AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 11 May 2016

09:45am

Note:

- **Public Excluded Session 9:45 am 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 05 May 2016

Agenda
Meeting of the Board
11 May 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 (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Fiona Barrington	Change Director
Peter Aitken	Simon Bowen	Director of Health Outcomes – AHB/WDHB
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Judith Bassett	Joanne Gibbs	Director Provider Services
Dr Chris Chambers	Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Dr Lee Mathias (Deputy Chair)	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Robyn Northey	Fiona Michel	Chief of People and Capability
Morris Pita	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Gwen Tepania-Palmer	Rosalie Percival	Chief Financial Officer
Ian Ward	Linda Wakeling	Chief of Intelligence and Informatics
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	Elizabeth Jeffs	Group HR Director
	Bruce Levi	General Manager Pacific Health
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Marlene Skelton	Corporate Business Manager
	Gilbert Wong	Director Communications
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members:

Apologies Staff:

Karakia

Agenda

Please note that agenda times are estimates only

9:45am **1.** **ATTENDANCE AND APOLOGIES**

2. **RESOLUTION TO EXCLUDE THE PUBLIC**

12:45pm **3.** **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?

	4.	**CONFIRMATION OF MINUTES 30 MARCH 2016**
12:50pm	**5.**	**ACTION POINTS 30 MARCH 2016**
1:00pm	**6.**	**CHIEF EXECUTIVE'S REPORT**
	7.	**COMMITTEE REPORTS - NIL**
1:10pm	**8.**	**PERFORMANCE REPORTS**
	8.1	Financial Performance Report
	8.2	Funder Performance Report
1:30pm	**9.**	**DECISION REPORTS**
	9.1	Approval of Appointment of Directors to Northern Regional Alliance Ltd
	9.2	Diabetes Specialist Service Future Directions Paper - 2016
	10.	**DISCUSSION PAPER - NIL**
1:35pm	**11.**	**GENERAL BUSINESS**

Next Meeting:	Wednesday, 22 June 2016 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						
Joanne Agnew	1	1						
Peter Aitken	1	1						
Doug Armstrong	1	1						
Judith Bassett	1	1						
Chris Chambers	1	1						
Lee Mathias (Deputy Chair)	x	1						
Robyn Northey	1	1						
Morris Pita	1	1						
Gwen Tepania-Palmer	1	1						
Ian Ward	1	1						
		Key: 1 = present, x = absent, # = leave of absence						

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 30 March 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]
2. Register of Interest and Conflicts of Interest	As per that stated in 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 30 March 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 Draft Strategy for Auckland DHB	**Commercial Activities (1)** 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 Auckland DHB Patient Safety Strategy: Phase One, Development	**Commercial Activities (1)** 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

	Protect Health or Safety (5) 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)]	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 Building Resilience – Auckland DHB Elective Delivery - Presentation	**Commercial Activities (1)** 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]
5.1 Health and Safety Report	**Protect Health or Safety (5)** 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]
6.1 Northern Electronic Health Record (NEHR) Programme April Update	**Confidence (8)** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) Would disclose a trade secret; or ii) Would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 Update on Facilities Plan for Remediation of Plan and Equipment	**Commercial Activities (1)** 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]
7.2 Business Case – Regional Clinical Pathways	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage,	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of

	commercial activities [Official Information Act 1982 s9(2)(i)]	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 Funding Request – School Based Rheumatic Fever Throat Swabbing and Management Programme continuation	**Commercial Activities (1)** 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]
7.4 Funding Request – Childhood Obesity Plan Services Development	**Commercial Activities (1)** 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]
7.5 Contract – Allocation for Contract Value Increase – primary Care, Community Care and Aged Related Residential Care	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.6 Contract – Funder Procurement Plan	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.7 WALSH Trust Mother and Baby Acute Crisis Residential Respite and Packages of Care	**Negotiations (2)** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official	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

Services – Request for Contract Extension	Information Act 1982 s9(2)(j)]	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]
7.8 Outcomes – Support Hours Model Review	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.9 Business Case – Nurse and Midwifery Uniforms	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.10 Business Case – Auckland City Hospital New Main Sub-Station Seed Funding Capex	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.11 Business Case – Starship Lifts Upgrade	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]

7.12 Business Case – Ultrasound Machine Fleet Capex programme 2015/2016	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.13 Five Year Bed Replacement Programme	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
7.14 Request for Additional Seed Funding of $80,000 for the redesign and Expansion of the Adult Emergency Department and the Admission and Planning Unit	**Commercial Activities (1)** 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]
7.15 Endoscopy Business Case Budget Change Request	**Commercial Activities (1)** 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 2016/2017 Accountability Documents	**Commercial Activities (1)** 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	**Commercial Activities (1)** To enable the Board to carry out,	That the public conduct of the whole or

Forensic Pathology	without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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 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 (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations (2)** 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]
10 Information Reports – Nil	N/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]
11.1 Collaboration Governance Group Minutes 24 February 2016	**Commercial Activities (1)** 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]

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 - 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 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	09.02.2016
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Peter AITKEN	Pharmacy Locum - Pharmacist Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd Shareholder/ Director - Pharmacy New Lynn Medical Centre Shareholder/Director – New Lynn 7 Day Pharmacy Shareholder/Director – Belmont Pharmacy 2007 Ltd Shareholder/Director – TAMNZ Limited Shareholder/Director – Bee Beautiful Limited	07.10.2015
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter is a partner – Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	14.07.2015
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
Chris CHAMBERS	Employee - ADHB Wife is an employee - Starship Trauma Service Clinical Senior Lecturer in Anaesthesia - Auckland Clinical School Member – Association of Salaried Medical Specialists Associate - Epsom Anaesthetic Group Shareholder - Ormiston Surgical	26.01.2014

Lee MATHIAS	Chair - Counties Manukau Health Deputy Chair - Auckland District Health Board Chair - Health Promotion Agency Chair - Unitec Director - 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	18.11.2015
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 Husband – Chair, Auckland District Council of Social Service	17.02.2016
Morris PITA	Member – Waitemata District Health Board Shareholder – Turuki Pharmacy, South Auckland Shareholder – Whanau Pharmacy Limited Director and Shareholder of Healthcare Applications Ltd Owner and operator with wife - Shea Pita & Associates Ltd Wife is member of Northland District Health Board Wife provides advice to Maori health organisations	17.02.2016
Gwen TEPANIA-PALMER	Board Member - Waitemata District Health Board 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	02.04.2013
Ian WARD	Board Member - NZ Blood Service Director and Shareholder – C4 Consulting Ltd CEO – Auckland Energy Consumer Trust Shareholder – Vector Group Shareholder / Director - Eltham Investments Limited Shareholder / Director - Cavell Corporation Limited Shareholder / Director - Ward Consulting Services Limited Trustee - LP Leasing Limited Trustee - Chris C Lynch Limited Son – Oceania Healthcare	07.10.2015

Minutes
Meeting of the Board
30 March 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 30 March 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 – AHB/WDHB
Peter Aitken	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Judith Bassett	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Chris Chambers	Fiona Michel	Chief of People and Capability
Dr Lee Mathias (Deputy Chair)	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Robyn Northey		
Morris Pita	Rosalie Percival	Chief Financial Officer
Gwen Tepania-Palmer	Linda Wakeling	Chief of Intelligence and Informatics
Ian Ward	Sue Waters	Chief Health Professions Officer
	Auckland DHB Senior Staff Present	
	Sally Bruce	Senior Communications Advisor
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

That the apology of Executive Leadership Team member Dr Margaret Wilsher be received.

2. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 5-11)

Resolution: Moved Gwen Tepania-Palmer / Seconded Judith Bassett

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 17 February 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]
2. Register of Interest and Conflicts of Interest	As per that stated in 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 17 February 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 NEHR Programme – Cost of current systems	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	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]
3.2 Health Gain Strategy including DAP link to the Strategy	**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]
4.1 Health and Safety – Contractors Online Induction Presentation	**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 Health & Safety Report February 2016	**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]
5. NIP Update – healthAlliance Infrastructure Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	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 Cyber Security Risk	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	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 Home Based Support Service Agreement Variations for in-between travel funding.	**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]
6.2 Emergency Dental	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage,	That the public conduct of the whole or the relevant part of the

Services for Auckland DHB	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)]	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]
6.3 Revised Auckland DHB Capital Policies	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	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]
6.4 Open Agenda for Audit and Finance Committee	**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]
6.5 Procurement Policy	**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]
6.6 Independent Security Risk Assessment External Reviews 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	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

	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)]	of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 NZ Health Partnerships	**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]
7.2 Auckland DHB Adult Palliative Care Strategy 2015-2018	**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]
7.3 Government Chief Privacy Officer Self-Assessment for Auckland DHB 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) Would disclose a trade secret; or Would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	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 Change in National Breast Feeding Target	**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

	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)]	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]
7.5 Submission of Annual Plan and Statement of Intent for Auckland DHB	**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]
8.1 Human Resources Report	**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]
9.1 Finance Update 2016/2017 Budget	**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)] **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]
9.2 Reducing Acute Flow to Auckland City	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage,	That the public conduct of the whole or the relevant part of the

Hospital's Emergency Dept	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)]	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 General Business	NIL	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. REGISTER OF INTEREST AND CONFLICTS OF INTEREST (Pages 12-14)

Doug Armstrong advised that while he was a shareholder in Orion Healthcare he had no beneficial interest as it was held through a Trust.

Morris Pita advised that he was a Director and Shareholder of Healthcare Applications Ltd, which was engaged in designing healthcare application to improve health outcomes in an Emergency Department setting.

There were no declarations of conflicts of interest for any items on the open agenda.

4. CONFIRMATION OF MINUTES 17 FEBRUARY 2016 (Pages 15-26)

Resolution: Moved Jo Agnew / Seconded Ian Ward

That the minutes of the Board meeting held on 17 February 2016 be confirmed as a true and accurate record.

Carried

5. ACTION POINTS 17 FEBRUARY 2016 (Page 27)

No issues were raised.

5.1 Management Operating System (Pages 28-31)

Dr Andrew Old, Chief of Strategy, Participation and Improvement and Tim Winstone, Programme Director, Performance Improvement asked that the report be taken as read. Andrew Old invited any Board members interested in seeing MOS actively used insitu to contact him and he would arrange a visit to a site utilising it.

Matters covered in discussion and response to questions included:

Advice was given that any Board member could view two videos that had been produced for internal and external use to describe the Management Operating System. The links to these videos can be found on the Auckland DHB internet site:

http://www.adhb.govt.nz/HealthProfessionals/Videos.htm

That the Board receives the report and notes the progress and status of the Auckland DHB Management Operating System (MOS).

Carried

6. CHAIRMAN'S REPORT

The Board Chair did not raise any matters at this point in the meeting.

7. CHIEF EXECUTIVE'S REPORT (Pages 32-40)

The Chief Executive, Ailsa Claire asked that her report be taken as read. Matters highlighted or updated by the Chief Executive included:

- In February a new Internal Communication Tool was introduced; -"In the know". It contains a round-up of key news and actions. The first sessions took place on 19 February and around 180 managers attended.
- Patient Experience Week took place 7 – 11 March. The theme of the week was Communication. The week opened with the Manaakitia Reflective Round at the Clinical Education Centre, entitled "Patients who have inspired me."
- A successful Sustainability Forum was held in February with Inspiring Guest Speaker Bob Harvey, former Waitakere Mayor.
- The project to free up 100 more parking spaces for patients and visitors was started with a marketing campaign based on the message "In one day one carpark means…" and highlighted patient and visitors stories about how being able to park easily made their experience better and lowered their anxiety. The campaign included offers to staff to try off-site parking serviced by a shuttle service to Auckland City Hospital and Greenlane Clinical Centre, a two week free trial of the AT HOP card, and discounts for staff wanting to try cycling.
- The Chief Executive, the Chief Medical Officer and the Director of Strategy, Performance and Improvement hosted a visit by a Danish parliamentary delegation

comprised of the equivalent of the Danish health select committee on 11 March. The parliamentarians focus was on care of the elderly, palliative care and advance care planning in New Zealand.

- The Governor-General, Lieutenant General, The Right Honourable Sir Jerry Mateparae visited the Design for Health and Wellbeing Laboratory at Auckland City Hospital on 23 March.
- Staff have been asked to complete a short survey to find out how we are doing against our values. The survey responses will be used as a benchmark to measure our values journey over the coming years. Survey results will be shared back with staff in March.
- Twenty six people were nominated as Local Heroes during January and February. The February and March Local Heroes are Nadya Atanasova, Health Care Assistant on ward 42, and Janice Duxfield, Nurse Unit Manager, Endoscopy.
- Auckland DHB has scored top marks for the second year in a row in an independent review of its compliance against its Good Employer reporting obligations. In an annual review by the Human Rights Commission, Auckland DHB's overall compliance is rated at 100% for its reporting of its good employer obligations.
- The National Health Targets Performance Summary status dashboard is not correct, Improved Access to Elective Surgery should be showing as yellow.
- 70 staff took part in a training exercise to test the level of preparedness for a major incident at Auckland City Hospital held on 18 March in the Clinical Education Centre. The scenario was power failure to the northwest corner of the main hospital (A32) due to failure in one of the substations. The scenario focussed on mitigating the risk to inpatient services and patient flow in multiple directorates, with a number of surgical and medical wards affected, as well as radiology and the adult and children's emergency departments. Findings from the exercise will provide valuable information to guide process reviews.
- Auckland DHB hosted a visit by clinician leaders from Metro South hospitals, Queensland. This was a peer group opportunity to share our approaches to quality and safety. Key learnings for Auckland DHB related to the development of a comprehensive safety scorecard and a tool for SMO performance development both of which are embedded in the Metro South network.
- Dr Angela Pitchford has provided positive feedback following her visit to learn about the systems and processes Auckland DHB has put in place to achieve the Shorter Stays in Emergency Department health target.
- The first Care Capacity Demand Management (CCDM) work streams are underway at Auckland DHB. Two work streams have been approved; Variance Response Management and Staffing Methodology in the Reablement Services.

That the Chief Executives report for March 2016 be received.

Carried

8. COMMITTEE REPORTS - NIL

9. PERFORMANCE REPORTS

9.1 Financial Performance Report (Pages 41-48)

Rosalie Percival, Chief Financial Officer asked that the report be taken as read, highlighting that the District Health Board financial result for February 2016 was a surplus of $2.7M which was favourable to budget by $16K. For the Year to Date (YTD), a surplus of $6.6M was realised, favourable to budget by $223K. Favourable Funder arm and Governance results (both for the month and YTD) fully offset unfavourable variance in the Provider arm. The full year financial plan is a $2.4M surplus, which management is on target to achieve.

That the Board receives the Financial Performance Report for February 2016.

Carried

9.2 Funder Performance Report (Pages 49-60)

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

- That while improvements had been seen, the cancer target was still of concern and efforts were continuing to be directed to further improve these indicator results for each tumour stream, with attention to data processes, pathways and the deployment of additional tumour stream coordinators.
- Efforts to increase immunisation coverage for Maori infants continue, though as previously noted, by 2 years of age 97% coverage is achieved. Outreach services are now being engaged earlier via safety-net referrals at 10 weeks, 4 months and 6 months of age in order to improve the situation.
- That she believed that the smoking target would be met.
- That while the Tertiary Services review had been progressing well a key resource had been lost through a resignation.
- That the Rural Alliance has representation from rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of 58,530 patients. To obtain a clearer understanding of the current environment and to establish a baseline, a stocktake of services delivered by Auckland and Waitemata DHB Rural General Practices is currently underway to inform the subsequent development of the Rural Alliance Work Plan.

Matters covered in discussion and in response to questions included:

- Debbie Holdsworth advised in response to a question from Morris Pita that a slowing in the Tertiary Services review may be seen due to recruitment required to replace a key staff member who had taken a position within the Auckland DHB Mental Health Services Directorate.
- Ian Ward drew attention to radiology indicators on page 51 of the agenda and commented that they were not being met in January and what improvement had been made. Jo Gibbs replied that there had been a significant improvement in February and targets were now being met. The issue had been with staffing capacity and not scanner capacity. The move to a 40 hour week had alleviated the situation. A new resourcing model was being investigated and Jo Brown, Funding and Development Manager Hospitals was looking at the issue from a region wide perspective and in particular, competitive pricing models across the region.

  Lester Levy asked how Auckland DHB would capture the use of new technology if it did not have a PET scanner. Jo Gibbs replied that a PET scanner was a relatively peripheral diagnostic tool. Debbie Holdsworth added that there was a report in existence on PET scanning. There were clear cut guidelines for its use and volumes did not warrant its purchase. Debbie was confident of the rigour applied in relation to the provision of a PET scanner within the public health service.

Action

That a report be provided on PET scanner usage across the region looking at private versus public usage and the point at which a PET scanner within the public health service became viable.

That the Funder Performance Report for March 2016 be received.

Carried

10. COMMITTEE REPORTS

Hospital Advisory Committee

10.1 Patient Experience Survey Net Promotor Score (Page 61)

Tony O'Connor, Director Participation and Experience asked that the report be taken as read.

Resolution: Moved Jo Agnew / Seconded Gwen Tepania-Palmer

That the Board:

1. **Approves the continuation of a Net Promotor Score based on Auckland DHB's own patient experience survey data.**
2. **Approves the creation of Net Promoter Scores using national patient experience survey data to allow comparison between Auckland and Waitemata DHBs.**

Carried

11. DECISION REPORTS

11.1 Auckland District Health Board 2016 Triennial Election (Pages 62-95)

Lester Levy introduced this item advising that the Board was required to make decisions around the order of candidate's names on voting documents and delegate authority to the Chief Executive to sign the memorandum of understanding with Auckland Council for the running of the 2016 Triennial Board election.

There was discussion around the difference between random order and pseudo-random order.

Resolution: Moved Lee Mathias / Seconded Robyn Northey

That the Board:

1. **For the 2016 Triennial District Health Board election adopt the random order of candidate names on voting documents as permitted under regulation 31 of the Local Electoral Regulations 2001**
2. **Authorise the Chief Executive to approve and sign the memorandum of understanding between the Auckland District Health Board and the Auckland Council for the conduct of the 2016 triennial Board election.**

Carried

12 DISCUSSION PAPER

12.1 Tamaki Programme Update (Pages 96-129)

Andrew Old, Chief of Strategy, Participation and Improvement introduced Johnny O'Connell, Programme Director – ProCare and asked that the report be taken as read.

Matters covered in discussion and response to questions included:

- Advice that success had been seen in the area of clinical engagement garnered with general practices in the Tamaki area. General Practitioners are now proactively asking to be part of the project.
- Lester Levy advised that this was an important initiative for Auckland DHB. Lester was given confirmation that the project was proceeding very well. The biggest risks to be aware of were:
    i) The ebb and flow of community engagement
    ii) Cross over or duplication of effort with the Tamaki Regeneration Company. There was a need to work in a complementary manner to avoid duplication of

services.

iii) Change to the number of initiatives involved.

Resolution: Moved Gwen Tepania-Palmer / Seconded Jo Agnew

That the Board:

1. **Notes the progress of the Tāmaki Mental Health and Wellbeing Initiative**
2. **Notes the related work with the Tāmaki Regeneration Company**

Carried

13 GENERAL BUSINESS

13.1 Design Lab Presentation

Andrew Old, Chief of Strategy, Participation and Improvement introduced Justin Kennedy-Good and Stephen Reay from the Design Lab. A presentation was made which can be found as attachment 13.1.1 to the minutes. The Presentation focused on initiatives which the Design Lab had been part of and how they had provided better healthcare experiences for patients, family and staff.

That the team from the Design Lab be thanked for their presentation.

13.2 General Practices – Potential to Overload

In relation to a comment made during a previous conversation about a concern held with the potential overloading of general practices, Chris Chambers asked a question relating to what was done to ensure that GPs were not overloaded and expectations were realistic. Chris was advised that every attempt was made to ensure focus was given to a limited number of priority areas, and that work was undertaken through the Alliance to ensure that practices were able to cope.

In an ideal world that would involve becoming involved in such things as Family Centres.

The meeting closed at 1.55pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 30 March 2016

Chair: _____ Date: _____

Lester Levy

Action Points from 11 May 2016 Open Board Meeting

5

As at Wednesday, 11 May 2016

Meeting and Item	Detail of Action	Designated to	Action by
30 March 2016 Item 9.2	**Pet Scanning** That a report be provided on PET scanner usage across the region looking at private versus public usage and the point at which a PET scanner within the public health service became viable. ***Update*** A strategic assessment of the current nuclear medicine service was undertaken by the radiology network in September last year. This was independently reviewed by an external expert – Dr Andrew Scarsbrook from the UK and a recommendation went to CEOs/CMO forum in December 2015 to undertake a review. The expected outputs are: • Document what a future Nuclear Medicine service looks like. • Facilitate the region to consider at what time is it clinically and economically appropriate to invest in public PET-CT • Understand and present future demand and service delivery options for investment in cyclotron and other radiopharmaceutical production facilities within the context of regional capital, facilities, and model of care planning. This is on the Service Review Group Agenda and the scoping of the review is expected to be completed within this financial year. Further updates will be provided to the Board as appropriate.	Debbie Holdsworth	Update Provided

Chief Executive's Report

Recommendation

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

6

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 11 March to 22 April, 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 Patient and Community

Communications manages a generic communication email box. This is one of only two email addresses on the Auckland DHB website and acts as an unofficial online contact centre. Many of the requests are outside of the scope of the communication team's duties. The team responds to all emails and connects people to the correct departments. For this period, 70 emails were received with approximately 40 referred to other departments and services at Auckland DHB.

2.2 External and Internal Communications

2.2.1 External

Auckland DHB made public statements about:

- Conversations that Count Day
- The cancellation of planned industrial action
- Date set for Auckland DHB elections 2016 on 8 October 2016
- Launch of new ERAS (Enhanced Recovery After Surgery) orthopaedic elective unit at Auckland City Hospital
- Evidence-based antenatal education curriculum for regional rollout
- Reciprocal dialysis arrangements with Australia
- Confirmed that double mastectomy for transgender patients not available

We received 73 requests for information, interviews or for access from media organisations from 11 March to 22 April. Media queries included interest in: planned industrial action, driveway accidents involving toddlers, and whooping cough prevalence.
Apart from those noted, 67 per cent of the enquiries over this period sought the status of patients admitted following crimes, road accidents or who were of interest because of their public profile.
The DHB responded to 18 Official Information Act requests over this period.

2.2.2 Internal

- Three CE blog posts were published. These covered commuting options, creating a Healthy Environment and Patient Experience Week.

- Hospital occupancy was updated daily on the Intranet.
- 14 news updates were published on the DHB intranet.
- six eNova (weekly electronic newsletters) were published.
- Mar/April edition of Nova magazine was published and distributed.

2.2.3 Events and Campaigns

At Our Best

Work continues on creating awareness and providing the tools to staff to best use our values programme to improve patient experience, care and treatment. On 11 and 12 May sessions aimed at resident medical officers will outline the evidence base for how values- driven staff can improve patient experience and how to use our values to enhance engagement and collaboration with patients, visitors and colleagues.

A+ Trust Nursing and Midwifery Awards 2016

The second annual A+Trust Nursing and Midwifery Awards were held on 10 May at the Langham Hotel. The event coincides with International Nurses and Midwives Day marked on 12 May, the birthday of Florence Nightingale. Nurses and midwives together make up the largest part of the professional health workforce at Auckland DHB and whether in hospital or in the community nurses have a great responsibility to improve the health of the populations and patients we serve. Every day nurses and midwives make a difference through the care they provide to patients and their families. The Awards recognise the different skills and attributes required by the professional nursing workforce. There are 25 Awards in total across all our Directorates.

Visit by United States Ambassador

United States Ambassador Mark Gilbert visited the Cancer and Blood Centre at Starship Children's Hospital in April. Mr Gilbert, a former major league baseball player for the Chicago White Sox who later went on to have a prominent career in the banking industry, was interested in the work Starship Children Hospital clinicians and patients have with the Children's Oncology Group, a multi-country clinical trials and research initiative supported by the American National Cancer Institute. The Starship team has been involved for 16 years and was pleased to meet with Ambassador Gilbert and provide him with a briefing on paediatric cancer in New Zealand.

Ambassador's visit: (From left) Child Health Director Dr Mike Shepherd, Chief Executive Ailsa Claire, Ambassador Mark Gilbert, Clinical Director Paediatric Oncology, Dr Lochie Teague, US Consul General Melanie Higgins.

National leadership role for Conversations that Count Day 16 April 2016

Auckland DHB led national project planning, communications and coordination of resource development locally and nationally, working with the National Advance Care Planning Cooperative and the Health Quality and Safety Commission,

Through work with consumer co-design groups we developed the theme 'Get Them Talking'. This is designed to encourage people to get their families talking so they can make the most of their lives and plan for their futures. With fantastic support from the A+ Trust, the team at Auckland DHB developed a range of other supportive resources and promotional material to leverage increased awareness and ACP participation in our community.

Within the Auckland DHB catchment we wanted our message to be heard in community libraries, farmer's markets, primary care, residential care homes and across our secondary care facilities. We knew that by working in partnership with local NGOs and patient advocacy groups we could utilise existing networks and communication channels to better promote our message.

Working with our Funding and Planning team, we were able to gain the support of 40 Residential Care Homes, 8 Public Libraries, Mercy Hospice, 11 Hospice Shops and 15 NGOs within our catchment. Participating NGOs included Parkinson's' Auckland, Lung Foundation NZ, Cystic Fibrosis NZ, Age Concern, St John, MS Society, Hospice NZ and Leukaemia and Blood Cancer Auckland.

We were also able to promote our message at the Parnell and Howick community farmer's markets and provided more than 35 presentations to community groups in the weeks leading up to and after 16 April. Community workshops, presentations and events reached more than 1000 Aucklanders as part of the Conversations that Count Day 2016 initiative. CTC Day also was promoted throughout our secondary care services and in public areas at Auckland City Hospital and Greenlane Clinical Centre.

In addition to training, resource distribution and our more traditional communications channels, we also worked to engage directly with staff and the public through our 'morning tea' stall, the video wall and Auckland DHB screensavers.

We anticipate that these efforts have had a significant impact on public awareness and participation in advance care planning, particularly from the residential care sector and internal clinical units. Measurement of the impact will be available in the coming months.

Feedback to Patient Experience Week 7-11 March

A wide range of positive feedback has been received from participants at Patient Experience Week held from 7-11 March. Attendance at events was strong throughout the week, with several full-houses. The week opened with the Manaakitia Reflective Round at the Clinical Education Centre, entitled "Patients who have inspired me." A collection of photo-story boards showed people's unique stories with quotes describing the difference communication with health professionals makes to their health and health care. We held a Patient Panel, where three patients told staff about their experience at Auckland DHB, with a particular focus on the difference communication made to their care. A strong theme was the importance of being listened to and the challenge being blind poses to accessing safe care and treatment. There stories were followed by facilitated discussion between the patients and staff. Professor Ron Paterson, a New Zealand Parliamentary Ombudsman and former New Zealand Health and Disability Commissioner, delivered a keynote presentation: *The Heart of Health Care: Effective Communication with Patients and Families*.

Mini role-plays were held were held on the wards, based on real-life scenarios, to demonstrate simple communication tools. These sessions were interactive to encourage frontline staff to think about and up-skill their clinician-patient communication. The region's DHBs co-hosted a community-based workshop to consider how the DHBs can communicate better with consumer representatives working with us on service management, design and improvement teams. The HQSC's 'Partners in Care' programme lead, Dr Chris Walsh, delivered the workshop's key-note address.

2.2.3 Social Media

Facebook likes: 3,421
Twitter followers: 2,190
LinkedIn followers: 4,715
Instagram followers (*New account*): 57

Most popular posts:

- Patient experience – applause & thank yous
- Patient donation to ward 67
- New elective surgical ward
- #AprilFallsNZ
- Conversations that Count Day
- Staff flu vaccines
- Stroke Awareness campaign
- Dawn for Diabetes campaign
- Governor General visit to DHW Lab
- RMO Career Fair
- Health Food Star Rating
- Rheumatic Fever campaign

2.2.4 People

Graduation ceremony for orderlies

The first group of Auckland DHB orderlies to complete the level 3 national orderlies qualification will be presented with their certificates at a ceremony on 12 May. The national qualification run by Careerforce, enables our orderlies to show they have reached the top level of training for their role. All orderlies joining the organisation are offered training and development opportunities. Forty of the 70-strong orderly team have accepted the opportunity and 20 of them will receive their full qualification at the graduation ceremony.

Local Heroes

Ten staff were nominated for the April Local Hero award. A sample of the staff nominated and reasons for nominations includes:
A visitor said of cleaner Geraldine Filipo,"Please thank this nice lady for us, while in ICU this cleaner showed an excellent attitude, not only was she kind hearted and wellspoken but professional. I really wanted to say thank you to her during our time in ICU Level 4. Keep up the great work."

A colleague nominated physiotherapists, Katie Jepson and Kane White, "Katie and Kane have consistently provided above and beyond care to patients in DCCM. They are always friendly and courteous and very flexible. I have on numerous occasions given them a call and they have turned up to my bed space quickly and when they said they would. Recently I cared for a patient with very fragile skin. Katie and Kane organised a special chair for my patient and also organised a number of their physio colleagues to help with the transfer to chair throughout the week, sometimes a couple of times a day. They are both stunning examples of leaders in their field, providing real, tangible, excellent patient care and teamwork."

A Nurse Unit Manager nominated healthcare assistant, Amapal Kaur: " We would like to nominate her for her team work, she never says "that is not my job", she quietly goes about her work, she is

diligent in completing all her work. She looks out for any extra jobs that need to be done. She is a role model of a staff member who lives our shared values. She is a great member of our team."

Registered nurse in the Advance Planning Unit Helene Whyte was nominated by colleagues:" A team that supports each other is the team that is best able to provide quality care for its patients. Helene is constantly looking for opportunities to let the APU team feel valued and supported - Easter treats, raffles, spreads for morning teas - and all organised in her own time. Helene epitomises Caring for the Carers. She is APU's local hero!"

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Mar 95%, Target 95%
Improved access to elective surgery		98% to plan for the year
Shorter waits for radiation therapy & chemotherapy		Mar 100%, Target 100%, Year to Date 100%
Better help for smokers to quit		Mar 94%, Target 95%
Cardiac bypass surgery		Mar 82 patients, Target < 104
More heart & diabetes checks *		Mar Qtr 92%, Target 90%
Increased immunisation 8 months		Mar Qtr 94%, Target 95%

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

* Provisionally correct, final results pending from MoH.

3.2 Financial Performance

The financial performance for the month of March 2016 was favorable to budget by $18K, against a planned deficit of $4.9M. The DHB financial performance for the year-to-date was favourable to budget by $241K, against a planned surplus of $1.5M. We are on track to fully achieve the 2015/16 planned surplus of $2.3M. For the nine months to March 2016, $17.5M savings have been achieved against a budget of $19.4M, resulting in an unfavourable variance of $1.9M. The unfavourable result is primarily driven by the increased acute demand volumes that have remained consistently high since December 2015. As a result, cost containment savings ($1.8M) and revenue growth savings

($855K) were not achieved, although these were partially offset by a favourable result of $775K from model of service delivery initiatives.

4.0 Clinical Governance Commentary

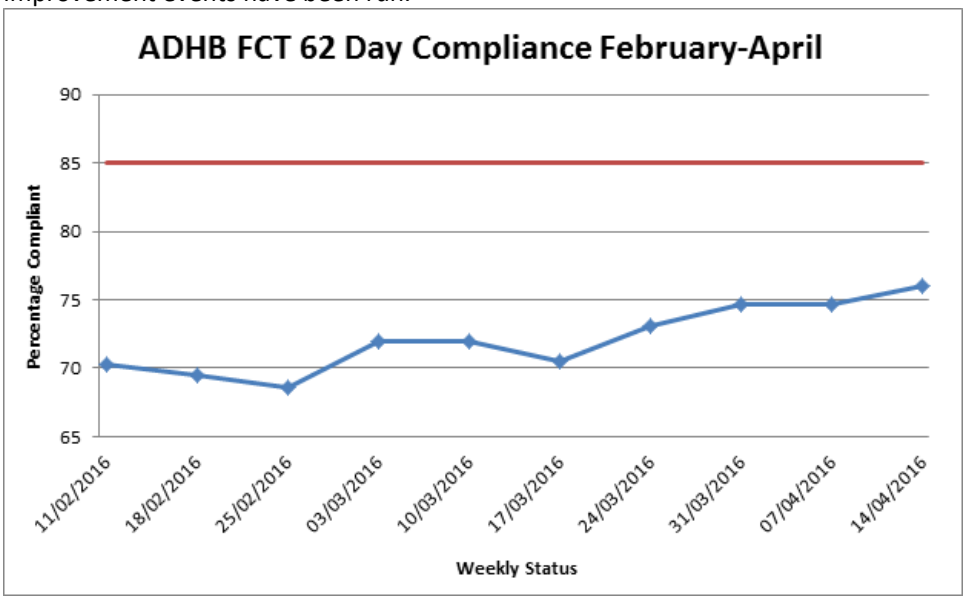
Improvement events support Faster Cancer Treatment

The Performance Improvement team have been working on the tumour stream pathways since last May including Lung, Gynae, Breast, and Melanoma, Haematology and Neurology to review and identity and implement improvements. Good progress has been made, but the impending FCT target date of 1 July this year has increased the urgency to improve these pathways for patients.

The team facilitates rapid improvement events, typically held over three days and involves the whole team working through the Auckland DHB improvement process: Define Measure, Analyse, Improve and Control (DMAIC). We have held two rapid improvement events during March, for the Colorectal and Genitourinary tumour streams, with events for the Upper Gastrointestinal and Head and Neck tumour streams in the coming months. The key outputs for these events have been improvements that are common to all tumour streams that will contribute to reducing waiting time and improve the patient experience. In addition to these improvements we are:

- Gathering patient experience stories to identify issues
- Getting staff feedback on new processes

This year's compliance against the 62 days target has been steadily improving since the rapid improvement events have been run.



Better planning and visibility for radiology services

Auckland DHB has participated in the National Radiology Service Improvement Initiative (NRSII) over the past 18 months to further improve its service to patients and referrers. The primary objectives of the project were focused on ways to reduce outpatient and community waiting time for CT and MRI. In addition to this Auckland DHB also focused efforts on improving timeframes for scanning and reporting ultrasound patients and also improved processes for meeting the requirements of acute patients and services.

The project was successful in delivering on the objectives set-out in the four key work streams: Demand Management, Improving Acute Diagnostic Flow, Imaging Throughput / Patient Flow Improvement, Improved Reporting and Visibility of performance. Through engaging clinical and non-clinical teams in these work streams, there have been tangible improvements made to processing of referrals, booking times, imaging capacity, timeliness of service and coordination of patient referrals. Ultimately this has resulted in a significant reduction in the waiting list for MRI, CT and Ultrasound as well as significant improvements in the proportion of patients who met the national indicator of less than six weeks from referral to imaging/reporting complete for outpatient and community referrals.

In addition to these improvements Auckland DHB has developed the capability to sustain and further improve on these gains by developing a performance dashboard and reports to provide better visibility and data for our teams. The service has also developed production planning processes to include a broader range of staff and have greater visibility of areas where patients are at risk of having delayed service. The team now has the right people, with the right information to make better decisions at the right time.

Green Belt improvement practitioner projects underway

Twenty staff attended their second of three Improvement Practitioner (Green Belt) training sessions on 20 April. This programme is a key part of our commitment to empowering our staff to continually improve our services. Each Green Belt staff member progresses a project using improvement principles. Projects include:

- Reduce time from referral to first treatment for haematological cancer patients in support of the Faster Cancer Treatment programme
- Increase the proportion of Rheumatic Fever patients who receive their 21/28 day injections within 5 days of due date as administered by District Nursing
- Reduce the time taken from hiring decision to producing a letter of offer for new roles in Lab Plus to within 5 days
- Increase our haemodialysis patients' adherence to their prescribed dialysis session duration and blood flow rate to improve patient wellbeing

Clinician elected to key professional role

Auckland City Hospital gastroenterologist Mark Lane is the President Elect for the Royal Australasian College of Physicians (RACP). Mark led the Gastroenterology Department at Auckland City Hospital for 17 years and is the patron of the Coeliac Society NZ and of Crohns and Colitis NZ.
Mark Lane, also an associate professor at the University of Auckland's School of Medicine, is president elect from 18 May. Following two years in the role, he will then serve as president for two years from 2018.

Progress on patient safety strategy

In April the Chief Medical Officer convened the first of two workshops to develop our patient safety strategy. Facilitated by Anne Patillo, workshop participants included senior DHB clinical leaders, the Chair Health Quality and Safety Commission, local and national quality and safety experts, the Chair Auckland Metro Clinical Governance Group, University of Auckland human factors experts. The second workshop in May will see Professor Cliff Hughes, CEO Clinical Excellence Commission and two lay representatives take part.

Milestones

Mr Alan Kerr, retired cardiac surgeon and previously Director of Cardiac Surgery at Green Lane Hospital, was honoured in Ramallah, Palestine in March this year as the "father of paediatric cardiac surgery in Palestine" by the Palestinian Children's Relief Fund and the Palestinian Ministry of Health. Alan has led approximately 40 missions to Palestine since 2001, operating in East Jerusalem, the West Bank and Gaza and for much of that time personally performed more than half of the operations on children as part of the Palestinian programme.

Paediatric Surgeon, Mr Stuart Ferguson, retires in May this year. Stuart has worked at Auckland DHB since 1965, as a consultant surgeon since 1973 and at Starship Children's Hospital since it opened in 1991. He was the first full time paediatric surgeon in New Zealand and was head of department for 25 years. He was also President of the Pacific Association of Paediatric Surgeons. His main interests have been outreach paediatric surgery, surgical oncology and trauma. He has always been a vocal advocate for child health and played an important role in the advocacy for the building of Starship, and inclusion of the Paediatric Intensive Care in particular.

Thanks should also go to four other notable clinicians who after many years of service to Auckland DHB have decided to retire. Dr Paul Drury has served as the Service Clinical Director of our Diabetes Services and Dr Sue Rudge, his wife, has been a paediatric rheumatologist. Kathryn Crosier, a haematologist and her husband Phil Crosier also both hold professorships at the Faculty of Medical and Health Sciences at the University of Auckland.

Financial Performance Report

Recommendation

That the Board receives this Financial Report for March 2016

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for March 2016 was a deficit of $4.9M which was favourable to budget by $18K. For the Year to Date (YTD), a surplus of $1.7M was realised, favourable to budget by $241K. Favourable Funder arm and Governance results (both for the month and YTD) fully offset unfavourable variance in the Provider arm.

YTD revenue is favourable to budget by $9.6M. Underlying this revenue variance are significant movements including: $2.8M additional MoH PBFF sourced funding due to additional Capital Charge funding for assets revalued at 30 June 2015 and to additional Community Palliative Care funding ($1.2M for 2015/16); $1.2M additional MoH contracts Devolved funded initiatives under NGO services (mainly contracts finalised after budgets were set, with corresponding additional expenditure); $6.2M additional other income (includes research income and one off settlement of commercial contracts); offset by unfavourable financial income ($1.6M) and donation income ($1.3M). YTD expenditure is unfavourable to budget by $9.3M. Significant variances include unfavourable outsourced personnel of $5.8M; clinical supplies of $4.3M; infrastructure and non-clinical supplies of $1.2M and capital charge of $1M; offset by favourable Funder payments to NGOs of $2.8M and personnel costs of $1M.

The full year financial plan is a $2.4M surplus and we are on target to achieve that based on YTD performance and that forecast for the rest of the year.

Auckland District Health Board
Summary Results: Month of March 2016

$000s	Month (March-16)			YTD (9 months ending 31 March-16)			Full Year (2015/16)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	93,132	92,819	313 F	838,185	835,367	2,818 F	1,117,580	1,113,823	3,757F
MoH Contracts - Devolved	6,541	7,060	519 U	64,772	63,539	1,233 F	86,905	84,719	2,186F
	99,673	99,879	206 U	902,957	898,907	4,051 F	1,204,485	1,198,542	5,943F
MoH Contracts - Non-Devolved	5,138	4,841	297 F	43,672	42,950	723 F	61,622	57,598	4,024F
IDF Inflows	54,777	54,105	672 F	488,059	486,943	1,115 F	666,507	664,406	2,101F
Other Government (Non-MoH, Non-OtherDHBs)	3,039	2,809	229 F	25,914	25,633	281 F	33,421	34,212	791U
Patient and Consumer sourced	1,871	1,544	327 F	13,940	13,899	41 F	0	0	0
Inter-DHB & Internal Revenue	1,157	1,291	134 U	11,393	11,345	48 F	18,256	18,532	276U
Other Income	3,968	3,697	271 F	39,985	33,799	6,186 F	49,567	43,216	6,351F
Donation Income	510	569	59 U	3,879	5,181	1,302 U	6,011	7,830	1,819U
Financial Income	426	662	236 U	4,260	5,836	1,576 U	5,915	8,608	2,693U
Total Income	**170,559**	**169,398**	**1,160 F**	**1,534,059**	**1,524,492**	**9,567 F**	**2,045,784**	**2,032,944**	**12,840F**
Expenditure									
Personnel	76,115	75,946	169 U	642,528	643,554	1,027 F	856,116	857,732	1,616F
Outsourced Personnel	2,471	1,505	965 U	19,371	13,560	5,811 U	22,691	18,082	4,609U
Outsourced Clinical Services	1,855	1,896	41 F	17,335	16,871	465 U	22,898	22,515	383U
Outsourced Other Services (incl. hA/funder Costs)	4,600	4,591	9 U	41,368	41,317	51 U	55,140	55,089	51U
Clinical Supplies	22,369	20,471	1,899 U	183,234	178,953	4,281 U	242,953	239,097	3,856U
Funder Payments - NGOs	43,330	44,987	1,657 F	402,061	404,883	2,822 F	539,504	539,844	340F
Funder Payments - IDF Outflows	9,270	9,269	1 U	83,694	83,409	285 U	111,643	111,228	415U
Infrastructure & Non-Clinical Supplies	11,480	11,097	383 U	101,083	99,898	1,186 U	136,752	132,983	3,769U
Finance Costs	480	1,066	586 F	10,017	9,967	50 U	13,728	13,093	635U
Capital Charge	3,438	3,438	0 F	31,647	30,601	1,046 U	41,960	40,914	1,046U
Total Expenditure	**175,408**	**174,266**	**1,143 U**	**1,532,338**	**1,523,012**	**9,326 U**	**2,043,385**	**2,030,577**	12,808U
Net Surplus / (Deficit)	**(4,850)**	**(4,867)**	**18 F**	**1,721**	**1,480**	**241 F**	**2,399**	**2,367**	**32 F**

2. Result by Arm

Result by Division	Month (March-16)			YTD (9 months ending 31 March-16)			Full Year (2015/16)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	1,582	194	1,387 F	6,579	1,748	4,831 F	9,635	2,330	7,305F
Provider	(6,546)	(5,061)	1,484 U	(6,404)	(268)	6,137 U	(8,326)	37	8,363U
Governance	114	0	114 F	1,547	0	1,547 F	1,090	0	1,090F
Net Surplus / (Deficit)	**(4,850)**	**(4,867)**	**18 F**	**1,721**	**1,480**	**241 F**	**2,399**	**2,367**	**32 F**

The YTD $4.8M favourable Funder arm and $1.5M favourable Governance results fully offset the $6.1M unfavourable result realised in the Provider arm.

- The favourable YTD Funder result reflects lower expenditure for demand driven services and favourable 2014/15 adjustments. Favourable 2014/15 adjustments include Community Laboratory wash-ups, Pharmac GST claims and higher Pharmac rebates. These were offset by adverse net IDF flows from PHO quarterly wash-ups and additional revenue allocations to the Provider Arm. Higher YTD revenue from funded initiatives is accompanied by equivalent expenditure and has a nil impact on the results.
- The unfavourable YTD Provider Arm result is driven by net unfavourable expenditure – primarily Outsourced Personnel, clinical supplies and Infrastructure and Non Clinical Supplies costs.
- The favourable YTD Governance Arm result is driven by favourable outsourced costs (mainly joint funder costs) and infrastructure costs (mainly professional costs, IT systems and other operating expenses), with a corresponding reduction in internal allocations. The Governance result is forecast to be on target by year end.

Overall, the consolidated year end forecast is on target to achieve the planned $2.4M surplus, with the favourable Funder Arm and Governance Arm result forecast to fully offset the forecast unfavourable Provider Arm result.

3. Financial Commentary for March 2016

Month Result

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

Revenue was greater than budget by $1.2M, mainly driven by:

- MoH devolved contracts, $520K unfavourable due to an accounting adjustment effected in March month to align the ADHB Funder and the WDHB Funder accounting policy for recognising Funded Initiatives revenue. Funding received for specific initiatives but not yet expensed is now taken up in the balance sheet. This adjustment has a nil net effect on the core result but is the primary driver of the adverse MOH Contracts revenue variance for the March month.
- IDF inflows are $672K favourable due to Own Provider Inflows that are mainly the National services revenue and minor service changes. IDF Service changes occur periodically during the year and are realized immediately in the Ministry IDF cash receipts/payments each month and are accounted for accordingly.

Expenditure was greater than budget by $1.1M. Significant variances are described below:

- Personnel/Outsourced Personnel costs $1.1M (1.5%) unfavourable. FTE were 115 above budget equating to $0.9M of the unfavourable variance with the balance of the variance due to cost per FTE targets not met.

  The key unfavourable variance is Nursing which is 73FTEs above budget - this reflects the temporary peak for the February intake of new graduates as they transition into their roles as Registered Nurses – FTE are expected to reduce in April once this is complete. In addition, additional beds were opened for the Orthopaedics Elective Unit in Ward 62 (11 FTE - unbudgeted but funded via reduced outsourcing) along with an additional three Bone Marrow Transplant beds to reduce wait times (6 FTE).
  On-going mitigation strategies include:
    - Nurse Directors have implemented daily staffing oversight forums with a focus on the efficient use of staff resource across the directorates while maintaining a quality, safe service. This includes a refinement of the set of principles for staff replacement with the accountability aligned to the Nurse Unit Manager
    - Focus on reviewing our systems, processes and models of care in regards to vulnerable patients who require a patient attender. An oversight group has been established to provide governance for identified work streams that improves the safety and quality of care to adult vulnerable patients. Work streams include Enhanced Support Rooms (ESR), Management of AWOL, Post-operative/Post-arrest Delirium and Behaviours of Concern
    - Work continues on recruiting to target skill mixes – this is improving month to month
    - Use of flex beds only as needed, flexing down as soon as possible

- Clinical Supplies $1.9M (9.3%) unfavourable, with the following key variances:
    - Haemophilia blood products $0.5M – fully funded
    - Pharmaceutical costs in Oncology/Haematology ($0.3M unfavourable) due to additional costs for treatment previously funded under a research trial and high cost drugs in Haematology
    - Particularly high volume of high cost TAVI implant volumes for the month in Cardiology - $0.2M unfavourable
    - Surgical/Perioperative $0.6M unfavourable, reflecting very high surgical volumes for the month – 105% of contract
- Funder payments – NGOs $1.7M (3.7%) favourable is mainly from demand driven services and favourable prior year adjustments. These favourable prior year adjustments for 2014/15 relate to Community Laboratory wash-up, Pharmac GST claims and Pharmac rebates.

Year to Date Result

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

Revenue was higher than the budget by $9.6M. Significant movements underlying this included:

Favourable revenue variances:

- MOH Sourced PBFF revenue is $2.8M favourable YTD mainly due to additional Capital Charge funding (with offsetting expenditure) for assets revalued at 30 June 2015 ($2.5M full year impact) and additional Community Palliative Care funding ($1.2M for 2015/16). Community Palliative Care revenue is a funded initiative and is accompanied by equivalent expenditure requirement.
- MOH devolved contract revenue is $1.2M favourable YTD. This is mostly additional revenue for funded initiatives under NGO services. Favourable funded initiatives revenue is a result of contracts finalised by the Ministry after budgets have been set but have equivalent additional expenditures. The majority of the additional revenue for funded initiatives is for Zero Fees for under 13s programme. This favourable result includes the negative impact of National Services revenue now mostly received from other DHBs through IDF inflows ($2.8M for 2015/16). The

Auckland DHB's own population component is being self-funded in 2015/16 but this was advised by MoH after the budgets were set.

- IDF inflows $1.1M (0.2%) favourable. Own Provider Inflow was $1.6M favourable (mainly from National services revenue) and this offset unfavourable NGO inflow variance of $0.4M (which was mainly due to PHO quarterly wash-ups). IDF Service changes occur periodically during the year and are realized immediately in the Ministry IDF cash receipts/payments each month and are accounted for accordingly.
- Haemophilia funding $2.0M favourable for abnormally high blood product usage, bottom line neutral as offset by additional expenditure.
- Research Income $3.5M favourable, offset by equivalent expenditure.
- Pharmacy Retail sales $0.5M favourable, offset by additional cost of sales expenditure.
- One off revenue for settlement of commercial contracts $0.9M favourable.
- Inter DHB Revenue - IDF wash-up for 2014/15 $1.5M favourable – one off revenue.

Unfavourable revenue variances:

- Inter DHB Revenue - $1.5M unfavourable, reflecting the end of the LabPlus MidCentral DHB contract – the reduction in income is partially offset by favourable Clinical Supplies costs in LabPlus.
- Financial income $1.6M unfavourable due to lower market interest rates and lower cash balances than forecast ($994K relates to adverse DHB interest income and $581K relates to Trust interest income).
- MOH Public Health $0.7M unfavourable – in line with costs lower than budget for the YTD.
- ACC Income $1.4M unfavourable – primarily in elective surgery, reflecting the focus on achieving elective discharge targets.
- Donation Income $1.3M unfavourable – revenue fluctuates depending on timing of projects, and with no major projects in the current year, this variance will continue for the year.

Expenditure was higher than budget YTD by $9.3M, with significant underlying variances as follows:

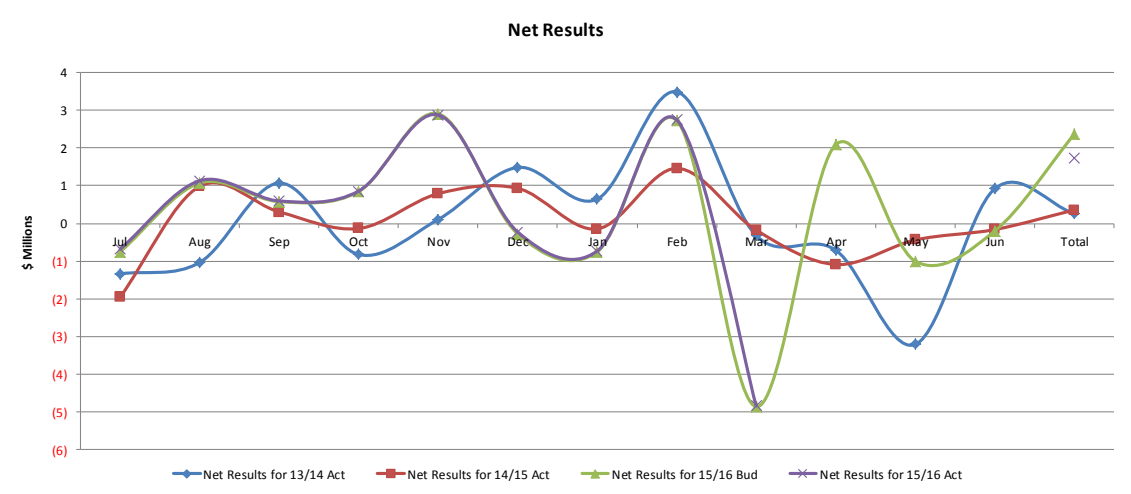
- Combined Personnel and Outsourced Personnel Costs are unfavourable to budget by $4.8M (0.7%) and combined FTEs are 19 (0.2%) below budget. Underlying this net variance is:
    a. Personnel Costs are $1M (0.2%) favourable due to FTE 170 below budget – the FTE variance is spread widely with vacancies across all categories other than Nursing which is 20 above budget YTD.
    b. This favourable variance in Personnel Costs is substantially offset by $5.8M (42.9%) unfavourable Outsourced Personnel costs (152 FTE above budget), primarily for contract Support and Administration staff covering vacancies.
- Clinical Supplies $4.3M (2.4%) unfavourable –the key unfavourable variances are in Cancer & Blood Services - abnormally high haemophilia blood product costs ($1.8M unfavourable) which are fully funded and pharmaceutical costs in Oncology/Haematology ($1.7M unfavourable) due to additional costs for treatment previously funded under a research trial and high cost drugs in Haematology.
- Funder Payments to NGOs are YTD favourable $2.8M (0.7%) and mainly driven primarily by favourable variances from demand driven services as well as favourable prior year adjustments for Community Labs wash-up, Pharmac GST claims and Pharmac drug rebates. These were partly offset by adverse variances from additional expenditure for funded initiatives which are accompanied by equivalent additional revenue.
- Infrastructure and Non Clinical Supplies $1.2M (1.2%) unfavourable, comprising the following key variances: In the Provider Arm, higher food costs during transition phase for new food services contract $1.3M unfavourable, costs of goods sold for retail pharmacy $0.5M unfavourable (offset by additional revenue), abnormally high cost of bad/doubtful debts $0.7M (these costs are variable from month to month), offset by favourable facilities costs for

depreciation and utilities $0.6M favourable. The unfavourable Provider Arm variances are offset by favourable Governance Arm variances.

- Capital charge is $1M unfavourable and is fully offset by additional revenue.

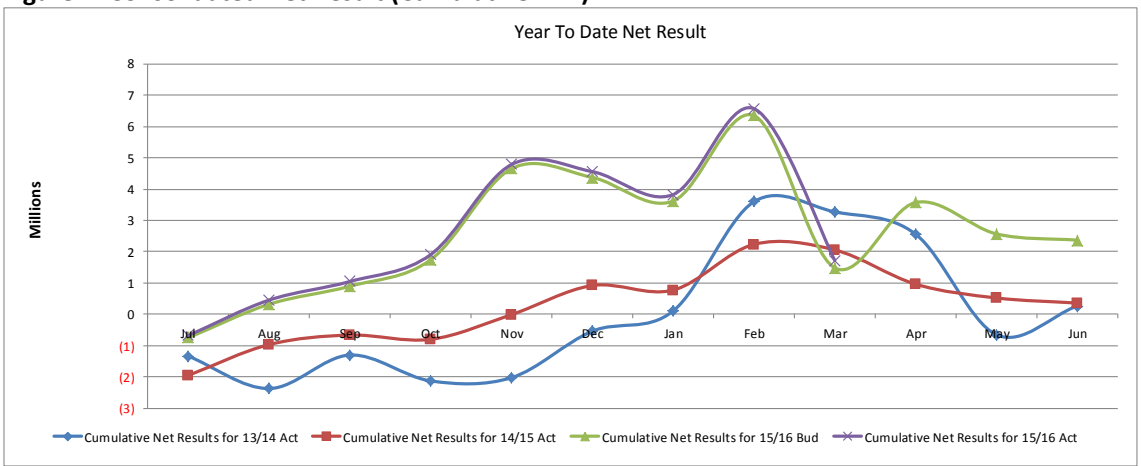
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Total
Net Result for 13/14 Act	(1.341)	(1.037)	1.072	(0.828)	0.105	1.486	0.645	3.494	(0.325)	(0.711)	(3.215)	0.918	0.262
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 Bud	(0.755)	1.072	0.577	0.846	2.911	(0.279)	(0.754)	2.731	(4.867)	2.090	(1.003)	(0.202)	2.365
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747	(4.850)				1.721

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Cumulative Net Result for 13/14 Act	(1.341)	(2.378)	(1.306)	(2.134)	(2.029)	(0.544)	0.101	3.595	3.270	2.559	(0.656)	0.262
Cumulative Net Result 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 Result for 15/16 Bud	(0.755)	0.317	0.894	1.740	4.650	4.371	3.617	6.347	1.480	3.570	2.567	2.365
Cumulative Net Result for 15/16 Act	(0.683)	0.450	1.045	1.904	4.785	4.557	3.824	6.571	1.721			
Variance to Budget for 2015/16	0.072	0.133	0.151	0.164	0.134	0.186	0.207	0.223	0.241			

5. Efficiencies / Savings

For the 9 months ending March 2016, $17.5M savings were reported against a target of $19.4M, resulting in an unfavourable variance of $1.9M. The unfavourable result is primarily driven by the increased acute demand volumes that have remained consistently high since December 2015. The main unfavourable impact on savings has been on cost containment initiatives -$1.8M and revenue growth - $855K. However, this has been partially offset by additional savings from model of service delivery - $775K.

The revenue growth strategy is unfavourable against budget by $855K. This is mainly due to Children's ACC revenue contracts $603K and Cardiovascular outsourcing and transplant initiatives $293K.

Model of service delivery changes initiatives are favourable against budget by $775K, largely attributed to Cardiovascular overseas resident revenue $231K, patient/surgical efficiencies $37K and Perioperative services' improved theatre efficiencies $520K.

Cost containment initiatives are unfavourable against budget by $1.8M. This is mainly attributed to the impact of service demand pressures on personnel within Adult Medical, Surgical Services, Cancer & Blood $364K and HealthAlliance clinical supplies $16M.

Note: Any year-end shortfall against specific initiatives is expected to be fully offset by the forecast favorable Funder position, enabling the DHB to achieve the planned surplus.

6. Financial Position

Statement of Financial Position as at 31 March 2016

$'000	31-Mar-16			29-Feb-16	Variance	30-Jun-15	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0F
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	438,457	406,629	31,828F	438,457	0F	438,457	0F
Cashflow-hedge Reserve	(3,879)	(3,833)	46U	(3,925)	46F	(4,293)	414F
Accumulated Deficits from Prior Year's	(464,047)	(459,677)	4,370U	(464,046)	1U	(464,402)	355F
Current Surplus/(Deficit)	1,723	-	1,723F	6,572	4,849U	356	1,367F
	(27,746)	(56,881)	29,135F	(22,942)	4,804U	(29,882)	2,136F
Total Equity	**549,052**	**519,917**	**29,135F**	**553,856**	**4,804U**	**546,916**	**2,136F**
Non Current Assets							
Fixed Assets							
Land	249,006	217,178	31,828F	249,006	0F	249,006	0F
Buildings	575,643	551,738	23,905F	577,719	2,076U	585,033	9,390U
Plant & Equipment	84,119	99,796	15,677U	84,508	389U	78,462	5,657F
Work in Progress	57,166	70,065	12,899U	55,075	2,091F	39,821	17,345F
	965,934	938,777	27,157F	966,308	374U	952,322	13,612F
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	49,585	44,930	4,655F	49,585	0F	42,170	7,415F
- HBL	12,420	12,420	0U	12,420	0U	12,420	0U
- ADHB Term Deposits > 12 months	5,000	-	5,000F	5,000	0F	-	5,000F
- Other Investments	462	-	462F	462	0U	462	0U
	67,467	57,350	10,117F	67,467	0U	55,052	12,415F
Intangible Assets	573	4,691	4,118U	612	39U	910	337U
Trust Funds	13,512	14,548	1,036U	13,219	293F	17,299	3,787U
	81,552	76,589	4,963F	81,298	254F	73,261	8,291F
Total Non Current Assets	**1,047,486**	**1,015,366**	**32,120F**	**1,047,606**	**120U**	**1,025,583**	**21,903F**
Current Assets							
Cash & Short Term Deposits	56,655	81,315	24,661U	46,302	10,353F	87,210	30,555U
Trust Deposits > 3months	11,600	7,700	3,900F	12,600	1,000U	8,500	3,100F
ADHB Term Deposits > 3 months	15,000	-	15,000F	15,000	0F	-	15,000F
Debtors	37,141	21,599	15,543F	32,151	4,990F	28,509	8,632F
Accrued Income	35,287	23,600	11,687F	38,831	3,544U	19,206	16,081F
Prepayments	3,077	1,166	1,911F	2,929	148F	1,035	2,042F
Inventory	13,493	12,723	770F	13,807	314U	13,154	339F
Total Current Assets	**172,253**	**148,103**	**24,150F**	**161,620**	**10,633F**	**157,614**	**14,639F**
Current Liabilities							
Borrowing	-	(4,715)	4,715F	-	0F	(52,454)	52,454F
Trade & Other Creditors, Provisions	(165,438)	(124,339)	41,099U	(152,096)	13,342U	(121,299)	44,139U
Employee Benefits	(169,431)	(176,254)	6,823F	(167,459)	1,972U	(176,735)	7,304F
Funds Held in Trust	(1,233)	(1,169)	64U	(1,230)	3U	(1,208)	25U
Total Current Liabilities	**(336,102)**	**(306,477)**	**29,625U**	**(320,785)**	**15,317U**	**(351,696)**	**15,594F**
Working Capital	**(163,849)**	**(158,374)**	**5,475U**	**(159,165)**	**4,684U**	**(194,082)**	**30,233F**
Non Current Liabilities							
Borrowings	(304,500)	(304,500)	0F	(304,500)	0F	(254,500)	50,000U
Employee Entitlements	(30,085)	(32,575)	2,490F	(30,085)	0U	(30,085)	0U
Total Non Current Liabilities	**(334,585)**	**(337,075)**	**2,490F**	**(334,585)**	**0U**	**(284,585)**	**50,000U**
Net Assets	**549,052**	**519,917**	**29,135F**	**553,856**	**4,804U**	**546,916**	**2,136F**

Comments

- The full revaluation of land completed at 30 June 2015 resulted in an increase in revaluation reserve of $31.8M, increasing the year end Equity position. A full revaluation of land and buildings is underway for 2015/16.

- Buildings, plant and equipment variances are largely due to different opening balances set in the budget. Capital spend is also $25M below forecast budget spend.
- Actual cash at month end is lower than budget cash and cash equivalents mainly due to favourable investments in term deposits. $5M matures within a year and $15M matures beyond a year. There was also a cashflow impact of $4.6M for investment in healthAlliance relating to regional IT projects approved in prior years but funded in 2015/16.
- Accrued income variance is mainly due to the timing of invoices to MoH and invoices accrued by the Funder.
- Trade & Other Payables reflect timing differences for creditors' payments, accruals and income in advance.

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

$000's	Month (March-16)			YTD (9 months ending 31 March-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	172,228	169,368	2,860F	1,513,099	1,524,360	11,261U
Payments						
Personnel	(74,143)	(71,055)	3,089U	(649,832)	(627,532)	22,299U
Suppliers	(32,829)	(35,917)	3,088F	(308,339)	(317,629)	9,290F
Capital Charge	0	(3,366)	3,366F	(21,334)	(30,246)	8,912F
Funder payments	(52,600)	(53,356)	756F	(485,755)	(480,207)	5,548U
GST	1,915	0	1,915F	(1,415)	0	1,415U
	(157,657)	**(163,694)**	6,037F	**(1,466,675)**	**(1,455,614)**	11,061U
Net Operating Cash flows	**14,571**	**5,674**	**8,897F**	**46,424**	**68,746**	**22,322U**
Investing						
Interest Income	426	668	242U	4,260	6,685	2,426U
Sale of Assets	0	0	0F	7	0	7F
Purchase Fixed Assets	(4,633)	(6,193)	1,560F	(46,844)	(73,731)	26,887F
Investments and restricted trust fund	418	0	418F	(26,715)	0	26,715U
Net Investing Cash flows	**(3,789)**	**(5,525)**	**1,736F**	**(69,292)**	**(67,046)**	**2,246U**
Financing						
Other Equity Movement	(0)	0	0U	0	0	0F
Equity Injections	0	0	0F	0	0	0F
New Loans	0	0	0F	0	0	0F
Loans Repaid	0	0	0F	0	0	0F
Equity Repayment	0	0	0F	0	0	0F
Interest paid	(427)	(1,112)	685F	(7,686)	(10,401)	2,715F
Net Financing Cashflows	**(428)**	**(1,112)**	**684F**	**(7,686)**	**(10,401)**	**2,715F**
Total Net Cash flows	**10,355**	**(963)**	**11,317F**	**(30,554)**	**(8,701)**	**21,853U**
Opening Cash	46,301	82,280	35,979U	87,210	90,018	2,808U
Total Net Cash flows	10,355	(963)	11,317F	(30,554)	(8,701)	21,853U
Closing Cash	**56,656**	**81,317**	**24,661U**	**56,656**	**81,317**	**24,661U**

ADHB Cash	53,058	76,212	23,154U
A+ Trust Cash	1,830	0	1,830F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	1,768	5,105	3,337U
	56,656	**81,317**	**24,661U**
ADHB - Short Term > 3 months	15,000	0	15,000F
A+ Trust Deposits - Short Term > 3 months	11,600	**7,700**	**3,900F**
ADHB Deposits - Long Term	5,000	**0**	5,000F
A+ Trust Deposits - Long Term	13,512	**14,548**	1,036U
Total Cash & Deposits	**101,768**	**103,565**	**1,797U**

Funder Update

Recommendation

That the Funder Update report for April 2016 be received.

Prepared by: Jo Brown, Funding & Development Manager Hospitals; Tim Wood, Funding & Development Manager Primary Care and Acting Funding & Development Manager Mental Health & Addictions; Kate Sladden, Funding and Development Manager Health of Older People; Ruth Bijl, Funding & Development Manager Women, Children & Youth; 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

ACH	-	Auckland City Hospital
AOD	-	Alcohol and Other Drug
ARRC	-	Aged Related Residential Care
CADS	-	Community Alcohol and Drugs Services
CEO	-	Chief Executive Officer
DHB	-	District Health Board
DNA	-	Did Not Attend
GP	-	General Practitioner
HCSS	-	Home and Community Support Services
MoH	-	Ministry of Health
MoU	-	Memorandum of Understanding
NGO	-	Non-Government Organisation
NZMA	-	New Zealand Management Association
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
SACAT	-	Substance Addiction (Compulsory Assessment and Treatment) Bill
TRC	-	Tamaki Regeneration Company

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 11 May 2016.

1. Planning

1.1 Annual Plan

Work is progressing on the Annual Plan (refer associated Agenda item). The date for submission to the National Health Board is 31 March 2016.

2. Hospitals

2.1 Cancer target

The ADHB FCT 62 day indicator result for the period January to March 2016 is 76.4% and this is an improvement on the previous quarter's result of 70.1%. The 31 day indicator result is 88.5% and this is also improved. (These results are based on internal DHB reports pending availability of Q3 national report). There is ongoing effort being directed to further improve these indicator results for each tumour stream with tumour stream coordinators continuing to actively monitor and support progress within each pathway. Rapid improvement events for tumour stream pathways have been held and communication roadshows are planned for May to further engage staff in FCT and tumour stream activities with the expectation these activities will contribute to improving FCT indicator results.

2.2 Auckland DHB 2015/16 Surgical Health Target

ADHB will likely have achieved 99% compliance with the Surgical Health Target, for Quarter 3 compared to 98.3% at the end of Quarter 2. (Awaiting final nationally reported Q3 results). There have been issues impacting the delivery of the health target including increased acute demand for the ADHB population and the highly variable demand for national services. However, there is still a strong focus within the ADHB provider, on implementing recovery plans by each specialty to increase the volume of elective surgery and this has contributed to achieving the overall improved result.

2.3 2015/16 IDF arrangements

The wash up position is monitored regularly and the funder works with Corporate Finance to ensure any anticipated financial risk is appropriately recognised. The Ministry of Health has acknowledged there is a need to review the 2015/16 reduction in funding for Eating Disorder Liaison services for the ADHB population and a review of this has been initiated. A meeting has occurred with Midland DHB Funders to resolve outstanding issues relating to the shortfall of funding for Eating Disorder Services in 2015/16 and a further meeting is scheduled before the end of April. There is no progress to report following these discussions, however agreement has been reached regarding the ongoing funding arrangements for Child and Family Unit services with wash up arrangements yet to be agreed.

2.4 2016/17 IDF arrangements

Final advice from the Ministry of Health regarding IDF and national service funding arrangements has now been received. Provisional costs of the new Eating Disorder service arrangements have been finalised and the forecast costs of the service are approximately $400K more than the available revenue. A clear agreement regarding the resolution of this shortfall is expected following a meeting of the Supraregional Transition Steering Group at the end of April. Following the independent review of the ADHB Ophthalmology service data, the funder will work with the Director of Provider services to establish and support a joint service improvement plan, including the appointment of a project manager, to resolve the service delivery and funding issues associated with services provided to the Waitemata population.

2.5 2016/17 ADHB funder/ADHB provider arrangements

The final draft of the ADHB provider volumes and non-volume arrangements for the ADHB population has been completed. The value of the funding allocated to the provider exceeds the total value of the volume and non-volume arrangements. Elective surgical health target volumes have been included in the price volume scheduled at a rate of this year's plan plus forecast population growth pending final agreement with the Ministry about the expected level of uplift for the ADHB population in 2016/17.

2.6 Tertiary services review

The service specific analysis for all Starship clinical services is complete and the project team is proceeding with the financial analysis. There has been delay in progressing the finalisation of the financial analysis and commencing stakeholder engagement due to the reduced availability of the project manager however a plan is in place to progress these activities within the next six weeks.

Action	Status February	Timeframe
Framework for service review established and tested	Complete	
All Starship service descriptions signed off by Steering Group	On track	18-Dec-15
Preliminary update to other funders	On track	22-Dec-15
Starship Tertiary service review complete and local service specifications documented	Nearly complete	31-Jan-16
Implement stakeholder engagement plan regarding service specifications and financial analysis findings	Not yet started	31-March-16
Implementation of Starship Tertiary service review recommendations following stakeholder feedback	Not yet started	March - June 2016
Scope and commence Adult Tertiary service review	Not yet started	March 2016

2.7 Policy Priority areas

Colonoscopy Indicators

All waiting time indicators for colonoscopy were met within internal capacity in March, however we are awaiting final nationally reported results for Quarter 3. There has been reduced internal production associated with a SMO vacancy and an international recruitment search is underway. Additionally there have been capacity constraints as a result of renovations to existing facilities and the development of an additional endoscopy room. The service has measures in place to meet the indicators while transitioning the service to new facility capacity by June 2016. If indicators continue to be consistently achieved in each of the months in quarters 3 and 4, additional funding will be made available to ADHB.

Radiology Indicators

ADHB has not quite met the outpatient CT indicator for March, achieving 94% against the target of 95%, however this is an improvement on last month at 90% and the service is on track to reach compliance in April.

There has also been an improvement in performance for both the outpatient MRI indicator- 57% achievement against the target of 85% (previously attained 53%), and the outpatient ultrasound indicator- 86% compliance against a target of 95% (previously attained 82%). The Radiology service continues to work to an established improvement plan and we expect ongoing improvements in all indicators over the next months.

Waiting Time Targets

At the end of March, ADHB was moderately non-compliant (yellow) for ESPI 2 (outpatient FSA) waiting time target and the ESPI 5 (booked for surgery) waiting times target. Key pressures continued in Paediatric (general) Surgery and other paediatric surgical sub specialties, however this is improving.

Bone Marrow Waiting Times
At the time of this report there were three patients waiting longer than the clinically recommended 6 weeks maximum waiting time guideline, with 15 patients on the wait list (five of these are on hold). Administrative process changes are being implemented to better plan and manage the demand alongside other variable and unpredictable acute demand pressures. Developments are underway to trial outpatient BMT delivery.

2.8 National services

Additional funding has been approved to enable increased capacity to be developed to support the national services and minimise disruption to other core clinical services. The Child Health team continue to make good progress with recruitment of additional staff to the National Paediatric Cardiac and Congenital Heart service and improvement is already occurring with reduced operating out of hours. At this stage cancellation rates have not materially changed however improvement is expected to have occurred by the end of the third quarter. Over recent weeks there has been a significant demand for transplant services including five heart or lung transplants completed (within a four day period) and six liver transplants in a six day period. The Director of Provider services and the funder met with the Acting Chief Medical Officer Ministry of Health to initiate discussions regarding the clinical and financial sustainability plan for national services provision. A National Services Governance Group is being established and the Director of Funding and Director Provider services ADHB will be members of this group.

2.9 Regional Service Review Programme

ADHB funder and provider continue to actively participate in the oversight and management of regionally prioritised service reviews. Regional planning for the local delivery of cancer services is progressing. The ADHB Urology service has identified there are less than expected referrals for elective surgery being sent to ADHB from CMDHB and there is a concern this reflects a service change may have been initiated. A meeting is to be scheduled to occur with CMDHB in the next few weeks.

3. Primary Care

3.1 Community Pharmacy

The 20 District Health Boards are now consulting with community pharmacy contact holders and the wider pharmacy sector on pharmaceutical margins and subsidised unregistered medicines (section 26 & 29). The consultation is based on work undertaken by the Pharmaceutical Margin Taskforce. This Taskforce had representation from the community pharmacy sector, the MoH, PHARMAC and DHBs. The Taskforce identified three impacts of the current Margin model:

1. variability in the total quantum of funding year to year may not fully reflect the variability in supply chain costs;
2. variability in pharmaceutical funding between types of medicines does not reflect the variability in supply chain costs; and
3. the progressive nature of the current Margin model (i.e. the fact that the Margin percentage increases when the Pharmaceutical Schedule pack subsidy is $150 or over) means that medicines with a low value subsidy are disadvantaged relative to medicines with a higher subsidy, given there are fixed costs in the supply chain.

The Consultation runs till Friday 22 April 2016**.** We are seeking community pharmacy views on a 'Hybrid Model' for margins with the proposed values of:

- a 2.5% margin payment on all subsidised pharmaceuticals; plus
- a $0.27 flat fee per pack of a subsidised pharmaceutical

This is shift from a current model that applies a percentage of the drug cost as the margin. The current percentages are 4% on pharmaceuticals with a schedule price of under $150 and 5% for pharmaceuticals with a schedule price of $150 or above.

Additionally we are seeking community pharmacy views on an interim option to address the issue of s26 and s29 medicines to reflect the current supply chain costs faced by pharmacy. The proposal is for an additional margins payment and an additional service fee to reflect the counselling delivered to the amount of $650,000 (approximately), around half of which is margins and half is the additional service fee.

Under the proposed model the majority of pharmacies would receive more funding, however some would receive less funding and a small number of pharmacies will be significantly affected. These include those pharmacies that supply an unusually large share of high value medicines, often located close to hospitals.

Following consultation, should the proposal be confirmed, DHBs would have individual conversations with those pharmacies significantly negatively impacted to discuss the possible support needed to transition to the new model, were those pharmacies to elect to transition.

3.2 System Level Measures Framework

One of the five themes of the New Zealand Health Strategy (the Strategy) is value and high performance which places an emphasis on measuring the performance of the whole system as well as its component parts. The Strategy recommends the development of an outcomes-based approach to performance measurement that will guide the delivery of constantly improving health services.

The Integrated Performance and Incentive Framework (IPIF) began in 2012 through the establishment of the Expert Advisory Group. The aim of IPIF was to drive stronger integration across the health system, improve quality and ensure long term system sustainability. IPIF was implemented in 2014 with primary care financial incentives directly linked to performance against the primary care National Health Targets (Better help for smokers to quit, Immunisation and More Heart and Diabetes Checks) and the cervical screening coverage.

The development of the overall IPIF framework was paused during the refresh of the Strategy. In May 2015 the Minister of Health decided not to introduce new performance measures in 2015/16 as he wanted more aspirational measures developed that looked at the performance of the system rather than just primary care. The Minister also wanted to change the focus from looking at outputs and processes to outcomes. The refresh of the Strategy provided the opportunity for this work and has built the case to extend and evolve the IPIF concept of System Level Measures.

The Ministry of Health (the Ministry) has been working closely with the sector to co-develop a suite of System Level Measures that provide a system wide view of performance. The System Level Measures to be introduced rely on the contribution of a wider group of providers. In 2016/17, the focus is on the contributions and performance of DHBs and PHOs. The contribution of wider groups will be seen over the next 18 months as the Ministry and the DHBs include System Level Measures in a wider range of contracts.

The four new System Level Measures to be implemented from 1 July 2016 are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds (i.e. Keeping children out of the hospital)
- Acute hospital bed days per capita (i.e. Using health resources effectively)
- Patient experience of care (i.e. Person centred care)
- Amenable Mortality rates (i.e. Prevention and early detection)

The following two System Level Measures will be developed during 2016/17 including definitions and identification of data sets:

- Number of babies who live in a smoke-free household at six weeks post-natal (i.e. Healthy start)
- Youth access to and utilisation of youth appropriate health services (i.e. Teens make good choices about their health and wellbeing).

More information about system level and contributory measures will be available from the Health Quality Measures Library by 30 May 2016 (www.hqmnz.org.nz). A measures guidance document Quality Measures Library by 30 May 2016 (www.hqmnz.org.nz). A measures guidance document explaining the concept of system level and contributory measures and how they can be selected and used will also be available on this site.

Auckland DHB will be working with the Auckland Waitemata Alliance and other key stakeholders to develop an Improvement Plan that will include:

- Improvement milestones for the four system level measures (total acute hospital bed days, ASH rates for 0 – 4 year olds, patient experience of care and amenable mortality)
- Contributory measures for each of the four system level measures

The MoH require all stakeholders responsible for activities in the plan (DHB and PHOs at a minimum) to sign the submitted plan.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

The HCSS Sector has raised its concerns, via the Home and Community Health Association, to all DHBs of the impact of the minimum wage increase on direct service costs in conjunction with the Employment Standards Legislation, which covers guaranteed hours for workers. These aspects will need to be considered in future contracting with our HCSS providers.

4.2 Aged Residential Care (ARC)

There are a number of closures and reconfigurations of ARRC facilities occurring:

- Ranfurly Village Bob Reed Unit; all male 23 bed dementia unit closed in March (ADHB)
- Lady Ascot; 15 bed rest home closing in June (ADHB)
- Upland House at Caughey Preston; 19 rest home beds closing in June (ADHB)
- St Catherine's; refurbishment and closing 17 rest home beds (ADHB)
- St Johns CHT; 20 new dementia beds (ADHB)

The closures are a reflection of the declining use of rest home beds and issues around the viability of stand-alone rest home only facilities. Planning & Funding and the DHB NASC are supporting residents and their families in transition to new facilities. The reduction in rest home beds appears

to be mirrored by an increase in dementia beds (with the exception of Ranfurly Village) due to providers anticipating an increased demand for this level of care.

5. Women, Children & Youth

5.1 Immunisation

The 8 months immunisation health target (to complete three immunisations due at six weeks, three months and five months to protect against diphtheria, tetanus, pertussis, polio, hepatitis B, haemophilus and pneumococcal diseases) is 95%. The target is reported quarterly, against all infants who turn 8 months in that quarter as recorded by the NIR. Auckland is unlikely to achieve the target in quarter three 2015/16. Auckland DHB sustained high coverage over the summer holiday period with 94% of infants fully vaccinated by 8 and 24 months of age, including a 5% improvement for tamariki Maori.

Immunisation Week is scheduled in the first week of May with a key message – Protection starts in pregnancy – encouraging uptake of influenza and whooping cough (pertussis) immunisation antenatally. Maternity services are well underway with promotional planning and report an increasing acceptability to recommend immunisations in pregnancy. The local primary care campaigns will extend the promotion of on-time immunisation 'Kids need Hugs – not Bugs' positive messages in communities. Further primary care education on discussing vaccine hesitancy with families is planned.

5.2 Rheumatic Fever

The refreshed Rheumatic Fever plans have now been endorsed by the Ministry of Health. The plans continue to build on the success of programmes such as the primary school sore throat swabbing programme and have identified opportunities for innovation and development, including the B4 School check nurse key message delivery. Some elements of the programme have been removed or scaled back from the future programme including the secondary school community health worker component, as this component of the intervention programme did not demonstrate 'value for money'.

Funding through to June 2017 has been confirmed through contracts with the MoH. A significant decrease in funding for 2016/17 in ADHB has been off-set by a Board decision to maintain the service for the financial year. Evaluations of key programme elements will take place in the next year to identify critical success factors for the programme.

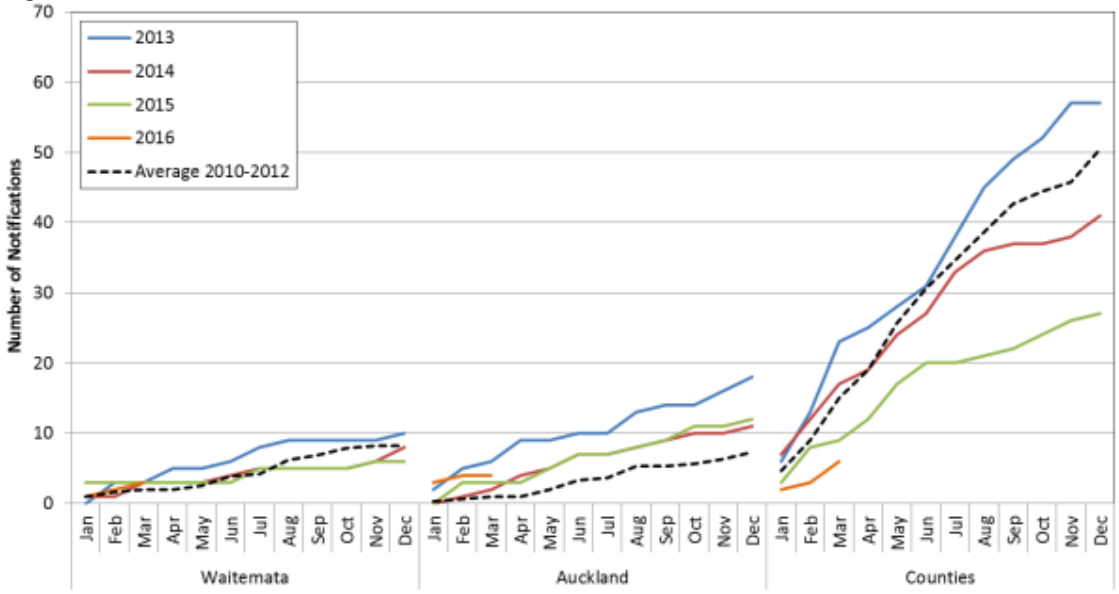
Funding from the Ministry for the programme for 2015/16 and 2016/17 is shown below.

Table 1: ADHB Rheumatic Fever Funding		
	2015/16	**2016/17**
School Based Throat Swab	$293,018	
Rapid Response	$743,792	
Not tagged	$309,054	$759,828
TOTAL RhF Specific Revenue	**$1,345,864**	**$759,828**

The joint Waitemata and Auckland DHB Steering Group has convened for the first time in its new combined form. The group is co-chaired by Dr Alison Leversha and Dr David Jansen.

The most recent data on Acute Rheumatic Fever for 0 – 19 year olds, produced by Auckland Regional Public Health Service (ARPHS), is shown below.

ARF Initial Attack Total Notifications by DHB and Admission Month in 0-19 year olds, 2010-2016 Auckland Region



The number of cases in 2015 and for the first quarter of 2016 is shown in the table below.

DHB	2015 (full year) 0-19 years	2016 (first quarter) 0 – 19 years	2015 (full year) All ages	2016 (first quarter) All ages
Waitemata	**6**	**3**	**7**	**4**
Auckland	**12**	**4**	**13**	**4**
Counties Manukau	**27**	**6**	**31**	**7**
Total	**45**	**13**	**51**	**15**

5.3 Childhood obesity

As reported in October 2015, the MoH released a Childhood Obesity Plan. This includes the new health target, and a package of initiatives to prevent and manage obesity in children and young people up to 18 years of age. The MoH plan has three focus areas and 22 initiatives, which are either new or an expansion of existing initiatives. The new health target is: "By December 2017, 95 per cent of obese children identified in the B4SC programme will be referred to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions." Reporting on this target will begin July 2016.

As previously, reported in preparation for the new target, and to focus local activity, we are preparing a local childhood obesity plan for Auckland and Waitemata.

The number of four year olds identified with obesity (BMI >98th percentile) through the B4SC is estimated to be 560 in Auckland DHB per annum. The highest proportion of children identified as obese at the B4SC are Pacific and Māori, and those living in quintile 4 and 5 areas.

A pathway for referral and management of children who are overweight or have obesity is being developed to enable streamlined and consistent care across and within WCTO, B4SC and primary care services. The Regional Child Health Network is coordinating the development of a regional health pathway for children who are overweight or have obesity. ADHB is on the working group to develop the pathway. However, an interim service is required to meet the needs of children with obesity that is identified in 2016.

As an immediate priority, we have entered into an agreement with Plunket to provide an interim service for children identified as obese where no other service is available. This will, as a minimum, provide individualised health promotion information and advice regarding healthy food choices and encourage families to participate in physical activity. This will be in addition to referrals to a GP or Paediatrician as appropriate and be overseen by the B4 School Check Governance and Clinical Reference Groups. The DHB Boards have approved funding for this and a number of other interim initiatives. At this time, there is little strong evidence regarding effective interventions for children who have obesity. Our approach is to take a life-course approach with a particular focus on pregnancy and the early years of a child's life. If successful, these would see a reduction in the number of children identified with obesity at 4 years of age.

5.4 Youth

The ADHB Youth Alliance is in the process of implementing a pilot navigator service for Alternative Education students. Two navigator social workers will be based in an identified alternative education facility to facilitate access to health services. The pilot grew out of ongoing concerns regarding how best to provide health services for young people (mostly 13 – 14 years of age) who are in alternative education (AE) settings and concern regarding the poor outcomes these young people experience. The Alliance commissioned a report which further highlighted that AE students have greater health and social needs and fewer resources to help them access health and social services. The Ministry of Education and Ministry of Social Development are supporting the pilot, with MSD co-funding part of the service. The service will be delivered by ADHB provider arm and independently evaluated by Synergia. Engagement of key stakeholders has occurred, the pilot model has established, the evaluation framework is in the final stage of development, and recruitment for the navigator roles is underway.

5.5 Oral Health – Emergency Dental Services

Emergency dental services are services that are required for the immediate relief of pain and infections for low income adults. Services are provided for low income adults aged 18 years and older who hold a valid community services card. Treatment is restricted to the current problem and does not include any preventative or maintenance treatment. It commonly comprises dental extractions and provision of pain killers and antibiotics. Services are currently provided by the Auckland DHB provider arm at Greenlane, Middlemore and a clinic in Bucklands Road. In addition Auckland DHB contracts with The Fono to provide services in the Central City.

A review of emergency dental services for the relief of pain was undertaken in response to concerns about poor access for many high needs patients due to the location of services. The review highlighted that services needed to be available in more community locations to improve access for low income adults, patient convenience and cost.

The current agreement The Fono is being exited and a competitive tender will be undertaken to improve access to emergency dental services for low income adults. Services will continue to be provided by the Auckland provider arm at this time.

5.6 Oral Health – Preschool and School Age

Oral health status is a reflection of eating habits, fluoride availability, tooth brushing, and dental treatment. Auckland Regional Dental Service (ARDS) provides care for pre-school and school aged children. Services include preventative work such as fissure sealants, health messages about oral hygiene and health eating, as well as dental treatment when necessary.

Auckland Regional Dental Service (ARDS) has a model of care which includes a risk assessment for each child at each visit alongside x-rays when required. Recall periods can be 6 months, 12 months or 18 months depending on the risk assessment. Maori and Pacific populations have higher risk of caries and are more often recalled at six monthly intervals.

A key measure of oral health status is the average rate per student of decayed, missing and filled teeth (DMFT). For the calendar year 2015, DMFT scores for children in year 8 (12 years old) are close to target.

6. Mental Health and Addictions

6.1 Suicide Prevention and Postvention Planning

The delivery of four rural *Safe Talk* training workshops to the rural communities was completed in March, 2016. This is part of the Government's 2015 National Emergency Response for the Rural Sector. The workshops were held in the Auckland and Waitemata Districts and supported by the Rural Alliance and Suicide Prevention Programme Manager.

The four workshops were delivered in Great Barrier Island, Kumeu, Warkworth and Wellsford and attracted a total of 71 attendees with a good mix of primary care staff, allied services and support personnel. Feedback immediately after each workshop was positive with many enjoying the interactive manner in which the workshops were run. Requests common to all workshops centred on the availability of additional training, especially for practice nurses.

There will be a further five "SafeTalK" workshops to be delivered to family and whanau within our district, in the next 3 months. Lifeline will facilitate this series of workshops, targeting communities identified as high risk populations: Māori; Pacific; Lesbian, Gay, Bisexual, Transgender and Transsexual (LGBTT); and Asian. It is projected that approximately 200 people, in total, will attend these workshops. There is a plan to facilitate more suicide prevention training workshops in the next financial year.

In November 2014 the MOH undertook a pilot of an on-line training tool for screening for risk of suicide. The tool, *Question; Persuade; Refer* (QPR) is targeted to community health workers, social support service staff, families, whanau, hapu, iwi and community members, to help identify and support individuals at risk of suicide and refer them to agencies that can help. The training includes information for increased awareness and knowledge related to screening for suicidal thoughts and behaviours, as well as practical skills training regarding when and how to ask the "Suicide Question". The MOH allocated 400 licences for community health workers across Auckland DHB and Waitemata DHB

In February of this year we were informed by QPR New Zealand that the Auckland and Waitemata DHBs still had 41 unused licences. These licences have now been fully utilised by frontline workers within our district.

Developed by Skylight and sponsored by the Ministry of Health, the primary focus of the *WAVES Bereavement Service* programme is to provide people with the opportunity to participate in a psycho-educational programme that offers an experience of healing and community by connecting them with other people who have been bereaved by suicide. The purpose of WAVES in this context is to help adults learn more about grief and suicide, find meaning in their experiences, learn to manage emotions, reduce stigmatisation and feelings of isolation, and assist them to move forward. We have trained nine facilitators within both Waitemata DHB and Auckland DHB, including six front line staff from the Non-Government Organisation (NGO) sector who participated on the two day training workshop. It is intended that facilitators are strategically positioned around the region to ease access for family and whanau. Currently a referral pathway for the community to access the WAVES programme is in development.

A new *suicide prevention guideline for hospital emergency departments* was released on the 4th of April, and will help to further improve care for those at risk. This new guidance from the Ministry of Health aims to improve the quality of care for people at risk of suicide when presenting to emergency departments. There are steps that can be taken to help assess and support those at risk. The guidance contains specialist advice on working with Māori, Pacific and Asian populations, as well as young and older people. It covers clinical risk assessment and referral pathways, as well as guidance on how clinicians can better interact with patients.

The guidance stems from the Suicide Prevention Action Plan 2013-2016. The mental health and addictions workforce centre, Te Pou o Te Whakaaro Nui developed the guidelines with assistance from an expert working group. Minister of Health Dr Coleman said in a media statement when releasing this guidance that: “Suicide is a serious issue for our communities. Around 500 New Zealanders take their own lives every year. Through the Suicide Prevention Action Plan, we are strengthening support for families and communities, and extending existing services. All DHBs now have plans in place, in partnership with their local communities, to prevent and respond to suicide at a local level.”

7. Maori Health Gain

7.1 Bariatric Service Project

The Māori Health Gain team has undertaken a range of activities to investigate access barriers to bariatric surgery for Māori and Pacific in Waitemata DHB and Auckland DHB. This work has developed into the Bariatric Service Project and a project brief will be finalised once a project manager has been recruited. The Project will focus on optimising the patient selection process through one Multidisciplinary Team (MDT) approach across both Waitemata and Auckland DHBs, similar to the Upper Gastrointestinal Cancer pathway. The Northern Region Clinical Practice Committee (NRCPC) has agreed to update their cost effectiveness analysis (last undertaken in 2008) and recommendations to inform the optimal patient pool for selection for bariatric surgery. The Project will also develop a service specification and five year funder plan for delivery of surgical volumes appropriate to the DHB populations.

7.2 HPV Self-Sampling Project

The human papilloma virus (HPV) Self-Sampling project has secured funding, including a grant from the Awhina Trust, and project planning is underway. From August the project will screen 200 Māori

women from West Auckland for HPV using the novel technology of self-sampling (swab rather than a cervical smear). HPV self-sampling will count for cervical screening coverage as the National Cervical Screening Programme transitions to HPV primary screening (conducted on a cervical smear sample) in 2018. The national transition to primary HPV allows the possibility of self-sampling, although this has not been included in the Ministry of Health transition process at present. This local research project is designed to inform national policy on the issue by providing evidence on the feasibility and acceptability of self-sampling.

Using the optimal HPV laboratory test self-sampling can detect pre-cancerous cervical changes with much higher sensitivity than the current cytology test, and with comparable sensitivity to HPV on a health professional cervical sample. Self-sampling has been successful at improving participation for underserved populations internationally, including a large Australian trial of mailed-out kit invitation where the best update was seen for women who had never been screened before. The project is led by the Māori Health Gain Team in collaboration with the Child Youth and Women's Health team and Primary Care Teams; Waipareira as MOU partner and Independent Service Provider (ISP) for cervical screening support to services; the colposcopy service; and laboratories (including an HPV expert from Massey University).

7.3 Ethnicity data

The results of the Waitemata DHB and Auckland DHB Ethnicity Data Audit Toolkit (EDAT) programme contributed to Ministry of Health refreshing the Ethnicity Data Protocols for the Health and Disability Sector. The DHBs are represented on the Working Group for the protocol refresh and have actively contributed to the protocols being developed as a key driver for information systems improvement across the sector. The protocols were peer reviewed by key experts in April 2016 and will be put out for public consultation.

Waitemata DHB conduced work in 2014 on the drivers of ethnicity data misclassification in cervical screening. Issues were noted with incomplete data on general practice laboratory forms and laboratories reducing ethnicities to a single ethnicity without prioritising the data. In March 2016 the National Cervical Screening Programme moved from using cervical screening register ethnicity to using the National Health Index (NHI).

8. Asian, Migrant and Refugee Health Gain

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

Work is almost complete for the Asian International Benchmarking Report comparing health outcomes for Asian subpopulations around the world, in order to identify potential emerging areas that may impact on the health of specific Asian groups in the Auckland and Waitemata DHBs' catchments.

8.2 Increasing Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 80% (ADHB) target by 30 June, 2016 (current rates 74%) as at Q1, 2016
A campaign is planned to promote culturally appropriate messaging about enrolling with a family doctor and the benefits of a regular family doctor to Asian students and new migrants living in the Auckland City Centre and inner city suburbs planned for roll out in May/June.

Indicator: Reducing acute flow to Auckland City Hospital's Emergency Department (ED)
The Board carried the motion to support the recommended solutions for 'Increasing awareness of the health & disability system to Asian students and new migrants as part of the findings of pieces of work including:

- Analysis undertaken of the utilisation of the Auckland City Hospital for identified domestic/long term and new migrant populations living in the Auckland Central Business District
- Analysis of a survey undertaken to understand both domestic and international student awareness of health services and health information in the Auckland District.

A suite of interventions to increase awareness of the health & disability system includes: video podcasts (English, Mandarin, Hindi (to be developed)), settlement information sessions to migrants and the workforce, targeted library engagement, information on immigration websites and social media, ethnic community events, policy inclusions in the New Zealand Qualifications Authority Code of Practice Guidelines for the Pastoral Care of International Students, NZ Now migrant website and facebook page, and dedicated one-stop website about enrolling with a family doctor, visit www.yourlocaldoctor.co.nz.

Indicator: Increase opportunities for participation of eligible refugees enrolled in participating general practices as part of the Refugee Primary Care Wrap Around Service funding

The Refugee Primary Care Wrap Around Service Agreements with PHOs are continuing to be rolled out with identified general practices participating in the programme offering subsidised culturally appropriate services to enrolled refugees within the practices. Professional development opportunities for primary health and the frontline workforce to upskill them on the soft skills and cultural competencies required to support refugee families at the practice level include:

- Receptionists training to frontline staff scheduled for 29 June, 2016
- A refugee health network forum to primary health professionals on 'Navigating the adult disability system for former refugees' is planned for 25 May

Approval of Appointment of Directors to Northern Regional Alliance Limited

Recommendation:

That the Board:

1. **Approve the appointment of:**
   - **Ailsa Claire on 17 December 2012**
   - **Margaret Wilsher on 15 May 2015**

   as directors of Northern Regional Alliance Limited.
2. **Note that these appointments have already been registered on the Companies Office on the dates specified above.**

Prepared by: Margaret Wilsher, Chief Medical Officer
Endorsed by: Ailsa Claire, Chief Executive

Glossary

DHB	-	District Health Board
NDSA	-	Northern DHB Support Agency Limited
NRA	-	Northern Regional Alliance Limited
Auckland DHB	-	Auckland District Health Board

1. Executive Summary

Auckland DHB has two directors on the Board of Northern Regional Alliance Limited (NRA). Legal advice has been received recommending that the Board formally approve the appointment of these directors.

2. Background

Auckland DHB has two directors on the board of NRA as follows:

- Ailsa Claire appointed on 17 December 2012
- Margaret Wilsher appointed on 15 May 2015

While these appointments have been in place for some time, it seems that they were not formally approved at the time they were made. It is not clear why no approval was obtained but it is appropriate for the Board to confirm formally these appointments to the NRA board now so that their mandate to act as directors is clear.

NRA

NRA was formerly known as the Northern DHB Support Agency Limited (NDSA). It was incorporated in 2001 and in 2012 was merged with Northern Regional Training Hub Limited and changed its name to NRA in 2013. Waitemata DHB, Auckland DHB and Counties Manukau DHB each own one third of the shares in NRA.

NRA has nine directors with two directors representing each shareholding DHB.

Governance of the NRA is through a Board of Directors comprising two representatives from each shareholding DHB.

NRA is a shared services agency joint venture owned by the three Auckland Metro DHBs (Auckland, Counties Manukau and Waitemata) in their roles as health and disability service funders, for areas of service provision identified as benefiting from a regional solution. NRA also provides services to Northland DHB as a client.

NRA's vision is to work with District Health Boards towards excellence in health and disability support services.

NRA's mission is to support the DHBs as funders of health and disability support services by:

- Being responsive to the identified needs of the DHBs
- Delivering on DHB expectations
- Being proactive in identifying and managing risks and opportunities for the DHBs
- Supporting constructive relationships with and between stakeholders

In supporting the DHBs, NRA's goals are to:

- Be responsive to the identified needs of populations;
- Recognise the need to give particular emphasis to improving Maori health status;
- Recognise the need to give particular emphasis to improving the health status of Pacific peoples;
- Build cross-sectoral relationships;
- Build on the organisational and individual skills and experiences in the sector;
- Develop the competencies, systems and processes to carry out core functions to support DHBs as funders of health and disability support services;
- Secure the confidence of our key stakeholders in our ability to meet our responsibilities.

Role of Auckland DHB's directors on NRA Board

The role of the Auckland DHB directors on the NRA Board is to represent Auckland DHB's interests as a one third owner of NRA within the overall context of NRA being an agency whose purpose is to provide services to the region as a whole.

Diabetes Specialist Service Future Directions Paper - 2016

Recommendation

That the Board:

1. **Receives the Diabetes Specialist Service Future Directions Paper 2016 report.**
2. **Endorses the interim plan for the diabetes specialist service within Auckland District Health Board.**
3. **Notes:**
   i. **the link between the Diabetes Service Level Alliance (DSLA) Work Programme and the diabetes specialist service future plan.**
   ii. **Notes a future plan for redesign of the entire diabetes pathway will be developed by the DSLA and presented to the Board once completed.**

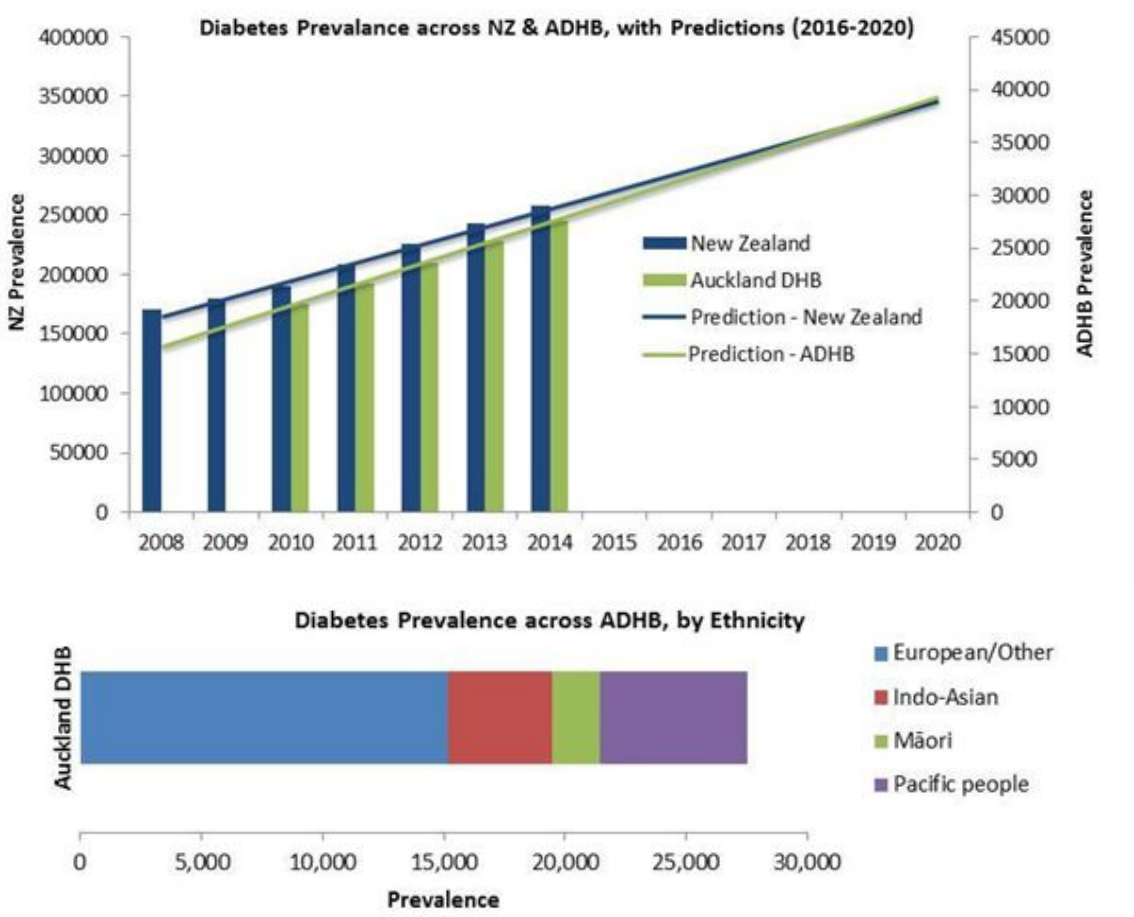
Prepared by: Judith Catherwood (Director – Community and Long Term Conditions and Dr Paul Drury (Service Clinical Director - Diabetes)
Endorsed by: Joanne Gibbs (Director – Provider Services) and the Waitemata Auckland Diabetes Service Level Alliance
Endorsed by Executive Leadership Team: Yes: Date: TBC

Glossary

ADHB - Auckland District Health Board
ALT – Alliance Leadership Team
DNA – Did Not Attend
CVD – Cardiovascular Disease
DSLA – Diabetes Service Level Alliance
DSME - Diabetes Self-Management Education
GP - General Practitioner
HQSC - Health, Quality and Safety Commission
LTC - Long Term Conditions
NGO – Non-Government Organisation
PHO - Primary Healthcare Organisation
SMO – Senior Medical Officer

Executive Summary

Around 27,000 people within ADHB had diabetes at the end of 2015 and this number has been increasing by 7-10% per annum (faster than the rest of New Zealand). The growth in prevalence of diabetes is particularly rapid among younger adults (aged 25-45) and the elderly (over 75). Diabetes is also more prevalent among Maori, Pacific and Indo-Asian populations.



Data Source: Virtual Diabetes Register (2008 – 2014)

People living with diabetes are heavy consumers of health services (2-3 times more than people without diabetes). They require more frequent primary care visits, have higher pharmaceutical use and are more likely to require hospital admissions, with a longer length of stay than those without diabetes. Furthermore, people with diabetes account for roughly 50% of those requiring renal replacement therapy and lower limb amputations as well as having increased rates of cardiac disease, stroke and blindness. Improvements in our management of risk factors have significantly reduced cardiovascular mortality in people with diabetes. This increased longevity and reduced but later complications lead to the increased numbers of elderly people living with diabetes and other co-existing long term conditions (e.g. arthritis, cognitive impairments). At the younger end of the age spectrum are increasing numbers of young adults with diabetes. This group is of concern as they are particularly vulnerable to complications, reduced life expectancy and have wide ranging personal and social impacts on their individual lives, their whanau and on future health utilisation and costs.

As a health system, Auckland District Health Board (ADHB) currently performs well in most, but not all, diabetes-related metrics against other DHBs. The diabetes specialist service has developed over recent years to an integrated and talented multi-disciplinary team which has progressively concentrated on more complex patients with multiple or complicated clinical problems. Primary care has become the medical home for most people with diabetes. However, models of care which maximise the opportunities of integrated health services and builds the capacity of society and the health system to support people with diabetes can be developed more fully.

The Waitemata Auckland Alliance Leadership Team (ALT) has recognised the importance of this work and has commissioned the Diabetes Service Level Alliance (DSLA) to redesign the entire diabetes pathway for our population. This work is in development and the ADHB Specialist Diabetes Service is actively involved. However, the Board have also approved a Locality Model of service delivery and whilst this work is being developed, the Community and Long Term Conditions Directorate wishes to support the Diabetes Service with a plan to integrate within the locality model and improve service delivery to Auckland DHB's population. This will support the horizontal integration of long term condition services with primary care and other partners within localities. Once the DSLA work programme is completed, this plan will be adapted to reflect the DSLA recommendations.

The diabetes specialist service has developed an interim plan to address these challenges, focusing on four priorities which include:

- Integrate services with primary care by moving to a locality model with specialist staff aligned to primary care to provide support and facilitate education for all practices. Specific additional support will be targeted in high deprivation (and high diabetes prevalence) communities.
- Clearly define and optimise the diabetes model of care to better meet the needs of Auckland DHB's unique population mix.
- Reduce the impact of inequalities, particularly for our Maori, Pacific and Asian communities.
- Fully develop the diabetes specialist service structure and optimise the productivity of the service.

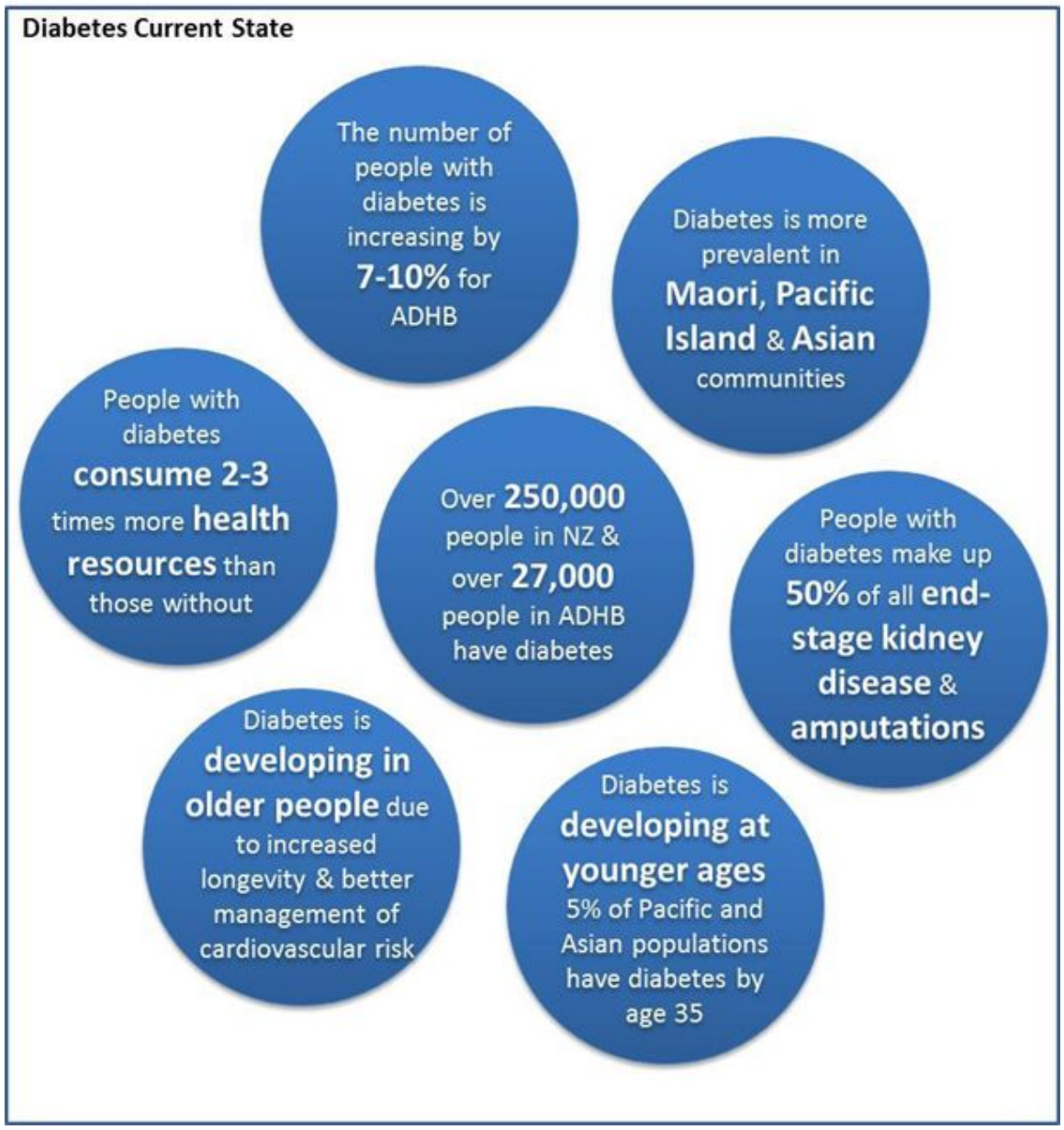
The Community and Long Term Conditions Directorate views the development of a plan for diabetes specialist service as a step forward in the delivery of a vision for integrated, holistic management of all long term conditions. Diabetes is therefore a beacon condition, on which other services may model their approach, towards the development of innovative and integrated health services for the future.

We request the approval of the Board to implement this interim plan, effective beginning immediately. This plan is cost neutral and involves the redesign of existing workforce resources. Future decisions on funding will be taken after the DSLA make their recommendations to the ALT.

Profile of Diabetes

Diabetes, especially type 2, is an increasing issue at a global, national and local level. The disease profile of diabetes highlights that there is considerable opportunity to improve the outcomes for people living with diabetes.

The statistics and information below outline the scale of opportunity for ADHB and the wider sector to achieve better outcomes.



Strategic Linkage

New Zealand Health Strategy & Living Well with Diabetes

There is considerable work already underway at all levels of the health system to improve services and outcomes for people living with diabetes. Nationally, addressing the impact of long-term conditions including diabetes is an important focus for the Government as signalled in the updated New Zealand Health Strategy (2015)[1].

In October 2015, the Ministry of Health released a five-year diabetes plan known as "Living Well with Diabetes – A plan for people at high risk of or living with diabetes, 2015-20" [2] . The vision is that all New Zealanders living with, or at risk of developing diabetes, live well and have access to high quality, people centred health services.

It outlines a multi-faceted programme with six 'priority areas for action' ranging from prevention and early detection to high-quality, integrated services. The priority areas include:

1. Prevent high risk people from developing type 2 diabetes.
2. Enabling effective self-management.
3. Improving quality of services.
4. Detection of diabetes early and reduction in the risk of complications.
5. Provision of integrated care.
6. Meeting the needs of children and adults with type 1 diabetes.

The plan also highlights three enablers that are applicable through all priority areas and are central to achieving this vision. These include a workforce with a proactive approach to managing diabetes, development and access to technology that improves patient outcomes and a robust system of clinical governance, and consumer participation at all levels of service.

The 'Living Well with Diabetes' plan is a key document to ensure regional and local activities are aligned to the overall vision and future direction of diabetes care in New Zealand.

[1] http://www.health.govt.nz/about-ministry/what-we-do/new-zealand-health-strategy-update
[2] http://www.health.govt.nz/publication/living-well-diabetes

The Waitemata - Auckland Diabetes Service Level Alliance (DSLA)

Background
Diabetes is a major health priority in both Auckland and Waitemata District Health Boards (DHBs) and is placing an increasing burden on healthcare services at all points along the continuum of care.

The Waitemata Auckland Alliance Leadership Team (ALT) recognises the impact of diabetes, and in August 2015, commissioned the formation of the Diabetes Service Level Alliance (DSLA) tasked with developing, overseeing and advising the ALT on appropriate work programme and investment decisions required to achieve the agreed outcomes for people living with type 2 diabetes.

Prior to establishing the DSLA the ALT also commissioned three significant pieces of work to set the scene and context for future diabetes work. These were:

1) a stocktake and gap analysis of current services being delivered to people with diabetes in the Auckland/Waitemata DHB areas
2) the development of the Diabetes Intervention Logic Model
3) the establishment of the Diabetes Cardiovascular Disease (CVD) Clinical Indicators and Measures.

The stocktake analysis identified the following areas for improvement:

- Geographical variation in funding, service provision and utilisation
- Lack of coordination / integration / communication between services / providers
- A lack of outcomes data to establish the quality / appropriateness/effectiveness of services
- Sub-optimal management of diabetes and cardiovascular disease
- Workforce sustainability issues
- Inequalities by ethnicity
- Lack of clarity around funding allocations

The Diabetes Intervention Logic Model and outcomes framework contains 22 indicators. The ALT agreed to implement five initially as part of the diabetes work programme. These include:

- **Glycaemic control** – 80% of enrolled patients with diabetes (aged under 80 years) who have good or acceptable glycaemic control (HBA1C <64)
- **Blood pressure control** – 80% of enrolled patients with diabetes (aged under 80 years) whose latest systolic blood pressure is <140
- **Management of microalbuminuria** – 90% of enrolled patients with diabetes (aged under 80 years) who have microalbuminuria and are on an ACE inhibitor or Angiotensin Receptor Blocker
- **Secondary CVD prevention (triple therapy)** – 70% of enrolled patients with known cardio-vascular disease who are on triple therapy (Statin + BP lowering agent + Aspirin)
- **Primary CVD prevention (dual therapy)** – 70% of enrolled patients with 5 year cardio-vascular risk >20%, (aged under 80 years, including those with a previous CVD event) who are on dual therapy (statin + BP Lowering agent)

DSLA Vision

The vision is that people living with diabetes are enabled to be leading partners in their own care within systems that ensure they can manage their condition effectively with appropriate support from proactive care teams. The DSLA has representation from a range of stakeholders including Primary Healthcare Organisations (PHOs), Memorandum of Understanding (MOU) Partners, consumers, specialist diabetes services and Planning and Funding.

DSLA Work Programme

The DSLA has been asked to commission a new diabetes work programme including an end to end pathway of care which addresses the concerns as identified in the stocktake and ensures the delivery of improved health outcomes for our population. The Work Programme is underpinned by the New Zealand Health Strategy and "Living Well with Diabetes" plan as outlined in the previous section and draws heavily on the findings of the stocktake and the regionally agreed clinical indicators.

The Work Programme is underpinned by the following principles:

- All people, including those living with diabetes, have equal opportunity and ability to live, work, and to contribute to and be part of New Zealand society.
- People with diabetes have appropriate access to services that provides equity of health outcomes across all population groups.
- Services for people with diabetes are patient and whānau centred.
- Services for people with diabetes are comprehensive, safe and sustainable.
- Services for people with diabetes are configured to support the delivery of integrated services and to better align care and incentives across the primary and secondary sectors.
- Advice and information provided by the DSLA will be data driven, evidence based, guided by expert opinion and include consideration and actions relating to health equity improvement.

The Work Programme has identified the following priority populations:

- People with newly diagnosed type 2 diabetes
- People with poorly controlled type 2 diabetes (HbA1c > 75 mmol/mmol)
- Maori, Pacific and Asian people with type 2 diabetes and,
- Quintile 5 populations with type 2 diabetes

The Work Programme comprises of four workstreams, each with a number of initiatives:

- **Workstream 1: Systems Redesign**

This refers to 'making managed coordinated and systematic changes across multiple areas and levels of the health system' and creating a new 'system' that is patient-centred, better integrated, accountable, and maximises outcomes for consumers. The aim of this workstream is to:

1. understand the current state (investments, activities and outcomes);
2. reorganise and better align the funding and delivery of diabetes services; and
3. restructure the system and alter system incentives such that desired performance is encouraged and promoted.

- **Workstream 2: Optimising Clinical Management**

This workstream aims to implement a range of complementary strategies targeted at improving prescribing such as supporting the implementation of a dynamic pathway, and other electronic decision support tools, measuring and reporting on clinical indicators, actively targeting specific individuals with poor control, and increasing GP knowledge by increasing GP access to specialist advice.

- **Workstream 3: Self-Management Support including Care Planning and Diabetes Self-Management Education (DSME)**

This workstream will review the effectiveness of the current DSME models of care as well as identify, explore and address the current barriers to access. It aims to standardise the quality of DSME being delivered in the region and monitors utilisation and also to evaluate the contribution of DSME to the overall diabetes outcomes framework.

- **Workstream 4: Workforce Development**

This workstream aims to adopt a systems approach to get the right people, in the right jobs, with the right skills, at the right time to improve the health and wellbeing of people with diabetes. In conjunction with the systems redesign workstream, the optimal workforce mix will be explored in order to maximise population health outcomes. This will include exploring the role of the non-regulated workforce and the voluntary sector.

It is of note that the Systems Redesign is considered as the overarching workstream that underpins the other streams. Furthermore, the different workstreams have considerable linkages, overlaps and inter-dependencies and will require alignment and integration in order to be effective. A lead for each stream working with key personnel from the group will link in with the other areas to achieve this integration.

The DSLA work will be producing a plan, through a process of co-design and systems redesign, to ensure the gaps identified in the stocktake are addressed and an equitable service is designed and implemented across the two DHBs.

Future Role of the Specialist Diabetes Service in ADHB

The ADHB diabetes team is a comprehensive, multi-disciplinary specialist service delivering medical, nursing, podiatry, dietetics and psychology services. The service receives over 4,000 referrals a year and delivers services from the Greenlane Clinical Centre, community settings (e.g. from local halls) and to inpatients at Auckland City Hospital. The service delivery locations are reflected in the ADHB locality map below.

Map of ADHB – Greenlane Clinical Site and Satellite Clinics*

* Although not represented on the map, the diabetes specialist service also delivers care to Waiheke & Great Barrier Island.

The diabetes specialist service has evolved over time and aims to deliver high quality secondary and tertiary services. ADHB compares favourably in many of the Health, Safety and Quality Commission (HQSC) diabetes measures particularly around screening compared to other DHBs. However, there are areas for improvement particularly around clinical management and equity of access.

Measure	ADHB	Mean	Lowest	Highest	DHB position (/20)
Prevalence of diabetes	5.9%	5.7	4.2	8.9	7th highest, marginally but significantly higher than mean
Bed days occupied	17	17	6.5	28	8th highest, average - recent rapid increase
HbA1c screening	89%	86	72	90	3rd highest - significantly better than average
Renal screening – urine	68%	65	40	75	5th highest - significantly better than average
Renal screening – blood	86%	84	76	88	5th highest - significantly better than average
Use of metformin	43%	42	28	47	6th highest - significantly better than average - but should be higher still
Use of insulin	15%	18	11	23	3rd lowest - significantly less than average - should be higher
Use of ACEII/ARB	50%	53	49	59	2nd lowest - significantly less than average - should be much higher
Admissions with ketoacidosis	0.21%	0.29	0.15	0.51	2nd lowest - significantly less than average
Admissions with hypoglycaemia	0.4	0.38	0.3	0.53	8th lowest - average
Amputations	0.15%	0.18	0.12	0.29	4th lowest - not statistically significant

Health, Quality and Safety Commission Diabetes Atlas measures (2014)

Our plan is to improve these parameters through the improvement work outlined in this document and in working through the DSLA work programme. The integration of services, development of improved clinical management, sharing of expertise and resources, and improved and integrated clinical and electronic systems etc. will aim to support changes in the manner in which our population use services, the support offered in self-management and outcomes for our population.

Diabetes Specialist Service Vision

The national strategy and the DSLA work programme set out a clear direction for future diabetes service and population outcomes. The diabetes specialist service within ADHB has had input into both of these underpinning documents and is committed to applying and implementing these at a local level.

The ADHB specialist service has developed a vision to guide the design and delivery of future specialist diabetes services:

- Holistic, culturally appropriate and patient centric care, where the patient is empowered to manage their healthcare journey.
- Accessible services. Each individual diagnosed with diabetes will be promptly offered appropriate services and support, from initial education and self-management support on diagnosis to expert, timely multi-disciplinary care for those requiring it.
- Seamless services allowing timely escalation and de-escalation of care between providers. This requires a strong focus on integration and communication with primary care, the voluntary sector and other agencies that have an impact on the social determinants of health. There will also be an emphasis on embedding care navigation principles and on coordination of services across specialities within the DHB (e.g. renal, cardiac etc.) to reduce the impact of multiple morbidities on individual consumers and their families/whanau.
- Diabetes micro- and macrovascular complications will be reduced as outlined in the National diabetes strategy targets, and quality of life and life expectancy increased across all ethnic

and age-groups. Avoidable hospitalisation and length of stay will be reduced as much as possible.
- Measurement will be by outcomes defined in the National strategy and the agreed DSLA clinical indicators, and will be transparently available across all levels of the health services.

The diabetes specialist service is focussed on delivering the wider Community and Long Term Conditions vision in conjunction with the aims of the DSLA workstreams. The diabetes specialist service has identified four key priorities of focus to help achieve our vision:

1. Integration and locality-model – Fully integrated diabetes care, delivered as close to home as possible, with the ability to escalate and de-escalate care seamlessly and promptly across providers.
2. Service delivery alignment - Clearly defined and optimised model of care, underpinned by an integrated health record, technology, informatics, workforce, evidence-based practice, and a fully developed wider health sector.
3. Reduce the impact of inequalities - Culturally appropriate service delivery model that promotes empowerment and maximises accessibility to achieve better outcomes for our ethnically diverse communities.
4. Enable and strengthen the workforce - Fully developed diabetes specialist sub-structure, with clear roles and responsibilities and aligned to the locality model.

These priorities are explored in greater detail in the following sections.

1. Integrating with Primary Care and Locality Model Working

The Community Services team within the Community and Long Term Conditions Directorate at ADHB are in the midst of moving towards a locality model. The aim of this model is to:

- Deliver services closer to home and support people living at home
- Improve collaboration and joined-up services with primary care and Non-Government Organisations (NGOs)
- Identify at risk patients earlier and reduce risk of hospital admission and readmission through provision of improved care up stream
- Potential to de-escalate patients to less intensive levels of care with local and integrated support
- Tailor services to meet specific community or population needs

There are five ADHB localities, each around 100,000 population, with an estimated 4000-6000 people with diabetes in each. The diabetes specialist service plans to implement the locality model which will facilitate effective and seamless integration with primary care. This will involve dedicated nurse specialists aligned to localities with an initial focus on the practices with the highest need and/or complex populations. In those particular practices, visiting Senior Medical Officers (SMOs) and other specialists (e.g. dietitians, podiatrist etc.) will support practice teams. The Long Term Condition Coordinators, currently being deployed into the locality teams within the Directorate will also act as conduits and facilitators of this work.

The diabetes specialist team will work closely with the DSLA and collaboratively with the PHO practice facilitators and practice teams to support the implementation of the DSLA work programme initiatives. This may include:

- Building capacity and capability across the healthcare system through the sharing of expertise (e.g. insulin initiation).
- Providing advice and guidance to support clinicians in enabling people with diabetes to take responsibility for their health and achieve optimal control of their condition.
- Building relationships to provide readily accessible information to improve timely and expert care for patients including the use of 'virtual consultations'.
- Exploring joint shared care clinics within GP practices.

The locality model also aims to increase collaboration with other community providers and NGOs operating within the localities, and increase support to elderly patients and those living with disabilities and/or chronic diseases.

Within the localities our team have identified a number of particular high-risk communities. These are outlined in red.

Rangitoto	Owairaka	Whau	Maungarei	Orakei
CBD	Balmoral	Avondale	Glen Innes	Ellerslie
Freemans Bay	Epsom	Blockhouse Bay	Mount Wellington	Greenlane
Great Barrier Island	Greenlane	Hillsborough	Onehunga	Kohimarama
Grey Lynn	Kingsland	Lynfield	Otahuhu	Meadowbank
Herne Bay	Mount Eden	Mount Roskill	Panmure	Mission Bay
Newmarket	New Windsor	New Windsor	Penrose	Remuera
Newton	Point Chevalier	Three Kings	Royal Oak	Saint Heliers
Parnell	Royal Oak			Orakei
Ponsonby	Sandringham			
Waiheke Island				
Westmere				

The aim is to rollout the locality model by suburb beginning with Maungerei and Whau localities which house the suburbs with highest prevalence of disease and where there is greatest opportunity to add value. Nurse specialists with knowledge of each locality have already been identified for each area, targeting practices with high-need populations.

Close partnerships with primary care and the other community agencies are vital to the successful implementation of the locality model. To inform this, Auckland PHO and the diabetes specialist service are piloting a project aimed at developing GP practice skills and systems. This project currently involves 0.5 FTE nurse specialist, supported by a supervising SMO, visiting seven primary practices concentrating on support to both practice nurses and GPs. This will help set in place systems, processes and inter-service relationships which we can expand into other practices in terms

of integrating working and skill development. The pilot project is governed by a steering group which reports to the DSLA and Auckland DHB executive team.

We will also use the learning on locality models from the international literature and from other DHBs to ensure consistency is achieved where possible and also embed an organisational learning approach to practice development in this field.

As part of this priority, the diabetes specialist service has two key actions:

Action	Owner	Q1	Q2	Q3	Q4
Implement and evaluate the Auckland PHO project to inform locality model and work across other PHOs.	SCD/Lead Nurse Specialist				
Develop and implement detailed diabetes plan to integrate with locality model and develop partnerships with external stakeholders.	SCD/Team Leads				

2. Clearly defining the role of the Diabetes Specialist Service

It is important to clearly define the role and contribution of the diabetes specialist service in an integrated health care system. The service will increasingly concentrate on specific areas where specialist expertise is required. Their other key role will be in supporting primary care and other providers to care for their patients as effectively as possible and closer to home. This will be represented in a model of care that highlights the service offerings that are available, appropriate and responsive to people with diabetes to achieve the best outcomes.

The key services for the diabetes specialist service team are likely to include:

- Patients with significant renal disease, especially if progressive
- Patients with multiple LTCs where diabetes is dominant and complicating the management of other conditions.
- Those with poor glycaemic control, despite appropriate clinical pathway actions
- Those with established or active foot disease
- Young adults with complex type 1 and 2 diabetes
- Those with persisting or recurrent hypoglycaemia or unawareness
- Type 1 patients requiring intensive or MDT input (e.g. insulin pumps, continuous glucose monitoring, DAFNE, frequency hypos, impaired hypo awareness)
- Pre-pregnancy counselling and optimisation of both Type 1 and 2 patients
- People admitted to hospital with uncontrolled diabetes or diabetes-related issue
- Patients with diabetes attending ADHB for tertiary services where specialist advice is requested and required to minimise length of stay or optimise outcome (e.g. transplants, cystic fibrosis, cancer therapies)
- Other patients where primary care have indicated the need for help, requested more support, or where there are minimal resources to support these patients.

The aim of these services are to:

- Provide rapid and responsive services for those patients with complex needs (including improving the attendance rates)
- Tailor services to meet specific community and population needs
- Support primary care in the clinical management of diabetes
- Reduce the length of stay in hospital
- Reduce readmission rates for patients with diabetes.

Partnerships between the DHB and primary care is critical to ensure services are comprehensive (i.e. there are no gaps in service delivery) and that care can be escalated and de-escalated in response to patient need. The diabetes specialist team, along with other stakeholders, will provide input into the current and future DSLA work programme (e.g. including the retinal screening programme, podiatry review) to develop a comprehensive view of diabetes care in Auckland and Waitemata. In addition to this, the joint work across the sector to develop clinical pathways will lead to greater consistency across the region and support the better use of resources.

To achieve this priority, the key actions for the diabetes specialist service include:

Action	Owner	Q1	Q2	Q3	Q4
Develop enhanced inpatient service offering and business case. Implement recommendations.	Lead Nurse Specialist				
Define new model of care including diversifying service offerings to meet the needs of the population (informed by the DSLA).	SCD/Team Leads				
Provide specialist input and expertise into retinal screening and podiatry reviews, self-management programme review and systems redesign as part of DSLA work programme.	Team Leads				

3. Reducing the impact of the inequalities

By defining a new model of care for diabetes, we have the ability to constructively review our service and determine whether we are meeting the needs of culturally diverse communities. This is an important activity to help improve the outcomes for these populations. This will involve engagement with Maori, Pacific Island and Asian health communities, agencies and DHB teams. This will be work the Diabetes Specialist Service will take forward as part of the DSLA work programme and the planned co-design.

Another factor to consider in reducing the impact of inequalities are the high rates of patients not attending appointments, known as Did Not Attend (DNA) rates. Currently, Maori and Pacific Island have DNA rates of 29% and 32% respectively compared to the average of 22% across diabetes (2016). As part of this interim plan, we aim to review how we work with patients to book appointments to ensure they are patient centric. Pilot initiatives are already underway in an attempt to reduce DNA rates and these will be refined if proven successful. Early indications are promising that these approaches have helped to improve attendance at clinics in the diabetes service by 10-15%, but further work is required. There are a number of drivers behind these high DNA rates. It is recognised this is a complex issue and implementing improved booking processes

are only part of a wider plan to address DNA rates. It is the view of the Directorate that a whole redesign of the diabetes model of care, as part of the work of the DSLA is required, including co-design work with our population, to see DNA rates falls to more acceptable levels. Current DNA levels could indicate parts of our population do not value the services and model of care current offered.

To achieve this priority, the key actions for the diabetes specialist service include:

Action	Owner	Q1	Q2	Q3	Q4
Reduce DNA rates by implementing patient centred booking and consider other approaches based on existing evidence and co-design process to come	SCD/Ops Manager				
Identify opportunities to refine service delivery model to engage communities (e.g. Maori, Pacific Island and Asian communities).	SCD/Team Leads				

4. Enhance and strengthen workforce

The diabetes team at ADHB are a high functioning, specialist workforce that continues to focus on widening skill sets of staff through a culture of both formal and informal education. For example, the diabetes nurse specialist role has been developed and takes a greater role as an expert in diabetes care management under supervision of SMOs. In addition to this, the service has also focused on developing nurse and dietitian prescribers and the podiatry scope of practice.

There are further opportunities to refine the skill mix of staff within the diabetes specialist team (e.g. using Health Care Assistants to help free up specialist clinical time) as well as clarify roles and responsibilities. This may involve creating a sub-structure within the service (i.e. team leads), developing clinical leadership and managerial skills within the teams, clearly articulating responsibilities and portfolios of practice across the team. This work will link in with the DSLA Workforce development workstream to ensure that going forward specialist workforce planning occurs within the context of the wider diabetes workforce in order to better meet the future needs of the sector.

In addition to this, there is an opportunity to gain clarity around the productivity of the diabetes specialist service, particularly given the HCC system upgrade, potential for improved reporting and capturing of patient care activities outside of clinical consultation time (e.g. virtual work, phone consults, and other non-direct patient contact work etc.). Currently there is limited data and current collection of funded activity volumes do not reflect all activity. This will help the team identify opportunities for improvement and the ability to ensure resources across the team are well utilised.

To achieve this priority, the key actions for the diabetes specialist service include:

Action	Owner	Q1	Q2	Q3	Q4
Develop a clear sub-structure for the diabetes specialist service and implement	SCD				
Identify and implement recommendations to improve productivity of diabetes specialist service	SCD/Ops Manager				

Next steps for the diabetes service: a summary

This plan addresses the challenging scale and complexity of diabetes. The plan aims to reorientate our services to match the needs of the population and achieve the best outcomes for people living with diabetes. The plan will be to match the increasing community commitment, while maintaining adequate specialist service capacity to meet the increasing needs associated with increased diabetes prevalence and longevity of people living with diabetes.

The vision that underpins our plan is to ensure that diabetes care is holistic, culturally appropriate, patient centric, accessible and seamless and is achieving the best outcomes for this population. This is in line with the vision and the underpinning principles of the DSLA work.

We plan to achieve this vision through four key priority areas:

- Integrate services with primary care by moving to a locality model with specialist staff aligned with primary care and other providers, to provide support and facilitate education for clinical teams in all areas, but with a focus on high deprivation (and high diabetes prevalence) communities.
- Clearly define and optimise the diabetes model of care to better meet the needs of the population.
- Reduce the impact of inequalities, particularly for our Maori, Pacific Island and Asian communities.
- Fully develop the diabetes specialist service structure and optimise the productivity of the service.

Going forward we will continue to be an active part of the DSLA and support their initiatives in addressing wider sector opportunities, including supporting learning from new initiatives, especially the locality model.

With Board approval, the diabetes specialist service will develop a detailed implementation plan and report back on progress made in early 2017.