AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
Chief Executive's Office
Level 12
Building 1
Auckland City Hospital
PO Box 92189
Victoria Street West
Auckland 1142
Ph: (09) 630-9943 ext: 22342
Email: ailsac@adhb.govt.nz

17 February 2021

[redacted]

Re: Official Information Act request – Data sharing within DHBs

I refer to your Official Information Act request dated 18 January 2021 requesting the following information:

I am writing a special report about data sharing at DHBs and PHOs, which I hope will be a resource for the sector on this important topic.

1. **Do you have a privacy officer and at what level of DHB leadership do they sit?**

   Yes – Sue Waters – Chief Health Professions and Auckland DHB Privacy Officer - she is on the Executive Leadership Team.

2. **Do you have a chief data officer and if so, what is their responsibility in the organisation?**

   Auckland DHB have a Data and Analytics Manager (reports to the Chief Digital Officer) for the Organisation. The Data & Analytics Manager is responsible for managing the data within the Organisation including how and where it is stored and accessed/shared.

3. **How do you gain patient consent for data sharing - ie via a consent form? (please provide a copy of the form or statement that explains how patient data is shared)**

   Patients sign a registration form when they engage with Auckland DHB. On this is a privacy statement that outlines who we share information with.

   GENERAL PRIVACY STATEMENT
   We collect your health information to provide you with appropriate care, to plan for and fund health services, to carry out research and teaching and to monitor quality. To further health research and education

you may be invited to participate in research projects and education of healthcare professionals. We share your information with other health care providers and agencies to assist in the provision of your care. We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons. You have a right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.

4. **For what purposes are you sharing patient identifiable health information within the DHB?**

   - **Clinical care**
   - **Analytics**
   - **Quality improvement**
   - **Planning**
   - **Research**

   Yes to all of the above.

5. **Do you share patient identifiable information outside of the DHB and if so, with what other entities? Ie other DHBs, PHOs, GPs, NGOs, social services. If so, what agreements do you have in place to support this?**

   Identifiable data is shared with medical professionals involved in a patients care in a primary care setting including: general practitioners; private specialists; rest homes. Information is also shared with other District Health Boards where care is shared and private hospitals.

   Other requests for sharing of identifiable data goes through an approval process to ensure disclosure meets the purposes for which the information was collected or that it is authorised by law to share - and where appropriate, the ADHB Information Governance and Privacy Group is consulted before a release occurs.

   Data sharing agreements, where appropriate, are created via our legal services. Work is underway to streamline the data sharing request and approval process and as part of this work, a data sharing agreement is being developed that will support this process.

6. **Do you share any personal data directly with patients? (appointment and discharge letters/ emails to patients should not be included in this definition of 'sharing personal data') If yes, what data do you share and via what method?**

   Yes – patients may be copied in on clinic letters or other clinical letters/reports (via email or paper via post). We also provide copies of patient clinical records as requested and/or consented by the patient via our release of information process – these are provided via secure link (Citrix ShareFile) or via hard copy.

7. **Do you plan to let consumers access and contribute to their own health information online, via something like a patient portal, in the future? If so: when do you plan to implement and what info will be shared first?**

   Yes, that is the plan when we move to a new Patient Administration System (PAS) solution, which we are in negotiations with our preferred vendor about.

   Demographic and patient appointment information will most likely be the first information to be shared – but that will depend on the implementation plan.

8. **How does your organisation govern data sharing?**

   Outside of normal patient care sharing requests, the Auckland DHB Information Governance and Privacy Group oversee other data sharing requests, to ensure data sharing approval is appropriate and relevant safeguards are in place to protect the data.

   In addition, a data sharing working group has been formed to look at the data request and approval process to support internal and external requestors to understand what the requirements are for accessing patient information, and ensure the process is consistent and all required approvals are gained before access to the information is given, and that the data is stored and destroyed appropriately when no longer needed.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive of Te Toka Tumai (Auckland District Health Board)

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Registration Form

MUST ATTACH PATIENT LABEL HERE

SURNAME: NHI:

FIRST NAMES: DOB:

Please ensure you attach the correct visit patient label

PATIENT DETAILS

Non-NZ Residents please write **name as per passport,** supply **permanent overseas address.** Complete **insurer details on Page 2**

FAMILY NAME	**GIVEN NAME(S)**	**PREFERRED NAME**
PREVIOUS FAMILY NAME	ALSO KNOWN AS	

GENDER: ☐ Male ☐ Female ☐ Gender diverse OR ☐ Please specify _____ | Title *(e.g. Mr/Mrs)* _____ | OCCUPATION

Date of Birth	Country of Birth	NZ Resident? ☐ Yes / ☐ No *(tick below)* ☐ Visitor ☐ Student ☐ Work Visa	Date of Arrival in New Zealand

ADDRESS
Permanent:

Temporary:
(NZ Address)

PHONE NUMBER
Home: Work:
Cell Phone:
Temporary Phone Number:

PATIENT E-MAIL ADDRESS FOR RECEIPT OF CLINICAL CORRESPONDENCE (PLEASE PRINT CLEARLY)
Please provide your e-mail address ONLY if you are happy for ADHB to send your clinical correspondence via e-mail instead of NZ Post. We may also invite you to give us feedback about your care. Advise ADHB in writing immediately if your contact information changes. Note: If you provide your email address, you will receive a separate email asking you to validate this email address.

LEAD SUPPORT PERSON: Name:
Address:
Relationship:
Home Phone: Work Phone:
Cell Phone:

ALTERNATIVE CONTACT: Name:
Address:
Relationship:
Home Phone: Work Phone:
Cell Phone:

FAMILY DOCTOR Name: Practice:

ETHNIC GROUP: Tick as many boxes as you need to show which ethnic groups you belong to:

☐ NZ European / ☐ Māori / ☐ Cook Island / ☐ Samoan / ☐ Tongan / ☐ Niuean / ☐ Chinese
☐ Indian / ☐ Fijian Indian / ☐ Fijian / ☐ Other *(e.g. Dutch, Japanese)* **Please state:** _____
☐ Other Pacific Peoples *(e.g. Tokelauan)* **Please state:** _____

Do you require an interpreter? ☐ Yes ☐ No If yes, please specify language:

Is this visit injury related? ☐ Yes ☐ No **If yes, complete Page 2** *(this is mandatory if you want us to lodge your ACC Claim)*

CHAPLAINCY: Would you like a chaplain to visit you? If yes, state Religion: _____

Have you been in hospital before? Hospitals and years: _____

PAYMENT FOR TREATMENT

If you are not eligible for publicly funded healthcare you will be charged for all services provided, with the exception of compulsory care provided under the Mental Health (compulsory Assessment and Treatment) Act 1992 which is publicly funded for all. ADHB Finance staff will advise if you are ineligible and must pay for services provided once they have reviewed the information you provide to us. We may need to disclose your information to NZ Immigration Services, who in turn will provide ADHB with the information they hold as to your residency status. By signing this form you acknowledge and consent to this disclosure by us and by NZIS.

GENERAL PRIVACY STATEMENT

We collect your health information to provide you with appropriate care, to plan for and fund health services, to carry out research and teaching and to monitor quality. To further health research and education you may be invited to participate in research projects and education of healthcare professionals. We share your information with other health care providers and agencies to assist in the provision of your care. We treat your information as confidential and ensure that it is kept secure and only accessed by authorised persons. You have a right to request access to your records and to request correction of the information. Information may be supplied to family, support people or other agencies if you give us your permission or disclosure is authorised by law.

I HAVE READ AND UNDERSTOOD THE ABOVE STATEMENTS OR EXPLANATION BY AN INTERPRETER. I DECLARE THAT ALL THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT.

Name _____ Signature _____ Date _____

If next of kin or guardian, state relationship to patient _____

REGISTRATION FORM

CR0001

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Registration Form

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

REGISTRATION FORM

ACC ACCIDENT AND EMPLOYMENT DETAILS (COMPLETE ALL RELEVANT DETAILS & SIGN THIS FORM)

Date of accident: _____ **Time of accident:** _____ am ☐ pm ☐

Accident scene? Home ☐ School ☐ Sports area ☐ Farm/Orchard ☐ Industrial/construction area ☐

Medical Area ☐ Recreational area/Public building ☐ Non-recreational/Commercial area ☐

Highway/Street/Road ☐ Other Transport Area ☐ Other _____

Accident Location: (e.g. Auckland, Taupo) _____

Did the accident occur in New Zealand? Yes ☐ No ☐

What were you doing? Paid work ☐ Unpaid work ☐ Education ☐ Sports/Exercise ☐ Play/Leisure ☐

Other Specified activity ☐ Being taken care of ☐ Travelling ☐

Other _____

Did the accident involve a moving vehicle on a public road, driveway, beach? Yes ☐ No ☐

If sporting injury, name the sport _____

What happened to you? Motor vehicle – driver ☐ Motor vehicle – passenger ☐ On bicycle ☐

Motorcycle – driver ☐ Motorcycle – passenger ☐ Pedestrian (walking) ☐ Other transport-related ☐

Burn ☐ Aminal ☐ Low fall (<1m) ☐ High fall (>1m) ☐ Drown ☐ Other threat to breathing ☐

Poison ☐ Cut or pierce ☐ Collision ☐ Other _____

How was the injury caused? _____

Occupation? _____

I am in paid employment ☐ I own / part own the company in which I work ☐

I am self-employed ☐ I am not in paid employment ☐

What type of work do you do? Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very heavy ☐

Did the accident occur at work? Yes ☐ No ☐

Name of business: _____

Address of business: _____

PATIENT AUTHORISATION AND DECLARATION

To assess cover and/or entitlements, ACC may need to collect medical and other records about you from a third party. For more details see ACC's privacy notice at www.acc.co.nz/privacy.

I authorise:

- ACC to collect medical and other records which are or may be relevant to my claim
- The treatment provider to lodge this claim for me.

I declare that the information I have given in this form is true and correct.

Name: _____ Signature: _____
(Patient / Guardian / Representative)

Relationship: _____ Date: _____

INSURER DETAILS (TO BE COMPLETED BY ALL NON-NZ RESIDENTS)

Name of Insurance: _____ Country: _____

Address: _____

Phone: _____ Fax: _____ Email: _____