Open Board Meeting

Wednesday, 22 June 2016

08:45am

Note:

- **Public Excluded Session 8:45 am to 11:15 am**
- **Open Meeting from 11:15am**

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

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Published 17 June 2016

Agenda
Meeting of the Board
22 June 2016

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

Time: 8:45am

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	
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting - Director Communications
	Tim Wood	Funding & Development Manager - Primary Care
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members: Judith Bassett

Apologies Staff: Linda Wakeling and Margaret Wilsher

Karakia

Agenda

Please note that agenda times are estimates only

8.45am **1. ATTENDANCE AND APOLOGIES**

2. RESOLUTION TO EXCLUDE THE PUBLIC

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?

11.15am	**4.**	**CONFIRMATION OF MINUTES 11 MAY 2016**
11.15am	**5.**	**ACTION POINTS 11 MAY 2016**
11.20am	**6.**	**CHAIR'S REPORT**
	6.1	Board decision-making - communications during the District Health Board election period (*Good practice for managing public communications by Local Authorities)*
11.30am	**7.**	**CHIEF EXECUTIVE'S REPORT**
	8.	**COMMITTEE REPORTS - NIL**
11.40am	**9.**	**PERFORMANCE REPORTS**
	9.1	Financial Performance Report
	9.2	Funder Performance Report
12 noon	**10.**	**DECISION REPORTS**
	10.1	2017 Meeting Schedule
12.10pm	**11.**	**DISCUSSION PAPER**
	11.1	Waiheke Island Health Service Review (T Wood 15 minute presentation)
12.30pm	**12.**	**GENERAL BUSINESS**

Next Meeting:	Wednesday, 03 August 2016 at 12:45pm A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

Members	17 Feb. 16	30 March.16	11 May. 16	22 Jun. 16	03 Aug. 16	07 Sep. 16	26 Oct. 16	07 Dec. 16
Lester Levy (Chair)	1	1	1					
Joanne Agnew	1	1	1					
Peter Aitken	1	1	1					
Doug Armstrong	1	1	1					
Judith Bassett	1	1	1					
Chris Chambers	1	1	1					
Lee Mathias (Deputy Chair)	x	1	1					
Robyn Northey	1	1	1					
Morris Pita	1	1	1					
Gwen Tepania-Palmer	1	1	1					
Ian Ward	1	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 11 May 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 the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confidential Action Points	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety report	**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. Informatics report	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

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
		9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 2015/2016 Year End Processes Update 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]
6.2 2016/2017 Capital Expenditure Budget Update	**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]
6.3 Business Case – Paediatric Cardiac Intervention Unit HVAC Installation	**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]
6.4 Business Case – SCH Facilities Enhancement Outpatients	**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]

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
6.5 Business Case – Improving Adult Acute Flow at Auckland City Hospital	**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]
6.6 Review of Residential Rehabilitation Services	**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]
6.7 Business Case – Community Falls Prevention Programme	**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]
6.8 Request for Extension on Auckland DHB Contract C1369512	**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]
6.9 Renewal of Appointments to Auckland and Waitemata DHBs' Community and	**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 meeting would be likely to result in the disclosure of

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
Public Health Advisory Committees	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)]	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 Strategy to 2020 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]
7.2 Clinical Services Plan	**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]
7.3 Non-resident debt write-off	**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]

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
7.4 Migrant Health Contract – Northern Regional Alliance Ltd	**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]
7.5 New Zealand Health Innovation Hub	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Human Resources	**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 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]
10.1 Board Resolution Status – Quarterly Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **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]

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 (no beneficial interest held) 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 Acting Chair - Health Innovation Hub Director - Health Alliance Limited Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships	11.05.2016
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation 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
11 May 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 11 May 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	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Judith Bassett	Fiona Michel	Chief of People and Capability
Dr Chris Chambers	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Dr Lee Mathias (Deputy Chair)		
Robyn Northey	Rosalie Percival	Chief Financial Officer
Morris Pita	Linda Wakeling	Chief of Intelligence and Informatics
Gwen Tepania-Palmer	Sue Waters	Chief Health Professions Officer
Ian Ward	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Sally Bruce	Senior Communications Advisor
	Brigita Krismayanti	Corporate Business Services Administrator
	Bruce Levi	General Manager Pacific Health
	Sharon McCook	Executive Business Manager
	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

There were no apologies.

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution: Moved Lester Levy / Seconded Ian Ward

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)] **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]
4.2 Building Resilience – Auckland DHB Elective Delivery -	**Commercial Activities (1)** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information

Presentation	Information Act 1982 s9(2)(i)]	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, 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]
7.3 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	**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

and Packages of Care Services – Request for Contract Extension	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]
7.8 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	**Commercial Activities (1)**	That the public conduct of the

Business Case – Ultrasound Machine Fleet Capex programme 2015/2016	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)]	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 Forensic Pathology	**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]
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]

3. REGISTER OF INTEREST AND CONFLICTS OF INTEREST

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

The following changes to the Interests Register were noted:

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

Lee Mathias that she wished it recorded that she was currently Acting Chair of the Health Innovation Hub.

4. CONFIRMATION OF MINUTES 30 March 2016 (Pages 14 to 26)

Resolution: Moved Lee Mathias / Seconded Gwen Tepania-Palmer

That the minutes of the Board meeting held on 30 March 2016 be confirmed as a true and accurate record.

Carried

5. ACTION POINTS 30 MARCH 2016 (Pages 27)

PET Scanning

Lester Levy drew attention to the update provided by Dr Debbie Holdsworth, Director of Funding – Auckland DHB/Waitemata DHB. He advised that this should be an item that management maintains an overview of and reports back to the Board as appropriate.

6. CHIEF EXECUTIVE'S REPORT (Pages 28 to 35)

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

- The second annual A+Trust Nursing and Midwifery Awards were held on 10 May at the Langham Hotel. The Awards were opened up to include the wider nursing industry and recognised the different skills and attributes required by the professional nursing workforce. There were 25 Awards in total across all Directorates.
- United States Ambassador Mark Gilbert visited the Cancer and Blood Centre at Starship Children's Hospital in April. Mr Gilbert was interested in the work Starship Children Hospital clinicians and patients have ongoing with the Children's Oncology Group, a multi-country clinical trials and research initiative supported by the American National Cancer Institute.
- The 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. The theme was 'Get Them Talking'. This was designed to encourage people to get their families talking so they can make the most of their lives and plan for their futures.

- A wide range of positive feedback has been received from participants at the highly successful Patient Experience Week held from 7-11 March. Attendance at events was strong throughout the week. 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 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 orderlies to show they have reached the top level of training for their role. Forty of the 70-strong orderly team have accepted the opportunity and 20 of them will receive their full qualification at the graduation ceremony.
- The National Health Targets are on track. Of some concern is the increased immunisation 8 month target as it only takes a very small number of babies to affect the final outcome.
- Good progress has been made with Improvement events to support Faster Cancer Treatment but the impending FCT target date of 1 July this year has increased the urgency to improve these pathways for patients. This year's compliance against the 62 days target has been steadily improving since the rapid improvement events have been run however, not at the rate that is required.
- 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. 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 and improved reporting and visibility of performance. Further gains were made by developing a performance dashboard and reports to provide better visibility and data for our teams.
- Twenty staff attended their second of three Improvement Practitioner (Green Belt) training sessions on 20 April. There are some very interesting projects being undertaken with presentations being set for July 2016.
- Acknowledgement of the retirement of:
  Paediatric Surgeon, Mr Stuart Ferguson, 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.

  Dr Paul Drury who has served as the Service Clinical Director of our Diabetes Services

for a number of years.

The Board asked that acknowledgement be made to those clinicians that were retiring thanking them for their service over the years.

That the Chief Executives report for May 2016 be received.

Carried

7. COMMITTEE REPORTS - NIL

8. PERFORMANCE REPORTS

8.1 Financial Performance Report (Pages 36 to 43)

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

- That the Board is $11K favourable to budget for the month of April.
- There continues to be cost pressure in the areas of Child Health, Cardiac and Surgery.
- The forecast, even with this cost pressure, is still on budget for year end.
- The sector results for March show only two provider arms nationally that are not currently in deficit.

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

- Lester Levy asked how the Investor Confidence Rating process was proceeding. He was advised that a survey was underway around eight elements of the process with different parties assigned to undertake the reviews. The self-assessment process had been completed and was now with the Ministry. The asset management review, along with the long term investment plan, for which help from PWC was sought, are complete.
  The score that is eventually obtained relates to how far the organisation is from the target that has been assigned to it. It is a time bound process over the next 18 months.
  Lester Levy commented that as a Board there was a need to be far more commercial in order to be able to meet the requirements of the Investor Confidence Rating process.

That the Board receives this Financial Report for May 2016.

Carried

8.2 Funder Performance Report (Pages 44 to 56)

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

- The Auckland DHB Urology service has identified there are less than expected referrals for elective surgery being sent to Auckland DHB from Counties Manukau DHB. This is due to a staff member from Counties being on leave creating unanticipated delays.
- In relation to health of older people the Director General's report on home based support has been released. The Home and Community Support Services 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 HCSS providers.
- There are a number of closures and reconfigurations of Aged Residential Care facilities occurring. 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. This has been mirrored by an increase in dementia beds due to providers anticipating an increased demand for this level of care.

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

- Lee Mathias commenting that while the cancer targets had improved it was unclear what plans had been put in place to ensure the targets were achieved. Jo Gibbs advised that investigation of some regional pathways had uncovered some real issues to be dealt with in other DHBs which impacted on Auckland DHB. The successful round of rapid improvement events had fostered required change but a challenge still existed with the denominators and around patient choice. This is a slow and complex change to implement.
- It was advised that Auckland now had two bariatric surgeons available and was on track to deliver the required volumes.
- Lester Levy commented that there appeared to be a problem around referral of patients and that pressure existed with bookings. He asked how vulnerable that made the Board. Jo Gibbs replied that in urology there were two waiting lists one for inpatients and one for outpatients with no visibility of the other DHB waiting lists. There is an administrative process around wait lists with a number of checks and workarounds in place. It will remain this way until an electronic system is in place.

That the funder Update report for May 2016 be received.

Carried

9. DECISION REPORTS

9.1 Approval of Appointment of Directors to Northern Regional Alliance Ltd (Pages 57 to 58)

Lester Levy advised that 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 appropriate for the Board to confirm formally these appointments to the NRA Board now so that the appointees mandate to act as directors is clear.

Resolution: Moved Lee Mathias / Seconded Judith Bassett

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.**

Carried

9.2 Diabetes Strategy (Pages 59 to 74)

Jo Gibbs, Director Provider Services introduced Judith Catherwood, Director Community and Long Term Conditions and Dr Paul Drury, Clinical Director of Diabetes Services.

Lester Levy acknowledged the impending retirement of Dr Paul Drury and thanked him for his exemplary service and long term dedication to his colleagues and patients.

Judith Catherwood asked that the report be taken as read highlighting as follows:

- The Diabetes Service Level Alliance (DSLA) has been commissioned to redesign the entire diabetes pathway for the Auckland population. This work is in development and the Auckland DHB 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 an interim plan to integrate within the locality model and improve service delivery to Auckland DHB's population.
- The interim plan will focus 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.

Dr Paul Drury added that:

The national increase in the rate of diabetes was historically 6%-8%. However, it had now dropped for the fourth successive year but, the rate is still higher in Auckland than is seen nationally.

This national decrease could be a reflection of the success of the cardiovascular risk assessment programme.

There are two groups that are not following the trend. The first group are the 25 to 50 year olds who have a loss of life expectancy of around 20 years and have a worse outcome than those with type one diabetes. The second group are the older population. This has more to do with the increased survival rate. There are now more over 90 with diabetes than those under 20. This makes for an increasingly dependent group given the other health issues that they have.

There are some positive signs however, in the cardiovascular area, with better renal outcomes and a falling amputation rate.

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

- Advice was given that this is an interim step and that a broader picture of diabetes will emerge when the redesign of the entire diabetes pathway for the Auckland population is released by the Auckland and Waitemata Alliance.
- Lester Levy commented that overall he was supportive considering this a prudent move and that he understood the interim nature of the plan but felt that there should have been an identification of risks associated with this plan along with a communication plan.

Resolution: Moved Gwen Tepania-Palmer / Seconded Robyn Northey

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.**

Carried

10. DISCUSSION PAPERS - NIL

11 GENERAL BUSINESS

There was none.

The meeting closed at 1.55pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 11 May 2016

Chair: _____ Date: _____

Lester Levy

Action Points from 22 June 2016 Open Board Meeting

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As at Wednesday, 22 June 2016

Meeting and Item	Detail of Action	Designated to	Action by
	No open items to report		

MINISTRY OF HEALTH
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10 June 2016

Dr Lester Levy
Chair
Auckland DHB
PO Box 92 189
Victoria St West
AUCKLAND 1142

Dear Lester

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

Further to our recent letter, the 2016 district health board (DHB) election period is almost upon us. As you will recall from the 2013 elections, the election period poses particular challenges for DHBs, boards and members, to ensure that policies which touch on election-related matters are being appropriately followed.

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

Board decision-making

The general practice with the local body and DHB elections is to treat the three months before the elections as the 'pre-election period'. The pre-election period, and the weeks after the election before new board members take office, is a sensitive time when additional protocols are frequently required. In 2016, the pre-election period will start on 8 July, with new board members due to take office on 5 December (58 days after election day on 8 October).

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

In the past, we have observed that it is helpful for new board members to be given observer status at board meetings from the time final results are announced until they take office on 5 December. While this is a decision for each individual board to make, it may allow for a smoother transition from the current membership to the new board.

Communications

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

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

Communications by DHB board members

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

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

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

Communications by DHBs

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

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

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

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

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

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

Communications from DHB staff

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

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

I trust that you find this information useful. Should you require clarification around any of the matters raised in this letter, Jonathan Morgan, Senior Advisor, Governance and Crown Entities, would be happy to assist. You can contact Jonathan on (04) 816 2678, or the team on vote2016@moh.govt.nz.

Yours sincerely

Jill Bond
Executive Director
Office of the Director-General

cc Ms Ailsa Claire, CEO, Auckland DHB, ailsac@adhb.govt.nz
Marlene Skelton, MarleneS@adhb.govt.nz

Encl.

The Controller and Auditor-General

Tumuaki o te Mana Arotake

Good Practice for Managing Public Communications by Local Authorities

April 2004

ISBN 0-478-18117-5

Foreword

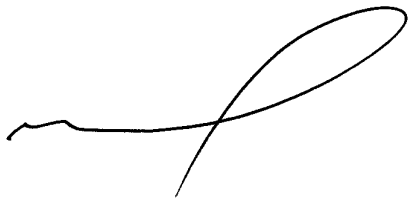
We first published our *Suggested Guidelines for Advertising and Publicity by Local Authorities* in 1996. We published a revised version of those *Guidelines* in 1999.

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

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

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

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



K B Brady
Controller and Auditor-General

14 April 2004

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1 Introduction

The importance of Council communications

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

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

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

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

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

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

Why this guide?

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

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

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

1.9 We derive our guidance from:

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

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

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

The objects and scope of the guide

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

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

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

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

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

What is the status of the guide?

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

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

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

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

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

2 Scope – What are "Communications"?

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

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

2.2 We make no distinction between:

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

The underlying principles are the same in each case.

2.3 Common examples of communications by Councils include:

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

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

2.5 The guide does not apply to:

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

- communications by Members using their own resources.

3 Communications – Whose Responsibility?

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

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

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

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

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

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

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

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

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

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

4 Principles and Practice

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

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

Legitimacy and justification

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

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

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

4.5 The main elements of justification are:

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

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

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

4.7 A communication will be lawful when it:

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

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

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

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

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

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

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

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

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

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

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

Collective position

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

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

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

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

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

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

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

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

Standards of communication

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

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

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

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

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

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

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

Consultation and public debate

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Communications by Members

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] LGA, Schedule 7, clause 15.

Members' personal profile

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

4.41 Two related objectives underlie this principle:

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

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

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

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

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

Communications in a pre-election period[13]

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

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

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

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

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

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

be suspended during a pre-election period.

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

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

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

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

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

4.50 "Electoral expenses"[15] include:

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

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

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

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

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

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

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

[15] Also defined in section 104.

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

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

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

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

5 Other Commonly Arising Issues

Use of surveys and market research

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

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

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

Joint ventures and sponsorship

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

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

5.5 Examples of joint communication could include:

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

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

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

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

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

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

5.7 As a minimum, the Communications Policy should:

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

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

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

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

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

Appendix 1

Principles of the Local Electoral Act 2001

4 Principles

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

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

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

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

Appendix 2

Statistics New Zealand Principles Applicable to the Production of Official Statistics

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

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

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

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

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

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

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

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

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

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

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

Chief Executive's Report

Recommendation

That the report be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 22 April to 10 June 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, 210 emails were received with approximately 70 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:

- Waiheke Health Services Review now available
- Regular tests advised as syphilis cases rise
- Immunisation Week targets immunisation during pregnancy
- Celebrating our nurses and midwives
- Pink Shirt Day to stand against bullying
- World Smokefree Day – Auckland DHB promotes a Smokefree Aotearoa
- Fighting Rheumatic Fever in our communities
- June is about men at Auckland DHB – Men's Health Month

We received 48 requests for information, interviews or for access from media organisations from 22 April to 10 June. Media queries included interest in an interview with Dr Patrick Kelly about child abuse prevention in New Zealand, alcohol related violence and ED admissions and mental health service capacity and funding.

Apart from those noted, 28 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 17 Official Information Act requests over this period.

2.2.2 Internal

- Three CE blog posts were published. These covered a personal insight to motivation at work, Orderlies aiming high and the importance of getting the flu vaccination.
- One Teamtalk Blog by Margaret Dotchin on Nursing and Midwifery Awards.
- Hospital occupancy was updated daily on the Intranet.
- 26 news updates were published on the DHB intranet.
- Six eNova (weekly electronic newsletters) were published.
- June/July edition of Nova magazine was published and distributed.

2.2.3 Events and Campaigns

Orderlies Graduation

Eighteen of our orderlies graduated with a new qualification at a laughter-filled, colourful ceremony alongside colleagues, friends and whānau in May. In partnership with Careerforce, our orderlies have the opportunity to earn a nationally recognised qualification designed specifically for them, and co-developed with the orderly sector itself. The NZQA-accredited 'Certificate in Health and Wellbeing (Level 3) Orderly Services' is now being offered in hospitals across the country, with Auckland DHB one of the first to take up the training.

The training itself was delivered by four members of our Orderly Services (Finau Taufa, Aiden Lees, Joseph Lafaele and Feroz Buksh), supported by the Careerforce team. These 'assessors' have been on their own journey of workplace learning, having completed the certificate themselves, and undertaking further training to be able to support others to do the same.

Dementia Champions

Across Auckland City Hospital and Greenlane Clinical Centre we have 46 Dementia Champions who support the roll-out of our 'Better Brain Care' pathway. This initiative detects cognitive impairment, involves whānau/families and plans a safe discharge for our elderly patients.

Using the Better Brain Care pathway, our Dementia Champions can help us provide the best person-centred care for our patients living with dementia. It will also increase our knowledge of this disease, and let us work towards becoming a dementia-friendly hospital. The Dementia Champions were recently presented with a purple daisy badge that identifies them and thanks them for becoming a Dementia Champion.

World Smoke Free Day

Quit now - it's about whanau. In May we celebrated World Smokefree Day, encouraging people to think about quitting and asking the people who are smoke free to tell us why.

Pink Shirt Day

Many of our staff showed their support for Pink Shirt Day, a national day to stand up to bullying. Posters were put in place and teams were encouraged to submit photos of themselves dressed in Pink.

June is Men's Health Month

Men's Health Month ambassador, Dr Inia Raumati, from our adult Emergency Department is supporting us to raise awareness of men's health issues and get men talking about their health this month.

#MenStartTalking is about breaking down communication barriers and getting men talking to reduce the staggering 3,000 annual preventable deaths of New Zealand men.

2.2.4 Social Media

Facebook likes	3,800
Twitter followers	2,394
LinkedIn followers	4,869
Instagram followers (new account)	75

Most popular posts:

- Running man challenge videos (109.8k reach)
- Local hero
- Nursing and Midwifery awards photo gallery
- Febrile convulsions in childhood – Seven sharp story
- US Ambassador visit
- New Elective Orthopaedic surgery ward
- FAST – stroke awareness campaign
- Queen's Birthday honours for our staff
- Pink shirt day
- Men's Health Month
- #patientexperience
- World Smokefree Day

2.2.5 Our People

Queen's Birthday Honours

Warmest congratulations to our staff who received Queen's Birthday honours in June. Dr Patrick Kelly for services to children's health, Dr Tom Miller for his contribution to medical research and Emeritus Professor Bryan Parry for services to colorectal surgery.

Celebrating Our People

Last year a number of our team at Auckland DHB made some significant achievements. We've published this in a book called 'Celebrating Our People.' This book includes the many people who were recognised with awards for everything from commitment to Auckland DHB with long service to those aiming high with specific awards during 2015. These people are just the tip of the iceberg and there are many more unsung heroes out there. The book is available on our website and copies have been circulated to the Board.

Local Heroes

There were 26 people nominated for local heroes. Our chosen heroes for April and May were Miriam Matenga, Staff Nurse on ward 25A/B, and Lee Eeson, Payroll Officer.

Miriam was nominated by a patient's mother who said: "My daughter was admitted with asthma, but had extreme anxiety around spacers. She would kick and scream with everyone every hour when she needed to use one. Miriam spent extra time with her before and after each spacer to read, sing, dance or play with her, to help her relax with the spacers. She stopped hating them so much and by the time we went home, we were able to give them to her easily. We knew Miriam was busy but she always made us feel like we were her only patients and like nothing was too much effort for her. She was truly a ray of sunshine for both my daughter and I."

Lee was nominated by a staff member who said: "When implementing the Clinician Leadership framework within our Directorate, Lee had to deal with many complex payroll issues for new positions and staff with multiple positions. In all the years I have dealt with payroll matters through Lee, I have found her to be professional, welcoming, respectful, extremely helpful and efficient when

it comes to sorting out complex payroll-position related matters. Nothing fazes her. Every issue she has been asked to address has been done so in a calm, timely and collaborative way. Lee also demonstrates a communication style on the phone that always makes you feel heard and that reflects our Auckland DHB values. Payroll staff often work quietly in the background but are an important part of our organisation and people like Lee at the end of the phone are like gold dust in a large organisation."

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Apr 95%, Target 95%
Improved access to elective surgery		100% to plan for the year
Shorter waits for radiation therapy & chemotherapy		Apr 100%, Target 100%, Year to Date 100%
Better help for smokers to quit		Apr 95%, Target 95%
Cardiac bypass surgery		Apr 99 patients, Target < 104
More heart and 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.

Better Help for Smokers to Quit

Final results reported by the Ministry of Health for Q3, 2015-16 showed a significant improvement in performance (87.6%) for Auckland DHB. This result (87.6%) was well above the national average of 85%. Nationally, Auckland DHB was ninth in the DHB's ranking.

Auckland DHB Planning and Funding Smokefree Team is working closely with PHOs to ensure that they are focused on achieving the target in Q4, 2015/16. Currently, all PHOs are required to provide a weekly report with activities and updated data to the team. The weekly updates provide useful information on the progress being made and interventions and activities applied at a practice level by the PHOs.

Overall, Auckland DHB is expected to meet the target by the end of 2015/16.

3.2 Financial Performance

The financial performance for the month of May 2016 was favourable to budget by $36K, against a planned deficit of $1.0M. The DHB financial performance for the year-to-date was favourable to budget by $288K, against a planned surplus of $2.6M. Year-end financial processes have commenced including review of accruals and provisions, IDF wash-ups, asset revaluations and staff liability actuarial valuations and we are still on track to fully achieve the 2015/16 planned surplus of $2.3M. The full year savings target of $26M will be achieved, noting this includes new savings realised to fully offset those no longer achievable.

4.0 Clinical Governance Commentary

Primary Care Open Evening

Auckland DHB held another successful Primary Care Open Evening at Auckland City Hospital on 28 May. These evenings are part of an ongoing strategy to develop closer relationships and integration between primary and secondary care health professionals. The evening focused on *'Latest Approaches and Innovations in the Management of the Health of Older Persons'* and included talks on dementia and frailty management, polypharmacy, referral requirements, an overview of the locality approach and community services such as the Rapid Response Service. More than 40 GPs and Practice Nurses attended the evening with most attendees finding the session 'useful' or 'extremely useful'. Those who attended also enjoyed the networking opportunity, collegial support and meeting hospital specialists – *'putting names to faces'.*

Changes to Welcome Day orientation sessions

From July to December 2016, an interim orientation day will be delivered to welcome new colleagues and help them to understand what is important at Auckland DHB. During this time we will formally review the best way to bring people on board. The interim Welcome Day will take place more frequently, every two weeks, to enable staff to attend close to their start date. It also means smaller group sizes increasing the level of discussion and interaction. The day will take place on-site reducing the cost to the organisation. Some of the mandatory training sessions will now be delivered through e-learning. Whilst this interim approach is underway, we will work with all key stakeholders to review and transition to a new, inspiring and engaging experience for our new employees from February 2017.

Ambulatory care area opens

Auckland City Hospital's new Ambulatory Care area opened on 31 May to improve the quality of care for patients in the Adult Emergency Department (AED) and Admission and Planning Unit (APU). The upgrade of non-clinical office space now provides a dedicated area and resource to treat up to 12 patients with minor conditions, allowing acute medical staff to manage more complex cases and improve the flow of patients through AED.

The ambulatory care area was designed by department staff and acts as a temporary measure to create additional patient space for winter, while more permanent plans to expand and upgrade existing AED and APU clinical space continue to develop for 2017-18.

The successfully-proven ambulatory care model is one of a number of initiatives being introduced to manage increased demand at AED, and is already reducing wait times and improving both patient and staff satisfaction.

Organ Donation New Zealand consultation

The Ministry of Health is consulting on proposals to increase deceased organ donation and transplantation in New Zealand. A consultation document released on 7 June sets out a number of changes to areas including raising awareness, standardising the way hospitals identify potential donors and how donation is discussed with families.

The consultation document follows a Ministry of Health-led review with the proposals based on international best practice, local evidence and advice from an expert advisory group.

All documents are available on the Ministry of Health website www.health.govt.nz with submissions closing on 29 July. In addition to consultation, the Ministry is engaging directly with interested stakeholders, including representatives from Auckland DHB, for more detailed and technical discussion of some of the proposals in the consultation document.

Nursing and midwifery uniform update

The design of the new Auckland DHB nursing and midwifery uniforms has been finalised with more than half of our nurses, midwives and healthcare assistants taking the opportunity to vote on their preferred colour, all of which were based on the Auckland DHB brand.

The Uniform Governance Steering Group worked with staff, patients, partners and the public to design a professional and practical style. Based on feedback, the styles were redesigned and have resulted in a range of collared and non-collared tunic tops being made available to wear over navy trousers. The revised designs were tested for fit and fabric and further consideration was given to the placement of the new security and identity badge.

Introduction of the new uniform will be phased over the next year with fittings beginning from next month.

Health Research Council fund record amount for projects and programmes

The Health Research Council of New Zealand has announced record funding grants for its projects and programmes this year. The increased amount was made possible following the Government's $97 million investment boost announced in last month's Budget.

More than one third of the 61 projects and programmes have been funded for Auckland-based doctors, professors and associate professors. Of particular note is the funding granted to Professor Ralph Stewart at Auckland DHB whose research will focus on 'Improving outcomes of patients with atrial fibrillation in primary care.'

Information about all of this year's funding grants and research proposals is available on the HRC's website www.hrc.govt.nz

Financial Performance Report

Recommendation

That the Board receives this Financial Report for May 2016.

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for May 2016 was a deficit of $967K which was favourable to budget by $35K. For the Year to Date (YTD), a surplus of $2.86M was realised, favourable to budget by $288K. YTD Favourable Funder arm and Governance results fully offset unfavourable variance in the Provider arm.

YTD revenue is favourable to budget by $8.0M. Underlying this revenue variance are significant movements including: $3.4M 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); $4.0M additional MoH contracts Devolved funded initiatives under NGO services (mainly contracts finalised after budgets were set, with corresponding additional expenditure); $8.2M additional other income (includes research income, pharmacy and one off settlement of commercial contracts); offset by unfavourable financial income ($2.1M) and donation income ($1.8M). YTD expenditure is unfavourable to budget by $7.8M. Significant variances include unfavourable outsourced personnel of $7.4M; clinical supplies of $6.5M; personnel cost $3M; infrastructure and non-clinical supplies of $1.3M; outsourced clinical services $1M and capital charge of $1.9M; offset by favourable Funder payments to NGOs of $13.5M.

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 last month of the year.

Auckland District Health Board
Summary Results: Month of May 2016

$000s	Month (May-16)			YTD (11 months ending 31 May-16)			Full Year (2015/16)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	93,132	92,819	313 F	1,024,448	1,021,005	3,444 F	1,117,580	1,113,823	3,757F
MoH Contracts - Devolved	7,586	7,060	526 F	81,734	77,659	4,075 F	87,211	84,720	2,491F
	100,718	99,879	839 F	1,106,182	1,098,664	7,518 F	1,204,791	1,198,543	6,248F
MoH Contracts - Non-Devolved	5,075	4,911	164 F	53,660	52,675	985 F	62,501	57,598	4,903F
IDF Inflows	53,979	54,105	126 U	590,847	595,153	4,306 U	645,734	649,257	3,523U
Other Government (Non-MoH, Non-OtherDHBs)	2,620	2,817	197 U	31,019	31,266	247 U	33,616	34,212	596U
Patient and Consumer sourced	1,535	1,544	10 U	17,121	16,987	134 F	14,660	15,147	487U
Inter-DHB & Internal Revenue	1,037	1,297	259 U	13,489	13,877	388 U	18,725	18,532	193F
Other Income	5,098	3,694	1,404 F	49,481	41,234	8,247 F	52,013	43,216	8,797F
Donation Income	249	588	339 U	4,559	6,339	1,780 U	6,448	8,608	2,160U
Financial Income	399	664	265 U	5,047	7,166	2,119 U	6,711	7,830	1,119U
Total Income	**170,710**	**169,499**	**1,211 F**	**1,871,405**	**1,863,361**	**8,043 F**	**2,045,199**	**2,032,943**	**12,256F**
Expenditure									
Personnel	75,076	72,048	3,028 U	788,799	785,765	3,034 U	857,513	857,732	219F
Outsourced Personnel	2,376	1,507	869 U	23,954	16,575	7,379 U	26,336	18,082	8,254U
Outsourced Clinical Services	2,373	1,897	476 U	21,640	20,633	1,007 U	23,709	22,515	1,194U
Outsourced Other Services (incl. hA/funder Costs)	4,271	4,591	320 F	50,265	50,498	233 F	54,820	55,089	269F
Clinical Supplies	22,054	20,624	1,430 U	225,473	219,011	6,462 U	246,834	239,097	7,737U
Funder Payments - NGOs	40,137	44,987	4,850 F	481,351	494,857	13,506 F	532,125	539,844	7,719F
Funder Payments - IDF Outflows	9,398	9,269	129 U	102,362	101,960	402 U	111,632	111,228	404U
Infrastructure & Non-Clinical Supplies	10,641	11,076	435 F	123,266	121,958	1,308 U	133,998	132,564	1,434U
Finance Costs	1,044	1,066	21 F	12,049	12,063	14 F	13,008	13,513	505F
Capital Charge	4,308	3,438	870 U	39,392	37,476	1,916 U	42,830	40,913	1,917U
Total Expenditure	**171,677**	**170,502**	**1,175 U**	**1,868,550**	**1,860,795**	**7,755 U**	**2,042,805**	**2,030,577**	12,228U
Net Surplus / (Deficit)	**(967)**	**(1,003)**	**36 F**	**2,855**	**2,567**	**288 F**	**2,394**	**2,366**	**28 F**

2. Result by Arm

Result by Division	Month (May-16)			YTD (11 months ending 31 May-16)			Full Year (2015/16)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	5,533	194	5,339 F	15,299	2,136	13,163 F	15,299	2,330	12,969F
Provider	(6,307)	(1,197)	5,110 U	(14,032)	431	14,463 U	(14,281)	37	14,318U
Governance	(193)	0	193 U	1,588	0	1,588 F	1,377	0	1,377F
Net Surplus / (Deficit)	**(967)**	**(1,003)**	**36 F**	**2,855**	**2,567**	**288 F**	**2,395**	**2,367**	**28 F**

The YTD $13.2M favourable Funder arm and $1.6M favourable Governance results fully offset the $14.5M 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 in Outsourced Personnel, clinical supplies and Infrastructure and Non Clinical Supplies costs. These variances are described further in section 3 below.
- 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).

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 May 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 which are $520K favourable due to funded initiatives but with corresponding additional expenditure
- IDF inflows are $0.1M unfavourable due to PHO washup
- Research Income $0.3M favourable, offset by equivalent expenditure
- Capital Charge Income $0.2M favourable, offset by additional expenditure
- Donation Income $0.3M unfavourable – revenue fluctuates depending on timing of projects - with no major projects in the current year, this variance will continue for the rest of the year
- Interest/Financial income $0.2M unfavourable due to the downward trend in interest rates

Expenditure was greater than budget by $1.2M. Significant variances are described below:

- Personnel/Outsourced Personnel costs $3.9M (5.3%) unfavourable mainly reflecting part adjustments for staff liability provisions (Retiring Gratuities and Long Service Leave – these liabilities are subject to annual actuarial valuations) and also the impact of FTE adverse variances (125 above budget).
- Clinical Supplies $1.4M (7.0%) unfavourable, with the key variances in:
    - Surgical/Perioperative $0.6M unfavourable, reflecting the ongoing high surgical volumes – 3.7% over contract YTD

    - Cardiovascular - $0.5M unfavourable due to greater than budget implants and prosthesis (volume driven TAVI and AICD implants)
- Funder payments – NGOs $4.7M (9.4%) favourable is mainly from demand driven services and favourable prior year adjustments (mainly Community Laboratory wash-up, Pharmac GST claims and Pharmac rebates).
- Infrastructure and Non Clinical Supplies $0.2M (1.3%) unfavourable, reflecting increased capital charge, and offset by additional revenue.

Year to Date Result

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

Revenue was higher than the budget by $8.0M. Significant movements underlying this included:

Favourable revenue variances:

- MOH Sourced PBFF revenue is $3.4M favourable YTD mainly due to $2.3M 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 $4.1M 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 expenditure. 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.
- Haemophilia funding $1.7M favourable for abnormally high blood product usage, bottom line neutral as offset by additional expenditure
- Research Income $4.2M favourable, offset by equivalent expenditure
- Pharmacy Retail sales $0.8M favourable, offset by additional cost of sales expenditure
- One off revenue for settlement of commercial contracts $0.9M favourable
- Inter DHB Revenue - IDF washup for 2014/15 $1.5M favourable – one off revenue
- Unbudgeted revenue for Maternal Mental Health Acute Continuum $0.8M favourable
- Safekids revenue $0.6M favourable – offset by additional promotional expenditure, bottom line neutral

Unfavourable revenue variances:

- IDF inflows $4.3M (0.7%) unfavourable. The Funder NGO Inflow adverse variance of $1.4M is primarily caused by PHO quarterly wash-ups. The Funder Own Provider IDF Inflow has a $6.5M adverse variance. This is mostly the result of YTD provisions for $8.5M of IDF inpatient revenue at risk, offset by favourable YTD service changes of $2.0M (mainly National services revenue now received through IDFs). 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.
- LabPlus revenue $0.3M unfavourable – mainly loss of the LabPlus MidCentral DHB contract, offset by an increase in other external Labplus revenue streams $0.8M favourable
- Financial income $1.9M unfavourable due to a combination of lower interest rates, lower cash on deposit and valuation losses for Trust investments.
- ACC Income $1.7M unfavourable – patients sent to Private providers to release capacity achieve elective MOH discharge targets
- Donation Income $1.8M unfavourable – revenue fluctuates depending on timing of projects- with no major projects in the current year, this variance will continue for the year.

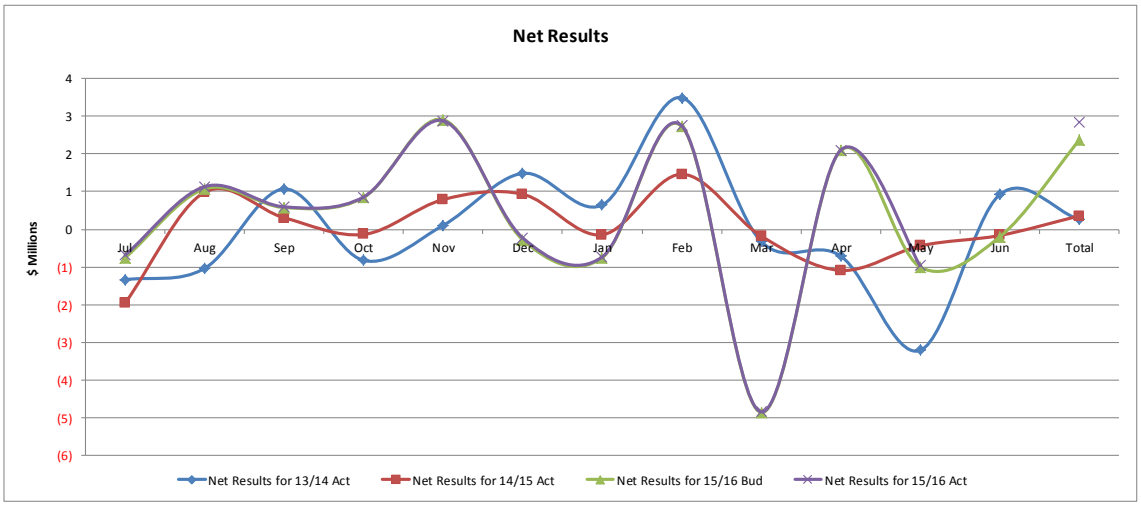
- MOH Public Health $1.1M unfavourable – in line with costs lower than budget YTD

Expenditure was higher than budget YTD by $7.8M, with significant underlying variances as follows:

- Net combined Personnel and Outsourced Personnel Costs $11.5M (1.4%) unfavourable. YTD FTE for total Personnel/Outsourced are very close to budget at 5 above budget. The unfavourable expenditure variance is due to staff liability actuarial valuation adjustments made in May (partially offset by accruals released), MECA costs above budget ($1.1M unfavourable) and cost per FTE targets not met.
    - Personnel Costs are $3.0M unfavourable - payroll FTE are 149 below budget but the favourable variance this creates is offset by MECA costs above budget ($1.1M unfavourable) and cost per FTE targets not met.
    - Outsourced Personnel costs are $8.5M (52.1%) unfavourable (154 FTE above budget), primarily for contract Support (Cleaners) and Administration staff covering vacancies
- Clinical Supplies $6.4M (2.9%) unfavourable with the key variances as follows:
    - The key unfavourable variance is in Cancer & Blood Services - abnormally high haemophilia blood product costs ($1.6M unfavourable) which are fully funded and pharmaceutical costs in Oncology/Haematology ($1.9M unfavourable) due to additional costs for treatment previously funded under a research trial and high cost drugs in Haematology.
    - High volume of TAVI implants in Cardiology (60 for current YTD versus 37 for last YTD) - $0.7M unfavourable
    - Radiology $0.8M unfavourable due to higher than budgeted volumes of Interventional Radiology procedures.
    - Pharmacy clinical supplies $0.4M unfavourable due to increased clinical trials – offset by additional trial revenue
    - Surgical Services/Perioperative Services are $1.5M unfavourable reflecting volumes at 103.7% of contract ($8.3M above contract) for year to date.
- Funder Payments to NGOs are YTD favourable $13.5M (2.7%) and mainly driven 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 $4.3M (2.6%) unfavourable, comprising the following key variances – higher food costs during transition phase for new food services contract $1.7M 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.
- Capital charge is $1.9M unfavourable and is fully offset by additional revenue.

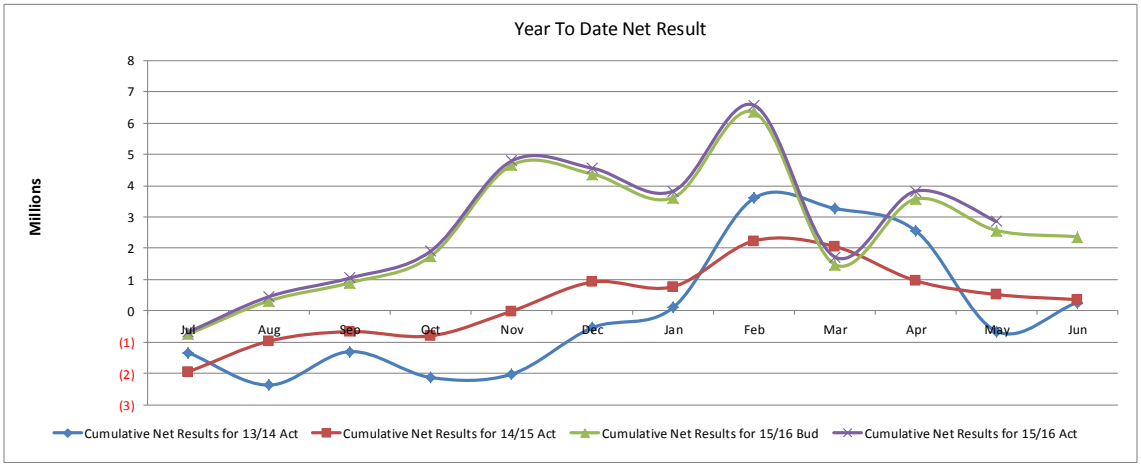
4. Performance Graphs

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)	2.101	(0.967)		2.855

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	3.822	2.855	
Variance to Budget for 2015/16	0.072	0.133	0.151	0.164	0.134	0.186	0.207	0.223	0.241	0.252	0.288	

5. Efficiencies / Savings

The desire to provide the latest financial result to the Board (May) has meant that there wasn't sufficient time to complete the savings reports (due to short timeframe between from month end close-off and Board agenda dates). A report on performance against the full year savings target will be provided at the next Board meeting. Overall, the full year savings program of $26M is expected to be achieved by year end, although this includes additional savings realised to fully offset those that were no longer achievable.

6. Financial Position

Statement of Financial Position as at 31 May 2016

$'000	31-May-16			30-Apr-16	Var	30-Jun-15	Var
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0F
Reserves							
Revaluation Reserve	438,457	406,629	31,828F	438,457	0F	438,457	0F
Cash Flow Hedge Reserve	(3,788)	(3,741)	47U	(3,879)	91F	(4,293)	505F
Accumulated Deficits from Prior Year's	(464,047)	(461,217)	2,830U	(464,047)	0F	(464,402)	355F
Current Surplus/(Deficit)	2,858	-	2,858F	1,723	1,135F	356	2,502F
	(26,519)	(58,329)	31,810F	(27,746)	1,227F	(29,882)	3,363F
Total Equity	**550,279**	**518,469**	**31,810F**	**549,052**	**1,227F**	**546,916**	**3,363F**
Non Current Assets							
Fixed Assets							
Land	249,006	217,178	31,828F	249,006	0F	249,006	0F
Buildings	592,473	562,910	29,563F	575,643	16,830F	585,033	7,440F
Plant & Equipment	83,686	104,881	21,195U	84,119	433U	78,462	5,224F
Work in Progress	43,024	64,012	20,988U	57,166	14,142U	39,821	3,203F
Total PPE	968,190	948,981	19,209F	965,934	2,256F	952,322	15,868F
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments							0F
- Health Alliance	51,042	47,430	3,612F	49,585	1,457F	42,170	8,872F
- 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 Investment	503	-	503F	462	41F	462	41F
	68,965	59,850	9,115F	67,467	1,498F	55,052	13,913F
Intangible Assets	738	5,712	4,974U	573	165F	910	172U
Trust Funds	14,154	14,548	394U	13,512	642F	17,299	3,145U
	83,857	80,110	3,747F	81,552	2,305F	73,261	10,596F
Total Non Current Assets	**1,052,047**	**1,029,091**	**22,956F**	**1,047,486**	**4,561F**	**1,025,583**	**26,464F**
Current Assets							
Cash & Short Term Deposits	59,240	81,193	21,953U	56,656	2,584F	87,210	27,970U
Trust Deposits > 3 months	11,000	7,700	3,300F	11,600	600U	8,500	2,500F
ADHB Term Deposits > 3 months	15,000	-	15,000F	15,000	0F	-	15,000F
Debtors	33,027	18,297	14,730F	37,140	4,113U	28,509	4,518F
Accrued Income	35,458	20,200	15,258F	35,287	171F	19,206	16,252F
Prepayments	2,298	1,166	1,132F	3,077	779U	1,035	1,263F
Inventory	13,625	12,723	902F	13,493	132F	13,154	471F
Total Current Assets	**169,647**	**141,279**	**28,368F**	**172,253**	**2,606U**	**157,614**	**12,033F**
Current Liabilities							
Borrowing	-	(4,046)	4,046F	-	0F	(52,454)	52,454F
Trade & Other Creditors, Provisions	(158,658)	(133,357)	25,301U	(165,439)	6,781F	(121,299)	37,359U
Employee Benefits	(175,718)	(176,254)	536F	(169,431)	6,287U	(176,735)	1,017F
Funds Held in Trust	(1,237)	(1,169)	68U	(1,233)	4U	(1,208)	29U
Total Current Liabilities	**(335,614)**	**(314,826)**	**20,788U**	**(336,103)**	**489F**	**(351,696)**	**16,082F**
Working Capital	**(165,967)**	**(173,547)**	**7,580F**	**(163,850)**	**2,117U**	**(194,082)**	**28,115F**
Non Current Liabilities							
Borrowings	(304,500)	(304,500)	0F	(304,500)	0F	(254,500)	50,000U
Employee Entitlements	(31,301)	(32,575)	1,274F	(30,085)	1,216U	(30,085)	1,216U
Total Non Current Liabilities	**(335,801)**	**(337,075)**	**1,274F**	**(334,585)**	**1,216U**	**(284,585)**	**51,216U**
Net Assets	**550,279**	**518,469**	**31,810F**	**549,051**	**1,228F**	**546,916**	**3,363F**

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 $26.2M 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 May 2016)

$000's	Month (May-16)			YTD (11 months ending 31 May-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	169,337	169,511	174U	1,851,192	1,863,314	12,123U
Payments						
Personnel	(67,007)	(71,192)	4,185F	(788,600)	(769,475)	19,126U
Suppliers	(37,676)	(36,093)	1,583U	(393,745)	(388,578)	5,167U
Capital Charge	(870)	(3,366)	2,496F	(22,204)	(36,978)	14,774F
Payments to other DHBs and Providers	(49,535)	(53,356)	3,822F	(583,713)	(586,919)	3,207F
GST	(8,963)	0	8,963U	(107)	0	107U
	(164,050)	(164,008)	43U	(1,788,369)	(1,781,949)	6,420U
Net Operating Cash flows	**5,286**	**5,503**	**217U**	**62,822**	**81,365**	**18,543U**
Investing						
Interest Income	399	668	268U	5,047	8,094	3,047U
Sale of Assets	18	0	18F	50	0	50F
Purchase Fixed Assets	(4,765)	(4,292)	473U	(56,999)	(83,196)	26,197F
Investments and restricted trust funds	1,281	(2,500)	3,781F	(28,041)	(2,500)	25,541U
Net Investing Cash flows	**(3,067)**	**(6,124)**	**3,057F**	**(79,943)**	**(77,602)**	**2,342U**
Financing						
Interest paid	(2,726)	(1,112)	1,614U	(10,851)	(12,551)	1,700F
Other Equity Movement	1	-	1F	0	0	0F
Net Financing Cash flows	**(2,725)**	**(1,112)**	**1,614U**	**(10,851)**	**(12,551)**	**1,700F**
Total Net Cash flows	**(506)**	**(1,733)**	**1,227F**	**(27,971)**	**(8,787)**	**19,184U**
Opening Cash	56,656	81,317	24,661U	87,210	90,018	2,808U
Total Net Cash flows	(506)	(1,733)	1,227F	(27,971)	(8,787)	19,184U
Closing Cash	**56,150**	**79,584**	**23,434U**	**59,239**	**81,231**	**21,992U**

ADHB Cash	57,687	77,822	20,135U
A+ Trust Cash	0	0	0F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	1,553	5,105	3,552U
	59,240	**82,927**	**23,687U**
ADHB - Short Term > 3 months	15,000	**0**	15,000F
A+ Trust Deposits - Short Term > 3 months	11,000	7,700	3,300F
ADHB Deposits - Long Term	5,000	0	5,000F
A+ Trust Deposits - Long Term	14,154	14,548	394U
Total Cash & Deposits	**104,394**	**105,175**	**781U**

Funder Update

Recommendation

That the report be received.

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

Glossary

ACH	-	Auckland City Hospital
ARC	-	Aged Residential Care
ARPHS	-	Auckland Regional Public Health Service
ASH	-	Ambulatory Sensitive Hospitalisation
AWHI	-	Auckland Wide Healthy Housing Initiative
CHSAG	-	Child Health Stakeholder Advisory Group
DHB	-	District Health Board
ED	-	Emergency Department
GETS	-	Government Electronic Tenders Service
HBHF	-	Healthy Babies Healthy Futures
HCSS	-	Home and Community Support Services
IBT	-	Inbetween Travel
MALT	-	Maori Alliance Leadership Team
MoH	-	Ministry of Health
NCHIP	-	National Child Health Information Platform
NIHI	-	National Institute of Health Innovation
NIR	-	National Immunisation Register
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
PRIMHD	-	Programme for the Integration of Mental Health Data
RFP	-	Request for Proposals
TRC	-	Tamaki Regeneration Company
TRIPLE P	-	Positive Parenting Programme
YSALT	-	Youth Service Alliance Leadership Team

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 Plans

Draft 2 of Auckland DHB's Annual Plan was submitted to the Ministry of Health (the Ministry) on 30 May 2016, after being presented at respective May Board meetings for approval. Feedback from the Ministry was provided in early May and resulting changes have been incorporated into draft 2 along with later advice related to System Level Measures, Social Sector Trials, National Entities and the National Pharmacy Agreement. Further Ministry feedback on the Plans is expected in June.

2. Hospitals

2.1 Cancer target

The ADHB provider reported FCT 62 day indicator result at 19th May was 75.2% and this represents a steady improvement towards the target of 85% by 1 July 2016. The 31 day indicator result has also improved to 88.5%. Nationally reported results for Quarter 3 show 75.1% for 62 day indicator and 83.5% for 31 day indicator. There is continuous effort and a range of targeted activities being directed to further improve these indicator results within each tumour stream.

2.2 Auckland DHB 2015/16 Surgical Health Target

ADHB achieved 98.3% compliance with the Surgical Health Target, for Quarter 3 compared to 96.8% at the end of Quarter 2 based on nationally reported data. The ADHB provider is working to a service specific recovery plan however there are ongoing challenges for the provider to achieve this plan as a result of physical operating room capacity, and financial resource constraints. The DHB is expected to achieve the health target by 30 June 2016.

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 shortfall in the Midland DHB IDF funding arrangements for Eating Disorder services in 15/16 (and 16/17) remains unresolved and the matter has been escalated to the Northern region CEO/CMO forum. The lead Northern region CEO for Mental Health, Dr Dale Bramley, will take up the 15/16 and 16/17 funding issues with the Midland lead CEO for Mental Health prior to any further escalation to the Ministry of Health.

2.4 2016/17 IDF arrangements

Final advice from the Ministry of Health regarding IDF and national service funding arrangements has now been received. The Child and Family Unit IDF arrangements have been agreed between Northern and Midland region funders without an agreement to wash up. The forecast net shortfall in the funding in 16/17 of the supra-regional EDS service is $200K (attributable to Midland DHBs) and this matter will be included for resolution in the CEO to CEO discussion highlighted above. The Director Funding is working with the Director of Provider services to establish an Ophthalmology service improvement plan that will be funded by the ADHB and Waitemata DHB funder. The service improvement plan deliverables will be clearly linked to an agreement to fund service delivery above the 2016/17 volume plan for the Waitemata population.

2.5 2016/17 ADHB funder/ADHB provider arrangements

The ADHB provider volumes and non-volume arrangements for the ADHB population has been finalised and the value of the revenue allocated to the provider by the ADHB funder exceeds the total value of the volume and non-volume arrangements. The DHB received advice from the

Ministry in the last week of May regarding the Elective surgical health target volume expectations for 2016/17 and this advice included confirmation of the additional funding available to the DHB to achieve the required volume uplift. The funder has been working with the ADHB Directors and production planning team to assess the population demand to inform the development of the 2016/17 population plan. The final plan is due to the Ministry by 1 July 2016. Work continues with the provider teams to identify how much of the required population plan can be provided by the ADHB provider and all volumes allocated to the provider will be paid at national price. Within the next two weeks the funder will initiate discussions with other providers as necessary to secure additional capacity to ensure the required Health Target uplift is achieved monthly from July 2016.

2.6 Tertiary services review

The service specific analysis for all Starship clinical services is complete and the final Child Health report is due within the next week. Work is underway presently to finalise internal and external stakeholder consultation and communication processes.

2.7 Policy Priority areas

Colonoscopy Indicators
The nationally reported results for waiting time indicators for colonoscopy for Quarter 3 show that ADHB did not meet the target for routine colonoscopy with 56.4% of patients waiting less than 42 days for their procedure against a target of 65%. This is a recent deterioration as the service has previously consistently achieved in excess of 60% compliance with this indicator. Changes in service leadership, SMO vacancies and facility renovations are all contributing to the reduced performance. The service reports measures are in place to meet the indicators while transitioning the service to new facility capacity by June 2016. ADHB is expected to achieve all three indicators consistently for Quarter 4, and access the additional $233K funding from MOH.

Radiology Indicators
ADHB has not met the outpatient CT indicator for April, achieving 91% against the target of 95%, however the service is on track to reach compliance by the end of May.

There has been a small improvement in performance for the outpatient MRI indicator to 58% (57% last month) against the target of 85% however the waiting times for children is worse than for adults with only 50% of children receiving their MRI within six weeks. There are longstanding issues relating to the provision of anaesthesia services for children and 80% of children waiting more than six weeks are those requiring General Anaesthetic (GA). The Director of Clinical Support Services is overseeing the development of a plan to sustainably address the anaesthetic capacity issue.

The outpatient ultrasound indicator performance has dropped from 86% reported last month to 81%, against a DHB target of 95%.

Waiting Time Targets
At the end of April, 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 capacity pressures remain in Orthopaedics, including spinal services, and Paediatric (general) Surgery and other paediatric surgical sub specialties.

Bone Marrow Waiting Times
At the time of this report there were two patients waiting longer than the clinically recommended 6 weeks maximum waiting time guideline. Developments are underway to trial outpatient BMT delivery which is expected to improve performance and reduce waiting times without requiring additional inpatient bed capacity.

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 occurring with reduced elective operating out of hours and a reduction in cancellation rates. Over recent weeks the demand for transplant services has reduced. A National Services Governance Group has been established, with the Director of Funding and Director Provider services ADHB members of this group and it is expected that this group will provide the opportunity to review the current mechanisms of funding for national services.

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 and there is agreement that new service arrangements will be implemented from July 2017 subject to the required business case process. The Directors of Provider services for ADHB and CMDHB have also met to agree a regional approach to improving performance in the management of regional Urology services.

3. Primary Care

3.1 Community Pharmacy

The 20 District Health Boards have completed the consultation with community pharmacy contact holders and the wider pharmacy sector on pharmaceutical margins and subsidised unregistered medicines (section 26 & 29). The consultation was based on work undertaken by the Pharmaceutical Margin Taskforce. This Taskforce had representation from the community pharmacy sector, the Ministry, PHARMAC and DHBs. The majority of respondents did not accept that the proposed model was suitable. Consequently the DHBs are required to consider the options in light of this feedback. Further work is underway on alternatives.

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 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).

Following discussions at the Alliance Leadership Team it has been agreed that wherever possible and practical a common approach will be agreed with Counties Manukau Health Alliance Leadership Team. This reflects the commonality of PHOs and the need to ensure their focus is as consistent as possible.

3.3 Hospice Innovation Funding

The three metro Auckland DHBs, the Ministry of Health, Hospice New Zealand and the six hospices in the region have meet to consider allocation and use of national innovation funds. In the 2015 Budget funds were made available to Hospices to implement innovative service improvement opportunities. Proposals were sent, by the Hospices, to Hospice New Zealand who assessed their appropriateness for funding. The proposals from the Hospices in the Northern Region were ambitious in scope. Hence the MoH and Hospice New Zealand wished to discuss these in detail to agree on a process to refine to ensure the scopes are achievable and align with the available budget. Further work is now underway to refine the proposals so that the funds can be released.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

The Director General's Reference Group Report 'Towards Better Home and Community Support Services for all New Zealanders' has been released. There are 15 recommendations in the report that stem from two working groups set up to provide advice to the Reference Group covering:

- a review of home and community support services (workstream 1)
- the impact and affordability of transitioning to a regularised workforce (workstream 2)

The majority of recommendations are likely to be agreed to however there are some fundamental issues that have not been agreed including a move to a national agreement.

Monitoring Inbetween Travel (IBT) claims is ongoing and it is yet to be determined if any party (support workers, HCSS providers, DHB) is going to be financially disadvantaged through this process. Exceptional travel was implemented when IBT was devolved to DHBs to manage on 29 February 2016; exceptional travel applies to any distance over 15 km. Payment for exceptional travel claims are based on actual time taken and actual distance travelled as opposed to the flat band rate used for journeys less than 15 km. We are noting from our IBT claim reports to date that support workers may live a significant distance from their first appointment of the day and travel times in Auckland can sometimes be lengthy, which is likely to be due to traffic congestion.

4.2 Aged Residential Care (ARC)

The Quality and Monitoring Managers for ARC have been in place for nearly year. In this time the roles have evolved and there is now a comprehensive and consistent process for monitoring issues in ARC including section 31 notifications, complaints and risk pros. This work occurs in conjunction with managing corrective actions identified through the audit process. There have been 30 audits undertaken in ADHB ARC facilities since the 1 July 2015.

5. Women, Children & Youth

5.1 Immunisation Health Target

Our current coverage for all infants fully immunised at 8 months of age is 94% Total, 90% Maori, 96% Pacific, 97% Asian, 90% Other.

It will prove difficult to achieve the immunisation health target this quarter. A range of additional initiatives have been identified and are being progressed to support achievement of the health target. These include targeted education for LMCs/Pregnancy and Parenting providers and GPs/Practices that have high decline rates. Other strategies targeting communicating with families and whanau are being progressed, including leveraging off measles outbreaks in the Waikato. In essence, we will be looking at having vaccine conversations earlier (during pregnancy) and at making access to pregnancy vaccines easier where possible. We will be continuing our strong programme of work around primary care processes and systems supported by an effective population information system and outreach services for those that need extra support to access a timely childhood vaccination programme.

5.2 Rheumatic Fever and Housing

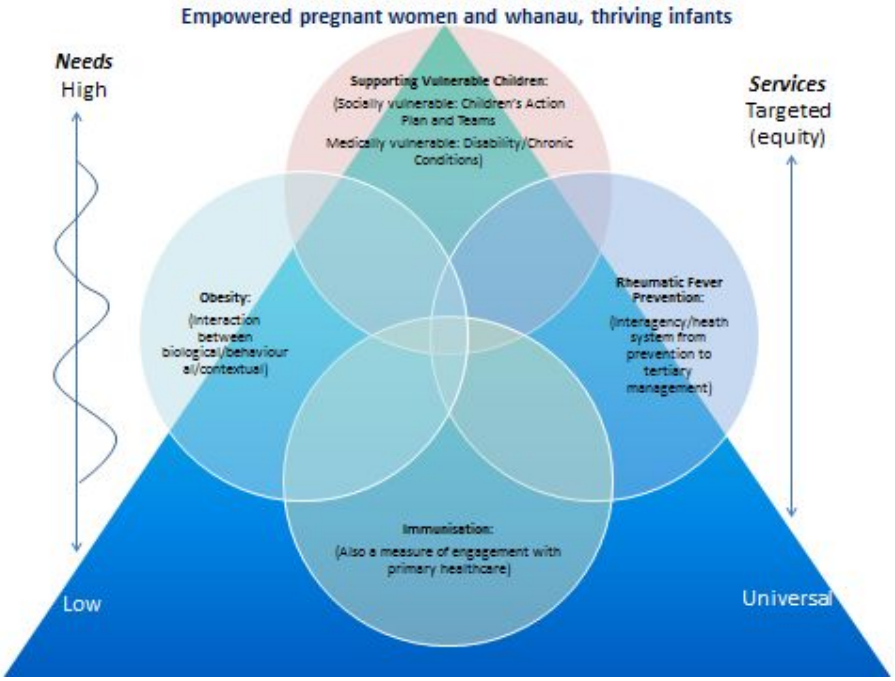
A co-design process regarding accessing warm, dry housing has been led by the Southern Initiative. With CMDHB, we have been working to understand how better we could deliver improvements to children at risk of rheumatic heart disease, in relation to housing. We have met with the Ministry of Health regarding our current programme, delivered through the Auckland Wide Healthy Housing Initiative (AWHI). Improvements to programme design as well as supply side responses have been identified. We would like to acknowledge the active contribution to this co-design process of community members, NGO, health staff and land-lord representatives. We are awaiting further information from the Ministry regarding housing following the Budget.

5.3 Childhood Obesity

The Ministry of Health met with DHBs regarding their expectations in relation to the obesity health target. There is still a lack of strong evidence regarding effective interventions in this area but the Ministry are happy to work with DHBs to unlock this information over time. A number of evaluations are underway in New Zealand which we are continuing to watch with interest. The Ministry were positive regarding our progress to date and our regional approach in relation to a childhood obesity pathway. They were clear that part of the pathway needs to include referral to a general practitioner.

5.4 Other child health

We continue our strategic focus within child health on pregnancy and the first year of life. There remains much work to do but we remain committed to proportionate universalism, as discussed with CPHAC in September 2014 (*Changing the Landscape of Childhood Vulnerability: An Inter-Agency and Community Challenge*). In addition we have four government priorities: supporting vulnerable children, rheumatic fever, immunisation and child obesity. It should be recognised that families move in and out of vulnerability so we need engagement and systems to help us identify when a family might need more support. We also need service design that allows us to deliver services to the majority most efficiently to free up resources for those that need more support (proportionate universalism). The design of our health system, including funding models, does not always facilitate this approach most effectively. This approach is shown graphically in the diagram below where the triangle in the background represents our universal services – such as maternity care for all pregnant women and Well Child Tamariki Ora services for all children and the joined circles the additional priorities overlaid on this.



In May, the inter-sectoral Child Health Stakeholder Advisory Group (CHSAG), chaired by Dr Alison Leversha, met to discuss the implications of changes proposed to Child, Youth and Family. This is expected to have some significant implications for services provided by health, particularly in relation to expectations regarding provision of universal services.
Finally, we are progressing a regional business case for the National Child Health Information Platform (NCHIP). As with the National Immunisation Register (NIR), a single shared record that shows whether or not a child has received all the core checks and services (such as new born hearing screening, immunisations, oral health and well child checks) will help us better identify children who need more support to access health care and improve our ability to stay connected with those families.

5.5 Youth

We submitted a paper to the Audit and Finance Committee regarding contracting processes. Amongst a number of other agreements, the Committee endorsed extending the contract with Procare on behalf of the Youth Alliance subject to all the PHOs agreeing to continue with the existing arrangement. The PHOs passed a resolution endorsing this approach at the Youth Service Alliance Leadership Team (YSALT) meeting on 25 May 2016.

5.6 Women

In May, we launched the pregnancy and parenting website and app commissioned by the Funder jointly with CMDHB. This was obtained from the University of Auckland jointly. The purpose of the website and app is to provide a source of evidence based information as an adjunct to information provided by more traditional face to face health professional interactions.

5.7 Oral Health

The recent review of the Auckland and Waitemata Emergency dental services for low income adults, identified a need to increase the geographical reach of the service and improve equity of access. The Boards approved entering a competitive procurement process. The Request for Proposals (RFP) was issued on 12th May 2016 with a closing date of 17 June 2016. The RFP was posted on the Government Electronic Tenders Service (GETS) website and promoted to dentists via the NZ Dental Association.

We are seeking to ensure access to low income adults living in areas of high deprivation such as Tamaki, Mt Roskill, Wesley, Avondale, Waiheke, Great Barrier Island, Henderson, Ranui, Central City, Otahuhu, Wellsford and Helensville. These are services that are required for the immediate relief of pain and infections only for low income adults aged 18 years and older who hold a valid community services card. Interest in providing services appears to be strong.

6 Mental Health and Addictions

6.1 Auckland and Waitemata DHB's Mental Health and Addictions Employment Strategy - Everyone's Business

From 1 July 2014 Auckland and Waitemata DHB NGO providers have reported service user employment status upon entering an NGO service and then by each quarter until they exit the service. The key outcomes of the Q1, Q2 and Q3 2015/16 period are:

- 35 (3.7%) of 957 people gained paid employment during their stay in supported Housing and Recovery Services after being unemployed at entry; and
- An additional 72 people (90%) maintained their paid employment status on entry through to exit from supported housing and accommodation services.

The number of people failing to gain employment or supported to maintain employment while accessing NGO Housing and Recovery services is a significant issue and is the burning platform for establishment of the "Everyone's Business" strategy. This is the mental health and employment strategy for Auckland and Waitematā DHBs, that has set a target of at least 50% of people exiting from specialist mental health and addictions services will be in employment by 2020.

The two current actions being implemented from the strategy are:

1. DHB provider arm services will begin to report service users' employment status and
2. NGO providers will establish Employment Specialist roles.

From 1 July 2016 DHB provider services are required to report employment status at entry and exit to the service within the Programme for the Integration of Mental Health Data (PRIMHD). It is anticipated that usable DHB provider arm data will be available during Q2 2016/17. Discussions are underway with NGO providers to develop employment focused/specialist employment roles within existing Support- Hour- based services. Currently two providers, namely Equip and West Auckland Living Skills and Housing (WALSH) Trust, are developing these roles within their services. In addition discussions are underway with Te Pou and Career Force to identify and establish training and on-going support of these roles as they are being developed within NGO sector to improve their success in achieving the 2020 strategy.

6.2 Auckland and Waitemata DHB's Mental Health and Addictions Social Outcomes Indicators development

The social outcome indicators work undertaken by Auckland and Waitemata DHB NGOs continues to focus on measuring changes in employment status, and has included housing status for 2016/17.

Housing status compares a person's housing (based upon Statistics NZ definitions) status when they enter service to when they exit. The key outcomes of the combined Q1, Q2 and Q3 2015/16 period are:

- 943 (87%) of the 1024 people are discharged from NGO supported Housing and Recovery services into independent accommodation.
- 31 (77.5%) of the 40 people who are categorised as homeless on entry to NGO supported Housing and Recovery services are still homeless on discharge.

There are some limitations with Statistics NZ definition of Homelessness, as it is defined as living situations where people with no other options to acquire safe and secure housing: are without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing. The homeless data includes for example people who have recently separated from partners and are living with other whanau as an interim measure or adults who have returned to live with parents/whanau to access natural supports due to onset of mental illness episode. A current project is in place within the NGO sector to expand the data about "homeless" accommodation in order to understand this state and then identify evidence based interventions based upon this analysis.

The majority of people exiting NGO services will be discharged to independent accommodation. Currently both the Auckland DHB Innovate group and the Waitematā Provider Executive Group (PEG) have dedicated accommodation workstreams with key focus areas to establish DHB provider arm reporting and to develop housing facilitation roles within NGO providers. Service Users' accommodation status (from both DHB Provider Arm and NGO Services) will be a PRIMHD reporting requirement from 1 July 2016. Discussions are underway with NGO providers to develop dedicated housing facilitation roles within existing Support Hours based services. One provider (that is Equip) has established this role already.

6.3 Auckland DHB's Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot has linked three NGOs with two GP practices and is preparing to link a third GP practice.

The pilot working group is currently focused on the development of primary care/NGO integration in further ADHB localities. The development of further localities will be based on the learning's from the pilot, with an example of this is providing some dedicated NGO resource (taken from existing Support Hours services) during the developmental phase into any new locality.

7. Maori Health Gain

7.1 Healthy Babies Healthy Futures

The Healthy Babies Healthy Futures (HBHF) Programme is focused on preventing maternal and child obesity for four ethnic populations in the Waitemata and Auckland District Health Board regions through improved nutrition and increased physical activity. The implementation structure is partnership and community-based, and supports innovation and integration. Four ethnic-specific service providers deliver health promotion and education initiatives to their respective communities (Māori, Pacific, Asian and South Asian), while The University of Auckland National Institute of Health Innovation (NIHI) delivers a supporting text messaging service to the same populations. For the current financial year the programme has delivered the following results:

TEXTMATCH ENROLMENTS:

	YTD	TARGET
Māori	**193**	**250**
Pacific	**214**	**250**
Asian	**303**	**250**
South Asian	**241**	**250**
Total	**951**	**1000**

GROUPS DELIVERED:

	YTD	TARGET
Māori	**8**	**6**
Pacific	**5**	**6**
Asian	**7**	**6**
South Asian	**4**	**6**
Total	**26**	**24**

MOTHERS COMPLETED:

	YTD	TARGET
Māori	**54**	**90**
Pacific	**88**	**90**
Asian	**81**	**75**
South Asian	**41**	**60**
Total	**223**	**315**

Recently the Ministry of Health confirmed that the Programme will continue to be funded for another two-year period based on the work completed and the direction HBHF is heading given the new service improvements to be implemented. An external evaluation is being conducted with the final report expected in October 2016.

7.2 Cancer evaluation Māori and Pacific Faster Cancer Treatment pilot ADHB 14/15

The Māori Health Team are working with the Auckland Cancer and Blood Service to evaluate the Māori and Pacific Faster Cancer Treatment Pilot. The Pilot was undertaken in 14/15 was funded by the Ministry of Health to support Faster Cancer Treatment through a contract with the Northern Regional Alliance Cancer Network. The intent of the Pilot was to deliver a Māori & Pacific cancer navigation based services to improve timeliness of access, reduce DNA's and improve health literacy. We will evaluate the impact for Māori and Pacific patients of the pilot and take the opportunity to problem solve and inform actions for future service improvement and investment. The navigator evaluation interviews are underway and will be completed by June 30.

7.3 Māori Alliance Leadership Team - MALT

The Maori Alliance Leadership Team (MALT) governs the implementation of the Auckland and Waitemata DHB Maori Workforce Development Strategy. The first meeting was held in February 2016, the main focus for the group was to review the target in the strategy and determine a revised target utilising the working age population. The activities completed are development of a standardised Auckland and Waitemata data dashboard for regular reporting, updating of the strategy with an additional section focused on "Keeping People" which focuses on retention of staff, a revised target reflecting the working age population and priorities for action 16/17. The next meeting is scheduled for 10 June.

7.4 Māori Health Plan

We have received the initial feedback from the Ministry of Health for the draft 16/17 Waitemata District Health Board Māori Health Plan. The Ministry have approved seven of the twelve indicator areas with the remaining five areas receiving tentative approval and requiring only minor changes to be acceptable. We are making the required changes in consultation with our MoU partners, Māori providers, PHOs and internal stakeholders. The Māori Health Gain Advisory Committee will also be provided with an opportunity to provide input to the updated activities.

8. Pacific Health Gain

The implementation of Pacific Health Action Plan (PHAP) is on target for Priorities 1 – 5.

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

One *Living Without Violence* programme is being implemented in a Samoan congregation in Westmere. The next training of *Living Without Violence* facilitators will be held on 10th and 11th June in the Onehunga area and about 40 people have registered to participate.

One *Incredible Years (IY) parenting* programme is currently being implemented in the Tongan Methodist Church in Ponsonby. *Incredible Years* and *Positive Parenting Programme* (Triple P) are two parenting programmes that are endorsed by the Ministry of Health (MOH) and Ministry of Education. Triple P is an eight week programme as compared to the 14 week IY programme. MOH contracts Waipareira Trust to train Triple P facilitators and we are in negotiation with Waipareira to train Pacific facilitators. Community feedback also supports the 8 week programme. We will be able to deliver more programmes with the current funding allocation.

Two consultation meetings have been held regarding oral health of Pacific children and two more will be held. This will feed into the Pacific Oral Health Strategy being developed by the Auckland Regional Dental Health Service.

8.2 PHAP Priority 2 –Pacific People are smoke-free

The Pacific Quit Smoke Service provided by Auckland Regional Public Health Service (ARPHS) will cease as of 30 June 2016. The new provider/s of quit smoke services have not been formally announced but we are holding informal talks with a Pacific provider that is part of negotiations with the Ministry of Health as to furthering that ethnic specific quit smoke approach with Cook Is women, Tongan men and Samoan people, as the Pacific ethnic groups with the highest smoking rates.

We met with Dr Robyn Whittaker from National Institute of Health Innovation (NIHI), and West Fono Health Trust regarding a text messaging quit smoke support service in the Samoan language, that NIHI has developed with the Ministry of Health, Western Samoa. We will work with the new quit smoke provider to explore whether this will be a useful tool in the new quit smoke service and whether this could be developed in other Pacific languages.

8.3 Priority 3 – Pacific people are active and eat healthy

We have initiated discussions with Pacific researchers, Pacific Heartbeat (National Heart Foundation), Pacific primary care providers, the Pacific Health Action Plan Working Group, in the process of identifying a specific Pacific response to childhood obesity. The appointment of Dr Corina Grey, a public health physician to work with the Pacific team will ensure that all Pacific specific interventions will be designed in a way that will enable data to be collected so that evaluation can be undertaken. Although there are no new resources currently, we can re- focus the HAVZ and Enua Ola programme to focus on the nutrition and physical activity needs of children and young people.

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

The *Fanau Ola* Integrated Services contract that ADHB has with AH+ PHO has provided its Q3 2015/16 report. The number of families enrolled with the service continue to increase, so whilst the contract requires the services to work with 322 families in a period of a year, the total number of families with the service as of end of Q3 is 458. We are continuing to work with AH+ to identify the number of hours that are going into individuals and family members and outcomes that are being achieved. This analysis is not at a point that will enable us to determine a funding level different from the current, so we have agreed with AH+ to renew the current contract with the same volumes and funding for another six months whilst we continue with the analysis.

The translation of the Stanford Chronic Disease Self Management Education Programme Leader's Manual into Samoan is now complete and was sent to Stanford University, California at the beginning of this month. The Manual will be launched on 3rd June. Three Samoan self management programmes are currently delivered in the communities through Alliance Health+. Most of the participants are people with long term conditions and carers of people with long term conditions. A 4-day Leader's Training for Samoan SME facilitators is currently being delivered for 8 community lay facilitators.

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

The Pacific GM for Hospital Services reports on this priority.

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

We maintain a relationship with Ministry of Business, Innovation and Employment.

At a meeting with Tamaki Regeneration Company (TRC), it said that its connection to the Tongan community could be stronger. We assisted to organise a meeting between leaders of the Tongan community and Tamaki Housing, the social housing arm of TRC. The General Manager of Tamaki Housing was able to answer many questions from the community that clarified a lot of issues for them. Subsequently, the Tongan leaders decided that it is important that they have a structure that will enable them to communicate with Tamaki Housing and the TRC in an ongoing manner, and we provide some support to enable this to happen.

8.7 General

New Pacific Health Action Plan
We have established a working group to guide the development of the new Pacific Health Action Plan, from July 2016 onwards. Six community people are part of the group as well as Procare, AH+ and Pacific provider representatives. The Working Group has confirmed the goals of the current Plan to continue, but with a renewed emphasis on child health and childhood obesity. They would also like to consider further responses to mental health and addictions as well as health of older people. We will continue to work on developing a draft plan which we will consult on, both in the community and within the DHB.

***Safe Talk* Workshop**
A *Safe Talk* workshop was held for Pacific people at Tamaki College, Glen Innes. 35 people attended, most from the Glen Innes, Panmure and Orakei areas. This is one of the workshops delivered as part of the implementation of the DHB's suicide prevention strategy. The workshop was well received and generated good discussions. We are confident that if other workshops are offered, they will also be well attended.

9. Asian, Migrant and Refugee Health Gain

Key projects driving efforts towards the goal of increasing health gain in targeted Asian, migrant and/or refugee populations where health inequalities impact on their health status in the Auckland DHB are:

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

Asian International Benchmarking Report to be completed by end June 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.

9.2 Increase Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a Primary Health Organisation (PHO) to meet 76% (ADHB) targets by 30 June, 2016 (current rates 74% (ADHB) as at April, 2016)

- The Auckland DHB rate has remained the same at 74% between the two quarters, however due to record net migration there were still 1,175 new enrolments.

- 'Where should you go for Healthcare?' campaign will be rolled out in June tailored to promote culturally appropriate messaging about enrolling with a family doctor and the benefits of it to students and new migrants living in the Auckland City Centre and inner city suburbs.

9.3 Indicator: Reducing acute flow to Auckland City Hospital's Emergency Department (ED)

A suite of interventions to increase awareness of the health & disability system includes: video podcasts (English, Mandarin (completed and promoted), and Hindi (completed), settlement information sessions to migrants and the workforce, targeted library engagement, information and links to videos added to Immigration NZ's- NZ Now healthcare page. A link to your local doctor website posted on the Immigration NZ's- NZ Now Facebook page and added to the calendar for future posts as well. It will also feature in two of the main publications, SETTLEMENT ACTIONZ and LINKZ. 2), social media Facebook page for the INAKL International Student Network, and presentation at the Auckland International Education Conference (6/7).

9.4 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 have been reviewed for the 2016-17 financial year. 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:

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

AUCKLAND DHB 2017 Board and Committee Meeting Schedule

Recommendation:

1. That the Board approves the attached meeting schedule for 2017, with meetings scheduled on a six weekly meeting cycle as follows:

1.1 The Auckland DHB Board, Audit and Finance Committee and Hospital Advisory Committee meetings schedule follows the current basis for meetings to be on a six weekly meeting cycle.

1.2 The combined Auckland DHB and Waitemata DHB Disability Support Advisory Committee and the Maori Health Gain Advisory Committee continue to meet four times per year on a six weekly meeting cycle.

1.3 That the combined Auckland and Waitemata DHB Community and Public Health Advisory Committees will meet four times per year on a six weekly meeting cycle, bringing the Committee into alignment with the combined Auckland DHB and Waitemata DHB Disability Support Advisory Committees and the Maori Health Gain Advisory Committees meeting schedule.

2 That the Board approve an amendment to the Terms of Reference for the combined Auckland and Waitemata DHB Community and Public Health Advisory Committees to meet in a combined forum four times per year, as noted in recommendation 1.3 above.

Prepared by: Marlene Skelton (Corporate Business Manager)
Endorsed by: Dr Lester Levy (Chairman)

Note: the proposed Schedule is also being referred to the Waitemata DHB Board on 29th June for approval.

Glossary

ADHB - Auckland District Health Board
CPHAC - Community and Public Health Advisory Committee
DSAC - Disability Support Advisory Committee
MHGAC - Manawa Ora (Maori Health Gain Advisory Committee)
WDHB - Waitemata District Health Board

1. Summary

It is proposed that the 2017 Board, Audit and Finance Committee and Hospital Advisory Committee meetings schedule follows the current basis for meetings to be on a six weekly meeting cycle.

It is proposed that there be a change to the frequency of the combined Auckland DHB and Waitemata DHB Community and Public Health Advisory Committees (CPHAC) meeting and that it be held four times per year. This will allow the Committee to better optimise its use of time and align the schedule with the current combined Auckland DHB and Waitemata DHB DSAC and MHGAC meetings. These Committee meetings will continue to operate on a collaborative basis with Waitemata DHB within the six weekly meeting cycle.

The proposed six weekly meeting cycle for 2017 follows below and the attached 2017 meeting schedule (attachment 1) designates the dates for each Board and Committee meeting and is coordinated with Waitemata DHB's cycle. The schedule allows for the week four meeting day to be

dedicated to the Board meeting only (including the Auckland DHB Human Resources Sub-Committee and the Auckland DHB and Waitemata DHB Collaboration Committee on week five).

Regular health and safety site visits will also be held on weeks three and six following any combined Committee meetings scheduled, timing and dates of the visits will be coordinated by the Board Secretaries at both Auckland DHB and Waitemata DHB. In addition, Board members will be allocated lead roles in specific critical areas of activity: patient safety, patient experience, finance/budgets, health and safety, IT/innovation, facilities/equipment, primary care/NGOs/community care, care of elderly, mental health and risk. Board members will need to spend time on and develop particular knowledge around their lead role area.

The proposed cycle for 2017 follows the pattern (all meetings on Wednesdays):

Current	**Proposed**
Week 1 – ADHB Audit and Finance and DiSAC or Manawa Ora	**Week 1** – ADHB Audit and Finance and ADHB Hospital Advisory Committee
Week 2 – WDHB Audit and Finance and CPHAC	**Week 2** – WDHB Audit and Finance and Hospital Advisory Committee
Week 3 – may be used at times for special meetings, workshops and the like	**Week 3** – Manawa Ora/CPHAC and DiSAC (alternating) followed by a Health and Safety site visit ***
Week 4 – ADHB HAC and ADHB Board	**Week 4** – ADHB Board*
Week 5 – WDHB HAC and WDHB Board	**Week 5** – WDHB Board**
Week 6 – may be used at times for special meetings, workshops and the like	**Week 6** – Health and Safety site visit (may also be used at times for special meetings, workshops and the like) ***

** The ADHB Board HR Sub-Committee will continue to be held on the ADHB Board meeting day*
*** The ADHB and WDHB Collaboration Committee will continue to be held on the WDHB Board meeting day.*
**** Time can be assigned to lead roles on these days (weeks 3 and 6)*

The only variation to this is in December, because week 5 falls on Wednesday 20th December, it is proposed to hold the WDHB Board meeting on Thursday 14th December 2017.

The proposed cycle for the two Boards for 2017 commences on 01st February and concludes on 15th December.

Once both Boards have confirmed the schedule, a final schedule showing venues will be distributed to Board and Committee members, staff and interested parties and included on the DHB's website.

Note: Elections 2016

Elections are due on Saturday 8th October 2016, with newly elected members coming into office on 5th December 2016. This means that (in addition to induction sessions) both ADHB and WDHB newly elected members will have one Board and HAC meeting day prior to the end of the calendar year.

Proposed 2017 Auckland DHB Meeting Schedule

Six weekly meeting cycle: Week 1: ADHB Audit and Finance and HAC; **Week 2:** WDHB Audit and Finance Committee and HAC; **Week 3:** MHAC or CPHAC and DiSAC*; **Week 4:** ADHB Board; **Week 5:** WDHB Board; **Week 6:** no regular scheduled meeting*

* Health and safety site visits will be schedule on weeks 3 and/or 6

COMMITTEE	TIME	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
Audit and Finance Committee	8.30am		**01/02**	**15/03**	**26/04**		**07/06**	**19/07**	**30/08**		**11/10**	**22/11**	
Hospital Advisory Committee	1.30pm		**01/02**	**15/03**	**26/04**		**07/06**	**19/07**	**30/08**		**11/10**	**22/11**	
Maori Health Gain Advisory Committee (Manawa Ora) (MHGAC)	10.00am		**15/02**			**10/05**			**02/08**		**25/10**		
Community and Public Health Advisory Committee (CPHAC)	10.00am			**29/03**			**21/06**			**13/09**			**06/12**
Disability Support Advisory Committee (DSAC)	1.30pm			**29/03**			**21/06**			**13/09**			**06/12**
Week 3: Health and Safety site visits	*tba*		*15/02*	*29/03*		*10/05*	*21/06*		*02/08*	*13/09*	*25/10*		*06/12*
BOARD **Board Only Time** **Board meeting *open following by confidential*** **Board HR Sub-Committee**	 9am 9.45am tba		22/02		05/04	17/05	28/6		09/08	20/09		01/11	13/12
Week 6:Health and Safety site visits				*08/03*	*19/04*	*31/05*		*12/07*	*23/08*		*04/10*	*15/11*	*n/a*

10.1

Waiheke Island Health Services
Summarised Results

June 2016

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Purpose of Health Services Review

Auckland DHB has recently completed a review of Waiheke healthcare services to ensure:

- people have access to good quality health services regardless of their income
- current health services meet the needs of Waiheke Island residents and visitors
- we make it easy for people to get appropriate health services
- health services are coordinated and connected with each other
- we can plan for future health needs of Waiheke Island residents and visitors
- services meet the needs of seasonal changes and likely population growth

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Health Services on Waiheke Island

How are we doing?

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What do People want from Waiheke Islands Health Services….

Range of expectations from ***"We live on an Island, what can we expect, if we can't get it here, we can go to Auckland"*** to ***"We need a hospital"***

However, on the whole people were looking for services that are;

- Affordable
- Able to see a Doctor when they need it
- Locally based as much as possible
- Co-ordinated
- Good communication
- Friendly
- Trustworthy – competent and confidential

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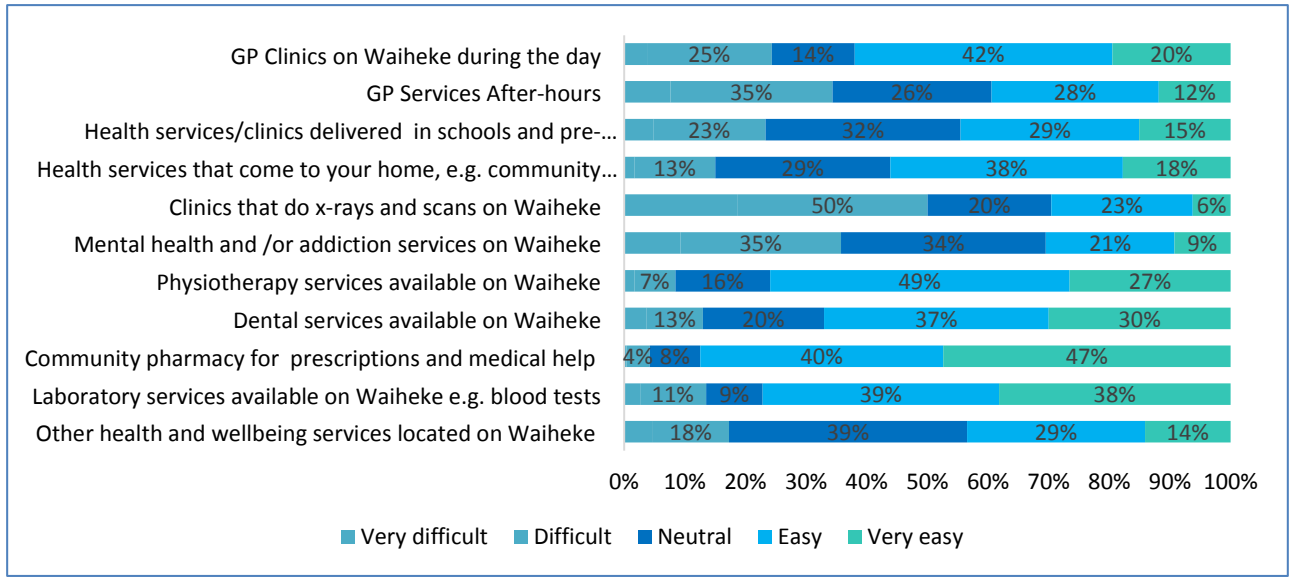
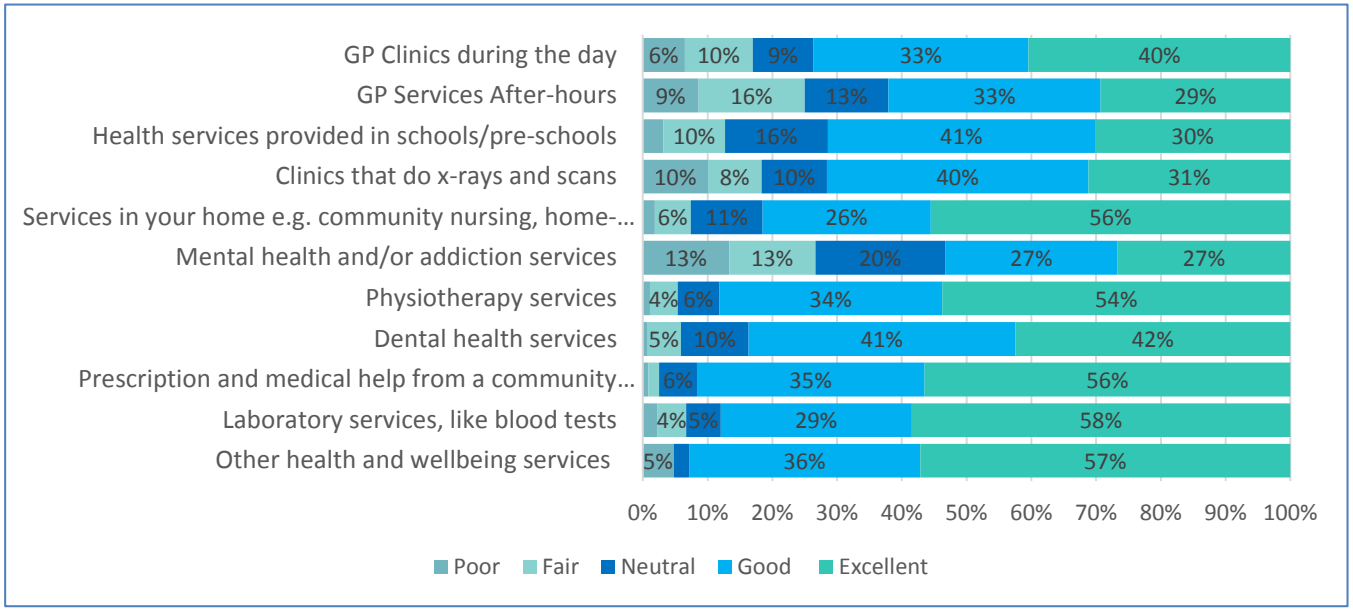
Peoples Thoughts on How Easy is it to get Healthcare on Waiheke Island



Community Pharmacy, GP services during the day and community health services such as home help, dental services and laboratory services were seen as relatively easy to get on Waiheke Island. GP services after-hours and mental health and addiction services were seen as more difficult to access.

Peoples Thoughts on Quality of the Health Services used on Waiheke Island



The above graph shows that people feel that, on the whole, they have access to high quality health services on Waiheke Island. Areas for improvement were identified as mental health and addiction services and GP After-hours Services.

What Services are Working Well on Waiheke?

What Health Services are Working Well on Waiheke?

General Practice

"Local GPs often go extra mile even when under-staffed"

Community services

"support and willingness to go the extra mile"

- Accessible
- Comprehensive
- Helpful
- Home help service enables people to stay on the Island and in their own homes

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Other Services that are Working Well on Waiheke

- Emergency support from St Johns and Air Ambulance Service excellent
- Pharmacy – excellent services and extended hours are good
- Laboratory Services – excellent service but hours not long enough
- Physiotherapy – but charges need to be the same as what we would pay if we lived in other parts of Auckland
- Access to school dental nurse works well
- Midwifery services are good – but perception is they are currently at capacity

Perceived Gaps in Health Services

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Service Gaps

- After-hours hours too short and expensive
- No Accident and Emergency facility on the Island
- Better access to radiology services including ultrasound on the Island
- Improved access to mental health and addiction services on the Island – particularly respite and crisis services
- Hospice services on Island - respite services

Service Gaps Contd.

- Facility for minor surgery/short stay beds/childbirth

"A good medical centre would be great as it could provide overnight stays for minor things."

"Day night monitoring beds for patients when their condition is still being assessed to prevent needless expense and waste of time …tripping to hospital"

- More outpatient services delivered on Island

"We need more clinics on the Island to save so much travelling"

- More affordable dental care

"Dentists are out of a lot of people's reach"

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Service Gaps Contd.

- Rest-home and respite facilities for older adults

  "The largest gap is for the long term elderly residents who need to be in a rest home/private hospital care. It is sad to witness the elderly travelling to Auckland suburbs via public transport to visit their wife/husband/partner"

- Better access to services to support vulnerable children and youth

  "Disabled children are marginalised due to difficulty with transport/access off Island and lack of resources"

- Optometry services on the Island
- More podiatry services on the Island

Outcomes

- Venesection kits are now being funded and supplied by DHB to General Practices on Waiheke
- A Waiheke Radiology Service review has also been completed, with the transfer of decommissioned Auckland DHB radiology equipment currently being organised
- A review of General Practice ‘Under 13 years’ fees is underway
- Other initiatives will be driven through the Auckland Waitemata Rural Alliance

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Who did we hear from?

- An on-line survey was undertaken as part of the Waiheke Health Service Review - 312 people completed the survey
- Information was also collected through provider meetings and stakeholder interviews
  - 22 individual interviews
  - Six group interviews
  - Six paired interviews