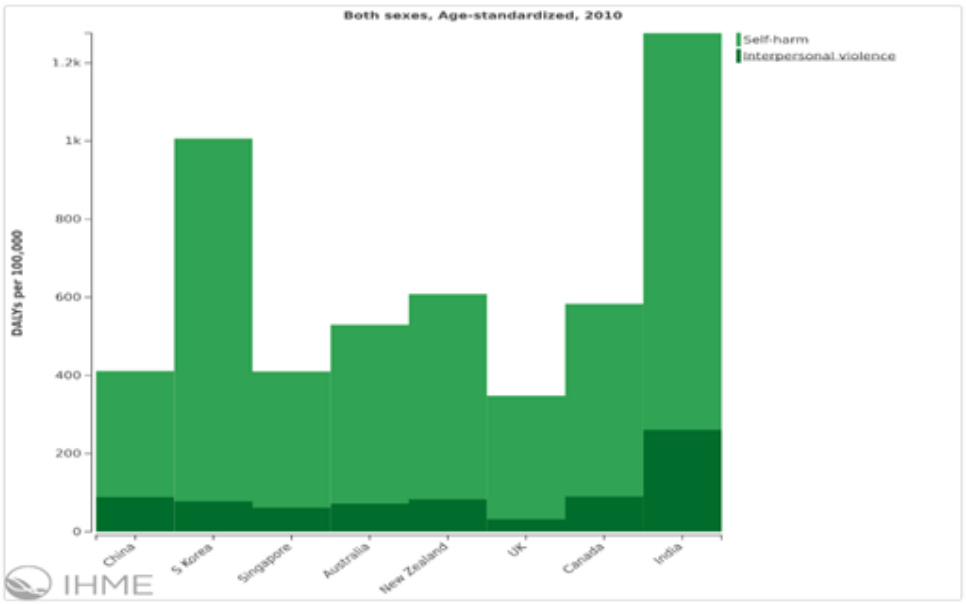


Figure 15 Age standardised DALYs for self-harm and interpersonal violence, both sexes, GBD 2010

Among youth, New Zealand had high mortality and DALYs rates for intentional injuries just behind India, particularly for males. This was true for both 15-19 and 20-24 year olds. The UK, China and Singapore performed better in these two age groups.

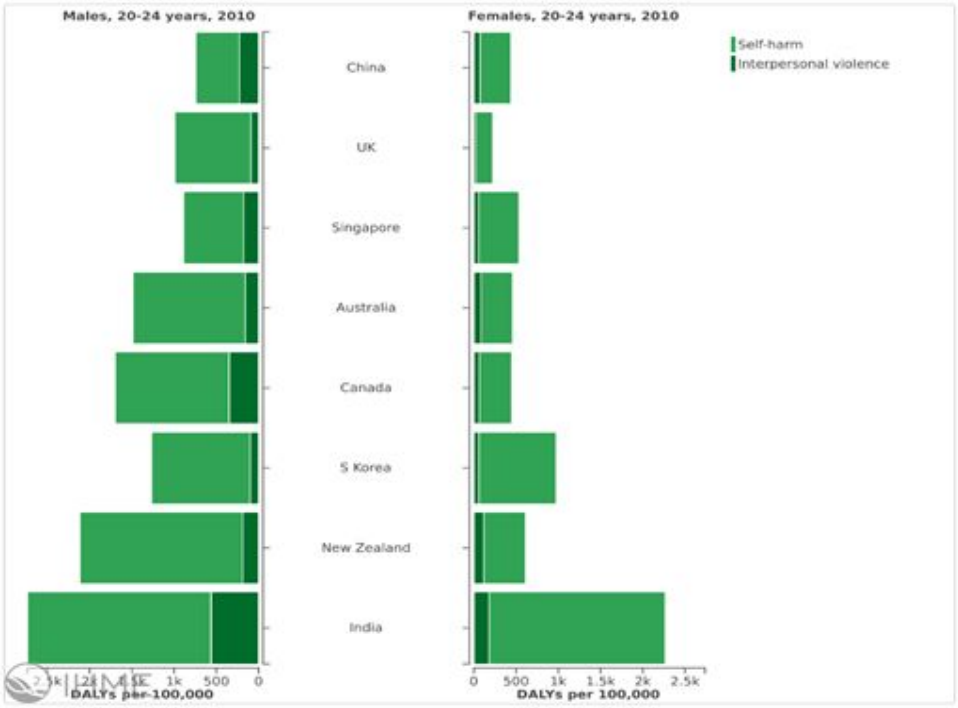


Figure 16 DALYs rate of self-harm and interpersonal violence, by sex, 20-24 yrs, GBD 2010

Asian residents in both DHBs performed best in mortality rates at the country level, that is, close to the UK and Australia for women and close to the UK and China for men, given their standardised rate ratio was 24%-65% of the New Zealand averages. As for the YLL rate, Asian residents in both DHBs were also likely to be among the top performers at the country level, given their standardised rate ratio was 24%-48% of the New Zealand averages. In Waitemata DHB the YLL rates were 120 per 100,000 women and 401 per 100,000 men. In Auckland DHB the YLL rates were 208 per 100,000 women and 264 per 100,000 men. No attempts were made to look at the variations by Asian sub-group due to the small numbers.

Interpretation and reflection

Of importance to New Zealand, are the higher mortality and DALYs rates for males aged 15-19 and 20-24 years due to intentional injuries. The two DHBs are committed to roll out the 'Suicide Prevention and Postvention Action Plan 2015-17, following the "Prime Minister's Youth Mental Health Project".

Asian residents did very well in mortality and YLL rates. However, we should not under-estimate the non-fatal burden of health loss due to mental health conditions including depression for a largely migrant population. The prevalence of mental health conditions is potentially under-estimated in surveys due to issues such as stigma, lack of knowledge and awareness of services and how to access them, and cultural and language barriers (Appendix 6). Efforts that work towards "Rising to the Challenge" and reducing morbidity and mortality for people with mental illness include the Asian Mental Health Work Stream Plan as part of the Waitemata Stakeholders Network Strategic Plan 2015-2020, and delivery of Asian Mental Health Services in both DHBs alongside other NGO and community-based services. The localities Tamaki Mental Health & Wellbeing project (Auckland DHB) is an initiative that enabled opportunities to 'listen' to the voice of Burmese youth and adult

populations about barriers to access and utilisation of mental health services , they were: 1) language and accessing interpreters, 2) unsure of where to access information about the New Zealand health and disability system, 3) choosing to not tell their family doctor (GP) about their 'problems', rather keeping it to themselves, 4) health literacy, 5) cultural competency of health professionals, 6) perceptions of being looked down on by other staff, and 7) poor experiences with services.

It is imperative that the System Level Measures in the metro Auckland DHBs work to increase youth access to and utilisation of youth appropriate health services, i.e. Young People Make Good Choices, and those services that deliver practical interventions that are multilingual, culturally sensitive and community focused to support segments of the Asian population who engage late and delay accessing services due to cultural issues such as stigma. Up-skilling a culturally competent mental health workforce is critical through initiatives such as Waitemata DHB's eCALD® services (WDHB, eCALD, 2016).

Maternal health

Internationally	• The maternal mortality ratio of New Zealand was not as low as that of many of western comparator countries and was nearly twice as high as that of the country with the highest (Australia)	
Nationally	• Indian and Other Asian women in New Zealand had a higher maternal mortality ratio than New Zealand European	

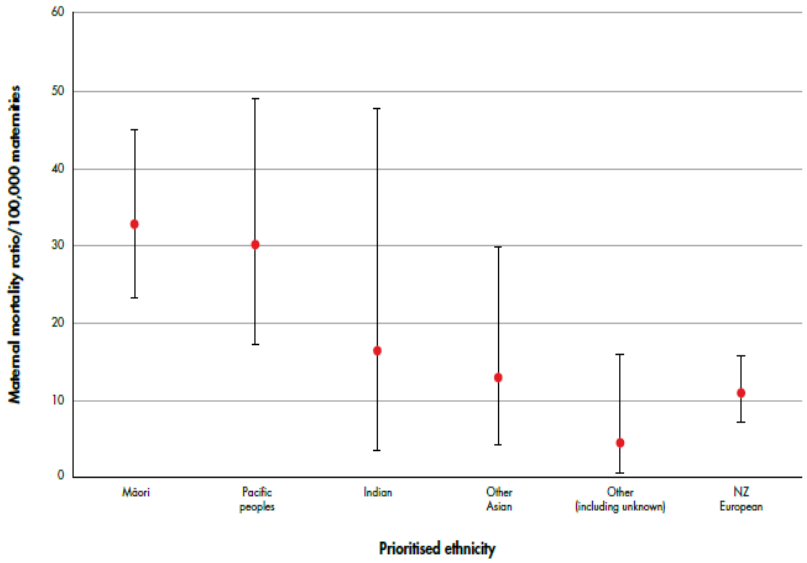
Using the GBD 2013 definitions and estimation methods, the table below provides MMR with their 95% uncertainty intervals. India is clearly an outlier with much higher MMR than all other countries on the list. Singapore and Australia did the best, followed by the UK and Canada. New Zealand had a comparable rate to Korea and did better than China. However, the reduction of MMR over the 10 years between 2003 and 2013 saw New Zealand make only a 0.1% annualised reduction, while China and Singapore made a 13.2% and 6.8% annualised reduction in MMR respectively.

Table 14 Maternal mortality ratio (per 100,000 live births, 95% uncertainty level) by country, GBD 2013

Country	2003	2013	Annualised rate of change in MMR
Australia	5.1 (4.4, 6.0)	4.8 (3.7, 5.9)	-0.7%
Canada	9.2 (7.6, 10.7)	8.2 (6.3, 10.3)	-1.2%
China	64.1 (58.2, 70.1)	17.2 (14.0, 20.3)	-13.2%
India	382.0 (315.3, 472.8)	281.8 (207.0, 371.2)	-3.1%
New Zealand	**9.4 (7.9, 11.3)**	**9.3 (7.2, 12.1)**	**-0.1%**
Singapore	8.8 (7.2, 10.8)	4.5 (3.4, 5.8)	-6.8%
South Korea	15.4 (12.8, 19.0)	12.0 (8.7, 16.7)	-2.6%
UK	7.7 (7.0 to 8.3)	6.1 (5.2 to 6.9)	-2.4%

Source: Global, regional, and national levels and causes of maternal mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013, Kassebaum, Nicholas J et al. The Lancet, Volume 384, Issue 9947, 980-1004

According to the PMMRC report, 'there has been no statistically significant change in maternal mortality ratio in New Zealand since data collection by the PMMRC began in 2006'. The three-year average MMR for 2011–2013 was 16.8/100,000 maternities[5] (95% CI: 11.8, 23.8/100,000). The MMR for direct deaths alone for the years 2009–2013 was 4.8/100,000 maternities (95% CI: 2.9, 7.9/100,000), and for indirect deaths 11.8/100,000 maternities (95% CI: 8.6, 16.2/100,000) (PMMRC, 2015). New Zealand Indian and Other Asians had slightly higher MMRs compared to New Zealand European, but the differences were not significant. We assume the Asians in Waitemata and Auckland DHBs followed the national pattern as illustrated below and had rates comparable to other high income countries, as there were no calculations undertaken for MMR by ethnicity at DHB level due to very small numbers.



[5] Maternities are defined here as 'all births at 20 weeks or beyond or weighing 400g or more if gestation was unknown'.

Source: PMMRC. 2015. Ninth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2013. Wellington: Health Quality & Safety Commission.

Figure 17 Maternal mortality ratio (per 100,000 maternities) by ethnicity, New Zealand

The 'Maternal deaths in Australia 2008–2012' (Humphrey MD, 2015) report showed that MMR was 6.0 maternal deaths per 100,000 women giving birth for women born in Australia and 6.3 for women born in other countries. There was no data for women born in Asia. The numbers in this report were higher than the figures in GBD 2013 (4.8 per 100,000 live births), acknowledging the difference in estimation methods (women giving birth vs. live births as the denominator) and years for comparisons (2008-12 vs. 2013). In the UK, neither Indian nor Chinese stood out in terms of maternal deaths or severe maternal morbidity reports or studies, which may suggest their risk of maternal death is comparable to the UK average. However, best estimation is that Asian as a whole may still present a moderately higher level of maternal mortality and severe maternal morbidity in the UK.

Interpretation and reflection

The findings highlight that greater improvement is needed in maternal mortality ratio for New Zealand, being placed last among the 'Western countries' on the list and having the smallest annualised reduction in MMR in the past ten years since 2003. Efforts will need to be made to reduce ethnic differences in health outcomes such as the number of Māori, Pacific and Indian maternal deaths - covering the whole spectrum of maternity care and support from early pregnancy, delivery through to post-natal care.

Asian online respondents (n=95) of the Waitemata DHB Primary Birthing Facility Consultation 2016 were fairly equally in favour of all three Waitemata DHB operated primary birthing units which were (a) In community, DHB operated, (b) On hospital grounds, in a separate building, and (c) In hospital, near the maternity unit. However Asian groups who attended the forums (n=52) favoured (a) On hospital grounds, in a separate building, and (b) In community, DHB operated. Asian staff preferred either a community-based, DHB operated or hospital-based facility near the maternity unit.

Top four features identified as essential for Primary Birthing Units (PBU) were:

1. Breastfeeding support/advice
2. Family friendly
3. Partners to stay overnight
4. Easy to get to by car

Asian groups were most likely to rate having community health facilities nearby as essential for PBUs.

Waitemata DHB's eCALD® services have developed the "Maternal Health for CALD Women: Resource for Health Providers working with Asian, Middle Eastern & African women" (WDHB, eCALD, 2016). This resource is the first of its kind for maternal health service-providers. It will help services and practitioners develop the cultural competencies to work with Asian women and their families during their pregnancy and birth. It contains research materials and provides guidance, essential culture-specific knowledge, cultural assessment tools and case scenarios. The resource complements the CALD Cultural Competency Training Programme, and is available on the eCALD® services website at www.eCALD.com.

Infant and child health

Internationally	• New Zealand had an infant mortality rate that was simliar to the majorty of the comparator countries, but over twice as high as the country with the lowest (China) • Auckland and Waitemata DHBs had a combined infant mortality rate among the lowest when compared with the comparator countries	 
Nationally	• Asians of Waitemata and Auckland DHBs combined had a lower infant mortality rate than New Zealand	

Three indicators are presented in this section: low birth weight, infant and child mortality.

According to the World Bank, India had a much higher rate of low birth weight than all other countries on the list. China had the lowest rate of low birth weight and New Zealand was comparable to all other countries in the middle range.

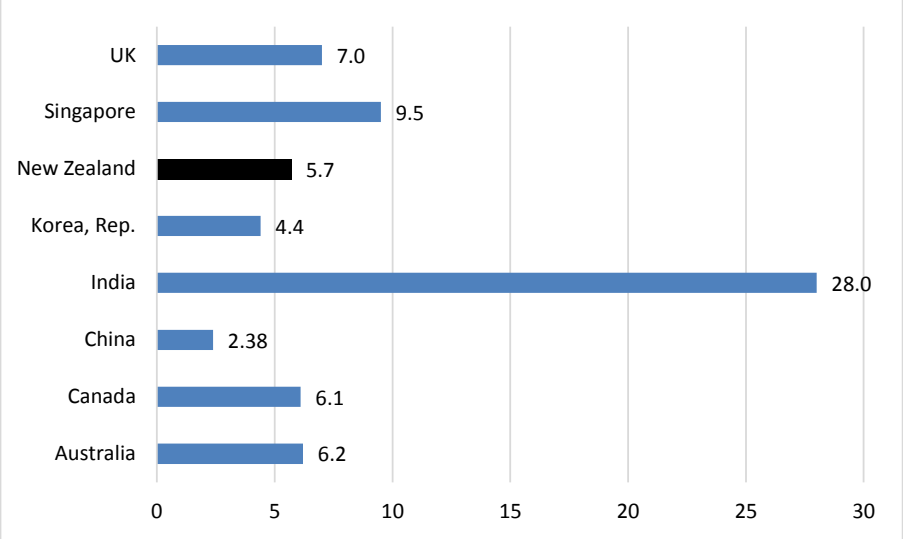


Figure 18 Low birth weight rate (%) by country, World Bank

The low birth weight rate was 6.2% in 2012 according to the Ministry of Health (The Ministry of Health, 2015), and it has been stable at around 6.0% for the years since 2008. These rates were very close to the World Bank (The World Bank, 2016) figures. Nationwide, Asian had higher rates of low birth weight than European/Other or the total population. The low birth weight rates were respectively 6.5% and 8.3% for Waitemata and Auckland DHBs over the years 2010-2012 combined, which matched Waitemata Asian with the UK (the third highest at country level) and Auckland Asian to one close to Singapore (the second highest). In both DHBs, Indian had the highest rates of all three Asian sub-groups (8.3% in Waitemata DHB and 12.2% in Auckland DHB), whereas Chinese did the best at 5.2%-5.8%. Other Asian sat at slightly more than 7% in both DHBs.

According to the most recent report produced by the UN IGME (UN IGME, 2015), Southern Asia is another region besides Sub-Saharan Africa where increased effort is urgently required to reduce child mortality.

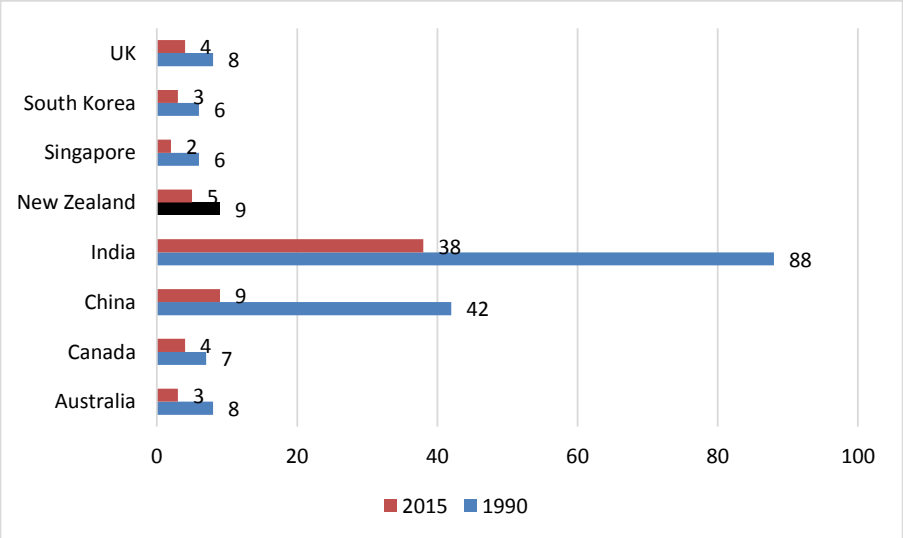
International collaboration has occurred to agree on a new framework, the Sustainable Development Goals (SDGs), with the end of the MDG. The SDG target - an under-five mortality rate of 25 or fewer deaths per 1,000 - has been achieved by all the countries except India. The under-five mortality rate target of the high-income countries, 6.8 deaths per 1,000 live births by 2030, has also been achieved by all the high income countries on the list. China is not far away from the 2030 SDG target although it is a middle income country. Actually, between 1990 and 2015, China had made the fastest reduction in under-five mortality rates (annualised rate of reduction, ARR: 6.5%), followed by Singapore (ARR, 4.2%) and India (ARR 3.9%). In 2015, New Zealand had an under-five mortality rate of 6 per 1000 live births, placing us last of the high income countries on the list, although the differences were not always significant.

Table 15 Under-five mortality rate (U5MR, per 1000 live births) by country, UN

Country	2000 (90% UI)	2015 (90% UI)	Annualised rate of reduction (ARR, %) 1990-2015	Rank by ARR
Australia	6 (6, 6)	4 (4, 4)	3.5	4
Canada	6 (6, 6)	5 (4, 6)	2.1	8
China	37 (35, 39)	11 (9, 13)	6.5	1
India	91 (88, 95)	48 (42, 53)	3.9	3
New Zealand	7 (7, 8)	6 (5, 7)	2.7	7
Singapore	4 (4, 4)	3 (2, 3)	4.2	2
South Korea*	6 (6, 6)	3 (3, 4)	2.9	6
UK	7 (6, 7)	4 (4, 5)	3.2	5

Data source: Levels and trend in Child Mortality - Report 2015: page 18-25

In 2015, New Zealand had an infant mortality rate of 5 per 1000 live births, which was largely comparable to all other countries on the list except India, with more than 7 times the rate of New Zealand. Singapore had the lowest infant mortality rate at 2 per 1000 live births and was the second fastest country at reducing the rate between 1990 and 2015, with China being the top performer.



Data source: Levels and trend in Child Mortality - Report 2015: page 18-25

Figure 19 Infant mortality rate (per 1000 live births) by country, the United Nations

In the 2013 birth cohort of the UK, based on linked data, Indian and All Others (including Chinese and other groups) had an infant mortality rate comparable to the average in England and Wales (though slightly higher than White British). Pakistani infants still had the highest mortality rate of all ethnic groups, children of Bangladeshi origin showed a rate higher than White British; however, it is not known whether this is due to random variation over time or whether it is a real trend potentially explained by social or clinical factors.

For relatively small populations, random variation in the number of deaths tends to have larger effects than for big populations. For this reason, deaths for three years (2010-12) were aggregated to calculate the two rates. The aggregated infant mortality rates were respectively 0.2 and 4.0 per 1000 live births for Waitemata and Auckland DHBs' Asian infants. This has put Waitemata Asian infant survival at the top place at country level. For under five mortality rates, Waitemata stood at 0.2 per 1000 live births again and it was 4.2 per 1000 live births for Auckland DHB. Again, Waitemata Asian infant survival was the best at country level and Auckland Asians were comparable to all other high income countries. The combined Asian infant mortality rate for Waitemata and Auckland DHBs for the years 2010-12 was 2.2 per 1000 live births, which looks to be much better than the Asian rates in England and Wales in 2013. No estimates were made for Asian sub-groups due to the very small number of deaths, particularly for Waitemata DHB.

Table 16 Infant mortality rate and under-five mortality rate, Waitemata and Auckland DHBs, 2010-12

Death rate	DHB	Ethnicity	Deaths	Live births	Rate (per 1000)
Infant mortality rate	**Auckland**	Asian	21	5,282	4.0
		European/Other	26	7,867	3.3
		Māori	13	2,756	4.7
		Pacific	29	3,875	7.5
	Waitemata	Asian	1	4,804	0.2
		European/Other	37	11,480	3.2
		Māori	22	4,785	4.6
		Pacific	12	2,870	4.2
U5MR	**Auckland**	Asian	22	5,282	4.2
		European/Other	29	7,867	3.7
		Māori	18	2,756	6.5
		Pacific	35	3,875	9.0
	Waitemata	Asian	1	4,804	0.2
		European/Other	49	11,480	4.3
		Māori	28	4,785	5.9
		Pacific	15	2,870	5.2

Interpretation and reflection

New Zealand performed very well in terms of the low birth weight rate and was the best of the 'Western countries' compared. However, Indians had a higher risk of having low birth weight new-borns of the three Asian sub-groups in both DHBs, which resulted in an increased rate for Asians as a

whole at DHB and national levels. The relatively higher rate of low birth weight in Singapore may also be associated with a high Indian population make-up. Low birth weight is a risk factor for a variety of short-term and chronic conditions at a later stage in life including obesity, diabetes and CVD. This does not seem to be a prioritised area at this stage, but research and health promotion targeting high-risk groups such as Indians should be encouraged, in the context of reducing childhood obesity and raising healthy kids.

New Zealand has already achieved the under-five mortality SDG target of 6.8 deaths per 1,000 live births, but was placed the last of the high income countries on the list, suggesting we have room to improve. New Zealand rates similarly for infant mortality to that of under-five mortality. Ongoing efforts are required to reduce risk factors for sudden infant deaths such as smoking and bed-sharing, and increasing greater access to universal healthcare services for newborns less than three months, particularly in Māori and Pacific children. Waitemata Asians had the best under-five and infant mortality rates at country level, which need to be maintained. This can be achieved by ongoing efforts to increase the proportion of Asian newborn infants enrolled with a PHO, and multi-enrolment with Well Child Tamariki Ora providers, Oral Health and newborn hearing screening services to meet the 98% target (Auckland and Waitemata DHBs).

Risk factors and prevention

Waitemata and Auckland DHBs encourage their residents to take responsibility for their own health and that of their family/whānau by making healthy lifestyle choices and engaging in prevention and early detection to increase health outcomes, reduce potentially avoidable hospitalisations and amenable mortality. Strategies to achieve this include immunisation programmes, access to primary care services and cancer screening programmes. Breast screening programmes can reduce mortality rates from breast cancer though it does not reduce the incidence rate. For ease of reading, both cervical and breast screening programmes are included in this section.

Healthy lifestyles

Internationally	• New Zealand had among the highest rates of fatal health loss due to tobcaoo smoking when compared to the comparator countries	
	• New Zealand had smoking rates similar to the majority of the comparator countries	
	• Asians of both DHBs had lower smoking rates than the comparator countries	
	• New Zealand had a higher mortality rate attributable to obesity compared with the comparator countries	
	• The obesity rates for the Asians of both DHBs were higher than Asian comparator countries	
	• Asians of both DHBs were likely to be the least physically active when compared to the comparator countries	
Nationally	• Asians of Waitemata and Auckland DHBs had lower smoking rates than New Zealand	
	• Asians of Waitemata and Auckland DHBs had lower obesity rates than New Zealand	
	• Asians of Waitemata and Auckland DHBs, particularly Waitemata had lower prevalence rates of physical activity than New Zealand	

In this part, a snapshot of key findings from the Asian Health in Aotearoa in 2011-2013: Trends since 2002-2003 and 2006-2007 report (Scragg, 2016) are provided, along with age standardised mortality rates and DALYs attributable to the joint effects of all the risk factors benchmarked internationally.

Findings of risk factors from the Asian Health in Aotearoa

The report by Scragg (Scragg, 2016) provides an overview of the time trends in the health status of Asian participants interviewed in recent New Zealand Health Surveys. The report provides comparisons between the 2011/13 survey and two previous surveys: the 2002/03 and 2006/07. The health status of the main Asian groups – South Asian, Chinese and Other Asian have been compared

with three other main ethnic groups – Māori, Pacific, and European & Other to identify any trends amongst the Asian communities over these time periods. The key areas for comparison include:

Lifestyle (nutrition, physical activity and TV, tobacco smoking, alcohol, gambling, acculturation to lifestyle)

- All Asian ethnicities, along with Māori and Pacific, had lower proportions of people eating the recommended daily number of serves of fruit and vegetables (≥5) than Europeans
- Adults from all three Asian ethnic groups, along with Māori and Pacific, were less likely to be physically active than European & Other
- The proportion of alcohol drinkers in the Asian community (combined) increased from 2002-03 to 2006-07, but remained unchanged from then to 2011-13.

Chronic disease

- Eczema was more common in children of all three Asian ethnicities (17% combined), and also in Māori (21%) and Pacific (20%) children, compared to European & Other (13%).
- South Asian people had increased age-and sex-adjusted prevalence of being on treatment for hypertension and for high cholesterol, compared to European & Other
- The age- and sex-adjusted prevalence of being on treatment for diabetes was increased five- to six-fold in South Asian and Pacific, and three-fold in Māori and two-fold in Other Asian, compared with European & Other
- Self-reported depression was less common in Chinese (1%), South Asian (3%), Other Asian (4%) and Pacific (2%), compared to Māori (6%) and European & Other (7%).

The executive summary from Asian Health in Aotearoa in 2011-2013: Trends since 2002-2003 and 2006-2007 is available in the Asian health benchmarking technical report.

Risk factors benchmarked internationally

Australia and Canada had the best age standardised mortality rate and DALYs attributable to the joint effects of all the risk factors considered, followed by New Zealand, while India and China had the highest burden of deaths and DALYs. Singapore did slightly better in standardised rates of years of life lost. For years lived with disability, China and the Republic of Korea had the lowest burden, while India and the UK had the highest health loss due to disability attributable to the risk factors.

Tobacco smoking

China and the UK had the highest mortality rate attributable to tobacco smoke while Australia and Singapore did the best and New Zealand ranked the third best. India surpassed the UK and China for DALYs whereas New Zealand still stood in the middle. The distribution of years of life lost attributable to tobacco smoking was very similar to the pattern of DALYs. However, the distribution of YLD showed a very different picture to the other three metrics, all the Asian countries had relatively lower burdens than the 'Western' countries including New Zealand. This may actually suggest better survival and treatment or better health services and community support, but is worth further investigation. There were differences in the burden of disease due to tobacco smoking by sex.

According to the WHO report (WHO, 2015), New Zealand's age standardised rate of daily smoking was 15.5% (95% credible interval: 13% - 18%) in 2013. New Zealand sat in the middle for both sexes. However, New Zealand was the second highest following the UK for women; for men, the Republic of Korea and China had very high rates just as they did for current tobacco smoking. New Zealand had comparable rates to all other countries except Korea and China.

Table 17 Age standardised prevalence rate of daily smoking, by country and sex, 15+ years, 2013

Country	**Female**			**Male**		
	Rate	95% credible interval		Rate	95% credible interval	
Australia	12.4	9.9	14.7	15.1	12.3	18.0
Canada	9.9	8.2	11.6	13.9	11.5	16.4
China	1.6	1.3	2.1	42.0	33.6	51.6
India	1.9	1.5	2.4	19.1	14.7	25.3
New Zealand	14.7	11.8	17.5	16.4	13.4	19.2
Republic of Korea	3.5	2.0	5.5	48.5	32.8	66.1
Singapore	3.6	2.6	4.8	23.1	17.1	28.5
UK	19.5	14.9	25.1	21.1	15.9	27.0

A study was undertaken in Canada using the three cross-sectional cycles (for 2000, 2003 and 2005) of the Canadian Community Health Survey of people aged 12 years and older. The surveys employed self-reported questionnaires (Richard Liu, 2010). After adjustment for sociodemographic characteristics, people from most visible minorities including Chinese (adjusted odds ratio [OR] 0.35, 95% CI: 0.28-0.43), Korean/Japanese (adjusted OR 0.67, 95% CI: 0.49-0.72) and South Asian (adjusted OR 0.36, 95% CI: 0.29-0.44), were less likely to smoke, in comparison to Caucasian.

The age standardised rate of regular smoking of all adult New Zealanders from Census 2013 was very comparable to the daily smoking rates of the WHO report, which facilitates direct comparisons between the two DHBs and the countries of interest. For both Waitemata and Auckland DHBs, Asians had lower rates than the New Zealand average for women and men combined. There were variations by sex and Asian sub-group. Asian women had a very low rate of regular smoking (1.5% - 4.0%), while Asian men (Chinese and Other Asian) had a rate comparable or even higher than their European/Other counterparts in both DHBs. Nevertheless, internationally, Asian residents of both DHBs seemed still to have or be close to having the lowest rate of tobacco smoking.

Table 18 Age standardised prevalence rate of regular smokers, Asian sub-groups, 15+ yrs, by sex, 2013

DHB	Ethnicity	Female			Male		
		Rate	95% confidence interval		Rate	95% confidence interval	
Auckland	Māori	26.7%	26.4%	26.9%	24.8%	24.5%	25.1%
	Pacific	17.5%	17.3%	17.7%	26.1%	25.9%	26.4%
	European /Other	8.2%	8.1%	8.2%	11.3%	11.2%	11.4%
	Chinese	2.4%	2.3%	2.4%	13.8%	13.7%	14.0%
	Indian	1.5%	1.4%	1.5%	8.9%	8.7%	9.0%
	Other Asian	4.0%	3.9%	4.1%	12.9%	12.7%	13.1%
Waitemata	Māori	28.0%	27.7%	28.2%	24.8%	24.6%	25.1%
	Pacific	16.6%	16.4%	16.9%	23.3%	23.0%	23.6%
	European /Other	10.2%	10.2%	10.3%	12.8%	12.8%	12.9%
	Chinese	2.0%	1.9%	2.0%	15.2%	15.0%	15.4%
	Indian	1.6%	1.5%	1.7%	9.5%	9.3%	9.7%
	Other Asian	2.9%	2.8%	3.0%	13.3%	13.1%	13.5%

High BMI

The WHO defines overweight as a BMI of ≥25 and obesity as a BMI of ≥30. Worldwide, the overweight rate was 39% of adults aged 18 years and over and 13% for obesity. In addition, overweight and obesity is associated with greater morbidity and mortality than underweight in most of the world's population. There is good evidence linking obesity and overweight to many non-communicable conditions, including cardiovascular diseases (mainly heart disease and stroke), diabetes, musculoskeletal disorders and some cancers (endometrial, breast, and colon).

Responding to the epidemic of obesity, the WHO Global Strategy on Diet, Physical Activity and Health was adopted by the World Health Assembly in 2004. In addition, the Commission on Ending Childhood Obesity (ECHO) presented its final report 'Ending Childhood Obesity' in January 2016 to the WHO Director-General to address the alarming levels of world-wide childhood obesity and overweight (WHO, 2016).

New Zealand had the highest mortality rate attributable to high BMI (60.8 per 100,000, 95% UI: 52-71) of all the countries on the list for women and men combined, followed by Australia and the UK, while the Republic of Korea and China had the lowest rate of high BMI. For DALYs, the UK surpassed New Zealand, while Korea and China were still the lowest. India became the country with the highest YLL rate, followed by New Zealand, with Korea still having the lowest rate. The UK had the highest burden of years lived with disability attributable to high BMI, followed by Singapore; New Zealand had a rate comparable to Australia and Canada. The remaining Asian countries, namely India, Korea and China had lower rates of YLDs attributable to high BMI. Generally, men had a higher burden of health loss attributable to high BMI than women for all the four metrics.

There is some level of evidence suggesting an alternate set of cut-off criteria for obesity and overweight for Asians based on measured body fat. In Singapore, because at any given BMI, Asians,

including Singaporeans, generally have a higher percentage of body fat than Caucasians, the BMI cut-off levels for Singaporeans have been revised such that a BMI 23 kg/m^2 or higher marks a moderate increase in risk while a BMI 27.5 kg/m^2 or more represents high-risk for diabetes and cardiovascular diseases. More research is required to address accurate measures of body fat for Asians, as they are more likely to be 'TOFI' ('thin outside and fat inside') (Stewart, 2015). If alternative criteria become internationally acceptable, the burden of disease will be heavier than it is now for Asian countries.

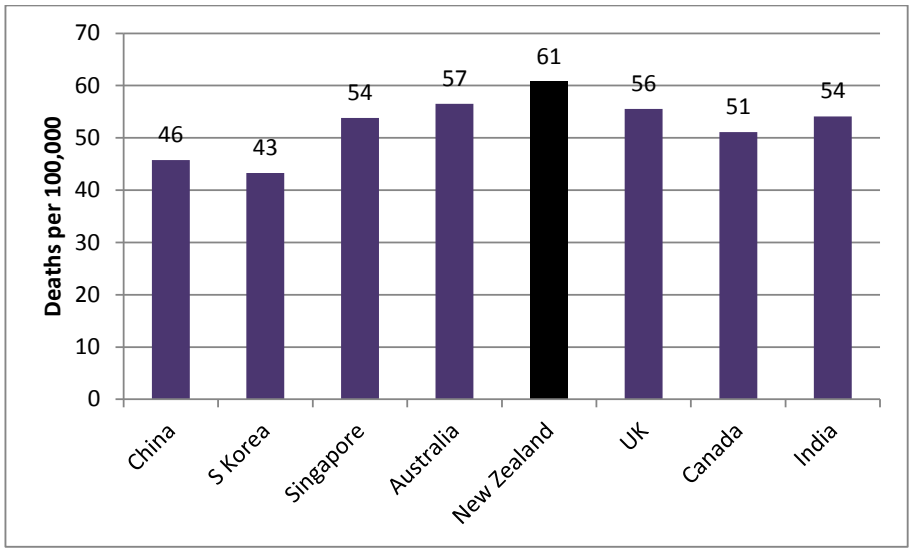


Figure 20 Age standardised mortality rate attributable to high BMI, by country, both sexes, GBD 2010

The Global Health Observatory data repository of the WHO provides estimates of obesity by country and WHO region (WHO, 2016). There were increases in the age standardised prevalence rate of obesity (18+ years) between 2010 and 2014 for all the countries on the list (though the differences did not always seem to be statistically significant). The Asian countries had much lower obesity rates (defined as equal to or greater than 30 kg/m^2) than the four non-Asian countries, led by New Zealand (both sexes, 29.2%, 95% CI: 25%-33%). Women had higher prevalence rates of obesity than men for all the countries on the list. By sex, New Zealand still ranked the top for women, but was overtaken by Australia for men in 2014.

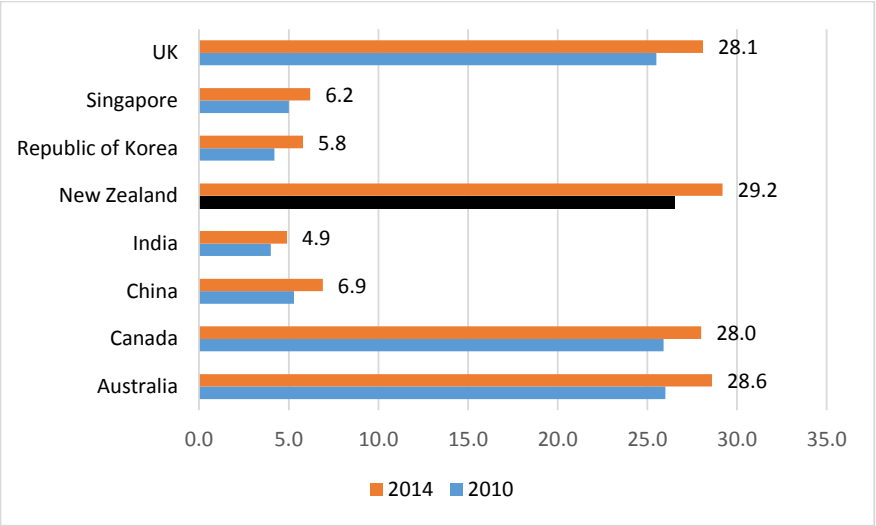


Figure 21 Age standardised prevalence of obesity, 18+ years, by country, both sexes, WHO

Table 19 Age standardised prevalence of obesity, 18+ years, by country and sex, WHO

Country	2014 (95% CI)		2010 (95% CI)	
	Female	Male	Female	Male
Australia	28.8 (23.3-34.5)	28.4 (22.8-34.3)	26.3 (22.4-30.3)	25.6 (21.8-29.7)
Canada	29.1 (23.1-35.4)	26.8 (20.8-33.4)	27.2 (22.8-31.7)	24.6 (20.3-29.1)
China	8.0 (4.7-12.3)	5.9 (3.2-9.3)	6.4 (4.2-8.9)	4.3 (2.7-6.3)
India	6.7 (4.4-9.6)	3.2 (1.8-5.1)	5.6 (4.1-7.4)	2.5 (1.6-3.7)
New Zealand	30.8 (25.2-36.6)	27.7 (22.1-33.7)	28.1 (24-32.6)	24.8 (20.8-29.2)
Republic of Korea	6.7 (3.9-10.5)	4.8 (2.6-7.7)	4.9 (3.3-7)	3.5 (2.2-5.1)
Singapore	6.8 (4.3-10.1)	5.7 (3.4-8.7)	5.6 (3.8-7.9)	4.4 (2.9-6.4)
UK	29.2 (24.4-34.2)	26.9 (22.1-32.2)	26.8 (23.6-30.2)	24.1 (21-27.5)

The aggregated data of NZHS 2011/12 and 2012/13 from the Ministry of Health (The Ministry of Health, 2016) indicated that Asian people in both DHBs had lower rates than the New Zealand average), which was comparable to the WHO estimate in 2014. In the international context, the Asian rates of obesity in both DHBs were higher than that of the Asian countries although there seemed to be some overlaps in the confidence intervals. Using ethnic specific definitions of obesity, it was found that the prevalence of obesity was higher in all three Asian sub-groups (aside from Chinese women) than European/Other, using NZHS 2011-13 data (Scragg, 2016).

Table 20 Age standardised prevalence of obesity, 18+ years, both sexes, NZHS 2011-13

DHB	Asian		European/Other		All	
	Rate	(95% CI)	Rate	(95% CI)	Rate	(95% CI)
Waitemata	14.1	(9.4-19.9)	22.0	(19.1-25.2)	23.4	(20.5-26.6)
Auckland	11.6	(7.8-16.3)	18.5	(15.4-22.0)	21.5	(18.9-24.2)
Counties-Manukau	20.7	(16.3-25.7)	31.8	(28.3-35.6)	40.5	(36.7-44.4)
All 3 Auckland DHBs	15.3	(12.7-18.2)	23.0	(20.9-25.2)	27.8	(25.6-30.0)
New Zealand	14.5	(12.6-16.7)	26.0	(25.0-27.1)	29.1	(28.3-29.9)

Physical inactivity and low level of physical activity

WHO defines physical activity as 'any bodily movement produced by skeletal muscles that requires energy expenditure – including activities undertaken while working, playing, carrying out household chores, travelling, and engaging in recreational pursuits' (WHO, 2016). Insufficient physical activity is a key risk factor for many non-communicable diseases including cardiovascular diseases, cancer and diabetes. There were dedicated efforts made by WHO and its member states on primary prevention of NCDs through physical activity - the 'Global Recommendations on Physical Activity for Health', was published by WHO in 2010. In addition, physical activity was part of the "Global Strategy on Diet, Physical Activity and Health", which was adopted by the World Health Assembly in 2004. The WHO recommends (WHO, 2016):

Table 21 WHO recommendations of physical activity

Children and adolescents aged 5-17 years	Should do at least 60 minutes of moderate to vigorous-intensity physical activity daily
	Physical activity of amounts greater than 60 minutes daily will provide additional health benefits
	Should include activities that strengthen muscle and bone, at least 3 times per week
Adults aged 18–64 years	Should do at least 150 minutes of moderate-intensity physical activity throughout the week, or do at least 75 minutes of vigorous-intensity physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity
	For additional health benefits, adults should increase their moderate-intensity physical activity to 300 minutes per week, or equivalent
	Muscle-strengthening activities should be done involving major muscle groups on 2 or more days a week
Adults aged 65 years and above	Should do at least 150 minutes of moderate-intensity physical activity throughout the week, or at least 75 minutes of vigorous-intensity physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity
	For additional health benefits, they should increase moderate intensity physical activity to 300 minutes per week, or equivalent
	Those with poor mobility should perform physical activity to enhance balance and prevent falls, 3 or more days per week
	Muscle-strengthening activities should be done involving major muscle groups, 2 or more days a week

At country level, India had higher mortality and YLL rates attributable to low physical activity (mortality rate 50.3 per 100,000; 95% UI: 41, 60) and New Zealand had rates comparable to other countries, with Canada being the top performer. For DALYs attributable to low physical activity, Singapore stood out, closely following India, while Canada still had the lowest rate. For years lived with disability attributable to low physical activity, Singapore had the highest burden; India and China had the lowest rates followed by New Zealand. This may reflect more serious or fatal health loss in India and China, conversely, better survival and health care services in Singapore. Men had a higher burden of health loss attributable to low physical activity than women.

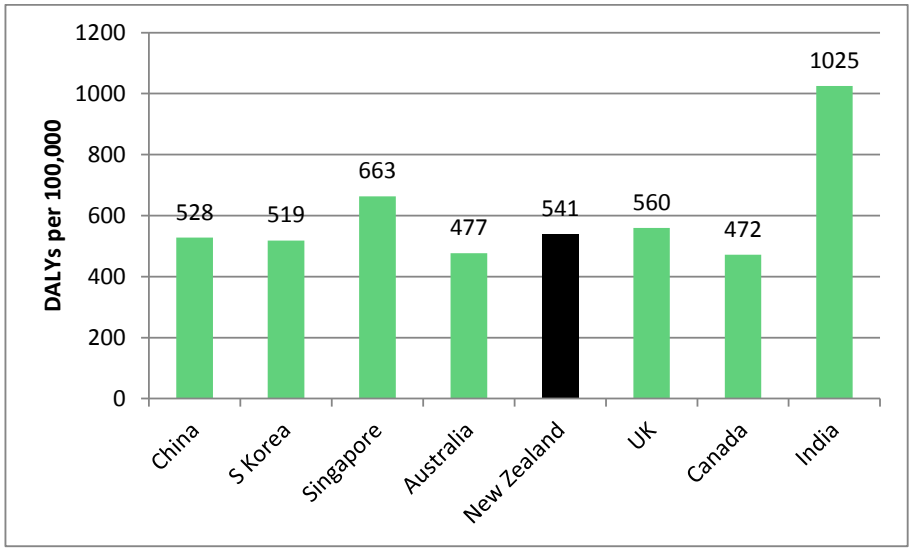


Figure 22 Age standardised DALYs attributable to low physical activity, by country, both sexes, GBD 2010

New Zealand had the highest rate of being 'insufficiently active' among adults aged 18+ years followed by the UK in 2010, while India had the lowest rate. This remained true when the data was considered by sex. In addition, women had higher rates of low physical activity than men.

In the health survey, New Zealand measures the proportion of people meeting the New Zealand physical activity guidelines in the past 7 days among adults 15+ years, i.e. did at least 30 minutes of exercise on 5 or more days in the past week. The New Zealand average for women and men combined in NZHS 2011-13 was 46.0% not meeting the guideline (95% CI: 44%-48%). Acknowledging the differences in years of comparison, age group and definitions of physical activity between NZHS and the WHO estimates, the New Zealand average is slightly higher than the WHO estimate for New Zealand.

Asian in both DHBs had higher rates not meeting the New Zealand guideline for physical activity than the New Zealand average (Waitemata Asian: 69.5%, 95% CI: 59%-79%; Auckland DHB Asian: 54.8%, 95% CI: 49%-61%). In the international context, Waitemata and Auckland DHBs would replace the New Zealand average to be the regions with the highest rate of insufficient activity for Asians, particularly in Waitemata DHB. Nationwide, lower (crude) rates of being physically active were reported among Chinese (40%), South Asian (46%) and Other Asian (46%), compared to European/Other (56%) in NZHS 2011-13 (Scragg, 2016).

The Canadian study also found that Chinese (adjusted OR 1.58, 95% CI: 1.41-1.78) and South Asian (adjusted OR 1.66, 95% CI: 1.48-1.85) were more likely to be physically inactive, compared to White (Caucasian) in Canada (Richard Liu, 2010). Korean or Japanese in this study had a rate comparable to the White (Caucasian). In the UK, the Health Survey for England (2004) examined the physical activity of ethnic groups, analysing the odds of meeting the physical activity guidelines of at least five days per week of moderate intensity exercise lasting 30 minutes per day (Higgins V, 2010). For men, only Bangladeshi and Pakistani groups were found to have lower odds than the White population. In women, South Asian and Chinese groups had lower odds, in comparison to the White population. In a separate study, it was found that within South Asian groups, people from the Bangladeshi community had much lower levels of physical activity than other South Asian groups, while those of Indian ethnicity had the highest levels, although still lower than the White population (Hayes L, 2002).

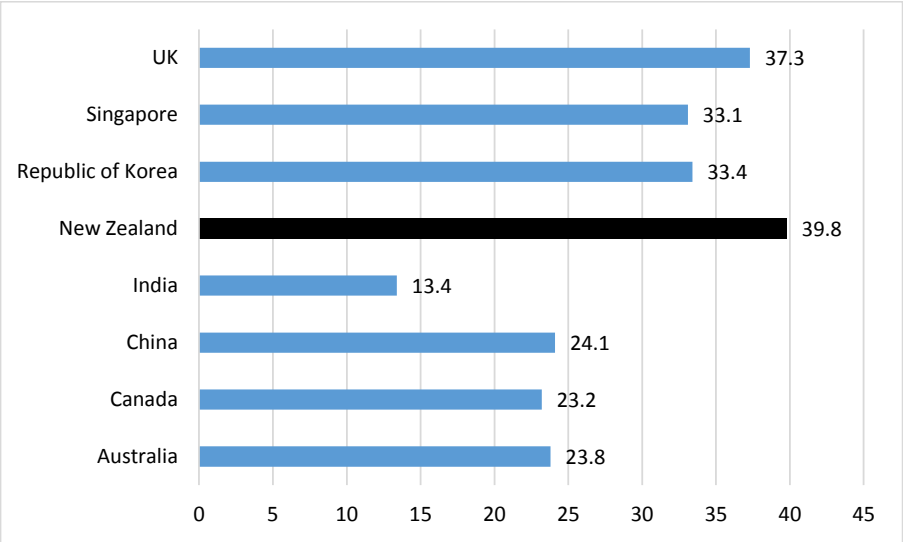


Figure 23 Age standardised prevalence of low physical activity, 18+ years, by country, both sexes, WHO

Table 22 Age standardised prevalence meeting physically active criteria* of New Zealand, 15+ years, NZHS 2011-13

DHB	Asian		European/Other		All	
	Rate	*(95% CI)*	Rate	*(95% CI)*	Rate	*(95% CI)*
Waitemata	30.5	(21.2-41.2)	48.3	(44.7-51.9)	45.2	(41.4-49.1)
Auckland	45.2	(39.1-51.4)	53.7	(49.6-57.8)	50.2	(46.6-53.8)
Counties-Manukau	38.1	(32.6-43.7)	38.5	(32.0-45.4)	37.2	(32.6-42.0)
All 3 Auckland DHBs	38.6	(34.4-42.8)	47.7	(45.1-50.4)	44.4	(42.0-46.9)
New Zealand	42.0	(38.6-45.4)	56.6	(54.2-59.0)	54.0	(51.8-56.1)

* Met physical activity guidelines in past 7 days, i.e. did at least 30 minutes of exercise on 5 or more days in the past week

Interpretation and reflection

Tobacco use accounted for 8.7% of all DALYs in 2013 in New Zealand, the third ranked risk factor after dietary factors and high body mass (The Ministry of Health, 2016). The second highest daily smoking rate of New Zealand women is mainly attributed to the higher smoking prevalence of Māori and Pacific peoples. However, Asian men also had a higher rate of daily smoking in both DHBs, suggesting this group of people (in particular Chinese and Other Asian men) should also be targeted alongside Māori and Pacific peoples in the delivery of culturally appropriate smoking cessation interventions i.e. brief advice, referrals to smoking cessation providers, prescribing pharmacy therapy and accessing behavioural support in appropriate languages in the broader context of 'Smokefree Aotearoa 2025'.

New Zealand had the highest age standardised rate of obesity (defined as BMI≥30) and the highest mortality rate attributable to high BMI of all the countries on the list. High BMI as the second ranked risk factor took 9.2% of total DALYs in 2013 in New Zealand (while dietary factors accounted for 9.4% of total DALYs) (The Ministry of Health, 2016). Māori and Pacific peoples had higher prevalence rates of obesity and thus heavy health loss due to obesity (CVD, type 2 diabetes and its complications). However, the fact that all three Asian sub-groups had higher prevalence of obesity when the ethnic specific criteria were applied (according to NZHS), provides the evidence base to include identified Asian groups in the 'co-design' of culturally appropriate lifestyle interventions that aim to prevent and manage obesity and reduce amenable mortality.

New Zealand as a country had the highest prevalence rate of being 'insufficiently active' (aged 18+ years) and Asians in both DHBs had higher rates not meeting the New Zealand guidelines for physical activity compared to the New Zealand average, suggesting the highest level of insufficient activity of Asians of the two DHBs internationally. There needs to be research undertaken to understand why New Zealand Asians are less likely to be physically active (e.g. enablers and barriers), as well as leveraging on cross-sectorial collaborations and strategies that adopt both upstream system measures that address the social determinants of health as well as opportunities for 'co-design' of culturally appropriate interventions (e.g. Healthy Auckland Together, Healthy Families Waitakere).

Health service use

Internationally	• New Zealand had immunisation rates simliar to the majority of the comparator countries	
	• Asian children of both DHBs had among the highest rates of immunisation when compared with the comparator countries	
	• The cervical screening rates for Asian women of both DHBs were lower than many of the comparator countries where screening data were available	
	• Asian breast screening rate was lower in Waitemata when compared to the comparator countries where screening data were available	
Nationally	• Asian children of Waitemata and Auckland DHBs had higher immunisation rates than the New Zealand average	
	• Asian women of both DHBs had lower cervical screening rates that the New Zealand average	
	• Asian women of Waitemata DHB had a lower breast screening rate than the New Zealand average	
	• Asian adults in New Zealand were less likely to have a usual health practitioner or service to visit when unwell than other ethnicities	
	• PHO enrolment rates among the Asian population in both DHBs are well below that of other ethnicities	

In this part, an overview of the Asian Health in Aotearoa in 2011-2013: Trends since 2002-2003 and 2006-2007 report (Scragg, 2016) of health service utilisation is included, along with childhood immunization coverage rates and cervical and breast screening programmes, benchmarked internationally.

Findings of health service utilisation from the Asian Health in Aotearoa Report

- Asian adults were less likely to have a usual health practitioner or service to visit when unwell (South Asian 88%, Chinese 87%, Other Asian 82%), compared to non-Asians (Māori 93%, Pacific 95%, European & Other 95%)
- The proportion of Asian children attending a public hospital increased between 2006-07 (14%) and 2011-13 (24%), while the proportion attending a private hospital decreased (from 2% to 0.1%)
- South Asian and Chinese children (both 74%) were less likely to have visited a dentist or oral health care worker in the last 12 months than European & Other (83%), who were similar to Other Asian
- Among adults, South Asian (31%), Chinese (36%) and Other Asian people (41%) were less likely to have visited a dentist or oral health care worker in the last 12 months than European & Other (49%).

Immunisation rates for children

WHO and the United Nations' Children's Emergency Fund (UNICEF) review data available on national immunisation coverage based on data officially reported to WHO and UNICEF by Member States as well as data reported in the published and grey literature, and then estimate the immunisation coverage by country, using established methods and processes (Burton, et al., 2009). New Zealand did reasonably well in immunisation coverage rates, but China and the Republic of Korea did the best. There was still some gap for India close in 2014. Not all countries had the same immunisation schedule.

Table 23 Immunisation coverage rate, WHO 2014

Vaccine	Australia	Canada	China	India	New Zealand	Republic of Korea	Singapore	UK
BCG			99	91		99	99	
DTP1	92	98	99	90	93	99	98	98
DTP3	92	96	99	83	93	99	97	95
HepB_BD			94	37		92	67	
HepB3	91	75	99	70	93	99	97	
Hib3	91	96		20	93	97		95
MCV1	93	95	99	83	93	99	95	93
MCV2	93	94	99	51	86	96	95	89
PAB				87				
PCV3	91	97			93			93
Pol3	92	96	99	82	93	99	97	95
Rota_last	84							

Data source: WHO.
http://www.who.int/immunization/monitoring_surveillance/routine/coverage/en/index4.html, accessed 28 March 2016, as of 10 July 2015

Notes by WHO:

1	BCG	Baccille Calmette Guérin vaccine
2	DTP1	First dose of diphtheria toxoid, tetanus toxoid and pertussis vaccine
3	DTP3	Third dose of diphtheria toxoid, tetanus toxoid and pertussis vaccine
4	HepB_BD	Hepatitis B birth dose estimates are for doses given within 24 hours after birth
5	HepB3	Third dose of hepatitis B vaccine
6	Hib3	Third dose of Haemophilus influenzae type B vaccine
7	MCV1	Measles-containing vaccine
8	MCV2	Coverage estimates are for the nationally recommended age for the second dose of measles containing vaccine.
9	PAB	Protection at birth
10	PCV3	Third dose of pneumococcal conjugate vaccine
11	Pol3	Third dose of polio vaccine
12	Rota_last	Rotavirus last dose (2nd or 3rd depending on schedule)

As at 30 June 2016, Asian children in both Auckland and Waitemata DHBs maintained higher immunisation coverage rates than the New Zealand immunisation coverage rate (92.7%), similar to

the level of China in 2014. In New Zealand, the vaccines currently included in the 8 month old Immunisation Health Target are (The Ministry of Health, 2016): diphtheria, tetanus, pertussis, Hib (Haemophilus influenzae type B), polio, HepB, pneumococcal and rotavirus. The Asian coverage rate at 8 months is 97% (Auckland DHB) and 98% (Waitemata DHB) as at 30 June 2016.

At age 15 months, children are offered booster doses of pneumococcal and Hib vaccines, and a first dose of MMR vaccine. The Asian coverage rate at 2 years is 95% (Auckland DHB) and 97% (Waitemata DHB) as at 30 June 2016.

At age 4 years, booster doses of diphtheria, tetanus, pertussis and polio vaccines, and a second dose of MMR vaccine are given. Overall, Asian children generally maintain immunisation coverage levels of greater than the recommended 95%, at both 8 months and 2 years, with the exception of the 4 year old immunisation event, where coverage is 88% and 90% for Auckland and Waitemata DHBs respectively fully vaccinated by 5 years. This is still higher than the DHB total 4 year old coverage rate generally, which is 86% and 83% for Auckland and Waitemata DHBs respectively.

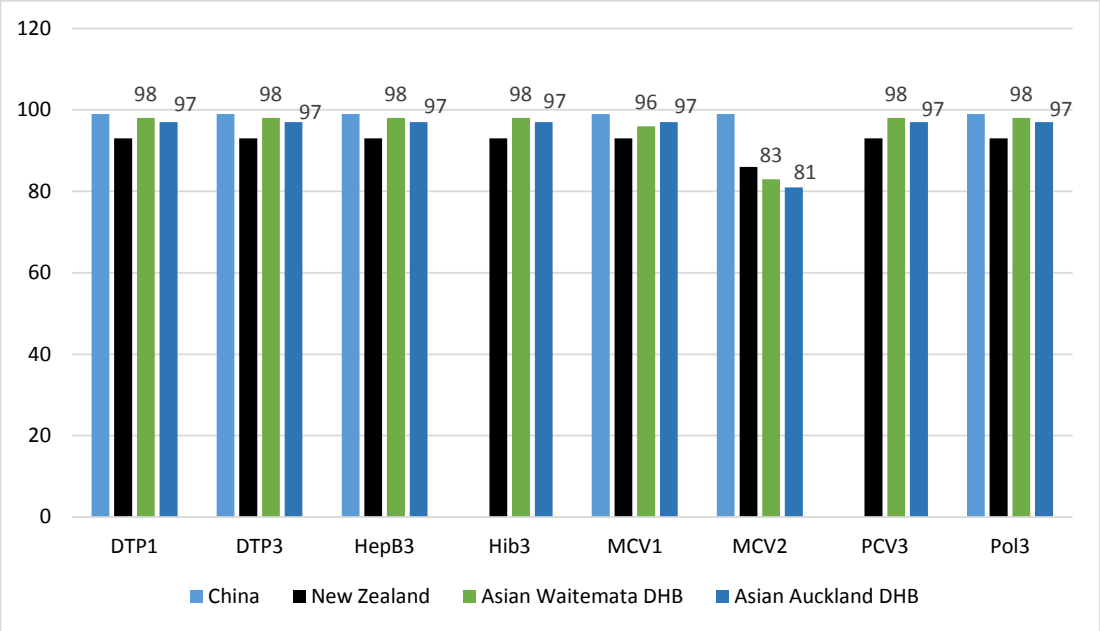


Figure 24 Immunisation coverage rate (%), Asian of Waitemata and Auckland DHBs, 2014

Cervical screening

The International Cancer Screening Network of the National Cancer Institute of NIH provided estimates of cervical screening rates based on an international survey (ICSN, 2016). In addition, organisation, policies and reach of the cervical screening programmes were also collected. Quality Watch of the UK also collected data of selected countries (QualityWatch, 2016). The New Zealand national programme started in 1991 and did very well compared to other countries on the list, with coverage rates being 75%, just behind the UK.

At the end of December 2015, the New Zealand average cervical screening coverage rate was 76.7% (three-year coverage) for women aged 25-60 years (official age group for reporting) (NCSP, 2016). As at 31 December 2010, Asian in Auckland DHB and Waitemata DHB had screening rates of 52.4% and

52.9% respectively (NCSP, 2016). Compared to the figures of other countries of the same time period, the Asian rates in both DHBs were lower than that of the averages of New Zealand and the UK. As at December 2015, the rates had increased to 66% for Asian women in both DHBs.

In Canada, the visible minority population in general were 53% less likely to have had a Pap smear, compared to White (Hude Quan, 2006). There was no breakdown of visible minority population in this study. Asian women in both Waitemata and Auckland DHBs seemed to have done better than the visible minority women in Canada, acknowledging that the data for comparison came from different years (Canada, 2001 vs. New Zealand, 2014-2015).

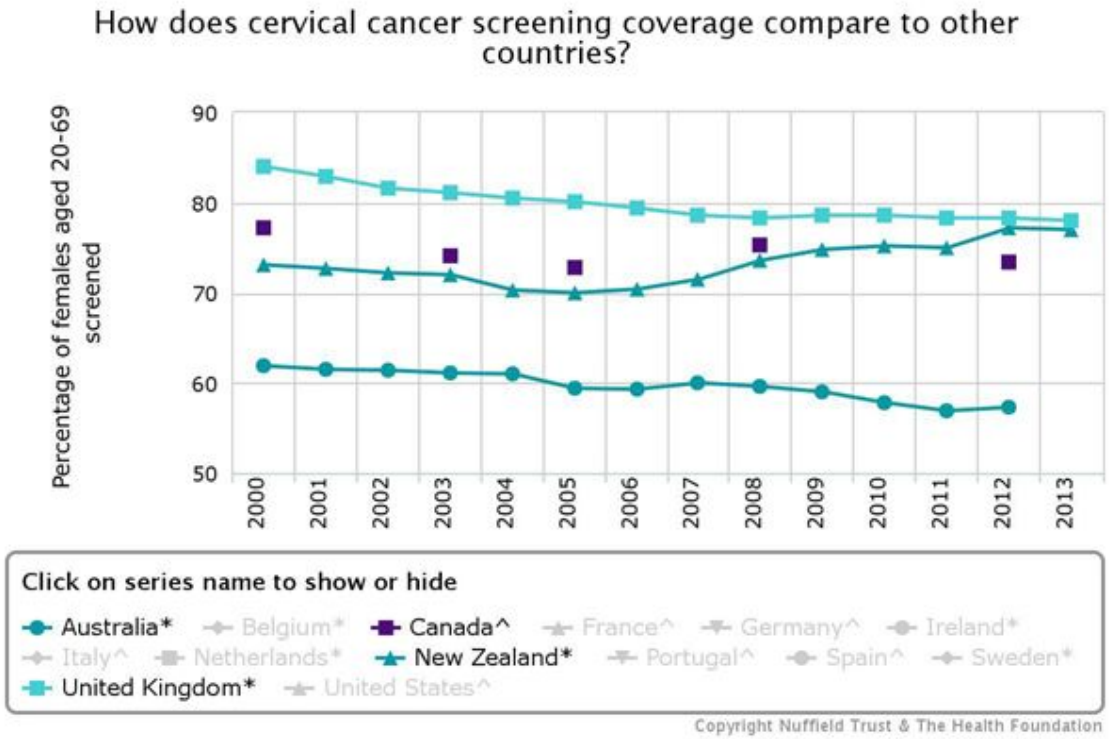
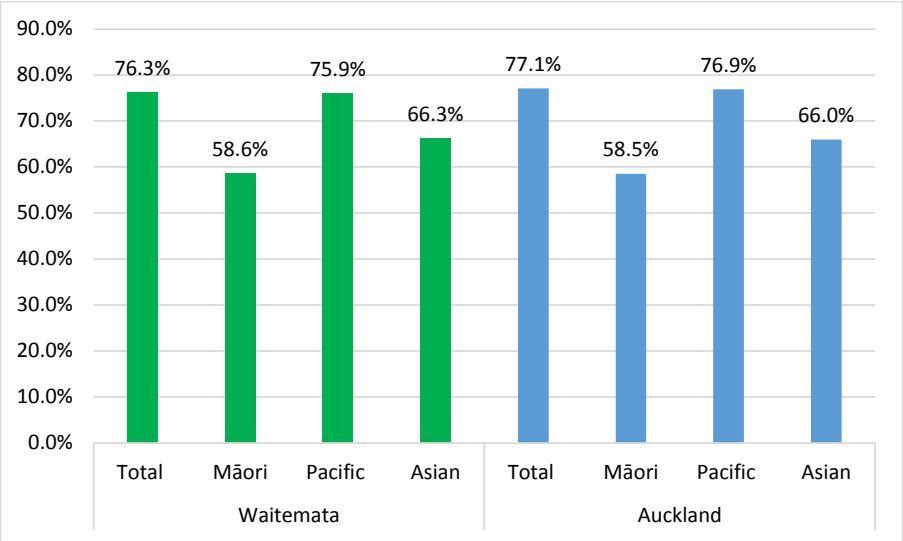


Figure 25 Cervical screening coverage rate (%) by country, 2000-2013



Data source: NSU/MoH.
https://www.nsu.govt.nz/system/files/page/dec_2015_ncsp_coverage_new_vs_old_method_final_0.docx+&cd=1&hl=en&ct=clnk&gl=nz, accessed 28 March 2016

Figure 26 Cervical screening coverage rate (%), Waitemata and Auckland DHBs, December 2015

11.2

Breast screening

New Zealand had a reasonably good breast screening coverage rate at 67.5% in 2010, according to the International Cancer Screening Network (ICSN, 2016). The data reported by Quality Watch of the UK gave time series coverage rates of selected countries (QualityWatch, 2016).

The screening rate in the two years ending 30 June 2016 was 71.4% for women aged 50-69 years in New Zealand (The Ministry of Health, 2016). The rates were approximately 72% and 66% for Asian women in Auckland and Waitemata DHBs respectively, during the same time period. There was still some gap for Waitemata Asian women to catch up with the New Zealand and the UK averages, although they did better than Canada and the Republic of Korea in 2010.

In Australia, during 2011–2012, the difference in the age standardised breast screening participation rates between English-speaking women (55.3%) and those who reported that they speak a language other than English at home (49.9%) was 5.4% (AIHW, 2014). Language spoken is clearly not the same as ethnicity or country of birth, but it may suggest new immigrant women born in Asian countries have a slightly lower breast screening rate. Nevertheless, these rates are clearly lower than the rates for Asian women in both Auckland and Waitemata DHBs (72% for Auckland Asian and 66% for Waitemata Asian as at June 2016). In Australia, there seemed to be a slow downward trend since 2008-09.

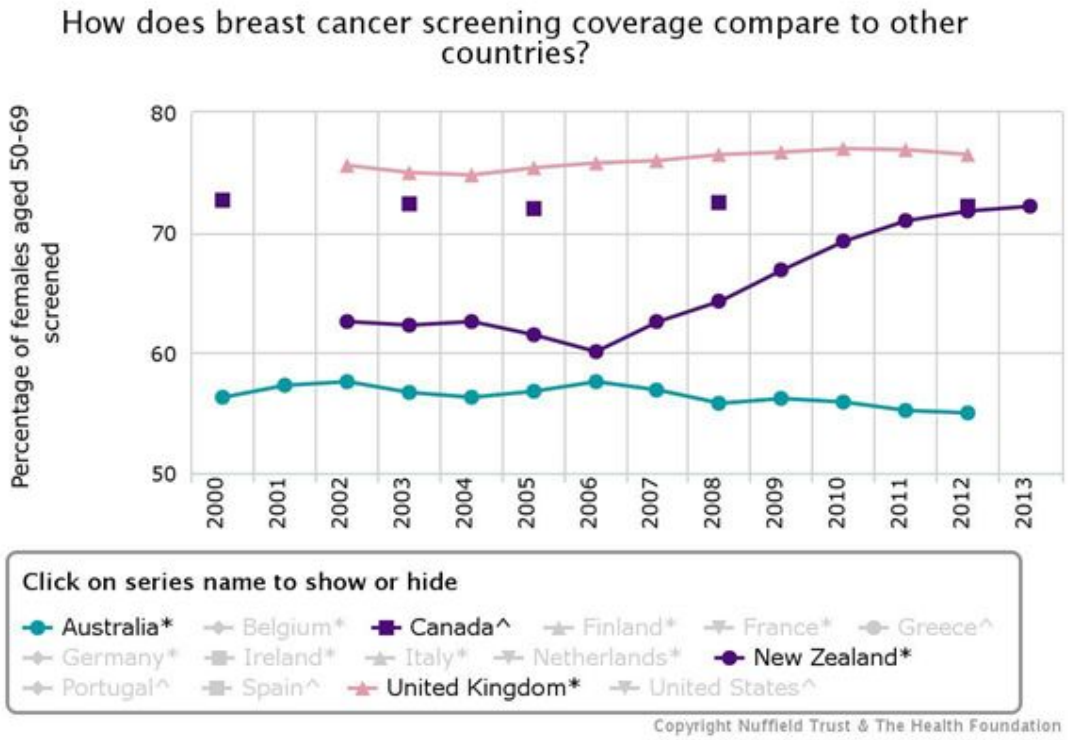


Figure 27 Breast screening coverage rate (%) by country, 2000-2013

Table 24 Breast Cancer Screening coverage, Asian, Waitemata and Auckland DHBs

Reporting Period	DHB	Asian Women screened (50-69 yrs)	Population Projections (50-69 yrs)	Coverage (50-69 yrs)	Asian Women screened (45-69 yrs)	Population Projections (45-69 yrs)	Coverage (45-69 yrs)
1 July 2012 - 30 June 2014	Auckland	8,329	11,260	74.0%	12,111	15,950	75.9%
1 July 2012 - 30 June 2014	Waitemata	6,281	9,910	63.4%	8,932	13,950	64.0%
1 July 2013 - 30 June 2015	Auckland	8,787	11,970	73.4%	12,592	16,780	75.0%
1 July 2013 - 30 June 2015	Waitemata	6,961	10,610	65.6%	9,684	14,750	65.7%
1 July 2014 - 30 June 2016	Auckland	9,226	12,840	71.9%	12,881	17,750	72.6%
1 July 2014 - 30 June 2016	Waitemata	7,577	11,430	66.3%	10,432	15,780	66.1%

Data extracted from the BSA Database on 1 August 2016 (using 2015 update of the Population projections)

Interpretation and reflection

Immunisation and cancer screening services are important public health measures to reduce the incidence and mortality rates of some communicable diseases and some cancers. Of note, the Asian immunisation rates of both DHBs were close to the top performer at country level – China. In comparison, the Asian cervical and breast screening rates were still far from the New Zealand and the UK averages, except for the breast screening rate in the Auckland DHB (although the coverage rate has decreased from December 2013 to December 2014). In addition, there were lower rates of PHO enrolment and use of primary care and oral health services by Asians. Reasons may be due to lack of awareness of and the role of primary health services based on limited exposure or availability of services in one's country of origin, and cultural beliefs and nuances adopted by certain ethnic groups which transfer to help-seeking and health seeking behaviours in New Zealand. This seems to explain why the immunisation rate is higher (immunisation coverage rates are usually high in Asian countries) and the cervical and breast screening rates are lower (these two screening programmes are gaining momentum in some Asian countries such as Singapore). In many Asian counties, there is no functional primary care system or primary dental services as we have here in New Zealand, although some countries are starting to grow their primary care and triage system.

It is important to work to address amenable mortality and to lower premature mortality from cancer. We must continue to address the barriers that segments of the Asian population experience in terms of awareness of and participation in screening programmes (Appendix 6). The low cervical screening coverage for eligible Asian women in both DHBs warrants a greater need for culturally appropriate and targeted awareness raising. This includes promotion of the Human Papillomavirus (HPV) vaccination for Asian parents of both girls and boys to reach the new national target of 75%, and ongoing comprehensive school-based immunisation programmes. Continuing to provide free smears for Asian women aged 30-69 years 'who have not been screened or under screened in the last 5 years' is an enabler that addresses 'cost' as a structural barrier to access, and is aimed at increasing the Asian cervical screening coverage rate.

Furthermore, a suite of strategies has been adopted across both DHBs and via settlement and ethnic partner platforms to increase awareness of the NZ health and disability system, provide information on how to access health services, the role and benefits of the family doctor, and provide prevention and lifestyle messages including multilingual Your Local Doctor campaigns, podcast videos, materials, presentations/workshops, social media, and cultural and language support services. Up-skilling the health workforce – particularly in primary health to undertake CALD Cultural Competency courses – is recognised and endorsed by New Zealand health professional bodies as a key enabler led by Waitemata DHB's eCALD® services (WDHB, eCALD, 2016).

Lastly, there needs to be greater reciprocity of learnings and experiences of best practice in service delivery between the DHBs, regionally and nationally to ensure efficiency and culturally responsive service delivery where DHBs are performing less well i.e. Asian breast screening in Auckland DHB compared with Waitemata DHB.

Patient experience and community engagement/participation

Waitemata and Auckland DHBs are committed to enhancing the experience of patients when they interact with health services. This section outlines what is already known about main Asian subgroup experiences and expectations in relation to access and utilisation of health services nationally and locally. A general overview will be shared of the culturally specific information including values, health beliefs and cultural expectations that influence main Asian subgroup attitudes and behaviours towards access and uptake of services and patient experience, as well as community engagement/participation initiatives, and growing a culturally competent workforce.

The qualitative findings enhance the assessment of DHB performance against the indicators within the respective Outcomes Frameworks'. Enhanced patient experience is a strategic priority and long-term outcome for the DHBs with the intent being to engage patients and communities in the design and delivery of the care they receive. Improving experience of health care services is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes. For example language, cultural beliefs and not knowing how to access services are identified as key barriers to use of health services for Asian migrants in New Zealand (Wong, et al, 2010).

- Asian Health in Aotearoa in 2011-2013: Trends since 2002-2003 and 2006-2007 (Scragg, 2016) indicated that:
    - Asian peoples who have resided less than 5 years in New Zealand are less likely to have access to a primary health care practice, and to health care practitioners, such as family doctors and medical specialists, as compared to those who have lived longer in New Zealand
    - Asian adults were less likely to have a usual health practitioner or service to visit when unwell (South Asian 88%, Chinese 87%, Other Asian 82%), compared to non-Asians (Māori 93%, Pacific 95%, European & Other 95%)
    - The proportion of Asian children attending a public hospital increased from 2006-07 (14%) to 2011-13 (24%), while the proportion attending a private hospital decreased (from 2% to 0.1%)

- Acculturation was cited as a key determinant affecting the likelihood of accessing primary care services such as general practice
- The HNA of Asian People Living in the Auckland Region (2012) report indicated that health service providers interviewed felt lack of familiarity with the New Zealand health system was a barrier to uptake of health service information by new Asian migrants
- The student survey report on 'Student awareness of health services and sources of health information in the Auckland district' highlighted that perceived understanding of the New Zealand health system, for European and Other ethnic groups had a higher mean score 188.1 and 178.32 respectively, as compared to Asian (128.8) (n=318).

Notwithstanding this, although 'Asian' is broadly classified and often treated as a homogenous group, there are cultural heterogeneous differences and similarities that are shared within and/or across

Asian ethnic groups to be considered in the planning and delivery of culturally appropriate and responsive health services and targeted interventions to increase health gain.

Highlights

Top Four Values about Health Services

In July 2014, the Auckland DHB ran an 'At Our Best' Values project where feedback was sourced via face-to-face workshops and surveys from over 80 Auckland Asian community voices from key ethnic groups such as Chinese, Korean, South Asian (Indian), Filipino and other Asian groups about 'What Matters' to them with respect to healthcare and patient experience. The top four values Asians placed on their experiences and expectations of health services were:

1. Excellence and professionalism
2. A professional connection with clinicians
3. Confidence about the level of care
4. Efficiency, productivity, and good processes.

Patient Experience

In 2015, Auckland DHB's Online Patient Experience Survey (In-Patient and Out-Patient) highlighted that Asian patients are less likely to rate their overall care and treatment as 'very good to excellent' (81%), compared to non-Asians (NZ European 84%, Māori 84% and Pacific 84%).

In 2015, only 58.7% of Chinese patients (n=303) who completed the Waitemata DHB's 'Friends & Family Test' were 'extremely likely' to 'recommend our ward to friends and family if they need similar care or treatment', compared to non-Asians (NZ European 70%, Māori 69.2%, Samoan 65.2% and Tongan 58.8%).

Access to Healthcare Services

Ethnic diversity and acculturation are important factors influencing health and access to health services. An Auckland DHB Community Health Survey (2012) found that Chinese respondents were more likely to rate their access to health care as low, compared to New Zealand Europeans (n=269). Factors attributing a low self-rating relate to cost of services and quality issues such as availability/waiting times at general practice.

Asian peoples who have resided for less than 5 years in New Zealand are less likely to have access to a primary health care practice and to health care practitioners, including family doctors and medical specialists, compared to those who have lived longer in New Zealand (Scragg, 2016).

A student survey (n=318) took a convenient sample of students from UoA, AUT (North Shore, City and Manukau campuses), Massey University (Albany campus) and NZMA (Sylvia Park campus) to inform the Auckland and Waitemata DHBs on 'Student Awareness of Health Services and Health Information in the Auckland District'. The results found that International students tended to have a lower level of

understanding of New Zealand health and disability systems, were less likely to have a usual family doctor or GP clinic to go to, and accessed EDs of public hospitals significantly less, after adjusting for the effects of ethnicity (New Zealand Māori, European, Asian and all Other). Ethnicity did not seem to affect ED visits, although Asian students had a lower ED access rate than other ethnic groups in the studied convenient sample.

Asian online respondents (n=95) of the Waitemata DHB Primary Birthing Facility Consultation 2016 were fairly equally in favour of all three Waitemata DHB operated primary birthing units which were (a) In community, DHB operated, (b) On hospital grounds, in a separate building, and (c) In hospital, near the maternity unit. However Asian groups who attended the forums (n=52) favoured (a) On hospital grounds, in a separate building, and (b) In community, DHB operated. Asian staff preferred either a community-based, DHB operated or hospital-based facility near the maternity unit.

Top Four Features as Essential for Primary Birthing Units

1. Breastfeeding support/advice
2. Family friendly
3. Partners to stay overnight
4. Easy to get to by car.

Asian groups were most likely to rate having community health facilities nearby as essential for PBUs.

Organisational values

Adopting a values-based approach as an organisation is key to ensuring the needs of all population groups - including Asian - are embedded into future organisational development and culture change.

Auckland DHB

Auckland DHB has been successful in undertaking a values driven 'At Our Best' project conducted in July 2014 where feedback was sourced via face-to-face workshops and surveys from over 80 Auckland Asian community voices from key ethnic groups such as Chinese, Korean, South Asian (Indian), Filipino and other Asian groups about 'What Matters' to them with respect to healthcare and patient experiences. Inputs from the 'At Our Best' project were then embedded into the newly updated set of organisational values approved by the Board in April 2015.

This was a positive step for the organisation and demonstrated an inclusive approach that will aim to translate to demonstrable behaviours and actions for the organisation as a whole, and at the service level where Asian cultural and health needs can be met.

Table 25 Top ten areas that Asian respondents value when they engage in Auckland DHB services (n=80)

1	Excellence and professionalism
2	A professional connection with clinicians
3	Confidence about the level of care
4	Efficiency, productivity, good processes
5	Get things right/ask the right questions
6	Have all the information – themselves and doctors knowing their information/history
7	Education and advice to self-manage
8	My opinion counts
9	Language barriers removed: doctors, nurse, city workers and district nurses workers
10	Home visits (avoid language barriers)

Waitemata DHB

Waitemata DHB undertook a process of redefining its purpose, promise and priorities and organisational values in 2012. In late 2013, this process invited consumers of our healthcare services and staff, across all ethnic groups, to participate in co-designing the standards and behaviours that underpin the Organisation's values. This work has now extended to a larger programme called 'The Waitemata Experience'. –

Patient experience

Auckland DHB patient experience survey

The Auckland DHB Online Patient Experience Survey (In-Patient and Out-Patient) is sent weekly to patients who have completed a clinic visit or been discharged from hospital in the week prior. Questions asked relate to dimensions of care that matter most to the individual patient, and also ask respondents to rate their overall care. In February 2015, the regular monthly report focused on culture, and highlighted some key areas about meeting cultural needs for Auckland DHB patients. Reviewing ratings over the past 12 months by ethnicity, shows that Asian patients are 'less likely' to rate their overall care and treatment positively, as compared to New Zealand European, Māori and Pacific inpatients who are 'most likely' to rate their experience at Auckland DHB positively. The surveys continue to record ethnicity so a further analysis can be completed based on the specific feedback received by the patients across the dimensions of care.

Table 26 Ratings over the last 12 months at Auckland DHB, by ethnicity

Ethnicity	Poor to fair (%)	Good (%)	Very good to excellent (%)
New Zealand European	6	10	85
Māori	6	10	84
Pasifika	3	13	84
Asian	6	12	81
Other	7	12	80
Total Auckland DHB	6	10	84

n=3,898 (New Zealand European n=2,641, Māori n=337, Pasifika n=301, Asian n=496, other n=604); the differences are significant ($p<0.05$)

Patient voice aligned to the Values

One Asian patient voice who rated meeting cultural needs 'highly' (10 on 0-10 point scale) strongly captured all four of the Organisational values.

"I think it helps having diverse staff in terms of ethnicity. So that new migrants to Aotearoa like myself would feel comfortable to speak with them. I think it's important to have ethnic diversity for this reason – and this met my cultural needs to have people I could relate to."

Waitemata DHB friends and family test

Patient experience is one of the three key components of quality: patient safety, clinical effectiveness and patient experience. The Waitemata DHB's 'Friends & Family Test' was developed to provide patients and their families with the opportunity to give feedback on the quality of care and treatment they receive, giving the DHB a better understanding of their needs and enabling improvements to the care and treatment provided. The test was developed in the UK and is now an integral part of Putting Patients First, National Health System (NHS) England's Business Plan for

2013-2016. In May 2013, the UK's Prime Minister announced that the 'Friends & Family Test' would be introduced across the NHS. The test aims to provide a single, simple headline measure of a patient's experience with answers on a five-point scale of extremely likely to extremely unlikely, or excellent to poor. The test gathers ethnicity data for two Asian ethnic subgroups - Chinese and Indian. Korean is not an ethnicity option in the test, however as part of the system redevelopment it will be included given it is the third largest Asian ethnic group in the Waitemata DHB catchment at 13.7% (as at June 2016).

For the 12 month period (01/01/2015 – 31/12/2015), 303 Chinese patients and four Indian respondents completed the test. Due to the low response rate, Indian data was not analysed. Key Chinese patient findings for the Waitemata DHB as a whole organisation were:

- Only 58.7% of Chinese patients (n=303) were 'extremely likely' to 'recommend our ward to friends and family if they need similar care or treatment'), compared to non-Asians (NZ European 70%, Māori 69.2%, Samoan 65.2% and Tongan 58.8%)
- 75.4% rated 'excellent' for feeling 'welcomed and friendly' (n=260)
- 72.8% rated 'excellent' that the DHB was showing 'care and respect' (n=300)
- 65.1% rated 'excellent' that the DHB 'met their expectations' (n=300)
- 69.4% rated 'excellent' that they felt they were 'listened to, and information explained' (n=300).

Patient voice aligned to the Values

"Staff are all friendly, supportive and professional. I feel that I had been taken good care of" [Chinese female, 19-30 years, North Shore Hospital Maternity Unit]

"Asian support is very important, especially for the palliative care patient and family" [Chinese male, 41-55 years, North Shore Hospital Ward 10]

"Staff and nurses are extremely caring thoughtful and all care is given to the needs you require, thank you all for caring" [Chinese female, 56-70 years, North Shore Hospital Ward 6]

"Staff are simply wonderful from specialists to cleaners. Extremely grateful for family support to be allowed to stay with our elderly mother" [Chinese female, 56-70 years, North Shore Hospital Ward 6].

Community engagement/participation

How are patients and the community engaged in designing, supporting, and evaluating health services? Three key projects aimed at listening to and responding to the voice of Asian communities in a collaborative process included:

A Community Health Survey (Auckland DHB)

A Community Health Survey was conducted (October, 2012) aimed at community members (n=2313) across the Auckland DHB Local Boards including:

- Waiheke
- Great Barrier
- Otahuhu
- Puketapapa
- Whau
- Waitemata
- Orakei
- Albert-Eden
- Maungakiekie Tamaki.

Information was gathered about:

- Perceptions of health status and the health of their community
- Experiences of health services in their area, and
- What could be done to lift and protect the health of the community.

Table 27 Snapshot of key findings across Local Boards, where Asian respondents were higher in the sample demographics

Local Boards	Key findings
Albert-Eden, Puketapapa	• Cost was a key issue, and a quarter of respondents would go to emergency services in the hospital as they can't afford a family doctor • After issues of cost and affordability, awareness of/access to mental health services was frequently mentioned as an issue (n=385) • Other barriers to accessing health care were opening hours, transport, availability of appointments • Obesity, poverty and the cost of health services were highlighted as the most important issues for residents • Ethnic diversity was an important factor influencing health and access to health services. Chinese respondents rated their access to health care as low compared to New Zealand Europeans (n=269). Factors attributing a low self-rating related to cost of services and quality issues such as availability/waiting times at general practice
Waitemata	• Comprises a higher number of youth and university students. Youth health concerns included affordability, alcohol, sexual health, diet and mental health (n=373)

Tamaki Mental Health & Wellbeing Project – Burmese engagement (Auckland DHB)

A co-design vision was established: 'an experience of mental health and wellbeing focused on the whole person in their family, whānau and community, over the whole of their life supported by integrated services that are relevant to Tamaki'. Demographic data from the 2013 Census indicated that nearly a quarter (23.7%) of the Maungakiekie-Tāmaki usually resident population identified with an Asian ethnicity, just above that for Auckland as a whole (23.1%). An identified vulnerable Asian subgroup within the Glen Innes area were the Burmese communities. In August 2015, 25 participants (both youth and adults) were invited to share their views about what mental health and wellbeing meant to them as a concept and/or their experiences as part of the Tamaki Mental Health & Wellbeing Project information session. The session was delivered in both English and Burmese, with written information made available in Burmese.

Table 28 Key barriers to access and utilisation of health services

1	The term 'mental health' is a western concept. Mental health is a not on a spectrum, you are either 'normal' or seen as 'crazy'.
2	Language and accessing interpreters
3	Unsure of where to access information about the New Zealand health and disability system
4	Not telling their GP about their 'problems', rather keep to themselves
5	Health literacy
6	Cultural competency of health professionals
7	Perceptions of being looked down on by other staff
8	Poor experiences with services. Wary of the medical system, feel that when they walk away from encounters with the system they feel worse

Primary Birthing Facility Engagement Consultation (Waitemata DHB)

A consultation to gain feedback on options for PBUs in Waitemata took place between 18 January – 29 February 2016. Respondents were asked to rank their preferences against four options approved by the Waitemata DHB board.

Located in the community, operated by the DHB

Located on hospital grounds in a separate building, with its own entrance, operated by the DHB

Located in the community, operated by a private or community contractor (but still free)

Located in a hospital, next to or very close to the maternity unit, operated by the DHB

The consultation was aimed at all of the DHB community, from health professionals to mothers and families, as many people are known to influence a mother's choice of birth location. Feedback was gathered to gain a better understanding of where an additional PBU should be located, what facilities should be there and how the unit should be managed. The consultation was intended to help the DHB to understand what would encourage the community to use the unit.

The consultation included an opportunity to provide feedback online, to attend one of a series of events, or to request a speaker for a group or network. Seven DHB run events took place over a range of dates and locations including weekends and evenings. These included targeted events for Asian, Pacific and Māori communities as well as general community events. Small group discussions were held with a wide number of groups and organisations.

Participation by Asian groups was 9.9%. The findings of the consultation were:

- Asian online respondents (n=95) were fairly equally in favour of all three DHB operated PBUs which were (a) In community, DHB operated, (b) On hospital grounds, in a separate building, and (c) In hospital, near the maternity unit
- Asian groups who attended the forums (n=52) favoured (a) On hospital grounds, in a separate building, and (b) In community, DHB operated
- Asian staff preferred either a community-based, DHB operated or hospital-based facility near the maternity unit.

Top four features as essential for PBUs

1. Breastfeeding support/advice
2. Family friendly
3. Partners to stay overnight
4. Easy to get to by car.

Asian groups were most likely to rate having community health facilities nearby as also essential for PBUs.

Student health (Auckland and Waitemata DHBs)

A student survey about 'Awareness of health services and health information in the Auckland district' took a convenient sample of students from UoA, AUT (North Shore, City and Manukau campuses), Massey University (Albany campus) and NZMA (Sylvia Park campus) (n=318). The survey period was between October 2015- March 2016.

Data was collected in three core domains:

- Your care from health professionals
- Your sources of information
- About you.

Key findings of the student survey:

- Relationship between level 1 ethnicity and student status, whereby the majority of international students were Asian (91%); and secondly, within Asian, the majority of students were domestic (79%). The make-up of the study sample by ethnicity and student status had implications for the study findings and their interpretation and generalisability
- International students tended to have a lower level of understanding of the New Zealand health and disability systems, were less likely to have a usual GP clinic to go to, and accessed EDs of public hospitals significantly less, after adjusting for the effects of ethnicity (New Zealand Māori, European, Asian and all Other). Ethnicity did not seem to affect ED visits

although Asian students had a lower ED access rate than other ethnic groups in the studied convenient sample.

a. Usual GP clinic (n=318)
- Of the 85.8% who responded 'yes' they have one GP clinic or community health clinic they usually go to, Asian was the least likely group (78%) to visit a general practice compared to European (91%), New Zealand Māori (96%) and Other (90%)
- International students were less likely to have a usual GP to visit than domestic students (47% vs. 90%).

b. Awareness of private after-hours urgent care clinics (n=318)
- Of the 58% of students who were aware of after-hours urgent care clinics in their community, domestic students (61%) had greater awareness than 34% of international students (Chi-square test, P=0.0040). Asian had a significantly lower rate of awareness than other ethnic groups (49% for Asian, and 63-66% for other ethnic groups).

c. Access to any EDs of public hospitals (n=318)
- 24% of the participants had been to an ED in the past 12 months. 6.3% of international students accessed ED services and 25.5% for domestic students. 20% of Asian students access EDs while it was between 23%-40% for other ethnic groups. After adjusting for the effects of ethnicity (New Zealand Māori, European, Asian and all Other), the logistic regression model indicated that domestic students were 3.6 times (360%) more likely to visit EDs than international students (0R=4.6, 95% Confidence Interval: 1.04, 20.4).

d. Awareness about the New Zealand health & disability system (n=318)
- For perceived understanding of the New Zealand health system, a mean score was calculated using the Wilcoxon rank sum scores based on the rating scale responses from 1-10 for the perceived knowledge of the New Zealand health system. Domestic students had a higher mean score 168.7 compared to international students 76.5. European and Other groups had a higher mean score 188.1 and 178.32 respectively, as compared to Asian (128.8).

e. Reasons for respondents not enrolling/registering with a GP were related to lack of awareness about the role of primary care (n=33)
- Didn't see the need to register/enroll with a GP (60.6%)
- Didn't know where to register/enroll (45.5%)
- Didn't know how to enroll with a GP (39.4%)
- Not sure about the role of a GP (33.3%).

f. Reasons for going to an ED service in the last 12 months were (n=77)
- I didn't know where else to go (37.0%)
- It was clearly an emergency (36.0%)
- My GP was not open after-hours (36.0%)
- I was told to go by family/friend (24.0%)
- Location (20.0%)

- I can't afford to go anywhere else (16.0%).

g. If you were sick and believe your condition was non-urgent and non-serious, where would you go to/contact first? (n=318)
   - 26.4% of students would not seek out any healthcare.

h. Sources of health information (n=317)
   - The main sources of health information to students are family (72%), friends (58%) and online websites e.g. google (58%). The majority of students (95%) did not use online websites specific to their ethnicity or culture. The 17 students (5.0%) who did so accessed health information from Skykiwi, Chinese radio, WeChat, Samoan radio, Christian life, university newsletters, and NZ Life. There is a need to increase engagement and awareness about health information and the health and disability system to broader population groups and settings that influence students and migrants.

Asian health beliefs

Each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices can differ from the traditional 'western' biomedical model used in New Zealand (WDHB, eCALD, 2016). Cultural beliefs and nuances held by individuals and communities, and variations in levels of health literacy can impact on 1) one's ability to find, process, understand and share health information and services to make informed health decisions for self and others, 2) appropriate access to, and use of health services at the right time and right place, and 3) patient experience. Appendix 6 provides a summary of the Asian health beliefs for Chinese, Korean and South Asian (Indian) about key health services and programmes, and engaging with health practitioners in the Waitemata and Auckland DHBs.

Culturally competent workforce

The increasing diversity of New Zealand's population makes it imperative that the development of CALD cultural competencies in the health sector include the recognition of culture as a determinant of health status; and the recognition of the need for a culturally competent workforce to address issues of health inequities and health disparities between some Asian, Middle Eastern, African and other population health groups in New Zealand.

A comprehensive and quality range of CALD online and face-to-face courses and resources for the New Zealand health workforce has been developed by Waitemata DHB's eCALD® Services (WDHB, eCALD, 2016) with the aim of:

- Improving the quality of engagement of health practitioners and CALD clients/patients
- Improving cross-cultural communication and interactions between employers and employees, as well as employees-to-employees working in a culturally diverse workplace.

eCALD® is an international leader in the production and provision of CALD cultural competency courses and resources. The design uses the latest technology for content management, the learning management system (LMS), e-learning, online resources, forum and e-news publications.

The following are the suite of CALD Cultural Competency "Courses for Working with Patients' which address the cross-cultural interactions between health practitioners and CALD patients/ clients and their families. CALD courses are available on-line and face-to-face, and are Continuing Medical Education (CME)/Continuing Nursing Education (CNE)/and Maintenance of Professional Standards (MOPS) accredited (WDHB, eCALD, 2016).

The courses are:

CALD 1 - Culture and Cultural Competence
CALD 2 - Working with Migrant Patients
CALD 3 - Working with Refugee Patients
CALD 4 - Working with Interpreters
CALD 5 - Working with Asian Mental Health Clients
CALD 7 - Working with Religious Diversity
CALD 8 - Working with CALD Families – Disability Awareness
CALD 9- Working in a Mental Health Context with CALD Clients.

Staff working in the NZ health and disability sector are eligible for free face-to-face and online CALD Cultural Competency "Courses for Working with Patients" if they work for:

- Public, primary and secondary health and disability services funded by Waitemata DHB, Auckland DHB, Counties Manukau DHB, or the Ministry of Health
- DHBs outside of Auckland (commenced 28th August 2015)
- Primary Health Organisations Outside of Auckland (commenced 1st January 2016)
- NGOs in the Auckland region (outside of Auckland non- governmental organisations commence September 2016)
- Northern Regional Alliance Ltd.

The CALD Cultural Competency "Courses for Culturally Diverse Workplaces" provides a suite of courses that addresses the cross-cultural interactions between employers and employees, as well as employees-to-employees in the workplace. These courses are offered as Auckland-based face-to-face courses and will be funded by the MoH from 1 July 2016. All the courses are published on the eCALD® services website at www.eCALD.com.

Opportunity

Overall social progress index score and its dimensions

Internationally	• New Zealand had the highest overall social progress index score among the comparator countries • Migrants in New Zealand experience the most equitable entitlement when compared to the comparator countries	☺
Nationally	• Higher proportions of Asian peoples aged 25+ years of Auckland and Waitemata DHBs had a bachelor degree/level 7 qualification or above than the New Zealand average	☺

New Zealand had the highest overall social progress index score of the countries of interest in 2015. New Zealand was ranked fifth in the world, followed by Canada (sixth), Australia (10th) and the UK (11th). India was ranked last, China second to the last.

There was not sufficient data for Singapore in the dimensions of basic human needs and foundations of wellbeing. New Zealand took third place (the 17th in the world) in basic human needs on the list, after Canada (seventh in the world) and Australia (13th in the world). New Zealand did even better in the dimension of foundations of wellbeing (top on the list and the sixth in the world), followed by Australia (12th in the world) and Canada (14th in the world), with India and China still the last two. New Zealand took the second place in the word in the dimension of opportunity after Canada, followed by Australia (the third in the world). The four Asian countries had relatively lower scores, with China being the last on the list.

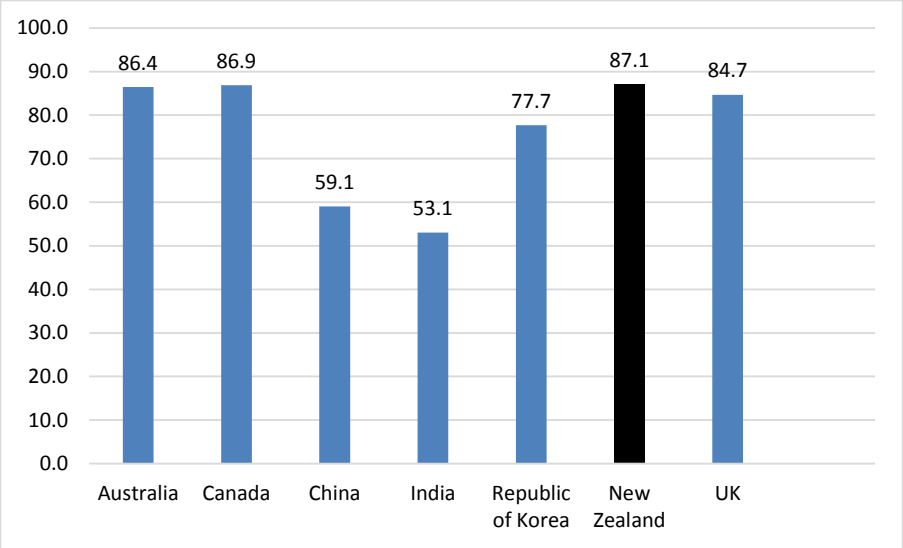


Figure 28 Overall social progress score by country, 2015

Scores of the components of opportunity

China had a very low score for personal rights (only 4.6 out of 100) and India had a lower score for tolerance and inclusion. New Zealand had higher scores in the three components of opportunity, personal rights (first in the world), personal freedom and choice and tolerance and inclusion. New Zealand was behind Canada, the UK, Australia and the Republic of Korea in the score of access to advanced education, but better than Singapore, China and India.

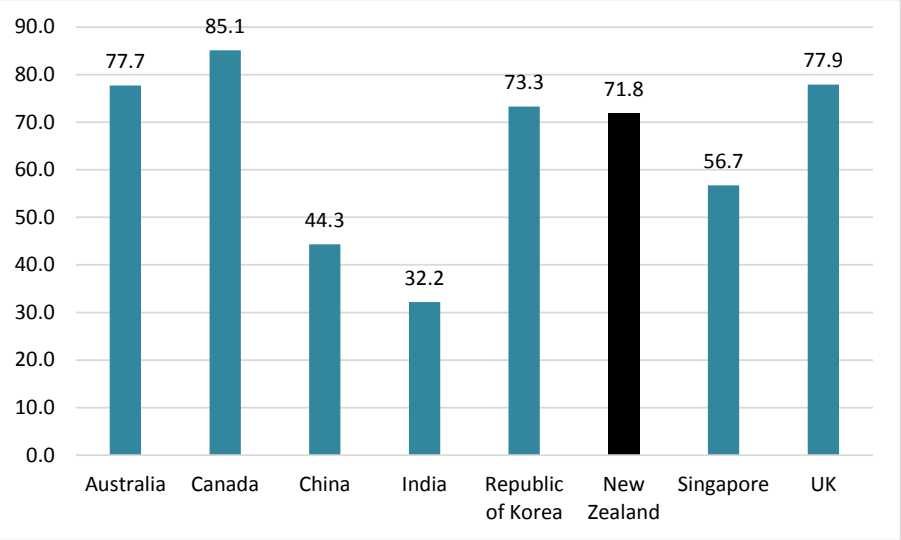


Figure 29 Score of access to advanced education by country, 2015

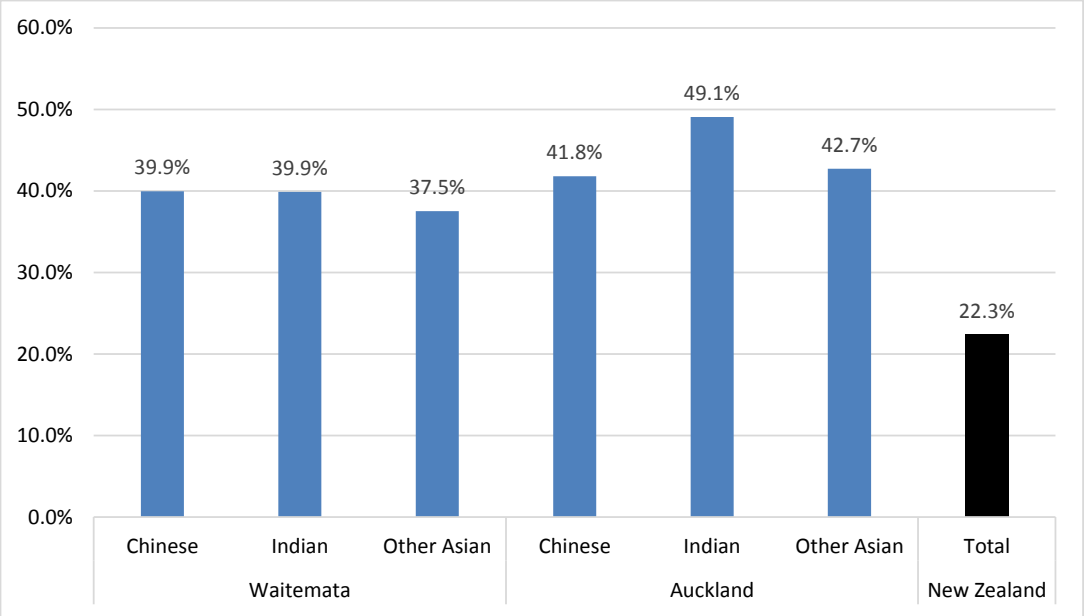
Outcome indicators of access to advanced education

Table 29 provides detailed information related to the outcome indicators that contribute to the component of access to advanced education. China had the lowest ranking of years of tertiary schooling (0.1 year, among people aged 25+ years) on the list and India scored the lowest for women's average years in school (8.9 years, among women aged 25-34 years). There were only two globally ranked universities in Singapore in 2015, while the UK had 74.

Table 29 Raw scores of outcome indicators of access to advance education, 2015

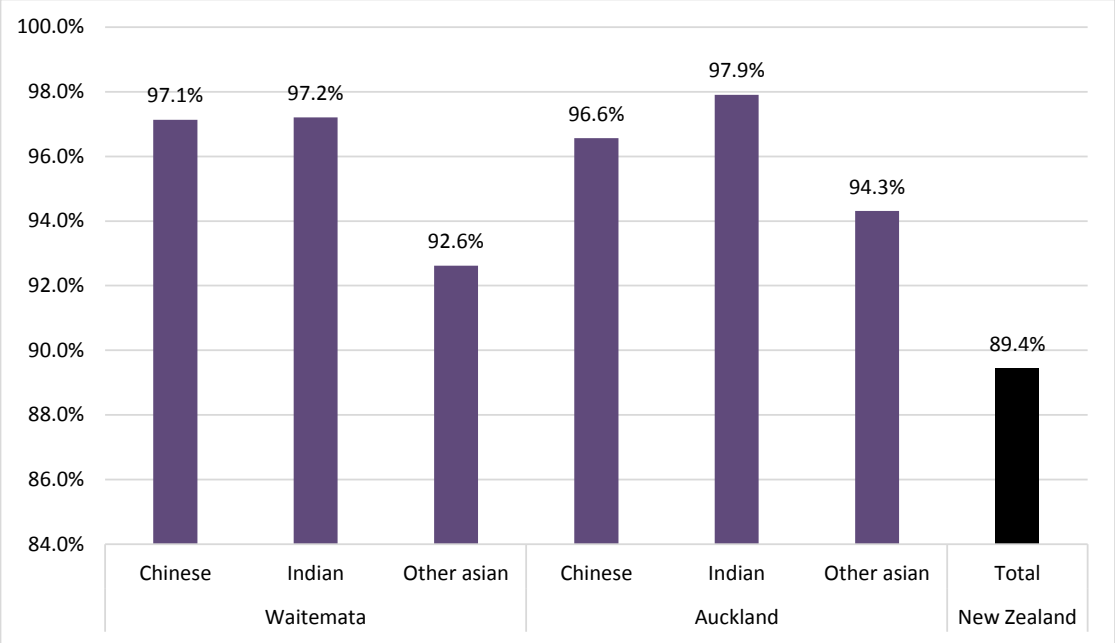
Country	Years of tertiary schooling	Women's average years in school	Inequality in the attainment of education	Number of globally ranked universities
Australia	1.3	12.5	0.018	33
Canada	1.5	15.0	0.040	26
China	0.1	8.9		46
India	0.3	5.6	0.421	14
Republic of Korea	1.5	14.6	0.281	24
New Zealand	1.1	13.6		8
Singapore	1.4	10.1		2
UK	0.9	13.6	0.026	74

Higher proportions of Asian peoples aged 25+ years in both DHBs had a bachelor degree/level 7 qualification or above when compared to the New Zealand average (22.3%), particularly true of Indian in Auckland DHB (49.1%; Waitemata DHB 39.9%). In addition, a higher proportion of Asian women aged 25-34 years in Waitemata and Auckland DHBs had a qualification (primary, secondary and tertiary) than the New Zealand average 89.4%. This is more so for Indian and Chinese in both DHBs (). While these two indicators are not comparable to the ones used in the Social Progress Index, namely years of tertiary schooling and women's average years in school including primary, secondary and tertiary, they indicate a better place than the New Zealand average in the world ranking for the component of access to advanced education, as well as the overall opportunity.



Source: Census 2013, licensed to Waitemata DHB

Figure 30 Proportion of residents with a bachelor/level 7 qualifications or above, aged 25+ years, New Zealand, Census 2013



Source: Census 2013, licensed to Waitemata DHB

Figure 31 Proportion of women with a qualification, aged 25-34 years, New Zealand, Census 2013

Interpretation and reflection

New Zealand had the highest overall social progress index score in the world in 2015 and Asian peoples of both DHBs had higher proportions of having a bachelor degree/level 7 qualification or above (which could be attributed to New Zealand's Immigration policies), compared to the New Zealand average. The New Zealand's Migrant Settlement and Integration Strategy recognises that New Zealand gains the best economic and social benefits from migrants when they settle here successfully (MBIE, Settlement Strategy, 2016). The Strategy identifies five measureable settlement and integration outcomes to focus on:

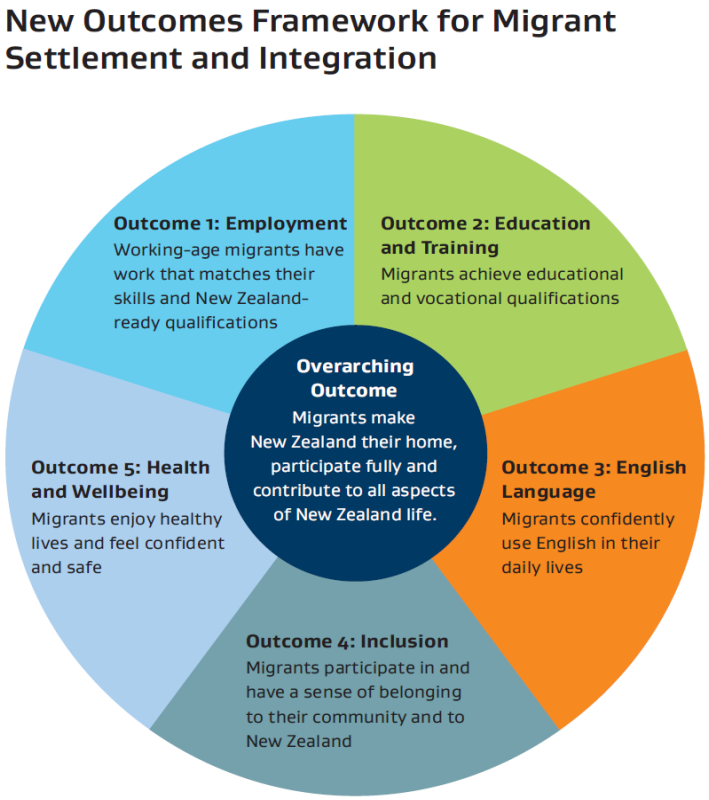


Figure 32 New Zealand's Migrant Settlement and Integration Strategy

Poor settlement experiences related to English language proficiency, unemployment or under-employment, and lack of sense of safety (real or perceived) and inclusion in New Zealand are significant determinants that contribute to poor health outcomes for Asian new migrants and their families/whānau.

Other national strategies that aim to improve the health of Asian populations from former refugee and/or international student backgrounds include:

- New Zealand Refugee Resettlement Strategy - Health & Wellbeing Outcome
- New Zealand International Student Wellbeing Strategy Outcomes Framework - Outcome 3: Health & Wellbeing.

Key findings

Outcomes, risk factors and health service use

Health Outcomes		
Life expectancy	• Both DHBs experience a higher life expectancy at birth (90 years, Waitemata; 89 years, Auckland; 92.9 years for Chinese in Waitemata) when compared to the comparator countries and to the Asian population of New Zealand.	
Cardiovascular diseases	• Both DHBs had the lowest rate of years of life lost (per 100, 000 population) from cardiovascular disease (Waitemata women 897, men 1,147; Auckland women 894, men 1,617).	
Cancer	• Both DHBs had among the lowest rates of years of life lost from cancer (Waitemata women 1,330, men 2,265; Auckland women 1,633, men 2,020).	
Mental health	• Both DHBs had lower overall years of life lost than the total population of New Zealand (Waitemata women 120 per 100,000 Waitemata, men 401 per 100,000, Auckland women 208 per 100,000, men 264 per 100,000).	
Diabetes	• Both DHBs had the lowest rates of years of life lost from diabetes (Waitemata women 154, men 204; Auckland women 174, men 212).	
Infant health	• Both DHBs had a combined infant mortality rate was amongst the lowest (2.2 per 1,000 live births).	
Risk Factors & Prevention		
Tobacco smoking	• Both DHBs had slightly lower smoking prevalence among the Asian population (9.9%, Waitemata; 9.8%, Auckland) than the New Zealand average (10%) • The prevalence in Chinese men is among the highest in the Asian sub-groups (15.2%, Waitemata; 13.8%, Auckland) and higher than the New Zealand average • There is a large inequality in smoking prevalence between sexes, with Asian males having a smoking prevalence five to seven times higher than females.	
Obesity	• The rates of obesity in both DHBs (14.1%, Waitemata; 11.6%, Auckland) are lower than New Zealand as a whole • The DHBs' obesity rates are higher than many of the	

	comparative Asian countries • New Zealand had the highest all-cause mortality rate (49.1 per 100,000 population) attributable to high BMI.	
Physical activity	• Both DHBs had a lower prevalence for adults meeting the New Zealand guidelines for physical activity (30.5%, Waitemata; 45.2%, Auckland) than the New Zealand average (54.0%) • Both DHBs had the lowest prevalence of sufficient physical activity when compared to the comparator countries.	
Health service use	**Immunisation** • Both 8-month and 2 year old immunisation rates are above the 95% coverage target. Rates are similar to the best performing comparator country (China). **Cancer screening** • The cervical screening coverage rates for Asian women of both DHBs (52.9%, Waitemata; 52.4%, Auckland) were lower that the New Zealand average (76.7%) • Asian breast screening rate was lower in Waitemata (66%) than the New Zealand average (71.4%) and lower when compared to the comparator countries. **Health service utilisation** • Asian adults in New Zealand were less likely to have a usual health practitioner or service to visit when unwell (<90%) than other ethnicities • PHO enrolment rates among the Asian population remain well below that of other ethnicities of both DHBs (82%, Waitemata; 74%, Auckland).	
Social Progress		
Social progress index & opportunity	• Higher proportions (>95%) of Asian peoples aged 25+ years in both DHBs had a bachelor degree/level 7 qualification or above than the New Zealand average (89%) • New Zealand had the highest overall social progress index score (87.1) among the comparator countries (2015) • Migrants in New Zealand experience the most equitable entitlement (Migrant Integration Policy Index report 2014) when compared to the comparator countries.	

Patient experience and community engagement/participation

Enhanced patient experience is a strategic priority and long-term outcome for the DHBs with the intent to engage patients and communities in the care they receive. Improving experience of health care services is an important indicator in assessing the quality of the care we provide and is strongly linked to overall health outcomes.

Patient experience of care	
Values	The top four values Asians placed on their experiences and expectations of Auckland DHB health services were: 1. Excellence and professionalism 2. A professional connection with clinicians 3. Confidence about the level of care 4. Efficiency, productivity, and good processes.
Experience of healthcare services	• Asian patients of Auckland DHB are less likely to rate their overall care and treatment as 'very good to excellent' (81%), compared to non-Asians (NZ European 84%, Māori 84% and Pacific 84%) • 58.7% of Chinese patients of Waitemata DHB were 'extremely likely' to 'recommend our ward to friends and family if they need similar care or treatment', compared to non-Asians (NZ European 70%, Māori 69.2%, Samoan 65.2% and Tongan 58.8%).
Access to healthcare services	• Chinese of Auckland DHB Local Boards were more likely to rate their access to health care as 'low', compared to New Zealand Europeans • Factors attributing to a 'low' self-rating relate to 'cost' of services and quality issues such as 'availability/waiting times' at general practice.
International students	International students tended to: • have a lower level of understanding of New Zealand health and disability systems • be less likely to have a family doctor (GP) clinic to go to • have accessed ED at public hospitals significantly less, after adjusting for the effects of ethnicity.

Reflections and next steps

The intent of this report is to profile and assess the health of Waitemata and Auckland districts' Asian population in an international context – considering their health status against our high level outcomes to maximise life expectancy and reduce inequalities in health outcomes. Areas of high and low performance, issues and unmet need for Asian subgroups, and suggested recommendations are highlighted with the intention of maintaining, improving or accelerating (if possible) health status where there are health outcome differences.

The overall findings within this report highlight that Asian populations of Waitemata and Auckland DHBs experience excellent health outcomes and health status compared to the rest of the New Zealand population and when benchmarked internationally. These areas include high life expectancy at birth, lower rates of infant mortality, and lowest rate of YLLs from CVD and cancer. The impact from diabetes for both DHBs was also low when considered internationally. These results are consistent with the well-established phenomenon of the 'healthy migrant effect'.

If we are to maintain or improve Asian health status we must address the disparities within Asian 'high-risk' subgroups associated with access to, and utilisation of health and disability services for newcomers, distribution of health determinants and risk factors, and a diminishing protective 'healthy migrant effect'. Disparities highlighted in this report include a greater risk of CVD for our South Asian population, and the higher Chinese risk of diabetes, youth mental health and childhood obesity.

The next step will include a follow-up report applying an Insight methodology as an opportunity for a 'deep dive' into identified Asian 'high-risk' subgroups. The intent is to provide greater understanding to funders and planners about the cultural nuances, beliefs, drivers, barriers, and mediators that are protective and promoting for Asian subgroups where there are variations in health outcomes in the main overarching areas of:

Areas for focus

The key recommendations are focused on the need to maintain and improve further the health outcomes our Asian populations already experience. Key areas for focus include:

Maintain health status

Life expectancy

- Continue to maintain Asian life expectancy at birth and lower rates of CVD and cancer mortality at country level.

Children get the best possible start in life

- Increase the proportion of Asian newborn infants enrolled with a PHO by three months of age and other child services.

Monitoring Asian & migrant health

- Monitor separately the health of South Asian, Chinese and Other Asian populations in national and regional surveys.

Policy & legal frameworks

- Align efforts to national strategies:
  - New Zealand Health Strategy: Future direction
  - New Zealand Migrant Settlement and Integration Strategy's - Outcome 5: Health & Wellbeing
  - New Zealand International Student Wellbeing Strategy Outcomes Framework - Outcome 3: Health & Wellbeing
  - New Zealand Refugee Resettlement Strategy – Health & Wellbeing Outcome.

Asian & migrant sensitive health systems

- Increase Asian PHO enrolment rates, with the commensurate benefits of seeing one regular family doctor (GP)
- Support the People Strategy (Auckland DHB) to increase promotion of the CALD cultural competency courses.

Networks & partnerships

- Asian consumer voices are included in service co-design planning cycles.

Improve or accelerate health status

Reduce premature mortality from cardiovascular disease

The lowest premature mortality from cancer

- Increase culturally appropriate messaging to South Asian and other targeted ethnic groups about CVD and diabetes risk assessments and healthy lifestyle behaviours.

Achieve a smokefree Waitemata and Auckland by 2025 (<5%)

- Promote culturally appropriate smokefree information and messages to male Chinese and Other Asian communities to achieve the Smokefree Aotearoa 2025 goal.

Reduce childhood obesity

- Work in partnership with Healthy Families Waitakere, the Healthy Babies Healthy Futures programme and other partners.

Children get the best possible start in life

- Promote awareness of the prevalence of measles and uptake of the 4-year immunisations in Asian communities.

Reduce morbidity and mortality for people with mental illness

- Work with Asian Mental Health Services (Auckland and Waitemata DHBs) to provide culturally appropriate support for Asian clients and their families.

Older people experience independence and quality of life

- Progress the roll out of the Cognitive Impairment Pathway and support the review of Day Programmes for older adults.

Patient experience

- At least 5% of Asian representatives join Reo Ora (Auckland and Waitemata DHBs).

Strategic approach

The Asian and MELAA Health Action Plan (Auckland and Waitemata DHBs) will be updated to address the areas of focus set out in this health needs assessment. This action plan will be overseen by the Asian & MELAA Health Governance Group (Auckland and Waitemata DHBs). Successful implementation of the action plan will require collaboration across the health sector.

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Appendices

Appendix 1 Healthy Migrant Effect

The 'healthy migrant effect' is a phenomenon where the health of first generation migrants is often better than the host population (Anikeeva, 2010) (Argeseanu Cunningham S, 2008) (Gushulak B. P., 2011) (Pasupuleti, 2015) (Biddle, 2007). This phenomenon is thought to occur for a number of reasons, mainly self-selection at the time of migration and the health prerequisites and resources associated with migration. This phenomenon generally manifests as lower mortality and hospitalisation rates, as well as lower rates of disability and risk factors, such as obesity and hypertension, when compared to the domestic population of the host country. Such health advantage often deteriorates with increased length of stay as explained by the lifestyle attitudes and behaviours adopted from the host population - known as 'acculturation'[6]. In many studies, acculturation is usually crudely measured by duration of residence since the time of immigration, and it plays a major factor in modifying the social, behavioural, and health characteristics of migrants, particularly of the Asian migrant groups (Singh G. H., 2006) (Arcia, 2001) (Singh G. K., 2009).

11.2

In New Zealand, Asian peoples generally have good health that is comparable to the general population (Statistics New Zealand, 2016). Data suggests that people of Asian ethnicity or descent, as a whole, have favourable outcomes on a range of health indicators compared to other major ethnic groups in New Zealand (Abbott, 2006) and like other migrants, this health advantage may be accredited to the 'healthy migrant effect'. However, relative to the New Zealand European ethnic group, the Asian group as a whole has lower rates of access to health services and health care utilisation, particularly by the Chinese population (Mehta, 2012). This includes primary healthcare enrolment, uptake of screening programmes, and access to mental health services, aged residential care and disability support (Jatrana, 2009). Possible contributors to these disparities include stigmatisation, language barriers, cultural attitudes and behaviours, understanding of the New Zealand health and disability systems, and lack of cultural competency in the health workforce (Wong A. , 2015).

- Low physical activity rates
- Mental and substance use
- Low cervical and breast screening rates
- Youth – self harm and interpersonal violence
- Asian obesity rates.

Appendix 2 Summary of key highlights

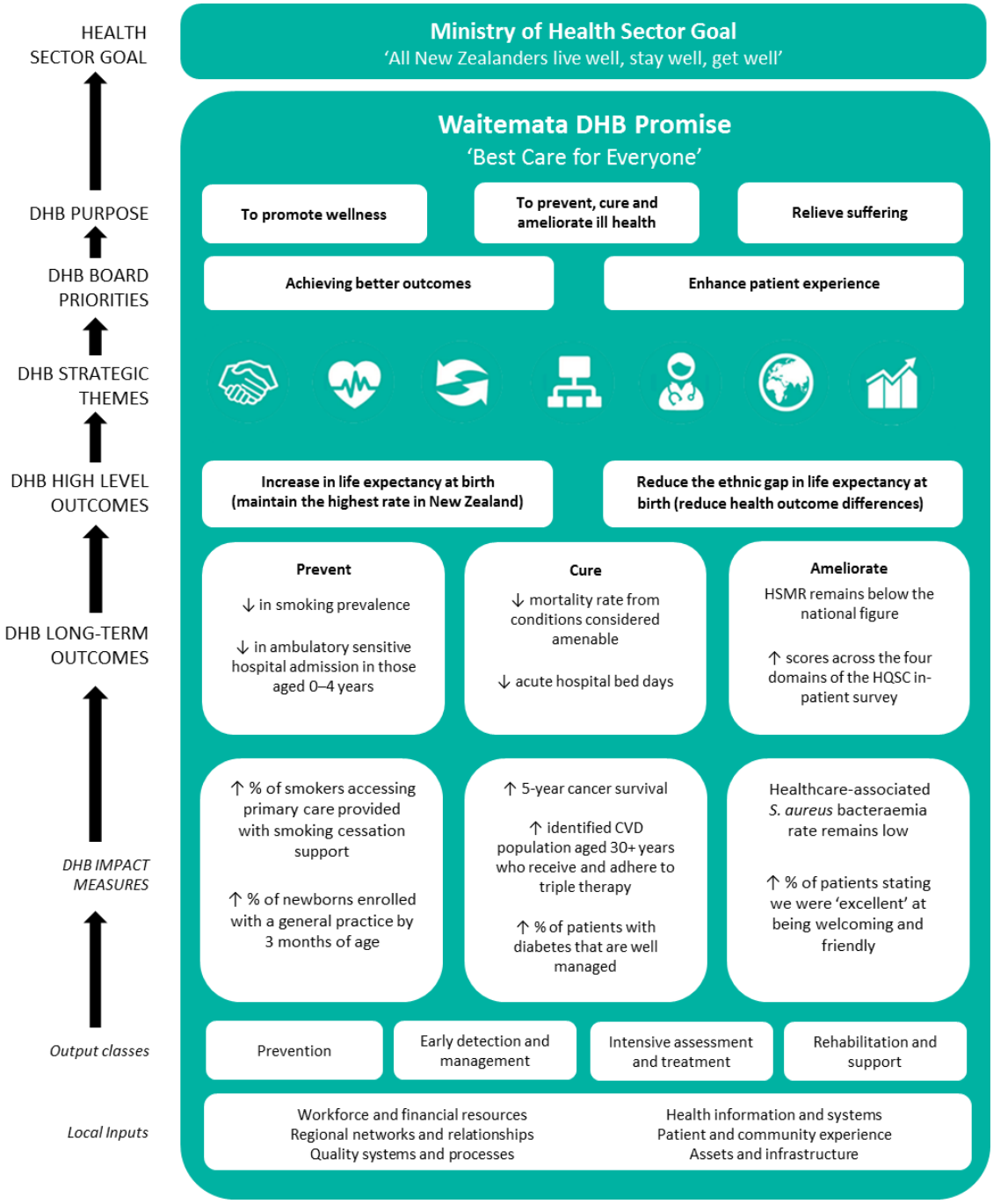
Group	Area	Measures	Asian of Waitemata	Asian of Auckland	New Zealand[#]	Other Countries[#]
Risk factors	Tobacco smoking	ASR* of prevalence	Chinese (15.0%) and Other Asian (13.1%) men, regular smoking rate, comparable to/higher than European/Other	Chinese (13.8%) and Other Asian (12.9%) men, regular smoking rate, comparable to/higher than European/Other	The 2nd highest daily smoking rate for women (14.7%)	Republic of Korea (48.5%), highest daily smoking rate for men
	High body mass index	ASR of prevalence	Higher in all three Asian sub-groups (aside from Chinese women) than European/Other, ethnic cut-off criteria apply		Highest (29.2%), 18+ years, women and men and women only	Australia No 1 for men
		ASR of deaths, DALYs			Highest mortality rate of all causes attributable to high BMI (60.8 per 100,000), women and men combined; DALYs rate No 2, women and men	Australia No 2 and the UK No 3 in mortality rate attributable, women and men combined;
	Physical inactivity and low level of physical activity	ASR of prevalence	Higher rate (69.5%) not meeting the New Zealand guideline for physical activity than the NZ average; Potentially highest rate of insufficient activity compared to other countries (indirectly)	Higher rate (54.8%) not meeting the New Zealand guideline for physical activity than the NZ average	No 1 (39.8%) 'insufficiently active', adults aged 18+ years	The UK No 2
		ASR of DALYs			In the middle (541 per 100,000)	India No 1 (1025 per 100,000) and Singapore No 2 in DALYs rate
General health	Life expectancy at birth	Life expectancy at birth	90 years for Asian; 92.9 years for Chinese, the highest, compared to other countries	89 years for Asian	Comparable to other high income countries (NZ 82 years)	Singapore/Australia (83 years) , the highest; India (66 years), the lowest

Group	Area	Measures	Asian of Waitemata	Asian of Auckland	New Zealand[#]	Other Countries[#]
Total burden of disease	Total DALYs	ASR of DALYs, deaths, YLLs	Lower mortality rate than the Asia born Australians; Lowest rate of YLLs at country level	Mortality rate comparable to the Australians born in Asia	Total DALYs rate, comparable to other countries; Lowest rate for communicable, maternal, perinatal and nutritional conditions	India, highest total DALYs rate; Singapore, lowest total DALYs rate
Non-communicable diseases	Cardiovascular diseases	ASR of YLLs, YLDs and DALYs	Lowest rate of YLLs (937 YLLs per 100,000 women and 1,216 per 100,000 men) at country level; Indian and Other Asian had higher YLL rate than Chinese	Lowest rate of YLLs (934 YLLs per 100,000 women and 1,714 per 100, 000 men) at country level; Indian and Other Asian had higher YLL rate than Chinese	Lowest rate of YLDs; Comparable rate of DALYs to other countries	India, highest DALYs rate; China, the second highest
	Cancer	ASR of YLLs, YLDs and DALYs	Lowest rate of YLLs (1,134 YLLs per 100,000 women and 1,937 per 100,000 men) at country level	Lowest rate of YLLs (1,392 years of life lost per 100,000 women and 1,728 per 100, 000 men) at country level	New Zealand had the highest rate of YLDs, with comparable DALYs rate	China had the highest rate of DALYs
	Diabetes Mellitus	ASR of YLLs, YLDs and DALYs	Indian women and men and Other Asian men followed India and Korea closely in YLL rate at the country level	Variations of YLL rate within Asian sub-groups in Auckland were very close to the pattern in Waitemata	Among the best countries in DALYs rate	India had the highest DALYs rate, followed by Singapore and the Republic of Korea; The UK did the best in DALYs rate; Singapore had the highest YLD rate; India and Korea had the highest YLL rate
	Alzheimer's disease and other dementias	ASR of YLLs, YLDs and DALYs	Close to China and India but behind Singapore and the Republic of Korea, in YLL rate	Close to China and India but behind Singapore and the Republic of Korea, in YLL rate	Comparable rates to other 'Western countries' (mortality, YLLs and DALYs); highest in YLD rate	The Asian countries led by Singapore and the Republic of Korea had much lower burden of disease rates (mortality, YLLs and DALYs)

Group	Area	Measures	Asian of Waitemata	Asian of Auckland	New Zealand[#]	Other Countries[#]
Injuries	Self-harm and interpersonal violence	ASR of death, YLLs and DALYs	Among the top performers in YLL rate at the country level	Among the top performers in YLL rate at the country level	Higher mortality and DALYs rates just behind India, particularly for males, among youth (15-19 and 20-24 year olds)	India and the Republic of Korea had the highest mortality and DALYs rates
Maternal and infant health	Infant	Low birth weight rate	Indian had the highest rate (8.3%) among Asians, Waitemata DHB	Indian had the highest rate (12.2%) among Asians, Auckland DHB	Comparable to other countries except for India	India had a much higher rate (28%) than all other countries; China did the best (2.4%)
		Infant mortality	Top place at country level (0.2% per 1000 live births)[$]	Comparable to other countries except for India	Comparable to other countries except for India	Singapore had the lowest rate at 2 per 1000 live births
Health service use	Immunisation and cancer screening	Children's immunisation rate and women's cervical screening coverage rate	The cervical screening coverage rate was lower than that of the averages of New Zealand and the UK (Waitemata 66% in 2015)	The cervical screening coverage rate was lower than that of the averages of New Zealand and the UK (Auckland 66% in 2015)	The average cervical screening coverage rate was 76.7% (three-year coverage) for women aged 25-60 years	China is the top performer in children's immunisation coverage rate
Social progress index and opportunity	Access to Advanced Education	Tertiary education	Higher proportions of Asian people aged 25+ years in both DHBs had a bachelor degree/level 7 qualification or above when compared to the New Zealand average (22.3%), particularly true of Indian in Auckland DHB (49.1%)		The highest overall social progress index score of the countries compared in 2015; access to advanced education, behind	Canada had the highest score of access to advanced education, with India and China the lowest

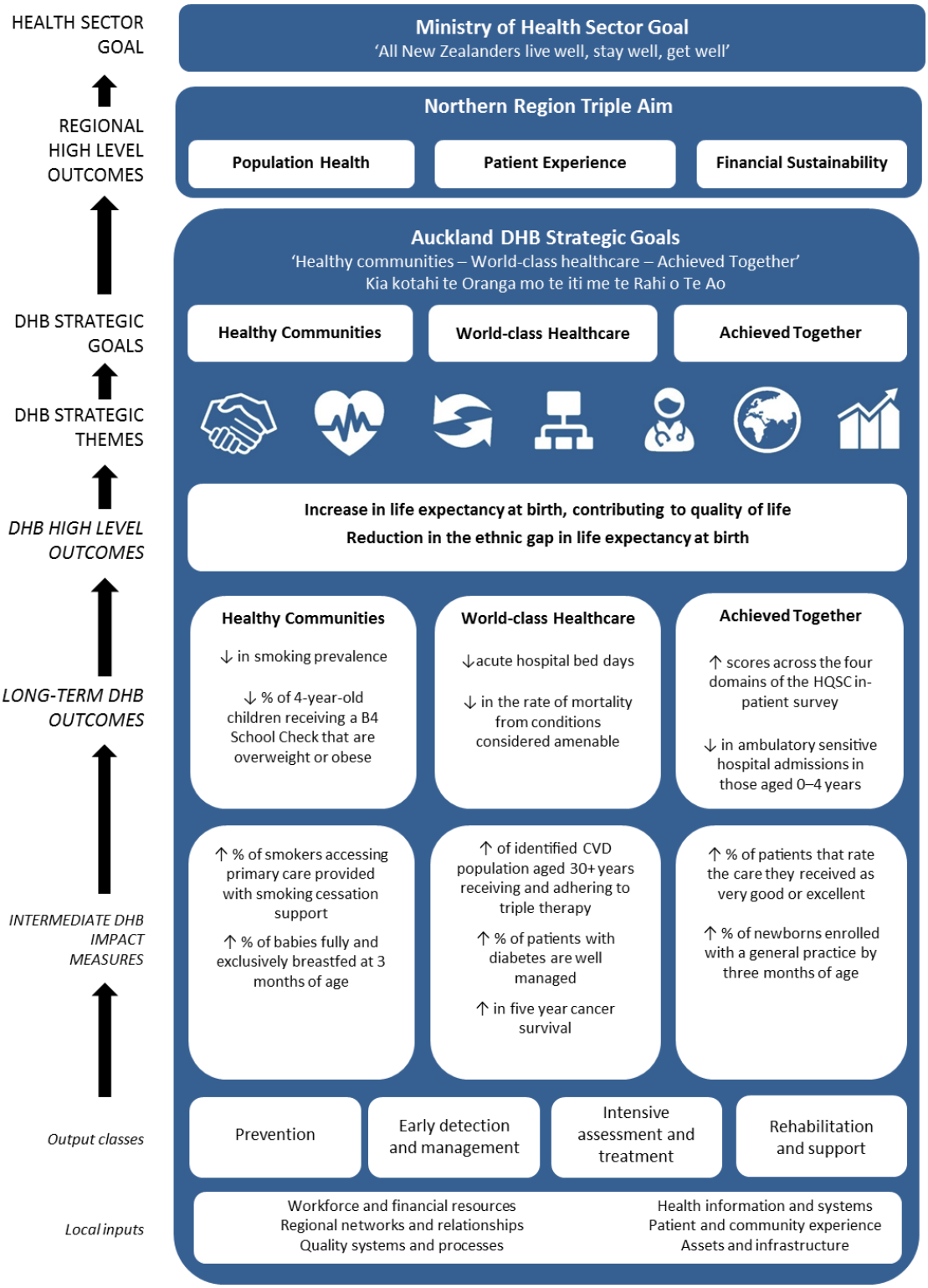
* ASR, age standardised rate
# Comparisons made among New Zealand, Australia, Canada, the UK, China, India and the Republic of Korea
$ Acknowledging potential random variation

Appendix 3 Outcomes framework and intervention logic, Waitemata DHB



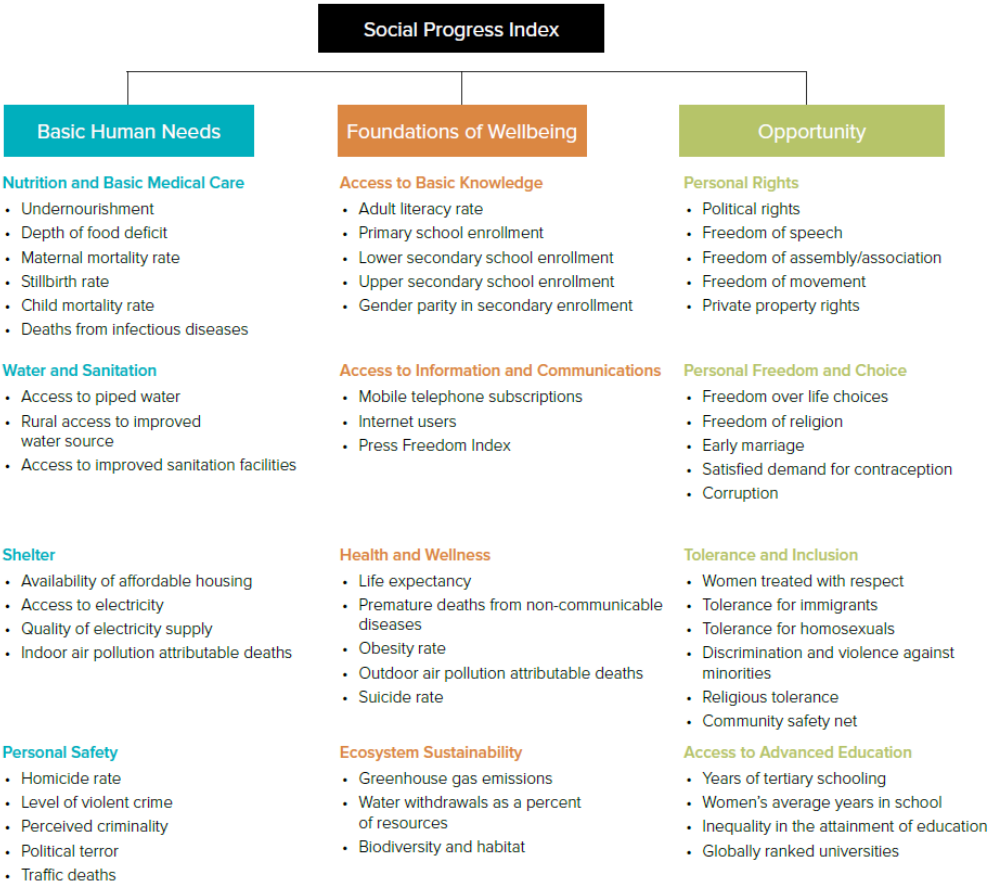
Source: 2016/17 Annual Plan, Waitemata District Health Board

Appendix 4 Outcomes framework and intervention logic, Auckland DHB



Source: 2016/17 Annual Plan, Auckland District Health Board

Appendix 5 Social Progress Index Indicator-level Framework[6]



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http://www.socialprogressimperative.org/system/resources/W1siZiIsIjIwMTUvMDQvMDgvMjMvMjMvNTMvNDAyLzIwMTVfU09DSUFMX1BST0dSRVNTX0lOREVYX0ZJTkFMLnBkZiJdXQ/2015%20SOCIAL%20PROGRESS%20INDEX_FINAL.pdf accessed 14 April 2015.

Appendix 6 Asian health beliefs about health services and engaging with health practitioners

Health services	Asian health beliefs
Child health	**Feedback by Asian families using Child Disability Services (Waitemata DHB)** **Barriers** • No knowledge of service's existence • Hard to understand the health system differences with those of home country • Introducing and explaining agencies such as Taikura Trust, CCS Disability Action, Ministry of Education, WINZ, and Housing NZ, and their roles in providing care for children with disabilities • Interpreting services and information about interpreting services in the DHBs **Enablers** • More cross cultural resources needed regarding general health and disability information • Healthcare, disability and culture related publications • Family support networks, social activities, such as multicultural playgroups • Disability awareness for stigma attached to disability • Access programmes for example: coping strategies, behaviour support Source: Waitemata DHB. (2016). Perspectives from CALD Cultural Case Worker (Asian), Child Disability Service.
Screening	
Breast & Cervical	**Feedback by Asian women using women's health screening programmes and services** **Barriers** • Communication difficulties (different languages, lack of time) • No after-hours or weekend services • Health literacy problems • Screening is not considered relevant or important

Health services	Asian health beliefs
	• Embarrassment • Cultural insensitivity and incompetence • Cold room • Fear of lack of confidentiality • History of sexual abuse • Fear or distrust of the process and/or the results • Obesity where there is discomfort and embarrassment • Transience, no fixed abode • Previous bad experience • Lack of time, transport, childcare • Cost • Being unprepared (for an opportunistic smear) • Difficulty in taking time off work • Lack of trust in health care system • Lack of community and family support • Concept of "preventive care" is foreign • Reassurance about the procedures • Perceptions about invasive procedures • Promotion often in English • Unclear about facts • Aotearoa line in English • Access to interpreter services Source: Mixed Asian feedback from Asian ethnic partner groups in the Waitemata and Auckland DHBs (2015)
PHO enrolment	**Barriers to PHO enrolment for Asian populations** • Didn't see the need to register/enrol at a GP • Cost as it was too much to see a GP • Not sure about the role of a GP • Don't know how to register/enrol with a GP • Don't know where to register/enrol • Previous bad experiences with GP/healthcare services • Language barrier • Different cultural approaches • Issues with claiming the GP fees with medical insurance provider • Transport • Readiness to seek out information • Knowledge of settlement service touch points • Competing information at orientation workshops during early settlement stages which leads to

Health services	Asian health beliefs
	information overload and loss of retention • Access to up-to-date and correct information by partners and providers • Access to information in multiple languages across mixed communication methods i.e. social media, face-to-face workshops and hardcopy collateral. Sources: Mehta S. (2012). Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency. Auckland DHB. (2016). Report on Student Awareness of Health Services and Health Information in the Auckland District. Auckland: Auckland DHB.

Appendix 6.1 Asian experiences about cervical smears

Asian subgroup enablers to increased uptake of cervical smears for Korean, Chinese and Japanese women in the metropolitan Auckland region.

Korean	**Chinese**	**Japanese**
1. Going for a cervical smear is very different to going to the doctor with a cough. If you needed advice on cervical screening and its relevance to you, and where to go for a smear, who would you talk to?		
• Friend • Church member • Neighbour (any ethnicity) • Family in Korea • Korean nurse	• GPs or nurses • Asian community agencies • Family Planning *Suggestion: need for more data, more promotion through different media and using different languages*	• GP or Nurse • Close friends that can be trusted and are non-judgmental
2. What can be done to make the whole process of going for a smear easier or more acceptable?		
• Female smear taker with relaxing technique • Convenience of appointment (aligned to medical check-up) • Communication in Korean language • Low cost or free	• Mobile services at weekends • Use of appropriate Asian language especially for the first time • Free or low-cost services	• Regular contact, and notices • Setting up a bidet (washlet-toilet-Japanese style • Handy location • Low cost
3. Think about the different age groups for the eligible women in your community between 20-69 years of age. What are the barriers or enablers they experience?		
• Culture and enhanced level of embarrassment • Lack of information about the procedure • Myth e.g. if no partner, no need	• 20-30 years: attend to cultural barriers, and low awareness • 31-50 years: home visits, more promotion, weekend services • 51-69 years: information in Asian languages	• Raising awareness • More information so that they can feel familiar • Discussing the concerns and misunderstandings (many websites give the impression that cervical cancer occurs if you have many

		sexual relationships, therefore there is a shame attached, with the association with feeling dirty etc.

Comments

- Korean women may prefer the smear to be done by a doctor rather than a nurse as they may not trust the quality of the process, being used to specialists doing these tests in Korea
- Women may have had a hysterectomy and not know if they still have a cervix. The notes do not always travel with the woman when she relocates to New Zealand
- There is dissatisfaction with the service e.g. lack of cultural awareness, and not having the smaller speculum available, when the smaller build of Asian women makes this obviously appropriate
- Women would appreciate services being "packaged" and all checks being available at the same time and same place as they are at home
- Daughters can help promote cervical screening to their mothers, where they have less difficulty in understanding the literature, and hence the relevance and benefits of having a smear

Source: Report from the Auckland Regional Cervical Screening Project Manager on Consultation with Japanese, Korean and Chinese women regarding Cervical Screening (2013).

Appendix 6.2 Asian bowel screening participation experiences

Barriers and enablers to bowel screening participation for Korean, Chinese and South Asian groups in the Waitemata DHB.

Korean	**Chinese**	**South Asian (primarily Indian)**
1. What are the barriers preventing you from doing the bowel screening test?		
• Language barrier • Attitude - I am healthy enough - I rather not know - The test is too simple – looks not effective - Too busy – I have more important things to do • The test looks complicated/difficult to do	• Language barrier • Don't understand the difference between the New Zealand health system, and the health system in mainland China or other Asian countries • I am healthy - I don't need to do the test • The test looks complicated/difficult to do • I would rather not know	• Indian community is very conservative- don't like to speak about embarrassing health issues • Language barrier • Fear of the unknown • The test is not reliable- used to larger samples • Other health priorities • I would rather not know
2. What can be done to help you do the test?		
• Translation of resources • Easy explanation about the test programme in my own language (from follow up phone call): - Why periodic screening is necessary - How the test is effective - Home visits to show how the test is done	• Translation of resources • Highlight that the test is free • Easy explanation about the test programme in my own language (from follow up phone call): - Why periodic screening is necessary - How the test is effective - Home visits to show how the test is done	• Translation of resources • Easy explanation about the test programme in my own language (from follow up phone call): - Why periodic screening is necessary - How the test is effective

Korean	Chinese	South Asian (primarily Indian)
3. What other support do you need?		
• Doctor's recommendation is very effective • Media promotion- raising awareness of the programme so people start discussing it • Community & family support	• Include family and educate why it is important for me • Doctor recommending me to do the test • Community support- through discussing at community meetings etc. • Media promotion	• Include family and educate why it is important for me • Doctors recommending me to do the test • Education around what bowel cancer is • Radio promotion
Comments		
• The premise of grasping the 'screening' concept is still an issue as many will do the test once but may not understand why they have to do it again. • Follow-up phone calls have been crucial for the Asian community in regards to providing information in their own language and educating why it is important to take the test. This has resulted in a participation rate that is higher than the overall Programme's participation rate. • Many Korean people have colonoscopies overseas so may not be eligible • Family members can help promote bowel screening to their parents/other family members, where they have less difficulty in understanding the resources, and hence the relevance and benefits of taking the test. Source: Waitemata DHB. (2016). Bowel Screening Community Team.		

Appendix 6.3 Asian experiences about health and diabetes checks

Barriers and enablers to heart and diabetes checks, and diabetes self-management for eligible Chinese and Korean groups in the Waitemata DHB.

Chinese	**Korean**
1. What are barriers that stop you from doing the heart and diabetes check?	
• Lack of understanding of heart & diabetes information • Low health literacy due to language barrier (19% of non-English speaking population at Waitemata DHB) • Cost involved (e.g. GP visits) • Busy lifestyle: No time to visit health professionals during weekdays (under 45yrs) • Lack of food/nutritional information & knowledge • Lack of information about availability of health services availability • Hardship using public transport to access health services • Some of them still think gaining weight is a good sign of wealthy and good life (elderly) • No help to seeking/fear of diagnosis	• Lack of understanding of heart/diabetes information • Low health literacy due to language barrier (26% of non-English speaking population at Waitemata DHB) • Lack of food/nutritional information & knowledge • Lack of information about availability of health services availability • No help to seeking/fear of diagnosis • Cost involved (e.g. GP visits) • Busy lifestyle i.e. busy during weekdays • Lack of transport (elderly or women) • Some of them still think gaining weight is a good sign of wealthy and good life (elderly)
2. If you need advice on diabetes, its relevance to you, and where to go for a diabetes check, who would you talk to?	
• GPs (Chinese or Kiwi) and nurses • Chinese herbal doctors • Asian community agencies • Ask for information from family/friends • Internet searching: online Q&A e.g. www.baidu.com	• GPs (Korean or Kiwi) or nurses • Korean pharmacists • Herbal doctors • Ask for information from family/friends or church members • Internet searching: online Q&A e.g. www.naver.com
3. What can help you with self-management of your diabetes?	
• Health professionals with Chinese language skills • Interpreter if no Chinese health professional available	• Health professionals with Korean language skills • Interpreter if no Korean health professional available

Chinese	**Korean**
• Professional practices that satisfy patients' cultural needs • Convenience of making/attending appointments • Weekend services for full-time workers • Free or low-cost services/free parking • Handy location (close to public transport) • Translated diabetes information and resources • Diabetes self-management courses facilitated by Chinese health professionals and dieticians • Chinese diabetes support group (local)	• Professional practices that satisfy patients' cultural needs • Convenience of making/attending appointments • Weekend services for full-time workers • Free or low cost services • Handy location (close to public transport) • Translated diabetes information and resources • Diabetes self-management courses facilitated by Korean health professionals and dieticians • Korean diabetes support group (local)
4. What other support do you need? Think about the different age groups of eligible people in your community between 20-69 years of age	
• 20-40 years - low awareness - high number of pregnant women with diabetes • 41-65 years - cultural & language barriers - more promotion and availability of weekend services - more information in other Asian languages • 65+ years - cultural & language barrier - more information in Asian languages	• 20-30 years - low awareness - high number of junk food intake • 31-50 years - cultural & language barriers - more promotion and weekend services - more information in Asian languages • 51+ years - cultural & language barriers - more information in Asian languages
Comments	
• There is dissatisfaction with the mainstream services, e.g. lack of cultural awareness • Asian foods are different from European foods. Therefore, mainstream food guides don't work for many Asians. • Lack of Asian workforce in the diabetes service area i.e. limited number of Chinese dieticians, and no Korean registered dietician in New Zealand. • Suggestions include need for more data, more promotion through Asian media using different languages. Source: Waitemata DHB (2016). Asian Health Service.	

Appendix 6.4 Preliminary summary for Indian, Chinese and Korean focus group about living with pre-diabetes and type 2 diabetes

Preliminary findings by the Waitemata DHB, Diabetes Service employee completing her PhD aimed at 'Designing and testing an online diabetes nutritional education programme for the New Zealand population'. A focus group was conducted in 2015-16 'Exploring emotions, knowledge and nutritional support in different ethnic groups living in New Zealand with pre-diabetes and type 2 diabetes. Participants included Asian groups from Chinese, Korean and South Asian (Indian) backgrounds.

Ethnic group	**Preliminary findings**
Indian	• All Indian participants have a strong desire to stay healthy and stop diabetes progression • Many Indian participants are worried about limited diabetes support in the Indian community • All Indian participants preferred clinicians to look after their diabetes • Amongst the participants, there was incomplete knowledge of Type 2 diabetes management, nutrition and diabetes medications. Some struggled to remember scientific terminologies leading to confusion which can be linked to issues of health literacy
Chinese and Korean	• All participants wanted to improve their diabetes and nutritional knowledge • Most participants were satisfied with their diabetes care • Concerns about inadequate consulting time
Source: Waitemata DHB. (2016). Diabetes Service employee completing her PhD aimed at designing and testing an online diabetes nutritional education programme for the New Zealand population.	

Appendix 6.5 Asian Mental Health Services' experiences

Barriers and enablers to access and use of Asian mental health services for Korean, Chinese and South Asian groups in both Waitemata and Auckland DHBs.

<table>
<tr><th>Korean</th><th>Chinese</th><th>South Asian (primarily Indian)</th></tr>
<tr><td colspan="3">1. What are the barriers preventing you from accessing and using mental health services?</td></tr>
<tr><td colspan="3">• Did not know mental health care services existed
• Did not know how to access services
• Believed the problem was not severe enough
• Shame tends to equate mental ill health to "craziness" and will be locked up
• Accessed other support instead of mainstream services (e.g. traditional healer, alternative therapies and spiritual and religious help)
• Believed services were not culturally appropriate
• Language issues or concerns
• Cost of service was a concern
• Issues with transportation
• Risk of stigma from the community was a concern
• Fear of personal shame and embarrassment
• Fear of being segregated or rejected
• Family did not support them accessing mainstream health care
• Concerns about their residency status
• Concerns about how accessing mental health services would impact on their future endeavours (e.g. education, employment and marital status)
• The concept of Mind and Body Inseparation encourages help seeking through physical practitioners
• Has a different definition of Mental Disorder, hence may report symptoms differently
• Prefers a "quick fix"
• Western medicine is too "toxic" and the side effects are too strong, more incline to seek traditional medicine which are perceived as "milder and less toxic"
• Worry about being "addicted" to Western medicines
• Male pride - men should be mentally stronger than women
• Small community and worried about gossip
• Accessing to service could be related to the level of acculturation and years in New Zealand</td></tr>
<tr><td>• Stigma
• Cultural barriers
• Language
• Use of alternative therapies</td><td>• Stigma
• Cultural barriers
• Language
• Use of alternative therapies</td><td>• Stigma
• Cultural barriers
• Use of alternative therapies
• Immigration</td></tr>
</table>

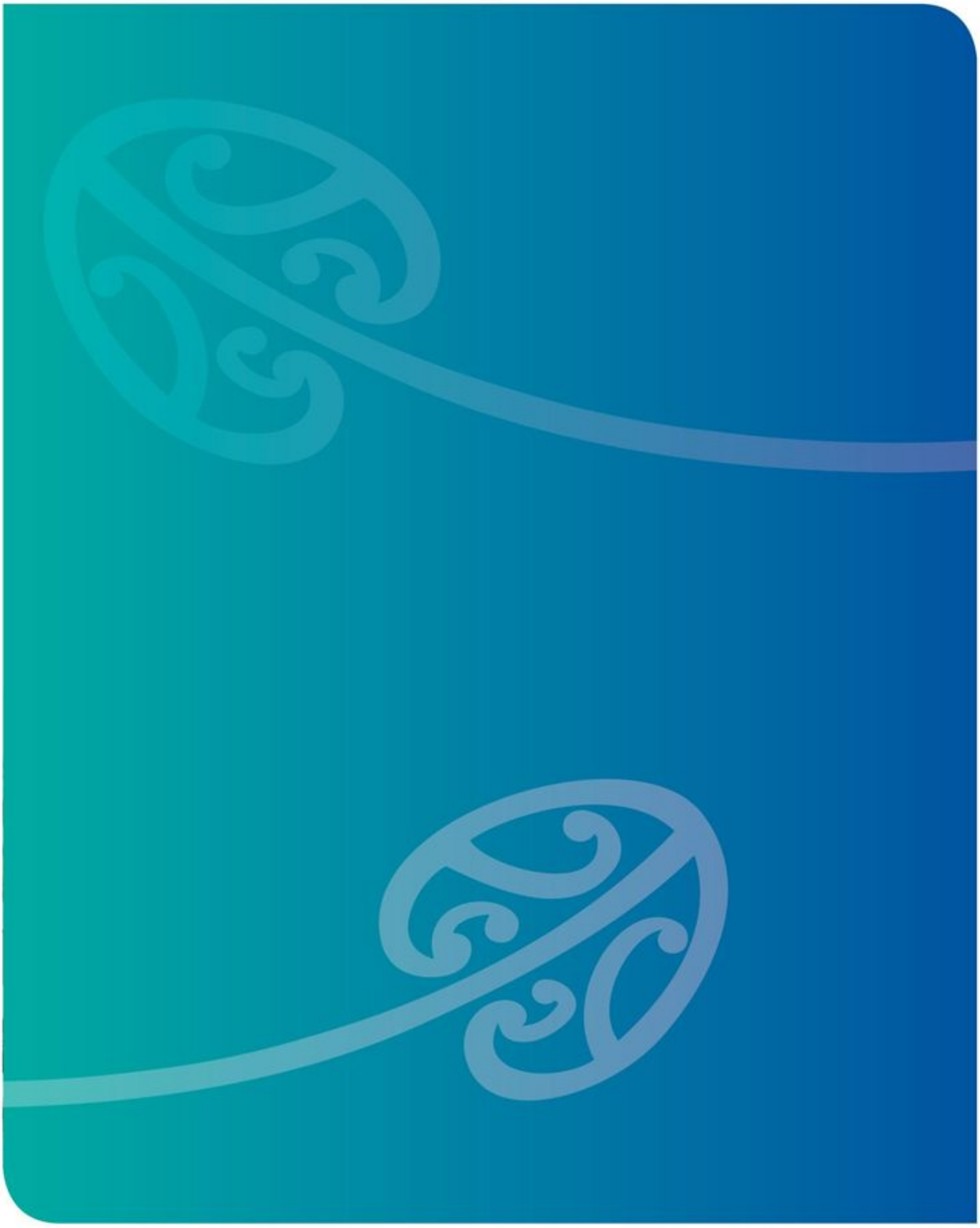
Korean	Chinese	South Asian (primarily Indian)
• Distrust of mainstream services • Immigration • Lack of awareness of services • Unfamiliarity with the structure of health care services	• Distrust of mainstream services • Immigration • Lack of awareness of services • Unfamiliarity with the structure of health care services	• Lack of awareness of services • Unfamiliarity with the structure of health care services
2. What can be done to help you to better use the mental health services?		
• A clearer road map or information line for Asian communities to enable them to access information about mental health services and service access criteria (three top Asian languages) • Service information is easy and simple to understand • Encourage early help seeking behaviour in order to avoid crisis interventions • Addressing stigma and discrimination associated with mental illness, i.e. programme such as Like Minds, Like Mine Chinese Media Campaign, Kai Xin Xing Dong • Psychoeducational information available to the general public in Asians languages (Chinese & Korean) to start with since these two are the largest non-English speaking Asian population in the Waitemata district • Use of the ethnic TV/media to help demystify "mental ill health", focusing on recovery • Working with GPs, given the physical explanation of mental illness, meeting at GP clinic may also help to "neutralise" the stigma • Seeing more Asian faces working in the Mental Health System to show that the DHBs are aware of my cultural needs • eCALD™ training to upskill staff on cross cultural clinical practice • Working with the traditional healers for engagement purposes • A 'One Stop Shop' health centre similar to the services provided by the home countries • Increasing the emphasis on cultural sensitivity of mental health services are available and able to meet the need of individual, i.e. eCALD™ training • Promoting the use of interpreter services for primary health and secondary services • Establishing an Asian Mental Health Community Awareness Working Group to develop a strategy that: o connects with Asian communities to address issues relating to stigma and discrimination in mental health through inter-sectorial links o raises awareness of mental health services which will result in an early engagement with services and improve mental health literacy.		
3. What other support do you need?		
• Timely access for clinical cultural specialist consultation • Timely access for matching language individual and group therapy interventions		

Korean	Chinese	South Asian (primarily Indian)
• Regular support group for mental health clients who may also be a parent • Regular clinical intervention parenting programme in both Mandarin and Korean • Parents/family support groups • More NGO non-clinical community support services • Well trained and professional Interpreter Services		
Comments		
There is evidence that the Asian populations are delaying seeking mental health services until they are acutely unwell. • Research indicates that there are multiple factors contributing to the barriers of access mental health services. • These barriers occur at an individual, community and societal level impeding the ability of Asian people to engage with mental health services. • There is evidence of multiple services nationally and internationally that have addressed these issues. • The practical interventions utilised by services to address access issues include services that are multilingual, culturally sensitive and community focused. • No single model can successfully overcome all of the access barriers that exist, most of the models focus on diminishing the impact of specific barriers. • Addressing the factors outlined above to improve access to mental health services will reduce the inequities that exist for some of the Asian populations compared to other populations in regards to utilising mental health services. Ultimately increasing access to health services will enhance Asian health outcomes and reduce health inequalities. Sources: Waitemata DHB. (2016). Asian Mental Health Team. Auckland DHB. (2016). Asian Mental Health Services.		

Appendix 6.6 Asian participation experiences about the Healthy Babies Healthy Futures project

Knowledge gain and behaviour changes reported by participants who attended Healthy Babies Healthy Futures workshops and activities provided by the Chinese New Settlers Service Trust and The Asian Network Inc , pregnant women, new mothers, fathers and their families. Experiences participating in the Healthy Babies Healthy Futures project for Chinese, Korean and South Asian groups in both Waitemata and Auckland DHBs.

Chinese pregnant women (n=31)	**Korean mothers and supporting family members (n=21)**	**South Asian mothers (n=47)**
• Making own lunch rather than buying already made food • Eating more vegetables and fruit • Drinking more water than soft drink and trying to reach 8 cups per day • Drinking water, not juice • Walking after dinner with husband at least half hours per day	• Use IT (Mobile, Internet) effectively for communication • Feel more confident to do active movement with baby • Know how to use various toys and house materials to exercise with baby • Utilise active movement differently with music • Gain confidence for cook with Korean ingredients • Avoid junk food or fast food	• New ideas of feeding fruit to their toddlers e.g fruit kebabs • Different ways of motivating kids and toddlers to increase fruit intake by making it fun • Best time for starting solids and preparation methods • Buying nutritious food on budget • Menu planning • Simple 1 minute exercise challenges • Alternatives or substitutes to decrease salt, sugar and decrease fat e.g. air-fried and not deep fried
Source: Reports from the Chinese New Settlers Service Trust and The Asian Network Inc., Quarter 3 from 01/01/16 – 01/04/16.		



AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Waitemata
District Health Board
Best Care for Everyone

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand 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 item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Confirmation of Confidential Minutes 26 October 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
1.1 Confirmation of Circulated Resolution – Contract for the Provision of Specialist Paediatric and Adolescent Rehabilitation	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Action Points 26 October 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Placement Orders – verbal update	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety Performance Report	**Prejudice to health or safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Chief Executive's Confidential Report	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Auckland DHB Strategy – Next Steps - Presentation	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Capital Expenditure Budget for 2016/2017	**Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Pre School Active	**Negotiations** Information relating to commercial	That the public conduct of the whole or the relevant part of the meeting would

Families and Green Prescription Procurement	and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage ADHB if made public at this time. **Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public.	be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Auckland DHB Business Objects Upgrade Business Case	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage ADHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.4 Variation Request for the Child and Family Unit Project	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage ADHB if made public at this time. **Prevent prejudice to commercial activities**	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public.	
7.5 CSSD Single Instrument Tracking Project	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage ADHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.6 Auckland city Hospital New Substation	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage ADHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Human Resources Update	**Privacy of persons** Information relating to natural person(s) either living or deceased is enclosed in this report. **Prevent improper gain** Information contained in this report could be used for improper gain or	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section

	advantage if made public at this time. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Voluntary Exit Policy	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 CT Scanner Upgrade for the National Forensic Pathology Service	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage ADHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and ADHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Approval for payments for C-Class Shares in healthAlliance	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Collaboration Minutes Collaboration Committee dated 29 June 2016 Minutes Collaboration	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section

Committee dated 10 August 2016		9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]