AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

FEBRUARY-MARCH • 2018

a voice for women's health

Jo Fitzpatrick

3 June 1955 ~ 15 March 2018

In this Edition

Farewell, Jo

loved friend and colleague

It was with sadness and an enormous sense of loss that the members of the Auckland Women's Health Council learnt of the death of our friend and colleague, Jo Fitzpatrick. Although we knew she had experienced recent poor health, we were unaware of how serious this was, and her death has been a shock. It was not Jo's intention to not communicate the seriousness of her illness to her friends and colleagues; she wanted to tell people personally, but she became too sick, too quickly, and the shock that is felt by many members of the wider women's health community is felt by us all.

Jo's association with the Auckland Women's Health Council goes back to the days, when as Director of Women's Health Action, she provided a place for AWHC to hold its meetings. Jo joined the AWHC committee in 2004, and she and her partner Alan also provided a meeting place in their home in Mangere for several years. Their hospitality was always warm and welcoming; we left nourished from Alan's soups.

Jo and Lynda in 2013

In talking among ourselves and with others close to Jo, as both friends and colleagues, what shines through was Jo's sense of humour, her cheerfulness and vibrant dress sense, her loyalty as a friend and her warmth. Even those of us who had known her for shorter periods and had spent less time working with her, felt supported and welcomed into the women's health community.

Jo was an astute judge of the political processes/dynamics that occurred at various meetings or within the health system. She had integrity and stood firm on issues and in her values. She brought humour and scholarship to the table. Her ability to interpret information quickly and provide direction to us was invaluable to the AWHC.

Jo was a very loyal friend and was especially close to Lynda Williams, through good times (Leonard Cohen and Bob Dylan concerts) and bad (supporting Lynda throughout her illness), and Jo's sudden death has heightened our sense of loss in the last year. Jo helped care for Lynda at the end of her life and was so gentle and loving. Jo knitted a number of things for Lynda, including a beautiful pair of soft slippers for her, which she put on her and gently massaged her tiny sore body. We were so grateful for the care and love our dear friend Jo showed our dear friend Lynda and wish we could have returned to her a little of what she gave to Lynda.

Jo was a woman who lit up the room with personality, intelligence and humour. She will be deeply missed by us all, not only for her in-depth contribution and insight into issues, but also for her warm friendship.

Our thoughts are with Jo's partner Alan, sister Jill, and their families.

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A Tribute to Jo Fitzpatrick

The eulogy for Jo Fitzpatrick presented by Ruth Bonita on behalf of many women in the women's health movement in general, and the Cartwright Collective in particular, provides a glimpse into her remarkable life.

Jo with the cartwright Collective in 2013

We are all deeply saddened, and deeply shocked, to be farewelling Jo Fitzpatrick today.

It is almost impossible to believe that someone as vital and alive as Jo, has died, especially so suddenly, and without an opportunity for each of us to say our goodbyes. It was not as she wished. As she said to Jill in the last few days of her life, the race ran faster than predicted.

Today – and in days, months, and years to come – we will remember the myriad ways in which Jo made a difference in so many fields and areas. She was a very principled woman who lived her life accordingly; she investigated issues fully, was always ethical and she never put herself before put the issue or the cause. She did things with a lot of grace and intelligence; she was warm, gentle and kind; and above all, Jo stood up for social justice and fairness and equal opportunities.

Jo's strengths were that she networked widely and thought carefully about the big issues and then found her own niche through becoming actively involved as a consumer representative in high policy level working groups for many key health system-planning activities. She brought her formidable consumer lens to a wide range of issues including:

- organ donation, and assisted reproductive technology (ECART);
- internet connectivity across the health sector including electronic health records and patient portal developments, being on the Consumer Panel of the National IT Board;
- chairing the NGO-Ministry of Health Working Party on the Regional Shared Care Project Consumer Empowerment Group;
- being on the Board of Diabetes NZ and bringing her personal experience with diabetes and her professional expertise in Governance to the organisation.

It would be impossible to include all the tributes that have flowed in, but these comments from Diabetes NZ, are reflected in statements from many others:

"Jo was insightful, shrewd, perceptive, as well as understanding. And when she was fired up about something she would reveal those qualities that we remember her for – being strong, powerful and committed. Her passion and commitment were driven by her

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AWHC GENERAL MEETING February 2018

Detailed minutes of this meeting are available on request. Matters discussed included:

- Funding
- Essure contraceptive device
- DHB and Ethics committee meetings

The next general meeting will be held at 4pm, 5th of April, 2018.

Further information on some of the above topics is contained in this issue of the newsletter.

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deep-seated values. No wonder she made such a compelling consumer advocate."

She was a true watchdog on behalf of consumers, and voiced her opinions on issues ranging from direct to consumer advertising of drugs, the high cost of medicines and cosmetic surgery, to doctors' professional standards. Jo was very positive about the recent progress being made in the development of the Northern Region's Roadmap for their Information-Systems Strategic Plan. In the digital health area she set a high bar such that the acceptance of consumer participation in programmes of development will be the norm going forward.

As Craig Reid from the National Electronic Health Record said:

"Continuing this work with a consumer perspective as a key driver for change is one way we can acknowledge the huge effort Jo made over many years".

This is, indeed, a lasting legacy.

So many groups, so many organisations, so many people thrilled to have Jo bring her significant experience and wisdom to the issues that she was most passionate about.

Perhaps the best person to describe Jo's abilities, qualities and values, is Jo herself! She described her key strengths as follows:

"I have," she writes in her extensive CV:

- "a strong commitment to the right to health and human rights for all people, and
- to protecting and promoting NGO participation in the health sector;
- a belief that inequality and discrimination are addressed by education and empowerment;
- the ability and stamina to achieve challenging goals in challenging environments."

She certainly demonstrated the latter. The value of her wider contributions, especially to women's health, were reflected in three NGOs in particular; as a long standing and highly valued member of Auckland Women's Health Council committee, as director of Women's Health Action, and as an integral member of the Cartwright Collective.

In her plenary address at a seminar on the Legacy of Cartwright marking the 25th anniversary of the Cartwright Report, Jo demon-strated her brilliant writing and oratory skills – the talk was called *In the Valley of the Missing Link*, quoting from her beloved Bob Dylan.

She summed up this major presentation on progress in the consumer experience since the Cartwright Inquiry, by saying loud and clearly:

Jo with other AWHC members at the Spirit of Peace statue outside the old National Women's Hospital on the 5th of August 2008.

"There has been very little ceding of power to consumers in health in the last 25 years. We need more consumer advocates in many more places in health. Consumer representation is not a competitive sport, we can all bring our experiences and advocacy to the role".

And she ended it this way –

"My first title for this presentation was *The Consumer Experience: A Lifesaver*. Why? – because lifesavers are the candy with the hole in the middle. And a life ring needs a consumer at its centre if we are to save lives. To fulfil the promise of Cartwright and save our lives, consumers need to fill that hole."

She called for action, and in honour of Jo, it is up to us to respond.

On behalf of the many people who have contributed to this tribute, may I extend our deepest sympathy to Jill and Alan, her dearly beloved.

Jo, it may seem to you as if we have been talking about you in the past tense. Be reassured this is not the case. We are talking with you. You are with us now. And will be with us into the future – those of us gathered here today [at her funeral] and the many, many others whose lives you have influenced. We will always carry you in our hearts. Go well, Jo.

This tribute was compiled by Ruth Bonita with significant input from many. Please contact Ruth for questions or a copy with full references R.bonita@auckland.ac.nz

Editor's note: As part of honouring Jo, her presentation at the seminar on the Legacy of Cartwright marking the 25th anniversary of the Cartwright Report, to which Ruth re-ferred in her eulogy, *In the Valley of the Missing Link: The Consumer Experience*, will be posted on the AWHC website.

Essure – Another Women's Health Disaster

It would be easy for women to come to the conclusion that the medico-pharmaceutical industry gives little thought and consideration to its approach to women's reproductive health. There is a plethora of shameful examples in the last 60 years alone, in which women have suffered considerable harm as a result of "well-intentioned" devices, treatments, procedures and drugs to address issues associated with their reproductive health. To name a few:

- Diethylstilboestrol given to prevent miscarriage, which resulted in a significantly increased risk of breast cancer in the mothers (recipients of the drug), and reproductive tract deformities, infertility and pregnancy loss, as well as an astounding increase in the risk of an otherwise rare vaginal cancer and increased risk of breast cancer, in the daughters.
- Thalidomide prescribed for morning sickness which caused severe birth defects in the mothers' babies.
- Primodos, a hormonally based pregnancy testing drug that led to severe birth defects in babies of mothers given the drug.
- HRT prescribed to women for menopausal symptoms, which led to a significantly increased risk of breast cancer.
- New Zealand's rather underwhelmingly labelled "unfortunate experiment", which should need no introduction and involved experimental lack of treatment for women with pre-cancerous cervical cell changes without the women's consent.
- Surgical mesh used to treat pelvic organ prolapse and stress urinary incontinence, which have left as many as 12 to 15% of women implanted with the mesh in crippling pain, with some unable to walk unaided or confined to a wheel chair, and many with no prospect of being able to have sex for the rest of their lives.

We can now add the Essure hysteroscopic sterilisation device to the list, albeit the apparently relatively low uptake of the treatment has meant that, in New Zealand at least, injury and ill health caused by the device appears to have been limited.

Lynda Williams wrote about the Essure device three times, in the October and November 2013 AWHC newsletters and in the December 2016 newsletter. All three articles can be found on the AWHC website.

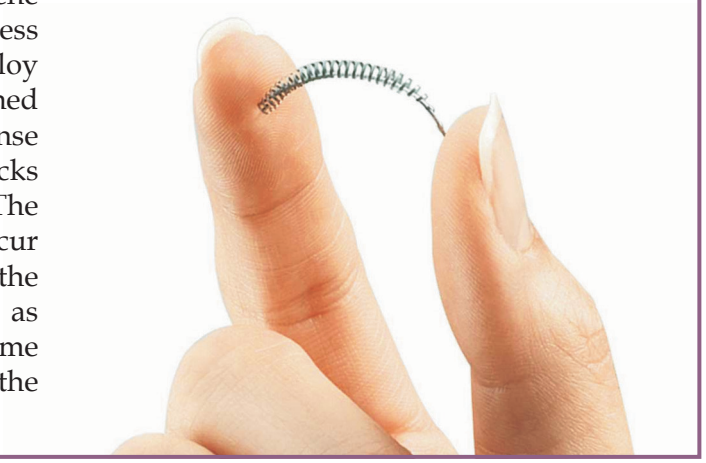
In October 2013 Lynda introduced the device thus:

"Over the past ten years another insidious experiment has been undertaken on women by obstetrician/ gynaecologists keen to be seen to offering women a new form of permanent contraception. Like many other medical devices it was released onto the market by the US Food & Drug Administration (FDA) without any decent sized long-term trials or adequate reporting of all the data. So it was utterly predictable that women began reporting severe problems with the device soon after it came onto the market."

Over time, so significant were the adverse effects of the device, sales of Essure were suspended in Brazil and the European Union

Essure Hysteroscopic Sterilisation

Essure is a permanent sterilisation device that has been offered as a less invasive alternative to tubal ligation, and which can be implanted in the fallopian tubes without an incision or anaesthetic. The device comprises an inner core of inner polyethylene terephthalate fibres, held in place by a flexible stainless steel inner coil and a dynamic outer nickel titanium alloy coil. The polyethylene terephthalate fibres are designed to work by stimulating an inflammatory response causing the growth of benign fibrous tissue that blocks the fallopian tube over a period of three months. The procedure is non-reversible and if side-effects occur the only method of removal is surgery to remove the fallopian tubes. In New Zealand this is only offered as part of a full hysterectomy, although in the US some surgeons offer a limited surgery that removes only the fallopian tubes.



before manufacturer, Bayer, in 2017, withdrew it from sale from all countries around the globe, except the US.[1]

Despite the very poor safety profile, the banning of the device in several countries and the addition of an FDA black box warning in 2016, Bayer insisted that its decision to pull sales and distribution was "not related to a question of safety or dangerousness of the medical device whose positive benefit-risk profile remains unchanged."[1]

In August 2017, Australasian Medical and Science Ltd (AMSL), in consultation with the Therapeutic Goods Administration, issued a hazard alert for Essure, recalled unused stock and withdrew the device from the Australian market.[2]

In Brazil in February 2017, the regulatory agency Agencia Nacional da Vigilancia Sanitaria (ANVISA) became the first to suspend sales and recall the device, and based their decision on technical and scientific reports.[3] ANVISA categorised the device as presenting maximum risk owing to certain side effects, including:

- changes in menstrual bleeding,
- unwanted pregnancy,
- chronic pain,
- perforation/migration of the device,
- allergy and sensitivity or immune-type reactions.

The US FDA continues to support use of the device in the US, and as of December 2017 said on their website that "the FDA continues to monitor the safety of Essure. The FDA continues to believe that the benefits of the device outweigh its risks, and that Essure's updated labelling helps to assure that women are appropriately informed of the risks."[4]

Given the suspension of sales in many countries before Bayer withdrew the device, and the high number of lawsuits taken against Bayer over the device in the US, it seems that the FDA's confidence in it is somewhat misplaced. The website Drugwatch says that Bayer faces thousands of lawsuits in the US as of October 2017 although they have yet to settle in any case.[5]

Drugwatch[5] goes on to say that the lawsuits claim Essure complications, including device migration, bleeding, device fracture and other complications requiring surgery, damage to organs and the birth of children with birth defects after the failure of the device to prevent pregnancy. Apparently Bayer is protected against liability by pre-emption laws, but judges are allowing lawsuits to continue despite this.

In their 2017 Annual Report, Bayer make the following statement:

Essure™: As of January 30, 2018, U.S. lawsuits from approximately 16,100 users of Essure™, a medical device offering permanent birth control with a nonsurgical procedure, had been served upon Bayer. Plaintiffs allege personal injuries from the use of Essure™, including hysterectomy, perforation, pain, bleeding, weight gain, nickel sensitivity, depression and unwanted pregnancy, and seek compensatory and punitive damages. Additional lawsuits are anticipated.

As of January 30, 2018, two Canadian lawsuits relating to Essure™ seeking class action certification had been served upon Bayer. Bayer believes it has meritorious defenses and intends to defend itself vigorously.[6]

In their 2016 Annual Report, Bayer disclosed that they had impairment losses of €391 million (approximately US$413 million) in connection with Essure.[7] In 2017 the Annual report specifically stated[6] that expenses related to significant legal risks "amounted to €258 million in 2017 (2016: €262 million), which, as in the previous year, primarily included expenses in connection with litigation relating to the products Xarelto™, Essure™ and Cipro™/Avelox™."*

Essure in New Zealand

It seems that New Zealand women may have gotten off fairly lightly in terms of the damage caused by Essure. There is not a lot of information available on the use of Essure in this country and there is currently no mention of it at all on the Ministry of Health website. We can ascertain from media reports that Essure became available in about 2003[8] and was then publicly funded through DHBs from about 2010.[9] However, it is evident from responses to enquiries by other organisations, such as the Palmerston North Women's Health Collective, in recent years, that not all DHBs offered Essure in their hospitals.[10]

The AWHC sent out requests for information on the use of Essure and any adverse impacts it caused to a number of agencies, including the Auckland metro DHBs including National Women's Hospital, ACC, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Medsafe, and distributor from 2009, NZSL.

The requests sought information on:

- the period of time Essure was used/available here;
- if there are any residual stocks of the device in New Zealand;
- the number of women who had the devices implanted in New Zealand;
- if any adverse event/reaction reports were lodged with regard to Essure;
- if Medsafe ever received any

* There was no breakdown of costs against specific products, so there is no way of telling what proportion of these figures were a result of legal action over Essure specifically.

information on, or issued any warning about, the safety of Essure;

- if any medical injury claims have been lodged with ACC as a result of women having had Essure implanted, and if so, were any accepted, and how many and what was the cost of those claims to ACC.

So far, the information that has come back is sparse and not very informative. Many of the requests were treated as OIA requests and we are still waiting on responses, including from Medsafe, the WDHB and ADHB/National Women's Hospital.

The CMDHB responded that Essure was never used in the DHB.[11]

ACC responded that:

"After a search through our treatment injury database, as well as our database for personal injury claims, we have been unable to identify any claims relating to, or mentioning, the Essure device."[12]

This appears to support an earlier letter to Lynda Williams in 2013, in which Medsafe said that at that time there had "been no reports of adverse events or complaints relating to the use of [Essure]."[13]

Jane Cumming from RANZCOG advised that ADHB started the Essure procedure in March 2010, did 240 procedures and did the last one in August 2017; one patient who had a previous background of chronic pain had the device removed.[14] Ms Cumming added that residual supplies were removed by Bayer in August 2017.

Editor's Note: An update will be included in a future edition of the Newsletter to reflect information that AWHC expects to receive from outstanding OIA requests.

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Acting Chairs Appointed to the Metro DHBs

Last December, Dr Lester Levy, then chairperson of all three Auckland DHBs, announced his resignation from the role, effective late January 2018. His maximum allowable tenure at Waitematā DHB would have ended in June 2018, and at the time of his resignation Dr Levy said that he brought forward his finishing date to avoid "any perceived conflicts" after being appointed in early December to the Ministerial Advisory Group on the Health System.

Three acting chairpersons have been appointed while the Minister for Health, Dr David Clark, considers the appointment of a permanent chair or chairs. Kylie Clegg has been appointed to the Waitematā DHB, Gwen Tepania-Palmer to the Auckland DHB and Rabin Rabindran to the Counties Manukau DHB. At a WDHB Board meeting in March Ms Clegg said she had been appointed for up to 12 weeks while the Minister considers who to appoint to the role.

While there is an expectation that a single Chairperson will be appointed, John Hobbs from the office of Minister of Health, said he did not know if that would be the case or how long the process would take.

A Health System in Crisis

A health system in crisis: it is a headline that has had plenty of use in the last few months. On the 21st of February, the Health Select Committee heard from the heads of the three Auckland metro DHBs that none of the DHBs were coping with demand, with underfunding and a "tsunami of patients" seeking urgent medical care.

Part of the problem is that funding is based on 2013 census figures while Auckland's population has significantly increased since then.

Former chairman of the three DHBs, Dr Lester Levy, who is now a member of the Minister of Health's new Ministerial Advisory Group on the Health System, said that acute demand, such as patients who presented to an emergency department, was particularly strained in Auckland.

"That has been increasing significantly over the past five years but over the last 18 months has really stepped up," Dr Levy said.

He said that the situation is "pretty difficult to manage" and that staff were working under "very high levels of stress", Levy said.

"And there is very little resilience, if any, in the system. The last year has taken us to the limit."

The severe pressure on the Auckland DHBs has been all too evident at DHB meetings, with both the ADHB and WDHB reporting at meetings this year that January saw the highest ever demand in the emergency departments, despite winter typically being the period of peak demand. Significantly, demand had not dropped away, and this bodes very poorly for when winter ills impact on demand for services. Senior DHB staff commented at these meetings that the increase in demand was over and above what could have been reasonably explained by population growth, and it is not hard to imagine that increasing social pressures – an aging population, homelessness and the housing crisis, poverty, spiralling food and energy costs, and mental health and addiction issues – are contributing to the incredibly high demand on our health services.

Dr Levy said that in the past five years the population had grown at 9.4% but emergency department attendances had increased 18.8%; in-patient discharges by 15%; and spending on services for older people by 14.4%.

CEO of Counties Manukau, Gloria Johnson, told the Health Select Committee that levels of demand were "so unprecedented and so extreme that we are actually no longer managing".

The Midwifery Crisis

The chronic shortage of staff in the midwifery workforce is just one symptom of our chronically ill health system.

Over the last year, the shortage of midwifery staff at the three Auckland DHBs has been a constant refrain at DHB meetings. At the February 2018 WDHB Hospital Advisory Committee meet-ing, Child, Women and Family Services reported a 30% vacancy rate (almost 15 full time midwives short of required) at North Shore Hospital, and a 25% vacancy rate (almost 10 full time midwives short of required) at Waitakere Hospital. At the February ADHB Hospital Advisory Committee meeting it was reported that there were 13 fulltime midwifery positions vacant, and from Board and Committee agendas and papers, it appears that in the CMDHB there are about nine current midwifery vacancies.

Such shortages are on top of the extreme shortage of independent midwives. The greatest shortage occurred over the Christmas period; New Zealand College of Midwives (NZCOM) adviser, Alison Eddy, told Stuff that hundreds of self-employed midwives exited the profession or left to work at hospitals because of "unsustainable" working conditions."

NZCOM CEO, Karen Guilliland said that midwifery was a "service in crisis" owing to years of underfunding.

"The college is increasingly concerned that every day we wait, the sustainability of the midwifery profession continues to be negatively affected and this in turn has a significant impact on women's access to maternity services. More and more women will be unable to find a midwife if this crisis is not urgently addressed," she said.

Alison Eddy reports that ADHB midwives have said that "they're increasingly concerned about the environment that they're working in, they're stressed and frustrated that there aren't enough of them and they can't give the level of care they want to."

The New Zealand Nurses Organisation (NZNO) share the concerns of midwives and their representatives regarding patient and staff safety. Auckland Lead Organiser Carol Beaumont says that "Our members are telling us regularly that every shift they are worried that the standard of care they can provide is compromised by short staffing and inadequate resources."

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The Performance Improvement Framework Review of the Ministry of Health

The PIF, which was released in early December 2017, is a review of where the Ministry is placed relative to its four-year excellence horizon – a vision for the future of the health system and the Ministry's role within it.

Dr Clark said the report echoed the concerns he had heard 'time and time again' from those at the frontline of the health system about a lack of Ministry leadership.

At the Waitematā DHB meeting on the 14th of December, immediately after the release of the report, criticism of the Ministry of Health was more overt than it had been in previous meetings in 2017, and there were comments to the effect that the "health system is broken" – a sentiment that has been regularly expressed in less formal situations over the last year. Then chairman, Dr Lester Levy briefly addressed the overall thrust of the PIF review in that meeting and advised that all people in the health sector should read it.

The breakdown of the relationship between then Director General of Health, Chai Chuah (see the January 2018 AWHC Newsletter for an article on Mr Chuah's resignation) and DHB heads appeared to be encapsulated by Labour's new Minister of Health when he said:

"We need a strong, stable and high-performing ministry leading our health and disability sector. The challenge for the ministry's new leadership will be to deliver just that."

He said it was vital the ministry rebuilt trust and confidence in itself so that it could deliver on the Government's health priorities, including making primary health-care more affordable and accessible.

So, What Was the Guts of the Review

The State Services Commission reviewers interviewed a wide range of health and disability sector stakeholders, including health works and consumers. They noted that the Ministry faces a number of challenges, in particular in responding to "shifting customer demands for health and disability support services" and changes in technology and demographics.

Urgent and essential work for the Ministry includes engaging others in a manner that enlists their support to deliver on its health and wellbeing goals, and working better with District Health Boards

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"Daily, our members are placed in situations where they feel their professional standards are jeopardised and as a result there is a high level of stress amongst the staff," she said.

The shortage of midwives is in part responsible for increasing Caesarean rates in both the ADHB and WDHB. While the national Caesarean rate is about 25%, in Auckland it is 38% and Waitemata 33%, while Counties Manukau is lower at 28%.

At the time of writing, on International Women's Day, NZCOM are asking for help, saying that "midwives and women have come together to show policy makers what midwifery means to women and how essential it is to properly fund the highly acclaimed system we have in New Zealand." Among their concerns are that:

- community LMC midwives lost the right to negotiate their working conditions in 2007;
- community LMC midwives have not received normal cost of living increases since 1996;
- community LMC midwives average income is less than the living wage. There is no pay equity with comparable professions;
- the workload has doubled in real terms;
- midwives are leaving the profession in significant numbers;
- women in many areas around the country are struggling to find an LMC midwife;
- hospital midwives are working under increasing pressure, many in understaffed, un-supportive environments; and
- hospital midwives do not have pay equity with other comparable professions.

Dear David

I started calling midwives at 5 weeks pregnant. They were all booked solid! I needed help from the hospital to book one. Please help!

- Anon

I am 12 weeks pregnant with my 3rd baby and can't find an LMC with space to take me on. I wonder why that is, David? Underpaid. Overworked. Do something - preferably before I have no-one to care for me and my baby at all!

- Anon

Two of many Dear David messages from pregnant women, midwives and their supporters on a Facebook page - www.facebook.com/deardavidclark/

and other Crown entities, such as the Accident Compensation Corporation and the Health Quality and Safety Commission

Despite the criticism implicit in the report, the State Services Commission committed to working "with the Ministry to help it improve its performance, with a particular emphasis on effecting better health outcomes at the earliest possible point."

In the first phase of the review, the State Services Commission developed a draft four-year excellence horizon. In this section the review set out two high-level outcomes for the Ministry and the Health and Disability System that align with and contribute towards the Government's strategic priorities:

- New Zealanders live longer, healthier and more independent lives.
- The health system is cost-effective and supports a productive economy.

While a full read of the review is very worthwhile, it is the ratings summary that provides the best indication of the state of our health system (see Table on page 11). Sadly, there is only one results area in which the Ministry ranks at the highest level of performance – Strong; that is, best practice/excellent – and that is for *increasing infant immunisation and reducing incidence of rheumatic fever*. Nine results areas received the lowest rating – Weak; that is, unaware or limited capability. The remaining rankings were split between "well placed" and "needing development", unfortunately with the scale tipping towards the "needing development" rating.

The final section, Results – and forming the greatest bulk of the review – looks in far greater detail at current situation in each of the results areas and provides a subsection on future focus for the Ministry. As critical as this review is – and it would be easy to be disheartened by how far we have to go before we have a Ministry of Health that is even close to fulfilling the Government's strategic priorities – it gives valuable insights, particularly for consumers, into the current national and global environment in which the Ministry must operate; the changing characteristics and needs of the New Zealand community; how the Ministry can begin to address the needs of a disparate population with often widely varying needs, and how that can be done in such a way as to eliminate inequities in both access and outcomes in our communities.

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Rating system *(see table on page 11)*

Rating	Judgement	What it means
	Strong (Excellent)	**Best practice/excellent** High level of capability, sustained & consistently high levels of performance
	Well placed	**Capable** Delivering to expectations with examples of high levels of performance
	Needing development	**Developing** Adequate current performance – concerns about future performance
	Weak	**Unaware or limited capability** Significant areas of critical weakness

Performance Improvement Framework Review Summary of Ratings

Results

Government Priorities	Rating
Fiscally sustainable Health System	
Implementing the New Zealand Health Strategy	
Better Public Services targets	
Retired BPS Result 3 – Increase infant immunisation and Reduce incidence of rheumatic fever	
Refreshed BPS Result 2 and 3 – A good start in life	
New BPS Result 4 –- Vulnerable children	
The Canterbury health system	
Budget 2016 and beyond priorities	
Social investment	
Implement bowel screening programme	

Core Business	Rating (Value to Customers and New Zealanders)	Rating (Increased Value Over Time)
Development of the New Zealand Health Strategy		
Building system capability and capacity		
Improved system performance / improved health outcomes		
Crown entity monitoring (non-DHB entities only)		
Regulatory stewardship		

Organisational Management

Leadership and Direction	Rating
Purpose, Vision and Strategy	
Leadership and Governance	
Values, Behaviour and Culture	
Review	
Delivery for Customers and New Zealanders	**Rating**
Customers	
Operating Model	
Collaboration and Partnerships	
Experiences of the Public	

Relationships	Rating
Engagement with Ministers	
Sector Contribution	
People Development	**Rating**
Leadership and Workforce Development	
Management of People Performance	
Engagement with Staff	
Financial and Resource Management	**Rating**
Asset Management	
Information Management	
Financial Management	
Risk Management	

HDC Annual Report

The Health and Disability Commissioner's annual report for the year to 30 June 2017 was released in November 2017.

In his foreword, Commissioner Anthony Hill reiterated the importance of informed consent as a central tenet of consumer/patient protection under the Code of Rights, saying: "The principle of informed consent lies at the heart of the Code, and services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent."

He went on to say that the HDC has continued "to hold a number of providers to account for their failure to obtain informed consent before providing services."

He also said that deficiencies in culture and leadership continue to play a part in complaints and there are environments in which more junior staff do not feel able to ask questions when they observe procedures and practices that raise concerns.

There was significant growth in the number of complaints in the year to June 2017, with 2,211 complaints received, an increase of 13% on the previous year. In addition, there were a further 4,000 consumer inquiries.

Of particular note:

- 2,015 complaints were closed, 85% within six months.
- 80 formal investigations were completed — 61 resulted in breach opinions, and 11 providers were referred to the Director of Proceedings.
- The Nationwide Health and Disability Advocacy Service closed 2,739 complaints and responded to over 10,000 public enquiries. Ninety-eight percent of complaints were closed within six months, and 91% of complaints were either resolved successfully between the parties or were withdrawn by the complainant.
- The HDC published two reports on areas of research interest to HDC. One report analysed the complaints received about residential aged care facilities, and the other report analysed complaints received about doctors.
- The public submissions on the consultation regarding research conducted with participants who are unable to give informed consent have been analysed, and a report will be released in 2018.
- A number of case studies of complaints received by the HDC feature in the report.

The 2017 Annual Report is available from www.hdc.org.nz/media/4540/hdc-annual-report-for-the-year-ending-june-2017.pdf

UPCOMING EVENTS

Waitematā DHB Board meetings 18 April and 30 May at 9:45am; **Hospital Advisory Committee** meetings 9 May and 20 June at 1:30pm; **combined WDHB and ADHB Community & Public Health Advisory Committee** meeting 4 April and 6 June at 10am. Meetings held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

Auckland DHB Board meetings 11 April and 23 May at 10am; **Hospital Advisory Committee** meetings 2 May and 13 June 1:30pm. Meetings are held in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB Board meetings 4 April, 16 May and 27 June at 9:45am in room 101 at Ko Awatea, Middlemore Hospital; **Hospital Advisory Committee** meetings **23 April and 6 June at 1pm** in room 101 at Ko Awatea, Middlemore Hospital; **Community & Public Health Advisory Committee** meetings 11 April and 23 May at 9am in the CM Health Board Office, 19 Lambie Drive, Manukau**.**

www.waitematadhb.govt.nz | www.adhb.govt.nz | www.cmdhb.org.nz

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Ethics Committee Meetings

Northern A and Northern B

(Novotel Ellerslie, 72-112 Greenlane Road East, Ellerslie, Auckland)

Northern A: Tuesday, 17 April | 15 May | 19 June | all at 1:00pm – open to public at 1:30pm

Northern B: Tuesday, 3 April | 1 May | 5 June | all at 12 noon – open to public at 12:30pm

www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

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Auckland Women's Health Council Annual General Meeting

The Auckland's Women's Health Council AGM will be held at 4 pm on Thursday 26 April in room AE109C at the AUT North Campus, 90 Akoranga Drive, Northcote.

For further information contact the Council on 09 520-5175 or email: awhc@womenshealthcouncil.org.nz

A voice for women's health