Open Board Meeting

Wednesday, 3 August 2016

09:45am

Note:

- **Public Excluded Session 9:45 am to 12 noon**
- **Open Meeting from 12:45pm**

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

Healthy communities | World-class healthcare | Achieved together
Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

Published 28 July 2016

Agenda
Meeting of the Board
03 August 2016

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

Time: 9:45am

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

Apologies Members:

Apologies Staff: Fiona Michel

Karakia

Agenda

Please note that agenda times are estimates only

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

2. **RESOLUTION TO EXCLUDE THE PUBLIC**

12.45pm **3.** **REGISTER OF INTEREST AND CONFLICTS OF INTEREST**

Does any member have an interest they have not previously disclosed?

Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

	4.	**CONFIRMATION OF MINUTES 22 JUNE 2016**
12.50pm	**5.**	**ACTION POINTS 22 JUNE 2016**
12.55pm	**6.**	**CHIEF EXECUTIVE'S REPORT**
1:10pm	**7.**	**COMMITTEE REPORTS**
		Disability Support Advisory Committee
	7.1	Collection of Data for Patients with Disabilities
1:20pm	**8.**	**PERFORMANCE REPORTS**
	8.1	Financial Performance Report
	8.2	Funder Performance Report
1:40pm	**9.**	**DECISION REPORTS**
	9.1	Directorships - healthAlliance
	10.	**DISCUSSION PAPERS - NIL**
1:45pm	**11.**	**GENERAL BUSINESS**

Next Meeting:	Wednesday, 07 September 2016 at 9:45am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

Healthy communities | World-class healthcare | Achieved together

Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

Attendance at Board Meetings

Members	17 Feb. 16	30 March.16	11 May. 16	22 Jun. 16	03 Aug. 16	07 Sep. 16	26 Oct. 16	07 Dec. 16
Lester Levy (Chair)	1	1	1	1				
Joanne Agnew	1	1	1	1				
Peter Aitken	1	1	1	1				
Doug Armstrong	1	1	1	1				
Judith Bassett	1	1	1	x				
Chris Chambers	1	1	1	1				
Lee Mathias (Deputy Chair)	x	1	1	1				
Robyn Northey	1	1	1	1				
Morris Pita	1	1	1	1				
Gwen Tepania-Palmer	1	1	1	x				
Ian Ward	1	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 22 June 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
1.1 Board circulated Resolution – Auckland DHB Long Term Investment Plans	**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. Action Points 22 June 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 Northern Electronic Health Record (NEHR) Programme - Update	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.2 Health and Safety Policy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.3 Presentation – Taking Health and Safety to the Next Step	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Tamaki Regeneration Programme: Next Steps	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Risk Management	**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

Discussion Document	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)]	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 Business Case – Cardiovascular Directorate – CIU Room One X-Ray Replacement	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Substitution – Fraser McDonald Unit Sluice Room	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Occupation Licence Agreements – Retail Outlets at Auckland City Hospital and Greenlane Clinical Centre	**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 Update – Progress on Implementation of new After-Hours Arrangements	**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	**Commercial Activities** To enable the Board to carry out,	That the public conduct of the whole or

Integrated Pharmacist Services in the Community – Implementing a New Approach	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)]	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 Auckland DHB Blood Services Work Area Technology Upgrade	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.9 Business Case Auckland City Hospital Support Building – Upgrade Service Lifts	**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]
6.10 Request for Funds to Complete Emergency Department Design	**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]
7.1 Strategy 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)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Auckland DHB programme	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of

Management: Implementing the Organisational Strategy	Information Act 1982 s9(2)(i)]	information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Auckland DHB Research Strategy	**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]
7.4 Auckland Healthy Food and Drink Policy	**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]
7.5 Draft Terms of Reference for an External Review of Orthopaedics	**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]
7.6 Shareholder Approval Request – NZ Health Partnerships	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Human Resources Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	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

	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)]	sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 External Bodies Findings Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] **Legal Professional Privilege** The disclosure of information would not be in the public interest because of the greater need to maintain legal professional privilege. [Official Information Act 1982 s9(2)(h)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Minutes – Auckland DHB and Waitemata DHB Collaboration Committee Meeting	**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]

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	Deputy Chair - NZ Blood Service Director and Shareholder – C4 Consulting Ltd 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	18.07.2016

Minutes
Meeting of the Board
22 June 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 22 June 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 8.45 a.m.

Board Members	**Auckland DHB Executive Leadership**	
Dr Lester Levy (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Simon Bowen	Director of Health Outcomes – AHB/WDHB
Peter Aitken	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Dr Chris Chambers	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Lee Mathias (Deputy Chair)	Fiona Michel	Chief of People and Capability
Robyn Northey	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Morris Pita	Rosalie Percival	Chief Financial Officer
Ian Ward	Sue Waters	Chief Health Professions 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)	

1. ATTENDANCE AND APOLOGIES

That the apologies for Judith Bassett and Gwen Tepania-Palmer be received. That the apologies for senior staff members Linda Wakeling, Chief of Intelligence and Informatics and Dr Margaret Wilsher, Chief Medical Officer be received.

The Board Chair, Lester Levy welcomed Suzanne Stephenson as Acting Director Communications to her first meeting of the Board. Andrew Old was asked to circulate Suzanne's CV to Board members to highlight the extensive experience she was bringing to the organisation.

Robin Cooper (Rob)

Lester Levy advised the Board of the passing of Rob Cooper. In 2007 and 2010 Rob was appointed to the Auckland and Waitemata District Health Boards and incorporated the separate Maori Health Committees into one. He was appointed as inaugural chair of the Whanau Ora Governance Group in 2010.

Rob had held many roles throughout his lifetime and was appointed a Companion of the New Zealand Order of Merit in 2015 in recognition of his contribution to Maori health, education and development over the past 30 years.

Lester Levy and Morris Pita paid tribute to Rob Cooper acknowledging him as a very loving man and a very family-orientated man. Rob was a deep thinker with a very keen intellect who fulfilled many roles around the boardroom tables of universities, district health boards and international institutions.

Morris Pita likened him to the late Sir James Henare who had been a mentor of Rob Cooper and said that he left a huge legacy and large shoes to fill.

Morris Pita and Gwen Tepania-Palmer would attend Rob's tangi and would convey the Board's best wishes to his family.

2. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution: Moved Lee Mathias / 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:

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	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information

	activities [Official 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]
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 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	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

	disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	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]
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**	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

	To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	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 Public Health Advisory Committees	**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]
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	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

	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)]	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]
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]

Carried

[Secretarial Note: A video depicting a patient's positive experience of care provided while admitted to Auckland District Health Board was shown.]

3. CONFLICTS OF INTEREST

The following changes to the Interests Register were noted:

Ian Ward advised that he had now been appointed as Deputy Chair of the Blood Services Board.

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

4. CONFIRMATION OF MINUTES 11 May 2016 (Pages 13-26)

Resolution: Moved Jo Agnew / Seconded Lee Mathias

That the minutes of the Board meeting held on 11 May 2016 be confirmed as a true and accurate record.

Carried

5. ACTION POINTS (Pages 27)

There were no current action points to report on.

6. CHAIRMAN'S REPORT (Pages 28-58)

6.1 Board Decision-making - Communication During The District Health Board Election Period

Lester Levy asked that board members carefully read the letter from the Ministry of Health dealing with Board decision-making and communication during the District Health Board election period. The advice given should be adhered to by all board members. Lester Levy advised members that it was their responsibility to act within the framework outlined.

There were no questions from Board members.

[Secretarial Note: Item 10.1 was considered next.]

7. CHIEF EXECUTIVE'S REPORT (Pages 59-65)

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

- In partnership with Careerforce, orderlies have had 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. Auckland DHB was one of the first to take up the training and orderlies have greatly valued this opportunity.

- Across Auckland City Hospital and Greenlane Clinical Centre there are 46 Dementia Champions who support the roll-out of the 'Better Brain Care' pathway. This initiative detects cognitive impairment, involves whānau/families and plans a safe discharge for elderly patients. The Dementia Champions were recently presented with a purple daisy badge that identifies them and thanks them for becoming a Dementia Champion.
- In May, World Smokefree Day was celebrated, encouraging people to think about quitting and asking the people who are smoke free to tell us why.
- Pink Shirt Day, a national day to stand up to bullying was recently observed with posters put in place and teams being encouraged to submit photos of themselves dressed in Pink.
- Men's Health Month ambassador, Dr Inia Raumati, from the adult Emergency Department is supporting Auckland DHB to raise awareness of men's health issues and get men talking about their health this month.
- 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.
- To celebrate significant achievements we've published 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.
- Overall, Auckland DHB is expected to meet the national health targets with the exception of "increased immunisation 8 months", by the end of 2015/16.
- The financial performance for the month of May 2016 was favourable to budget by $36K, against a planned deficit of $1.0M.
- Auckland DHB held another successful Primary Care Open Evening at Auckland City Hospital on 28 May, with 40 GP's and Practice Nurses attending. 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.
- 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. Next year it will take place more frequently, every two weeks, to enable staff to attend close to their start date.
- 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. This has an effect for Auckland DHB if the approach is successful as Auckland is the major transplant provider.
- 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 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. 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.

Andrew Old further advised that:

- The Design Lab had been successful in securing a catalyst seeding grant from the Royal Society to look at people living with dementia.
- Traditionally Maori and Polynesian women were not well represented when it came to taking advantage of cervical screening. At the International Cleaners Day celebration Andrew had heard a story relating to an opportunity offered by Auckland DHB during worktime where 38 of these women had taken advantage of free cervical smears.

That the Chief Executives report for June 2016 be received.

Carried

8. COMMITTEE REPORTS

There were none.

9. PERFORMANCE REPORTS (Pages 66-85)

9.1 Financial Performance Report (Pages 66-72)

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

- Savings for May were at $21M of the $24M target.
- Close attention is being paid to year end provisions to ensure all allowances are covered.
- On Friday Rosalie was to attend a Chief Financial Officers meeting in Wellington with Treasury dealing with the issue around capital and debt financing and would provide an update report to the Board at its next meeting.

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

- A question whether any analysis had been made of the High volume of TAVI implants in Cardiology (60 for current YTD versus 37 for last YTD) -$0.7M unfavourable mentioned on page 69 of the agenda. It was advised that TAVIs were more expensive than open heart surgery due to the high implant cost. Supply had been reviewed and "just in time supply' was set in place to control costs. It was thought that cost of the implants would come down over time. With the growing and wider application of TAVIs, work was also being undertaken to identify whether TAVIs were being utilised for the right patient groups.

- It was advised that the underspend in plant and equipment reported on page 71 was not a reflection of historical underspend and in fact all projects had been commenced. More was being done but it was a reflection of a number of IT projects not being delivered within the planned timeframe. This particular area, while showing

improvement over the last year, needs to improve phasing of expenditure. Next year the capital budget is actually oversubscribed in terms of cash available.

That the Board receives this Financial Report for May 2016.

Carried

9.2 Funder Performance Report (Pages 73-85)

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

- That in terms of the performance against targets the immunisation for 8 months had not been reached. A key issue has become the increasing decline rate and it has become clear that parents are waiting until the child is 12 months before immunising.

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

- An explanation was given in relation to the comment at the bottom of page 74, that reads, "the value of the revenue allocated to the provider by the Auckland DHB funder exceeds the total value of the volume and non-volume arrangements"; that this meant that the revenue was more than the revenue attributable by the national price.
- Lee Mathias questioned the statement on page 79 of the agenda relating to changes proposed to Child, Youth and Family which read, "This is expected to have some significant implications for services provided by health, particularly in relation to expectations regarding provision of universal services." Lee advised that the Minister had issued a strong message that there would be no changes to these services.
- Doug Armstrong asked why there why there was a division called Women, Child and Youth which is not inclusive of men given reference elsewhere in the agenda to men's health. He was advised that the use of Women was a catch all to cover a range of services for women which largely includes maternity but also the two national screening programmes, breast and cervical screening. Currently there were no national screening services aimed at men.
- Chris Chambers asked why it was reported that proposals from the Hospices in the Northern Region were ambitious in scope and was advised that this was funding bid for to provide innovative service improvement opportunities and is different to the proposals which have come to the Board about collaboration between the services.

Action
The Tertiary services reports be shared with Chris Chambers.

That the Funder Performance report for June 2016 be received.

Carried

10. DECISION REPORTS

10.1 Auckland DHB 2017 Board and Committee Meeting Schedule (Pages 86-88)

Dr Lester Levy, Board Chairman asked that the report be taken as read, highlighting:

- That the only significant change of note was the proposal to change the frequency of the combined Community and Public Health Advisory Committees meeting to four times a year aligning it with the other combined advisory meetings such as the Disability Support Advisory Committee and the Maori Health Gains Advisory Committee.
- The report covers the prescribed minimum number of meetings but does not restrict a committee chair from having additional meetings between meeting cycles if this proves necessary.
- Board members are to take lead roles on specific critical areas of activity. Reporting back to committees and the Board will be required. It is important that potential board candidates understand the time commitment associated and required with this.
- Wednesdays are allocated board business days with all health and safety site visits being held during weeks three and six of the meeting cycle.

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

- Doug Armstrong expressed a concern about the liability that board members now carried under the new health and safety legislation and that this should be made clear to intending district health board electoral candidates. It was agreed that this concern should be made known to the electoral officer so that intending candidates could be well informed when making the decision to put their names forward.
- Lee Mathias expressed a concern in relation to where discussion on locality issues would take place now that the combined Community and Public Health Advisory Committees would meet less frequently. The provider arm was well catered for by the Hospital Advisory Committee. Was the intent that locality issues be dealt with by the Board itself? It was advised that the Board would discuss these issues and if there was too much on the agenda or an in depth discussion was required a meeting between cycles could be held.
- Jo Agnew questioned whether there was going to be a review of the Disability Support Advisory Committee and was advised that this was not proposed at this time but could be considered in the future.

Resolution: Moved Peter Aitken / Seconded Lee Mathias

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 District Health 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 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.**

Carried

[Secretarial Note: Item 7 was considered next.]

11. DISCUSSION PAPER

11.1 Waiheke Island Health Service review (Pages 89-103)

Tim Wood, Funding and Development Manager Primary Care asked that his presentation, as included in the agenda, be taken as read.

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

- It was advised that there were just under 10,000 permanent residents on Waiheke Island. The population more than tripled in the summer months placing a significant impact on general practices. After hours rosters were difficult to maintain and it is hard to attract general practitioners.
- It was advised that Waiheke Island differed to other Auckland suburbs in that its location was a barrier which prevented ease of access to services that other suburbs took for granted.

That the presentation, "Waiheke Island Health Service review" be received.

Carried

12. GENERAL BUSINESS

There was none.

The meeting closed at 12.30pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 22 June 2016

Chair: _____ Date: _____

Lester Levy

Action Points from 3 August 2016 Open Board Meeting

5

As at Wednesday, 03 August 2016

Meeting and Item	Detail of Action	Designated to	Action by
22 June 2016 Item 9.2	**Funder Performance Reports** That the Tertiary Services reports be shared with Chris Chambers	Jo Gibbs	Completed

Chief Executive's Report

Recommendation

That the report be received.

6

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 13 June to 15 July, 2016. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits

2.1.1. Ministerial Visits

Health Minister Hon Dr Jonathan Coleman visited Auckland DHB on Tuesday 26 July; meeting with myself, heads and staff of the Adult and Children's emergency department, Transplant ward, PC3 Lab, as well as students from the Design Lab who mapped the Adult ED patient journey recently.

ACC Minister Hon Nikki Kaye and Minister for Senior Citizens, Hon Maggie Barry, visited Auckland DHB on 12 July and announced the national community falls prevention programme for people aged over-65. The Government will invest $30.5m over the next four years to support better outcomes for older people at-risk of a fall or injury.

2.1.2 State visits

The Head of State of Samoa, Tui Atua Tupua Tamasese Efi, opened Pasifika week on 11 July and visited Auckland City Hospital as part of ARPHS' *Talanoa*.

2.2 DHB Elections

Nominations are now open for District Health Board Elections 2016 (closing noon Friday 12 August). Our website has been updated to include relevant information and the nomination form.

2.3 CE Expenses

CE expenses were published on our website on 15 July in accordance with the State Services Commission's annual disclosure requirement (by the third week of July each year). These are also linked to www.data.govt.nz.

2.4 Patient and Community

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 200 emails were received with approximately 60 referred to other departments and services at Auckland DHB.

2.5 External and Internal Communications

2.5.1 External

Auckland DHB made public statements about:

- National community falls prevention programme
- HYPE 2016 reaches out to high school students about rheumatic fever
- Intensive care patients benefit from research funding
- Queen's Birthday Honours recognition

39 requests for information, interviews or for access from media organisations were received from 13 June to 15 July. Media queries included requests for information about suicide prevention, an interview with cardiologist Prof Rob Doughty to raise awareness of Heart Foundation's Heart Attack awareness campaign and an interview with Dr Claire McLintock to raise awareness about venous thromboembolism (VTE) - the formation of blood clots in the vein.

38 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 23 Official Information Act requests over this period.

2.5.2 Internal

- Two CE blog posts were published. These talked about *Celebrating our Diversity* as a workforce and Healthy eating.
- One Teamtalk Blog by Dr Stephen Childs talking about his experience sleeping out for LifeWise. Hospital occupancy was updated daily on the Intranet.
- 27 news updates were published on the DHB intranet.
- Six eNova (weekly electronic newsletters) were published.
- Three '*In the know*' sessions took place on 24 June. These are for all managers across the organisation.

2.5.3 Events and Campaigns

Te Wiki o te Reo Māori (Māori Language week)

Māori Language Week took place during July. Throughout the week we shared words for people to practice putting into their emails and everyday language.

Pasifika Week

Pasifika week took place in July with a visit from the Head of State for Samoa. The week highlighted the importance of achieving health equity for our Pacific communities. There were a range of activities throughout the week including, dancing and singing, health provider stalls, and cultural competitions including 'Best Pacific Ward' and 'Best Pacific Dress'. In addition, a range of speakers were invited to Auckland DHB on Pacific Health topics.

World Elder Abuse Awareness Day 2016

World Elder Abuse Awareness Day took place on 15 June. The day helps raise awareness and responsibility for preventing elder abuse, as well as celebrating older people in our society. Age Concern held an information stall at Auckland City Hospital during the day.

Organic Recycling and Sustainability forum

To continue on our sustainability journey we have reached out to connect with the wider community and organisations to share their insights at a series of Sustainability Forums. In June we welcomed Heather Tait, Sales and Marketing Manager for Living Earth to speak about *"Organic Recycling and Sustainability "*at one of these forums. The next Sustainability Forum takes place on Friday 29 July when we welcome Ann Stephens, CEO of Enviro-Mark Solutions.

2.5.4 Social Media

Facebook likes: 3,878
Twitter followers: 2,459
LinkedIn followers: 4,964
Instagram followers: 82

Most popular posts:

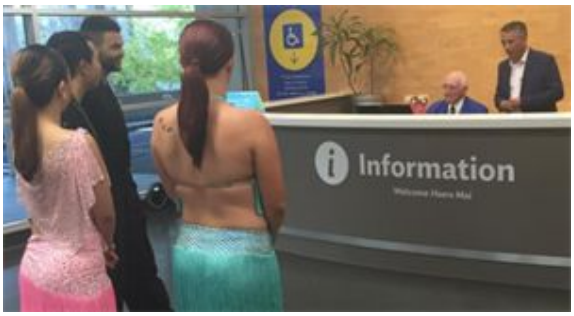
- Football Ferns visit to Starship Hospital
- Pasifika Week
- The Big Sleep Out
- #patientexperience letters
- Hon Minister Nikki Kaye & Hon Minister Maggie Barry's visit to ACH
- Redesigned stroke rehabilitation service
- Greenlane Surgical Unit picture book for patients
- University of Auckland's new Head of Paediatrics, Dr Cameron Grant
- CE's visit to Physical Containment Level 3 (PC3) Lab
- Dr Robyn Toomath book review
- Inflatable Colon at ACH
- Volunteer Week
- Immunisation facts
- Superhero window washers at Starship Hospital
- Weekly round-up of new job postings

2.5.5 Our People

Minister of Health Volunteer Awards and Volunteers Week

Congratulations to Geraldine Donovan who won the Health provider individual winner in the annual Minister of Health Volunteer Awards in July. Geraldine has been a Blue Coat volunteer at Auckland DHB since 2005. Geraldine is described as an exemplary Blue Coat, helping people to their appointments and making visitors feel welcome. This Award was presented in the run up to Volunteers Week.

We used the week to thank our volunteers with two morning teas as well as hosting information stands to encourage volunteering. TVNZ's *Seven Sharp* programme played special tribute to keyboard playing Blue Coat, Trevor Anderson, by surprising him with professional dancers to dance to his music.



Local Heroes

There were 18 people nominated for local heroes. Congratulations to our June and July Local Heroes: Paula Baker, Play Specialist at Starship and Anne Comber, Team Leader Oral Health.

Paula (pictured) was nominated by a patient's dad who said: *"Dealing with a child with cancer, or any severe sickness is tough enough for any parent. I want to thank those staff who make the process just that bit comforting. On our admittance, Paula not only took the time and discernment to understand who we were as a family, our psychology and values as people, but also to understand the significance of his relapse.*

Her stern mind was matched with gentle empathy and perfectly helped our son transition into being back into hospital (as he thought he was on holiday, unaware he was ill) while still having the huge element of play and learning for his development as a 3 year old while he begins his new journey. She created a happy environment for all of us."

Anne was nominated by a team member who said: *"Anne is the glue that holds us together. Over the last 6 years the service has experienced considerable upheaval with the appointment of a new clinical director, the retirement of several senior clinicians, and a rotation of 6 service managers. She has been a constant presence, solving patient and staff problems to keep the department functioning.*

Last year she researched and implemented a vital change to our Relief of Pain service, changing it from a walk in service to a booked clinic. This has resulted in increased patient satisfaction as people no longer queue up in the early hours of the morning in pain. Staff satisfaction has increased as patients attend throughout the morning and staff can be

redeployed elsewhere if the clinic isn't fully booked. This change to the Relief of Pain service has now also been implemented in Middlemore Hospital and Buckland Road clinics with great success. We all adore Anne."

Mandatory Health and Safety course for Managers

April marked the beginning of a new era in health and safety in New Zealand and accountability for managing health and safety risk is now much more clearly defined in the legislation. A new course for managers has been developed "*Managing Safely"* which is mandatory for anyone who manages a specific area or service.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary[1]

	Status	Comment
Acute patient flow (ED 6 hr)		Jun 96%, Target 95%
Improved access to elective surgery		100% to plan for the year
Shorter waits for radiation therapy & chemotherapy		Jun 100%, Target 100%, Year to Date 100%
Better help for smokers to quit		Jun 97%, Target 95%
Cardiac bypass surgery		Jun 84 patients, Target < 104
More heart & diabetes checks		Mar Qtr 92%, Target 90%
Increased immunisation 8 months *		Jun Qtr 93%, Target 95%

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

* Provisionally correct, final results pending from the Ministry of Health.

[1] Note that effective July 2016, ***Faster Cancer Treatment*** will replace Shorter Waits for Radiation Therapy & Chemotherapy and ***Raising Healthy Kids*** will replace More Heart & Diabetes Checks.

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

3.1.2 National Health Targets – YOY comparison Auckland region DHBs

*Denotes anomaly on MoH website – all DHBs were entered at 100

Auckland Region	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4
Shorter Stays in Emergency Departments – 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours.								
Auckland DHB	**93**	**94**	**95**	**95**	**93**	**95**	**95**	**96**
Waitemata DHB	95	97	95	96	93	95	96	TBA
Counties Manukau	95	96	96	97	95	95	96	TBA
All DHBs	93	94	95	95	92	94	94	TBA
Improved Access to Elective Surgery – The volume of elective surgery will be increased by an average of 4000 discharges per year.								
Auckland DHB	**100**	**100**	**97**	**100**	**93**	**98**	**98**	**100**
Waitemata DHB	109	109	107	104	101	101	102	TBA
Counties Manukau	111	112	108	108	99	103	105	TBA
All DHBs	105	107	107	107	104	105	106	TBA
Faster Cancer Treatment – 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.								
Auckland DHB	*****	**50**	**59**	**60**	**66**	**70**	**75**	**77**
Waitemata DHB	*	66	70	77	74	68	70	TBA
Counties Manukau	*	52	59	63	70	72	70	TBA
All DHBs	*	66	67	68	69	75	75	TBA
Increased Immunisation – 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.								
Auckland DHB	**96**	**94**	**94**	**94**	**95**	**94**	**94**	**93**
Waitemata DHB	92	94	92	93	93	95	93	TBA
Counties Manukau	94	94	93	95	95	95	94	TBA
All DHBs	92	94	93	93	93	94	93	TBA
Better Help for Smokers to Quit – 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. 95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.								
Auckland DHB	**P 100** **H 96**	**P 98** **H 96**	**P 96** **H 96**	**P 97** **H 95**	**85**	**86**	**88**	**97**
Waitemata DHB	P 99 H 97	P 100 H 98	P 99 H 98	P 94 H 98	85	88	90	TBA
Counties Manukau	P 98 H 96	P 96 H 95	P 95 H 95	P 96 H 95	87	88	89	TBA
All DHBs	P 88 H 95	P 89 H 95	P 89 H 96	P 90 H 96	83	85	86	TBA
More Heart and Diabetes Checks – 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.								
Auckland DHB	**92**	**92**	**92**	**92**	**92**	**92**	**92**	**TBA**
Waitemata DHB	90	90	91	90	91	90	91	TBA
Counties Manukau	91	91	91	92	92	92	92	TBA
All DHBS	**86**	**87**	**88**	**89**	**90**	**90**	**90**	**TBA**

3.2 Financial Performance

The financial performance for the month of June 2016 was favorable to budget by $216K, against a planned deficit of $200K. Overall, the DHB performed better than the full year financial plan, achieving a consolidated surplus of $2.9M against a planned surplus of $2.4M. While significant cost pressures were realized in the Provider Arm (across all expenditure categories) , resulting in a $20M unfavourable result, this was full offset by a $21M favourable position in the Funder and Governance Admin Arms, mainly due to less demand driven expenditure than forecast. Underlying this result, the DHB achieved savings of $21.8M against a budget of $26.9M. The savings not achieved ($5M) were fully offset by other savings realized outside the plan and other favourable movements against budgets. Focus now is on achieving the planned $4.5M surplus for 2016/17.

4.0 Clinical Governance

4.1 Consultation

4.1.1. NZ Health Research strategy

Auckland DHB representatives participated in the Ministry of Health/Ministry of Business, Innovation and Employment sponsored workshops as part of the NZ Health Research Strategy consultation process which is open until 5pm, Friday 29 July 2016.

The development of New Zealand's first health research strategy is the opportunity to decide how to get the best value out of New Zealand's investment in health research. The strategy will set a vision for health research over the next 10 years and set out the priorities and actions to achieve this. It seeks to build a more cohesive and connected health research and innovation system, enhance the uptake of health research results to improve health outcomes and maximise the economic and scientific benefits from our internationally recognised strengths in health research. This will also improve New Zealand's ability to attract and retain health researchers, including clinicians with an interest in health research.

4.2 Development and recognition

4.2.1 Leadership Development Programme

Delivered in partnership with JumpShift, the *Celebrate* programme has been put in place to equip and support clinician leaders with the skills and tools to deliver safe and quality care through their teams. 45 participants (across three groups) are currently taking part with a further 45 participants to begin the programme in August.

The first 12 participants completed the programme in June, and their efforts and contribution to the design of the programme and their leadership development was recognised at a celebration event held at the University of Auckland. As sponsor of the programme I joined the chair, Dr Lester Levy, in acknowledging participants and the importance of the programme. Participants shared the impact the programme had made on their leadership.

4.2.2 Health Excellence Grand Rounds

The first of the Grand Rounds takes place on 2 August focusing on improvements made for our patient, our community and our people. This will include presentations from Helen Evans and Paul Birch, last year's winners of the Community Health and Wellbeing Award and Natasha Caldwell, part of the winning team for process and systems improvement.

4.2.3 Health Excellence Award applications now open

Applications for the 2016 Health Excellence Awards opened in July. The Awards are an opportunity to celebrate some of the great achievements taking place in research, clinical care and wellbeing. Applications close on 5 September and winners will be announced at the 2016 Health Excellence Awards Evening on 1 December at Auckland Museum.

4.2.4 Farewell to Dr Tony Baird (retirement)

Dr Tony Baird retires on the 30th of September after a dedicated service of over 42 years and we wish him well in his retirement, along with staff from Auckland DHB Women's Health. Tony has been a clinical staff member since 1974, initially joining National Women's Health as a Senior Registrar. With his vast experience in Specialist Obstetrics and Gynaecology, Tony brought to the organisation a wealth of knowledge and experience. He holds a NZ Order of Merit for his contribution to health services and also as Chairman and President of the NZ Medical Association, President of the NZ Medical Council, President of the Royal NZ College of Obstetricians and Gynaecologists, and Chairman of Action on Smoking – Health.

4.3 New services

4.3.1 Physical Containment Level 3 (PC3) Laboratory opened

The PC3 Lab was opened on 27 June and I acknowledged those responsible for this state-of-the-art facility. Health Minister Hon Dr Jonathan Coleman intends to visit the Lab area on 26 July, as well as the Adult and Children's emergency department, Transplant ward, and meet students from the Design Lab who recently mapped the Adult ED patient journey.

4.3.2 Early Supported Discharge (ESD)

From 4 July, we now offer an ESD service to support appropriate patients to leave hospital sooner and return home for treatment before the end of their expected length of stay.

4.3.3 Falls prevention and fracture liaison service

ACC Minister Hon Nikki Kaye and Minister for Senior Citizens, Hon Maggie Barry, visited Auckland City Hospital in July and announced the Government invest $30.5 million over the next four years in supporting better outcomes for older people at-risk of a fall or injury.

The community falls prevention programme is the product of Auckland and Waitemata DHBs working closely with ACC to develop a new national model for improving the availability of falls and injury prevention initiatives.

4.3.4 All-age adult stroke rehabilitation service

The new all-age (adult) stroke rehabilitation service was launched in early July. I attended the launch of the new Stroke Rehabilitation Unit, along with 50 guests, including community partners and patients. The service is based within Auckland City Hospital's Rangitoto Ward as part of Reablement Services. Its purpose is to enhance stroke rehabilitation for all adult ages, and to strengthen links and flow with the Acute Stroke Unit and community rehabilitation services. Planning the unit has been based on these principles: available for all ages (adult), based on need, seamless for the patient, equitable, and focused on enhancing stroke outcomes.

4.3.5 Cancer Support team

The Cancer Support team is a new team that is part of a Ministry of Health initiative to improve the quality of life for people with cancer. The team provides psychological and social work support for patients and their whānau from the time when it is suspected they may have cancer through to the end of intensive hospital treatment.

4.3.6 Eating Disorder services - Tupu Ora

A fully integrated Eating Disorder Services hub now establishes a centre of excellence supporting eating disorder services in the Midland, Metro-Auckland and Northern regions. The changes follow a series of reviews and agreements for the new Hub and Spoke model supporting enhanced service provision across the EDS care continuum of which the residential service will be an important part. Auckland DHB welcomed staff from the former *Thrive* residential eating disorder service.

A new name for the Eating Disorder Services Hub was gifted to the service by the Chief Advisor Tikanga following an inclusive process involving staff and service users. From the 1st of August, services formerly known as "Thrive" and "REDS" will be collectively known as Tupu Ora. Key stakeholders will be advised.

Together the words capture the outcomes we seek for people who embark on their recovery journeys with us and who go on to live well in the presence or absence of their conditions.
Tupu: to sprout, grow, develop, mature, increase, spring, issue, begin, prosper, and flourish.
Ora: to be alive, well, safe, cured, recovered, healthy, fit, healed, to be satisfied with food, satiated, replete, to recover, revive, be healthy, fit, to have vitality.

4.3.7 Adult antimicrobial guidelines made available as mobile app

Prescribing the most appropriate antibiotic treatment for patients has been made easier with the development of a mobile app. The impact of the app on the antimicrobials prescribed for patients with infections at Auckland City Hospital is the focus of an Auckland DHB and HRC funded research project.

5.0 Funding

5.1 Applications open

5.1.1. A+ Trust Research Grants

Applications are open for the next A+ Trust research funding round based on scientific merit, feasibility, ability to deliver and opportunities to develop the capacity of new researchers/practitioners in clinical research. Two types of funding are available; Small Project Grant (maximum of $15K) or project grant (maximum of $50K).

5.2 Funding received

5.2.1 Health Research Council of NZ (HRC) 2016 funding recipients

The HRC supports research that has the potential to improve health outcomes and delivery of healthcare, and to produce economic gains for New Zealand. Over the past 10 years, HRC has invested about $7m in intensive care research which has paid for itself many times over – direct cost savings estimated to be well over $150m per year, with hundreds of people admitted to NZ's ICUs every year surviving as a result of the practice changes that have occurred in response to trials' findings.

The following Auckland DHB clinicians received funding in the June 2016 grant decisions, including:

- Department of Critical Care Medicine (Dr Colin McArthur) $4.8m Platform trial optimising interventions in severe community acquired pneumonia (60mths), plus $0.9m Pre-hospital anti-fibrinolytics for traumatic coagulopathy and haemorrhage (36mths)

- Cardiovascular Intensive Care Unit (Dr Shay McGuiness) $1.2m Transfusion requirements in patients for cardiac surgery – TriCS 111 (36mths)

- Consultant, Cardiovascular Unit (Prof Ralph Stewart) $1.2m Improving outcomes of patients with atrial fibrillation in primary care (36mths).

5.2.2 Data Futures Partnership (DFP)

On 1 July we were advised our data futures catalyst project application ($50K) to the DFP was successful. Catalyst projects are data use initiatives that have potential value of greater data use, supporting the data-use ecosystem mandated by Government. The project helps deliver the Board's 'Intelligence and Insight' theme, well done to the team involved.

Collection of Data for Patients with Disabilities

Recommendation

That the Board:

1. **Receives the report.**

2. **Notes that the Auckland Metro DiSAC groups:**
   - **2.1. Actively engage with the disability data and evidence working group**
   - **2.2. Seek to understand how the need for better disability population data will be reflected in the review of the disability strategy.**

3. **Notes that that the Auckland Metro DiSAC groups recommend to their Boards that:**
   - **3.1. The same method of data collection be employed across the three regional DHBs**
   - **3.2. They investigate processes for the collection of the identified data about staff with disabilities.**
   - **3.3. A small working party be established representing the three DHBs to establish guidelines relating to the collection of data to support the DHBs to be good employers of people with disabilities.**

Endorsed by: Marlene Skelton (Corporate Business Manager)

1. Background

This was discussed by the Regional Disability Support Advisory Committee at their meeting held on 1 June 2016 and was item 4.2 on the agenda (see pages 31-34).

The Disability Support Advisory Committee recommends to the Board as set out above.

Financial Performance Report

Recommendation

That the Board receives this Financial Report for June 2016

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for June 2016 was a surplus of $15K which was favourable to budget by $216K. The full year preliminary and unaudited result is a surplus of $2.9M. This was favourable to budget by $504K. Overall, Funder arm and Governance results were favourable by $21M and this fully offset the unfavourable variance in the Provider arm of $20.5M.

Full year revenue is favourable to budget by $16.8M. 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); $6.2M additional MoH contracts Devolved funded initiatives under NGO services (mainly contracts finalised after budgets were set, with corresponding additional expenditure); $9M additional other income (includes research income, pharmacy and one off settlement of commercial contracts); offset by unfavourable financial income ($2.4M) and donation income ($2M). Full year expenditure is unfavourable to budget by $16.3M. Significant variances include unfavourable personnel of $8.2M, outsourced personnel of $8.6M; clinical supplies of $6.2M; infrastructure and non-clinical supplies of $4M; outsourced clinical services $1.9M and capital charge of $1.9M; offset by favourable Funder payments to NGOs of $14.7M.

The full year financial plan of $2.4M surplus has been achieved as at 30 June 2016.

Auckland District Health Board
Summary Results: Month of June 2016

$000s	Month (June-16)			YTD (12 months ending 30 June-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Income						
MOH Sourced - PBFF	92,754	92,819	65 U	1,117,202	1,113,823	3,379 F
MoH Contracts - Devolved	9,155	7,060	2,095 F	90,889	84,719	6,170 F
	101,909	99,879	2,031 F	1,208,091	1,198,542	9,549 F
MoH Contracts - Non-Devolved	5,693	4,923	769 F	59,353	57,598	1,755 F
IDF Inflows	57,423	54,105	3,318 F	648,270	649,258	988 U
Other Government (Non-MoH, Non-OtherDHBs)	3,566	2,945	621 F	34,588	34,212	377 F
Patient and Consumer sourced	1,857	1,544	313 F	18,978	18,532	446 F
Inter-DHB & Internal Revenue	2,654	1,270	1,384 F	16,143	15,148	995 F
Other Income	4,480	3,682	798 F	53,958	44,916	9,042 F
Donation Income	337	569	232 U	4,896	6,908	2,012 U
Financial Income	408	664	256 U	5,455	7,830	2,375 U
Total Income	**178,327**	**169,582**	**8,745 F**	**2,049,732**	**2,032,943**	**16,788 F**
Expenditure						
Personnel	77,096	71,966	5,130 U	865,895	857,731	8,165 U
Outsourced Personnel	2,749	1,507	1,242 U	26,725	18,082	8,643 U
Outsourced Clinical Services	2,761	1,883	879 U	24,401	22,515	1,886 U
Outsourced Other Services (incl. hA/funder Costs)	4,474	4,591	116 F	54,717	55,089	372 F
Clinical Supplies	19,846	20,086	240 F	245,319	239,097	6,222 U
Funder Payments - NGOs	43,711	44,987	1,276 F	525,062	539,844	14,782 F
Funder Payments - IDF Outflows	9,414	9,272	142 U	111,776	111,218	559 U
Infrastructure & Non-Clinical Supplies	13,733	11,023	2,710 U	136,999	132,995	4,004 U
Finance Costs	1,013	1,030	17 F	13,061	13,093	32 F
Capital Charge	3,513	3,438	76 U	42,905	40,914	1,991 U
Total Expenditure	**178,312**	**169,782**	**8,530 U**	**2,046,861**	**2,030,577**	**16,284 U**
Net Surplus / (Deficit)	**15**	**(200)**	**216 F**	**2,870**	**2,367**	**504 F**

2. Result by Arm

Result by Division	Month (June-16)			YTD (12 months ending 30 June-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Funder	4,252	194	4,057 F	19,551	2,330	17,221 F
Provider	(6,474)	(395)	6,080 U	(20,506)	37	20,543 U
Governance	2,238	0	2,238 F	3,826	0	3,826 F
Net Surplus / (Deficit)	**15**	**(200)**	**216 F**	**2,871**	**2,367**	**504 F**

The Funder arm result was $17.2M favourable and for Governance, $3.8M favourable, fully offsetting the $20.5M unfavourable result realised in the Provider arm.

- The favourable full year Funder result reflects lower expenditure for demand type services, release of 2015/16 uncommitted contract expenditure and favourable 2014/15 adjustments. These were offset unfavourable national IDF wash-ups, adverse net IDF flows from PHO quarterly wash-ups and additional revenue allocations to the Provider Arm. Higher year to date revenue is mainly from funded initiatives and accompanied by equivalent expenditures, these have a nil impact on the results
- The unfavourable Provider Arm full year result is driven by net unfavourable expenditure primarily in Personnel, Outsourced Personnel, clinical supplies and Infrastructure and Non Clinical Supplies costs. These variances are described further in section 3 below.
- The favourable Governance Arm result for the year is driven by favourable outsourced costs (mainly joint funder costs) and infrastructure costs (mainly professional costs, IT systems and other operating expenses).

3. Financial Commentary for June 2016

Month Result

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

Revenue was greater than budget by $8.7M, mainly driven by:

- MoH devolved contracts which are $2.1M favourable due to funded initiatives but with corresponding additional expenditure.
- IDF inflows are $3.3M favourable due to PHO wash-up.
- Research Income $0.3M favourable, offset by equivalent expenditure.
- Capital Charge Income $0.2M favourable, offset by additional expenditure.
- Non Residents $0.3M favourable – this revenue is variable from month to month, with the full year result $0.6M favourable.
- Funding Subcontract revenue favourable primarily driven by NRA funding $1.6M, Clinical Genetics $0.4M, and funding for National Patient Flow project $0.2M.
- 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 $0.3M unfavourable due to the downward trend in interest rates.

Expenditure was greater than budget by $8.5M. Significant variances are described below:

- Personnel/Outsourced Personnel costs $6.4M (8.7%). FTE were close to budget, but the variance reflects cost per FTE targets not met combined with a one off net cost of $1.7M unfavourable for the revaluation of retirement gratuity and long service leave liabilities (the $1.7M is the net of a $4.2M increase in Nursing, offset by decreases totalling $2.5M across all other professional groups).

- The key unfavourable variance is Nursing which is $5.2M above budget - $4.2M of this relates to the one off revaluation of the retirement gratuity and long service leave liabilities (and is partially offset by the $2.5M reduction across the other professional groups). The remainder of the variance is due to cost per FTE targets not met, combined with Nursing FTE 35 FTE above budget. Additional beds with unbudgeted FTE account for 15 of this variance - the Orthopaedics Elective Unit in Ward 62 (11 FTE - unbudgeted but funded via reduced outsourcing) along with an additional three Bone Marrow Transplant beds to reduce wait times (4 FTE).
  Mitigation strategies include:
  - Nurse Directors have implemented daily staffing oversight forums with a focus on the efficient use of staff resource across the directorates while maintaining a quality, safe service. This includes a refinement of the set of principles for staff replacement with the accountability aligned to the Nurse Unit Manager
  - Focus on reviewing our systems, processes and models of care in regards to vulnerable patients who require a patient attender. An oversight group has been established to provide governance for identified work streams that improves the safety and quality of care to adult vulnerable patients. Workstreams include Enhanced Support Rooms (ESR), Management of AWOL, Post-operative/Post-arrest Delirium and Behaviours of Concern
  - Work continues on recruiting to target skill mixes – this is improving month to month
  - Use of flex beds only as needed, flexing down as soon as possible

- Clinical Supplies $240K (1.2%) favourable, primarily due to additional Pharmac rebate.
- Funder payments – NGOs $1.3M (2.8%) 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 $2.7M (24.6%) unfavourable, this primarily relates to one off abnormal costs. The key variances include $2.6M adverse facilities maintenance costs, mainly asbestos removal costs, Bad/Doubtful debts $0.7M and one off project costs $0.7M, this is offset by $1.25M favourable primarily driven by savings in Joint Funder Costs and fees on audit programmes associated with Provider Payments.

Full Year Result

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

Revenue was higher than the budget by $16.8M. Significant movements underlying this included:

Favourable revenue variances:

- MOH Sourced PBFF revenue is $3.4M favourable for the year mainly due to $2.5M additional Capital Charge funding (with offsetting expenditure) for assets revalued at 30 June 2015 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 $6.2M favourable. This is mostly a 2014/15 adjustment for additional electives revenue and additional revenue for 2015/16 funded initiatives under NGO services. Favourable funded initiatives revenue is a result of contracts finalised by the Ministry after budgets have been set but have equivalent additional expenditures. The majority of the additional revenue for funded initiatives is for Zero Fees for under 13s programme. This favourable result includes the negative impact of National Services revenue now mostly received from other DHBs through IDF inflows ($2.8M for 2015/16). The Auckland DHB's own population component was confirmed by the Ministry as requiring to be self-funded in 2015/16.
- Haemophilia funding $1.9M favourable for abnormally high blood product usage, bottom line neutral as offset by additional expenditure.

- Research Income $4.4M favourable, offset by equivalent expenditure
- Pharmacy Retail cash sales $0.9M favourable, offset by additional cost of sales expenditure
- One off revenue for settlement of commercial contracts $0.9M favourable
- Inter DHB Revenue - IDF wash-up (non MOH) $3.0M favourable
- Unbudgeted revenue for Maternal Mental Health Acute Continuum $0.9M favourable
- Safekids revenue $0.7M favourable – offset by additional promotional expenditure, bottom line neutral

Unfavourable revenue variances:

- IDF inflows $988K (0.2%) unfavourable, reflecting net inflow reductions resulting from the national IDF wash-up process. The unfavourable national wash-ups primarily relate to Provider Arm inpatient and outpatient services for other DHBs, offset by favourable wash-ups for PCT and Community Pharmacy services. Also included are favourable 2014/15 adjustments and 2015/16 service changes which include receipts for National services revenue offset by unfavourable quarterly PHO wash-ups. The National services revenue is less than expected under IDF due to Provider Arm reported under delivery for these services.
- LabPlus revenue net $0.3M unfavourable - Inter DHB Revenue $1.4M unfavourable for the loss of the LabPlus MidCentral DHB contract, offset by an increase in other external Labplus revenue streams $1.1M favourable
- Financial income $2.4M unfavourable due to a combination of lower interest rates, lower cash balances and valuation losses for Trust investments
- ACC Income $1.9M unfavourable – primarily in elective surgery, reflecting the focus on achieving elective MOH discharge targets
- Donation Income $2.0M unfavourable – revenue fluctuates depending on timing of projects - with no major projects in the current year
- MOH Public Health $0.7M unfavourable – in line with costs lower than budget

Expenditure was higher than budget for the year by $16.3M, with significant underlying variances as follows:

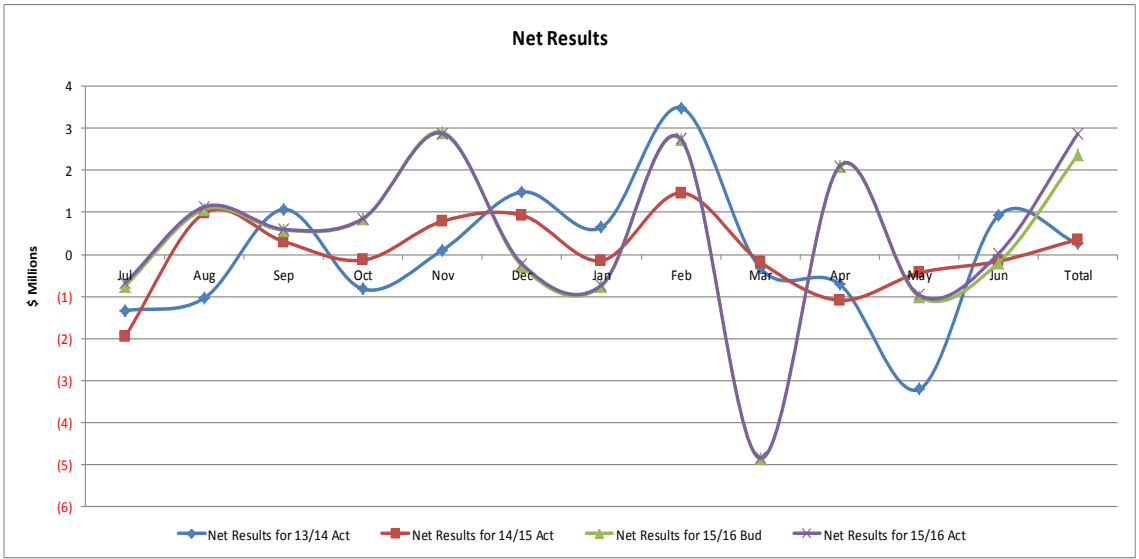
- Net combined Personnel and Outsourced Personnel Costs $16.8M (1.9%) unfavourable. Full year FTE for total Personnel/Outsourced Personnel are very close to budget at 8 above budget. The unfavourable expenditure variance is primarily due to cost per FTE targets not met, as well as MECA costs above budget ($1.5M unfavourable) and a one off net $1.7M unfavourable variance for revaluation of retirement gratuity liabilities.
    - Personnel Costs are $8.2M unfavourable - payroll FTE are 151 below budget but the favourable variance this creates is offset by cost per FTE targets not met, MECA costs above budget ($1.5M unfavourable) and a one off net $1.7M unfavourable variance for revaluation of retirement gratuity liabilities
    - Outsourced Personnel costs are $8.6M (47.8%) unfavourable (159 FTE above budget), primarily for contract Support (Cleaners) and Administration staff covering vacancies
- Clinical Supplies $6.2M (2.6%) unfavourable with the key variances as follows:
    - The key unfavourable variance is in Cancer & Blood Services - abnormally high haemophilia blood product costs ($1.8M 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 (67 for current year versus 41 for last year) - $0.8M unfavourable
    - Radiology $0.9M unfavourable due to higher than budgeted volumes of Interventional Radiology procedures
    - Pharmacy clinical supplies $0.3M unfavourable due to increased clinical trials – offset by additional trial revenue

- Surgical Services/Perioperative Services are $2.0M unfavourable reflecting volumes for adult surgery at 103.9% of contract ($9.6M above contract) for the year

- Funder Payments to NGOs are favourable $14.8M (2.7%) for the year and mainly driven by favourable variances from demand type services and release of service commitments not expensed for 2015/16. Also included are previous months' favourable 2014/15 adjustments for Personal Health, Mental Health, Community Labs, 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 $4M (3%) unfavourable, comprising the following key variances – higher food costs during transition phase for new food services contract $1.9M unfavourable, costs of goods sold for retail pharmacy $0.7M unfavourable (offset by additional revenue), abnormally high cost of bad/doubtful debts $1.8M and facilities repairs and maintenance costs, including asbestos removal, costs $2.3M unfavourable. This is offset by $1.2M favourable primarily driven by savings in Joint Funder Costs and fees on audit programmes associated with Provider Payments.
- Capital charge is $1.9M unfavourable and is fully offset by additional revenue.

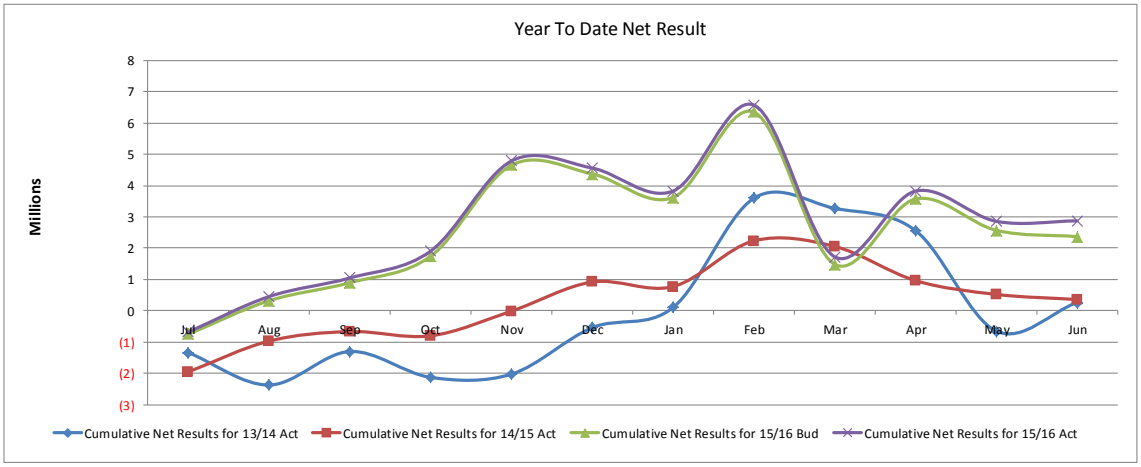
4. Performance Graphs

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)	(0.200)	2.367
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747	(4.850)	2.101	(0.967)	0.015	2.871

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	3.616	6.347	1.480	3.570	2.567	2.367
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	2.871
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	0.504

5. Efficiencies / Savings

For the full year to 30 June 2016, $21.8M savings were reported against the target of $26.9M, resulting in an unfavourable variance of $5M. The unfavourable result is primarily driven by the increased acute demand volumes that have remained consistently high since December 2015. The main unfavourable impact on savings has been cost containment ($6M unfavourable) and revenue growth ($848K unfavourable). However, this has been partially offset by model of service delivery which was $1.9M favourable.

The revenue growth strategy is unfavourable against budget by $848K. This is mainly due to Children's ACC revenue growth strategy ($525K) and Cardiac outsourcing and transplant initiatives ($375K).

Savings from model of service delivery changes were favourable against budget by $1.9M, largely attributed to Cardiac overseas resident revenue ($87K) and Perioperative service's improved theatre efficiencies ($2M).

Cost containment initiatives were unfavourable against budget by $6M. This is mainly attributed to the impact of service demand pressures on personnel within Adult Medical, Child Health, Cardiac, Clinical Support, Cancer & Blood ($3.1M) and healthAlliance clinical supplies ($3.1M).

The full year shortfalls against specific initiatives in the Provider Arm Services were fully offset by savings from the Funder.

6. Financial Position

Statement of Financial Position as at 30 June 2016

$'000	30-Jun-16			31-May-16	Variance	30-Jun-15	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0F
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	475,468	406,629	68,839F	438,457	37,011F	438,457	37,011F
Cashflow-hedge Reserve	(3,742)	(3,693)	49U	(3,788)	46F	(4,293)	551F
Accumulated Deficits from Prior Year's	(464,047)	(462,014)	2,033U	(464,047)	0F	(464,402)	355F
Current Surplus/(Deficit)	2,873	-	2,873F	2,858	15F	356	2,517F
	10,553	(59,078)	69,631F	(26,520)	37,073F	(29,882)	40,435F
Total Equity	**587,351**	**517,720**	**69,631F**	**550,278**	**37,073F**	**546,916**	**40,435F**
Non Current Assets							
Fixed Assets							
Land	286,017	217,178	68,839F	249,006	37,011F	249,006	37,011F
Buildings	589,257	576,525	12,732F	592,473	3,216U	585,033	4,224F
Plant & Equipment	85,564	107,220	21,656U	83,686	1,878F	78,462	7,102F
Work in Progress	43,872	62,860	18,988U	43,024	848F	39,821	4,051F
	1,004,710	963,783	40,927F	968,189	36,521F	952,322	52,388F
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	53,103	47,430	5,673F	51,042	2,061F	42,170	10,933F
- HBL	12,420	14,053	1,633U	12,420	0U	12,420	0U
- ADHB Term Deposits > 12 months	5,000	-	5,000F	5,000	0F	-	5,000F
- Other Investments	503	-	503F	503	0F	462	41F
	71,026	61,483	9,543F	68,965	2,061F	55,052	15,974F
Intangible Assets	762	7,856	7,094U	738	24F	910	148U
Trust Funds	14,495	14,548	53U	14,154	341F	17,299	2,804U
	86,283	83,887	2,396F	83,857	2,426F	73,261	13,022F
Total Non Current Assets	**1,090,993**	**1,047,670**	**43,323F**	**1,052,046**	**38,947F**	**1,025,583**	**65,410F**
Current Assets							
Cash & Short Term Deposits	39,460	77,752	38,293U	59,240	19,780U	87,210	47,750U
Trust Deposits > 3months	6,500	7,700	1,200U	11,000	4,500U	8,500	2,000U
ADHB Term Deposits > 3 months	15,000	-	15,000F	15,000	0F	-	15,000F
Debtors	29,871	16,599	13,273F	33,027	3,156U	28,509	1,362F
Accrued Income	31,090	18,500	12,590F	35,458	4,368U	19,206	11,884F
Prepayments	1,679	1,166	513F	2,298	619U	1,035	644F
Inventory	14,239	12,723	1,516F	13,625	614F	13,154	1,085F
Total Current Assets	**137,839**	**134,440**	**3,399F**	**169,648**	**31,809U**	**157,614**	**19,775U**
Current Liabilities							
Borrowing	(429)	(1,442)	1,013F	-	429U	(52,454)	52,025F
Trade & Other Creditors, Provisions	(132,193)	(142,150)	9,957F	(158,660)	26,467F	(121,299)	10,894U
Employee Benefits	(168,232)	(182,554)	14,322F	(175,718)	7,486F	(176,735)	8,503F
Funds Held in Trust	(1,239)	(1,169)	70U	(1,237)	2U	(1,208)	31U
Total Current Liabilities	**(302,094)**	**(327,315)**	**25,221F**	**(335,615)**	**33,521F**	**(351,696)**	**49,602F**
Working Capital	**(164,255)**	**(192,875)**	**28,620F**	**(165,967)**	**1,712F**	**(194,082)**	**29,827F**
Non Current Liabilities							
Borrowings	(305,065)	(304,500)	565U	(304,500)	565U	(254,500)	50,565U
Employee Entitlements	(34,321)	(32,575)	1,746U	(31,301)	3,020U	(30,085)	4,236U
Total Non Current Liabilities	**(339,387)**	**(337,075)**	**2,312U**	**(335,801)**	**3,586U**	**(284,585)**	**54,802U**
Net Assets	**587,351**	**517,720**	**69,631F**	**550,278**	**37,073F**	**546,916**	**40,435F**

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 has been completed for both land and improvements. The land value increased further from Jun 2015 to June 2016 by $37M and this has been included in the accounts summarised above. Analysis of the improvements impact (which is also an increase in valuation) is underway and will be included in the Audited result.

- Buildings, plant and equipment variances are largely due to different opening balances set in the budget. Capital spend is also $30.6M 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 June 2016)

$000's	Month (June-16)			YTD (12 months ending 30 June-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	178,866	169,629	9,237F	2,030,058	2,032,944	2,886U
Payments						
Personnel	(81,562)	(71,112)	10,449U	(870,162)	(840,587)	29,575U
Suppliers	(39,175)	(35,529)	3,647U	(432,916)	(424,106)	8,810U
Capital Charge	(20,701)	(3,366)	17,335U	(42,905)	(40,344)	2,561U
Funder payments	(53,126)	(53,356)	231F	(636,838)	(640,275)	3,437F
GST	(2,027)	0	2,027U	(2,134)	0	2,134U
	(196,590)	**(163,363)**	33,227U	**(1,984,955)**	**(1,945,312)**	39,643U
Net Operating Cash flows	**(17,724)**	**6,266**	**23,990U**	**45,103**	**87,631**	**42,529U**
Investing						
Interest Income	408	668	261U	5,455	8,762	3,307U
Sale of Assets	132	0	132F	183	0	183F
Purchase Fixed Assets	(3,234)	(7,665)	4,431F	(60,236)	(90,861)	30,625F
Investments and restricted trust funds	1,939	(1,633)	3,572F	(26,102)	(4,133)	21,969U
Net Investing Cash flows	**(755)**	**(8,630)**	**7,874F**	**(80,701)**	**(86,232)**	**5,531F**
Financing						
Other Equity Movement	0	0	0F	0	0	0F
Equity Injections	0	0	0F	0	0	0F
New Loans	0	0	0F	0	0	0F
Loans Repaid	995	0	995F	995	0	995F
Equity Repayment	0	0	0F	0	0	0F
Interest paid	(2,294)	(1,075)	1,219U	(13,145)	(13,662)	518F
Net Financing Cashflows	**(1,299)**	**(1,075)**	**225U**	**(12,150)**	**(13,662)**	**1,513F**
Total Net Cash flows	**(19,778)**	**(3,439)**	**16,340U**	**(47,748)**	**(12,263)**	**35,485U**
Opening Cash	59,239	81,194	21,953U	87,210	90,018	2,808U
Total Net Cash flows	(19,778)	(3,439)	16,340U	(47,748)	(12,263)	35,485U
Closing Cash	**39,462**	**77,755**	**38,293U**	**39,462**	**77,755**	**38,293U**

ADHB Cash	31,984	72,650	40,665U
A+ Trust Cash	422	0	422F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	7,056	5,105	1,951F
	39,462	**77,755**	**38,293U**
ADHB - Short Term > 3 months	15,000	0	15,000F
A+ Trust Deposits - Short Term > 3 months	6,500	**7,700**	**1,200U**
ADHB Deposits - Long Term	5,000	**0**	5,000F
A+ Trust Deposits - Long Term	14,495	**14,548**	53U
Total Cash & Deposits	**80,457**	**100,003**	**19,546U**

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
B4SC	-	Plunket Before Schools Check
CED	-	Children's Emergency Department
CSP	-	Waitemata Primary and Community Services Plan
DHB	-	District Health Board
ED	-	Emergency Department
GPs	-	General Practices
HCSS	-	Home and Community Support Services
HPV	-	Human Papillomavirus
IY	-	Incredible Years Programme
LMCs	-	Lead Maternity Careers
MALT	-	Maori Alliance Leadership Team
MoH	-	Ministry of Health
NCSP	-	National Cervical Screening Programme
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
SME	-	Self Management Education

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 22 June 2016.

1. Planning

1.1. Annual Plans

Both draft 2 Auckland and Waitemata DHBs' Annual Plans are currently under review by the Ministry of Health. These are being updated as feedback is received and we are working towards Ministerial sign off in July.

1.2. Annual Reports

Development work has commenced on both Auckland and Waitemata DHBs' 2015/16 Annual Reports. First drafts are being prepared for initial audit review in July.

2. Hospitals

2.1 Cancer target

The ADHB provider reported the FCT 62 day indicator result for May had fallen to 55%. This related to data processing and timeliness of service provision impacted by SMO availability across a range of specialities particularly Dermatology and Gynaecology. A recent review of breach records enabled targeted efforts to improve performance with the 62 day indicator now at 76.4% (12 July 2016) The service is working to implement mandatory delay code reporting including patient choice and increasing focus on the 31 day target to improve overall pathway performance.

2.2 Auckland DHB 2015/16 Surgical Health Target

The MOH has confirmed the DHB has achieved the Health Target. The following table provides a summary of the year end position for the Surgical Health target based on coded information available at 18 July. The table provides a breakdown of the different elements of the health target including the surgical elective theatre events versus other activity included in the health target count.

2015/16 ADHB Surgical Health Target

Surgical Health Target	Plan	Actuals	Variance	%
Surgical PUC - Arranged	1379	1506	127	109.20%
Non-Surgical PUC - Elective	618	654	36	105.80%
Non-Surgical PUC - Arranged	332	242	-90	72.90%
Surgical PUC - Elective	14371	14299	-72	99.50%
Surgical Health Target	**16700**	**16701**	**1**	**100.00%**

Surgical PUC Elective - Discharges				
ADHB Provider - Surgical Elective Theatre events	11763	11002	-761	93.50%
ADHB Provider - Skin Lesions	1029	1025	-4	99.60%
ADHB Provider - Avastins (Intraocular injections) - forecast*	726	1546	820	212.90%
IDF Out (Other DHBs)	853	726	-127	85.10%
Total - Surgical PUC Elective Discharges	**14371**	**14299**	**-72**	**99.50%**

* forecast at 18th July

2.3 2015/16 IDF arrangements

The year wash up forecast position is being finalised. An audit completed by the funder of domicile codes at other DHBs has identified errors favourable to ADHB of approximately $530K. Coding has yet to be finalised for the financial year however the funder has assessed all available information to establish a view of the final wash up position to appropriately manage the year-end financial risk. The shortfall in the Midland DHB IDF funding arrangements for Eating Disorder services in 15/16 (and 16/17) remains unresolved and the lead Northern region CEO for Mental Health, Dr Dale Bramley has had initial discussions with the Midland lead CEO in an endeavour to achieve a resolution. A formal response has not yet been received.

2.4 2016/17 IDF arrangements

Further work is needed in some key areas of IDF service delivery to quantify additional funding requirements to meet costs above national price for the Gynaecology Oncology services for the

Northern and Midland region populations and Clot Retrieval (Thrombectomy) services for the Northern region (and potentially Midland region populations). The Ophthalmology service improvement plan and associated funding agreement has yet to be finalised between the ADHB and Waitemata DHB funder and the provider service.

The funder has completed initial analysis of the Northern region impact on the drug and other operating costs associated with the new PHARMAC approval of the melanoma treatments. The intention is to implement a change to the IDF funding arrangements resulting in increased revenue to enable ADHB to establish the additional capacity to deliver this new service.

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 at National Price.

The final 2016/17 Electives population plan, as agreed with the ADHB Directors and production planning team, has been resubmitted to the Ministry of Health following feedback regarding the unacceptably high level of Avastin intraocular eye injections included in the first draft of the plan sent to the MOH by the 1 July 2016 deadline. Final feedback is needed from the MOH before confirming the overall DHB plan however the revised plan includes a level of combined skin lesion and Avastin procedures at 15.5% of the total surgical elective discharges which is at the upper boundary of acceptability to the MOH. As previously reported to the Board, the ADHB provider has insufficient internal surgical capacity to meet the increased elective discharge requirement from July and a plan for outsourcing ophthalmology and orthopaedic volumes has been initiated by the funder for the first quarter to ensure the required Health Target uplift is achieved monthly from July 2016. A separate Board paper is provided this month regarding the 2016/17 Elective plan.

2.6 Tertiary services review

The service specific analysis for all Starship clinical services is complete and the final Child Health report has been finalised. The Child Health financial analysis is currently being finalised before proceeding to confirm the internal and external stakeholder consultation and communication processes.

2.7 Policy Priority areas

Colonoscopy Indicators

The waiting time indicators for May (MoH data) show a marked improvement for routine colonoscopy from 54.4% to 67.3% with the target of 65%. For urgent colonoscopy the result for the indicator 100% within 30 days was just short at 98.3%. For surveillance colonoscopy the result for the indicator 100% within 120 days was also short at 80.2%. Targeted efforts have been applied to improve performance across all the indicators. The new endoscopy facility is to be operational in July following a blessing and official launch. This facility will increase capacity and enable the DHB to achieve all indicators, including the new indicators of improved access in 2016/17.

As a result of the improved performance in the final quarter ADHB will achieve the 2015/16 boost funding of $233K from MOH.

Radiology Indicators

June results are not available at the time of this report however performance against the outpatient radiology indicators improved in May for both the CT and MRI indicators, with the CT indicator at 93% (91% in April – target 95%) and the MRI indicator at 64% (58% last month) . There is still some way to go to achieve the target of 85% with the waiting times for children worse than for adults. Only 50% of children receive their MRI within six weeks as a result of longstanding issues relating to the provision of anaesthesia services for children (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 78%, against a DHB target of 95%.

Waiting Time Targets
At the end of both May and June, ADHB was moderately non-compliant (yellow) for the ESPI 2 (outpatient FSA) waiting time target and the ESPI 5 (booked for surgery) waiting times target. Key capacity pressures remain in Adult Orthopaedics, including spinal services, and Paediatric (general) Surgery and other paediatric surgical sub specialties. The provider has signalled the July position for both ESPI targets is likely to be non- compliant (red)due to a combination of factors, including winter acute pressures impacting on theatre and bed capacity, and school holiday period leave for SMOs.

Bone Marrow Waiting Times
At the time of this report there were no patients waiting longer than the clinically recommended 6 weeks maximum waiting time guideline.

2.8 National services
Additional funding in 2016/17 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 have made good progress with recruitment of additional staff to the National Paediatric Cardiac and Congenital Heart service and this has resulted in the required service improvement with reduced elective operating out of hours and a reduction in cancellation rates. There have been no cancellations of acute and semi-urgent cases in the 4th quarter, and only four PICU bed related cancellations compared with 23 in the same quarter last year.

The total payment to the DHB in the 4th quarter is equivalent to 94% of the available funding for additional FTE. The funder is working with the provider to develop proposals previously identified for additional investment in national services in 2017/18.

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. CMDHB has confirmed there is no change expected in the planned volume of Urology services to be provided by ADHB in 2016/17 however there is an agreement the two Urology services at CMDHB and ADHB will work together more closely to ensure a more timely and consistent approach to access.

3. Primary Care
3.1. Community Pharmacy
The 20 District Health Boards have provided a revised offer to community pharmacies on pharmaceutical margins and subsidised unregistered medicines (section 26 & 29). This was subsequent to the previous offer being rejected. The offer requires 100% of pharmacies to accept the offer. Engagement with community pharmacies is now under way to ascertain if all pharmacies will accept the offer or not. Those pharmacies indicating that they will not accept the offers are being given an opportunity to discuss this further with the DHB for further clarify the offer.

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).

A work programme has now been put in place involving all PHOs and DHBs in metropolitan Auckland to develop an Improvement Plan. Wherever possible the Improvement Plan will be consistent across all PHOs and DHBs. Each System Level Measure has a lead PHO and a DHB Public Health Physician who are accountable to obtain input from the appropriate stakeholders to develop the Improvement Plan section for that measure. The Improvement Plan is to be approved by the Alliance and with the Ministry of Health by 20th October 2016.

3.3. Rural Alliance

The Rural Alliance has completed a stocktake of all services provided by the general practice teams. This is informing the development of work plan that is likely to focus upon improved access to imaging, use of point of care testing to improve timeliness of a small selection of laboratory results, and an expanded range of service available via Primary Options for Acute Care.

The Rural Alliance is making good progress and has been approached by Alliances elsewhere in the country on the approach undertaken. The Alliance has very good support from the rural general practices who see the potential of the Alliance to help them further improve services to the rural communities.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

National work is continuing around the process to achieve a regularised HCSS workforce; this would incorporate guaranteed support worker hours, staff training and safe staffing ratios. A regularised workforce comprises part B of the Settlement Agreement for Inbetween Travel that all parties (providers, unions, DHBs, MoH) have agreed to.

The HCSS providers have agreed to participate in a trial for an in-home strength and balance exercise programme as part of the DHB's Community Falls Prevention Programme, which is being undertaken jointly with ACC and Waitemata DHB. The trial will determine if it is feasible, and acceptable to clients, to deliver this service through HCSS and whether it is effective in preventing injurious falls. Delivering such a programme through HCSS would be more cost effective than traditional in-home

exercise programme such as the Otago Exercise Programme and could be delivered for a more sustained period.

4.2 Aged Residential Care (ARC)

A fundamental change to the ARRC Agreement for 2016/17 is an amendment so that it applies to all needs assessed residents. This aligns the Agreement with the intent of the Social Security Act. Many of the provisions in the ARRC Agreement were inconsistent with the statutory regimen set out in the Social Security Act in that it could be interpreted that it applied to subsidised residents only. Therefore, throughout the Agreement, with a few exceptions, the term "subsidised resident" has been replaced with "resident".

4.3 Day Programme Review

We are undertaking a review of our Health of Older People contracts for day activity programmes and dementia day care; a number of these contracts are historical and were devolved from the MoH. The review will examine the aims, populations served and service delivery of existing contracts. It will also encompass a review of the evidence and define possible aims for the funding and prioritise these.

4.4 Health of Older People Strategy

The draft Health of Older People Strategy has been released this month for consultation, which closes on 7 September.

5. Women, Children & Youth

5.1 Immunisation

As previously signalled, Auckland DHB did not achieve the Immunisation Health Target of 95% of 8 month old infants fully immunised in Q4 2015/16. Auckland DHB achieved 93%. High coverage rates have been maintained in both Pacific and Asian communities (96% - 98%). However, equity gaps persist for Maori infants with only 89% fully immunised by 8 months of age. By 12 months of age, at least 95% of these infants are fully vaccinated. This suggests delays and declines remain a significant challenge.

In terms of numbers of children, the following table sets out the breakdown of those immunised (on time) compared with those not immunised, declined or opted off the register. (Both the decliners and the opt-off groups remain in the population denominator and have had contact with the primary care health system and outreach immunisation service).

Table 1: Immunisation status of children turning 8 months April-June 2016

Cohort and immunisation status	Auckland DHB
Number of infants turning 8 months in the quarter (April – June 2016)	1,428
Immunised on time	1,335 (93.4%)
Declined	32 (2.2%)
Opt off	9 (0.6%)
'Missed'	52 (3.6%)

The new action plan identifies the need to connect earlier – to engage during pregnancy so women have time to consider immunisation earlier and to help predict decliners/hesitant families earlier. The 'Protecting Baby Starts in Pregnancy' promotional campaign is underway via radio and social media. Laboratories have placed promotional posters.

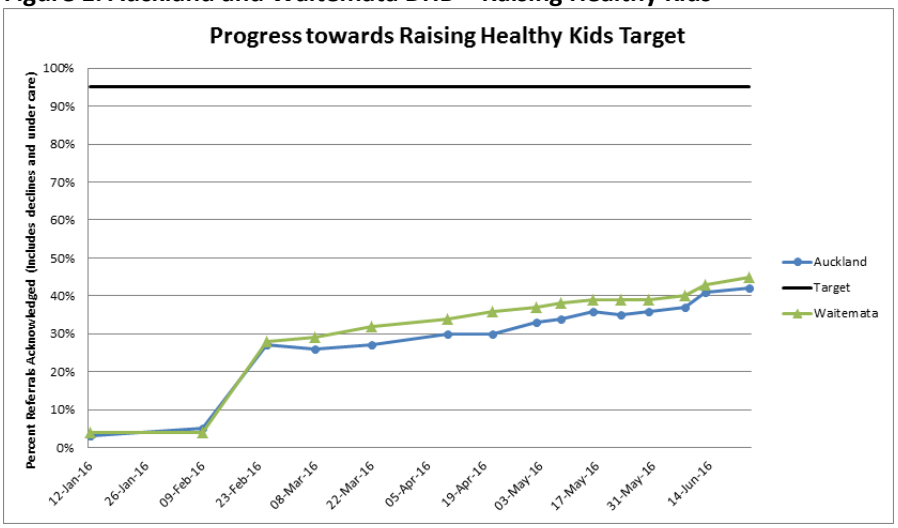
To address the significant decline/opt off rate, we are working with PHOs to refine and embed best practice in immunisation process across all General Practices. Joint DHB/PHO education sessions are underway for primary care practice staff and lead maternity careers (LMCs) across Auckland and we are working with PHOs to support practices in localities with high decline rates.

Specifically for Māori infants, a case review group led by the Community Paediatrician explores reasons where an infant has passed the milestone and is not fully immunised. This involves looking at all touchpoints in the health system and linkages between LMCs, primary care, well child and secondary care services.

5.2 Childhood Obesity

The obesity target requires the B4 School Check to establish whether a child is over the 98th BMI percentile, refer the child/family to the GP, and receive acknowledgement of the referral within 30 days. Early results suggest a solid start towards the target with Auckland performing considerably above the national average of 21%. In Auckland DHB, 38% of eligible children referred have been acknowledged by General Practice providers. There has been considerable and steady improvement over the course of 2016 (see Figure 1).

Figure 1. Auckland and Waitemata DHB – Raising Healthy Kids



The Health Target is still under development nationally and the definitions continue to be refined. Recently the Ministry set a lower BMI threshold for referral, and shorter 30 day period (down from 60 days) for general practices (GPs) to acknowledge referrals from the B4SC team. Work is underway to increase B4SC referral capacity, up-skill the B4SC providers, and develop appropriate referral pathways.

Auckland DHB has commissioned a first phase service with the Plunket Before Schools Check (B4SC) programme to implement a screening, brief intervention and referral programme for children identified as >98th percentile BMI in the 2016/17 year. From 2017/18 MoH funding is expected for family-based community programmes.

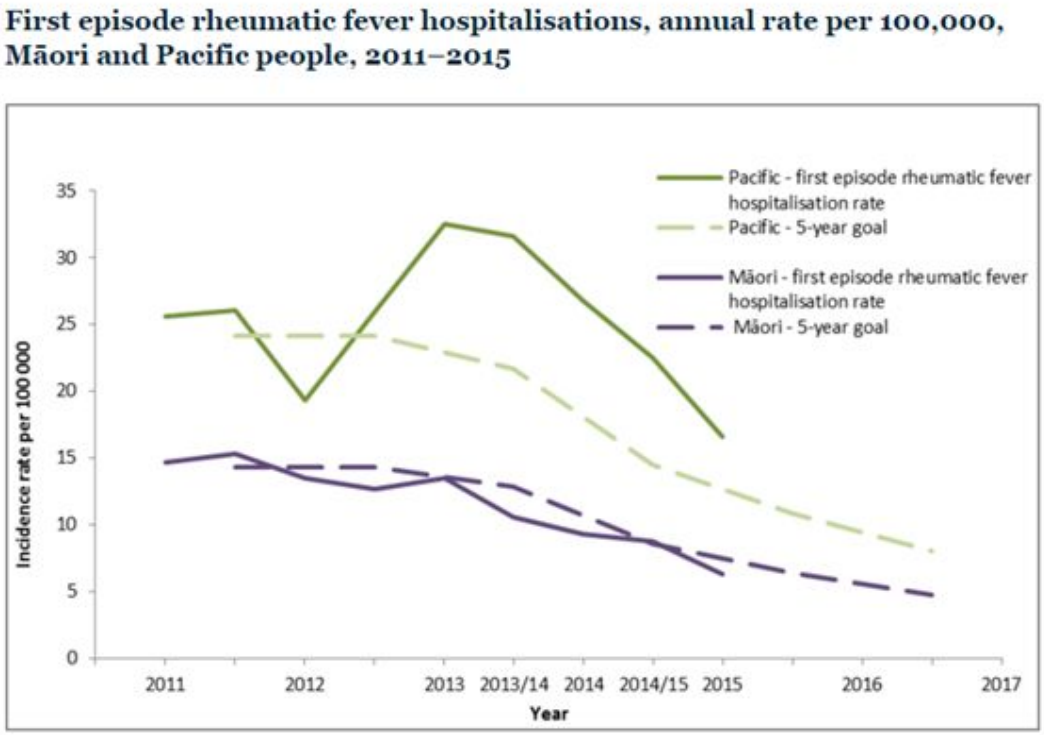
In the past six months, up-skilling has largely been delivered by Plunket, who are committed to achieving the target. Referrals to health professionals for four year olds above the 98th percentile have increased substantially to the point where additional staffing is now required to manage the follow-up of referrals within the new 30 day period. Advice and support is in addition to referral to GPs or paediatricians. GP consultations are free for families following the introduction of free under 13 care. Referral pathways are currently being defined by the Northern Regional Clinical Pathways working group and the draft is expected to be released for clinical consultation in July 2016.

We are making solid progress against this important new health target and will continue to report progress routinely to CPHAC through this scorecard.

5.3 Rheumatic Fever

Despite a number of interventions being implemented, Rheumatic Fever rates across Auckland DHB are not yet achieving the MoH target. While we are tracking better for Māori, Pacific rates continue to be a concern. There has been a reduction for Māori of approximately 50 percent since the programme began in 2011 (refer to Figure 2).

Figure 2:



Research shows that there is no clear single intervention that will completely reduce the rate of Rheumatic Fever. Research regarding our current position indicates that environmental factors including seasonal differences, unhealthy housing including overcrowding, genetic predisposition, access to health services, and the need for targeted promotion of health services (school-based and rapid response clinics). The need for consistent and appropriate messaging to the targeted population has also been identified as a potential contributing factor, particularly through research undertaken with young people that have rheumatic fever.

The current actions to reduce the incidence of Rheumatic Fever include:

- Healthy Homes Initiative
- School-based sore throat management Programme (in identified schools)
- Rapid response throat swabbing (dedicated clinics offering free throat swabbing for target populations- including Māori and Pacific)
- Community engagement (youth, community and sector)
- Governance restructure, including the development of the RhF Governance Group and Clinical and Operations Group
- Ongoing Māori key stakeholder meetings
- National and DHB communications strategy

- PHO Quality Improvement plan
- Appointment of RhF Champions across Auckland DHB
- Development of a communications plan using a variety of media which incorporates national and local health promotion strategies.

As previously reported, the Ministry of Health funding for the RhF programme is decreasing, while DHBs are expected to maintain a commitment to a range of evidence-based interventions. The Ministry is also shifting some of the focus (with additional funding) to the Healthy Homes Initiative. Specifically, this element of the programme is being expanded and, in addition to the Rheumatic Fever criteria, will now include:

- Those aged 0-5 hospitalised for an indicator condition (RhF, lower respiratory tract infections, group A strep disease)
- Priority population of 0 – 5s where families have at least 2 markers of vulnerability (CYP finding of abuse or neglect; caregiver with a Corrections history; mother with no formal qualifications; long term benefit receipt).
- At risk pregnant women/new mothers.

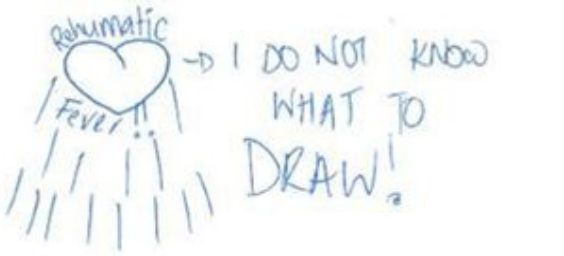
Discussions have begun with the Ministry of Health with the metro Auckland DHBs on the expansion of the Healthy Homes Initiative model. Discussions will continue over the next two months with the expectation that a final plan will be agreed with the Ministry by the end of August. (The Ministry has been informed that the DHBs may not be able to make formal commitments due to the DHB election period). An estimated additional 900 families in ADHB and 1,100 families in WDHB have been estimated by the MoH as meeting the new housing eligibility criteria. Estimates are being further refined.

While the Ministry of Health plans to contribute some funding for this initiative, it is clearly signalling that DHBs will be expected to contribute to the expanded programme. Options are currently being explored, including the tailoring of appropriate whanau support to meet individual needs such as public health nurses, Māori, Pacific and social work teams. In relation to interventions, in addition to identifying eligible families, undertaking a housing assessment and advocating for families with MSD, Housing New Zealand and with private landlords, various interventions are being offered. Some interventions being offered around the country include providing beds and bedding, paying power bills and installing carpets and curtains. We expect to bring a paper to the DHB Audit and Finance Committees regarding these initiatives when we have sufficient information.

In addition to the work on RhF prevention, there is an ongoing programme of quality improvement in disease management for RhF and Rheumatic Heart Disease. Activities include:

- Regular meetings of an ADHB disease management group which reviews all hospital admissions for RhF (management across primary and secondary care, consistency with the NZ Heart Foundation Guidelines, notification to ARPHS, etc.)
- Ongoing development of a Fight the Fever app using a sprint series of co-design workshops with a group of young people with RhF. Phase one is complete and the initial pilot is due to begin. Subsequent improvements and additions (such as development of peer support) as well as formal evaluation will be dependent on future research funding.
- Re-development of the Auckland Regional Rheumatic Fever Register. Current IT project, funded by ADHB, to enable regional provision of a disease database, secondary prophylaxis prescribing, and monitoring of bicillin adherence.
- Complete system review of RhF management and bicillin delivery within the community nursing service.
- Further development of the heart animations to support understanding on how RhF affects the heart (working with the Design and Wellbeing Hub).
- Planned summer studentship to work on a transition initiative for young people with RhF.

- Successful community workshop for young people with RhF and RHD: HYPE 2106: Health Youth Priority Event. Over 100 young people attended the event in Glen Innes, 66 of them have had Rheumatic Fever; 35 were young people with friends or whanau with RhF. The programme consisted of a leadership workshop, an in-depth and personal session on Rheumatic fever with local RhF champions and info-tainment sessions. An evaluation is underway to help inform organisation of HYPE17. Feedback from young people indicates that the event was highly successful. Following the event, the students spoke about the importance of maintaining their bicillin programme and ways that they will be able to ensure this happens.
- Exploration of young people's understanding of how RhF affects their heart and planned improvements in resources. Knowledge regarding RhF and heart health was variable even in the young people attending HYPE with personal experience of RhF. A Q and A session with doctors and nurses provided an opportunity for questions to be asked anonymously.



5.4 Proposed Immunisation Schedule changes

In May 2016, Pharmac released two consultation documents seeking advice and feedback to proposed changes to the National Immunisation Programme for 2017. The DHBs feedback on specific points is available on the PHARMAC website. Overall, the proposed changes are welcomed and will significantly improve protection from vaccine preventable diseases.

Significant changes signalled include:

- Human papillomavirus (HPV) vaccine from 1 January 2017
  - Funding for males as well as females
  - Eligibility extended to 26 years of age
  - Change from 4-valent to 9-valent vaccine
  - 2-dose regime for those 9-14 years of age, 3-dose 15-26 years of age
- Chicken Pox (Varicella) Vaccine
  - Funding starts from 1 July 2017 for 1-dose at 15 months of age with a 'catch-up' dose available at 11 years of age.
- Rotavirus vaccine
  - Change from 3-doses to 2-doses which must be completed by 24 weeks of age.
- Pertussis Tetanus, Diphtheria vaccine
  - Continue funding vaccine for pregnant women
- Pneumococcal Vaccine
  - Changes from 13-valent to 10-valent for universal programme
  - Re-introduces 13-valent for children with high-risk medical conditions
- Influenza vaccine
  - Move from the tri-valent to quadrivalent vaccine that will cover more influenza strains.

Other changes proposed include changes to vaccine brands, but no other significant schedule changes are proposed for 2017. Some of the changes will have a significant operational impact on the DHBs.

5.5 HPV vaccine

Evidence now shows that younger women (aged 9 – 14 years) have a naturally stronger immune response than their slightly older sisters (15 – 26 year olds). As a result, with the additional evidence regarding this particular vaccine, PHARMAC has now approved moving from a three dose, to a two dose schedule for the younger women. However, the older group still appear to need three doses.

Other countries that have already changed from a three-dose to a two-dose schedule include the UK, Switzerland, the Netherlands and Quebec. Immunisation rates may improve with a two-dose regime compared to the current three-dose regime. Nationally, 58% of 12 year old girls have received three doses of HPV vaccine whereas other countries have 70-80% coverage.

The Subcommittee also noted that there was also strong evidence that the HPV vaccine was effective for boys and men (Giuliano et al. N Engl J Med. 2011;364:401-11). Australia began including boys in its vaccination programme two years ago. HPV is common in both males and females. HPV can cause cancers of the anus, mouth, tongue, throat (oropharynx), and penis in males. Cases of anal cancer and cancers of the mouth/throat are on the rise.

The Subcommittee reported that there are no new safety concerns relating to the HPV vaccine since it was listed, and considers that the HPV vaccine has a good safety profile. Members considered that the vaccine may provide long acting immunity, similar to the hepatitis B vaccine.

5.6 Other National Immunisation Programme Updates

BCG vaccine

Global shortages of BCG vaccine have affected supply in New Zealand with the result that BCG vaccination is currently not available for high risk infants until further notice (not before 2017). There are no other options for sourcing the vaccine at this time.

Additional vaccines for Special Groups

From 1 March 2016, PHARMAC extended the National Immunisation Schedule to increase eligibility for additional funded vaccines for some special groups of people with conditions which predispose them to significant sequelae from vaccine preventable diseases. This includes people having transplants, who are HIV positive, have a cochlear implant, kidney disease, asplenia, or primary immunodeficiency.

More details can be found at the Immunisation Advisory Centre website:
http://www.immune.org.nz/sites/default/files/resources/ProgrammeScheduleChanges20160301V01Final.pdf

5.7 Oral Health

The oral health of children, particularly Māori and Pacific, is a concern across the region with significant inequities in access and outcomes. A review of service delivery and outcomes for ARDS is being led by Linda Harun, with input from a steering group, expert advisory group and external peer review. A full report will be completed by late August, early September.

Causes of high caries rates in children include issues such as access to transport, lack of understanding about the importance of dental cleaning, diets high in sugary drinks/food and access to toothbrushes and toothpaste.

The Ministry of Health is leading a national oral health project which will include giving tooth brushes and tooth paste to young children and babies. The roll-out is planned to run along-side a multi-media campaign about the importance of oral health care. The Health Promotion Agency is leading the communications campaign. The key messages in the first year are:

- Baby teeth matter

- Brush twice a day with fluoride toothpaste.

To improve caries free rates in children the following actions are being taken:

- A focus on seeing children for the first time before they turn one year age to provide oral health promotion and undertake an oral health risk assessment
- Training Well Child Tamariki Ora providers on the 'lift the lip' programme and other oral health messages
- Improving Māori engagement/access to service
  - Diagnostic vans are being converted to treatment vans for use at low decile schools
  - A supportive treatment Pathway Pilot to start in July 2016 - to provide additional support for high risk patients/whanau to access the ARDS service
  - Extended late night hours and Saturday clinics
  - Employing more Māori dental therapists and assistants
  - Patient-centred dental appointments
  - Text message reminders for parents/caregivers
- Focusing on preventive treatments such as
  - Hall technique - a treatment type that reduces bacterial load in the mouth and reduces risk of broken fillings
  - Fluoride varnish is applied when clinically indicated
  - High risk children are seen six monthly
- Preschool coordinators are
  - Focusing on early enrolment
  - Working with kohanga reo and kura to promote the service
  - Facilitating access to the service for high risk Māori & PI families
  - Working with Plunket nurses, Public Health Nurses, PHOs, Māori trusts and other related health services.

5.8 Breastfeeding

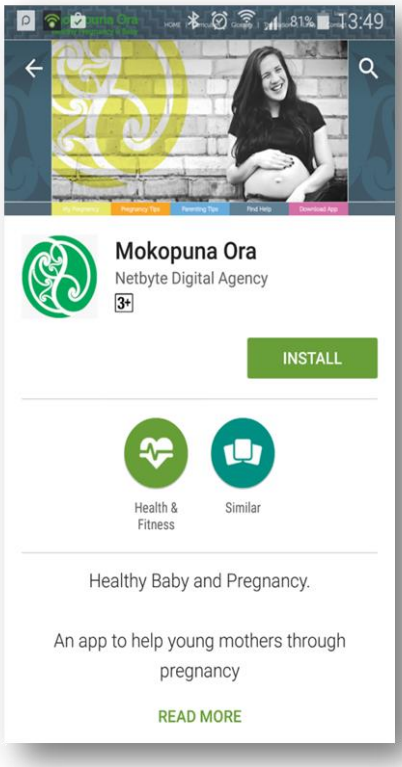
The Obesity Plan has identified increasing breastfeeding rates as key priority. To achieve this, we are exploring options for implementing the Le Leche League Breastfeeding Peer Counsellor Programme. We are learning from other providers currently running the programme, including CMDHB, particularly in relation to what has worked well and what could be done better. Their programme is currently run by community providers. The aim of the programme is to increase breastfeeding rates at three months of age and beyond. We expect to have a programme started in early 2017.

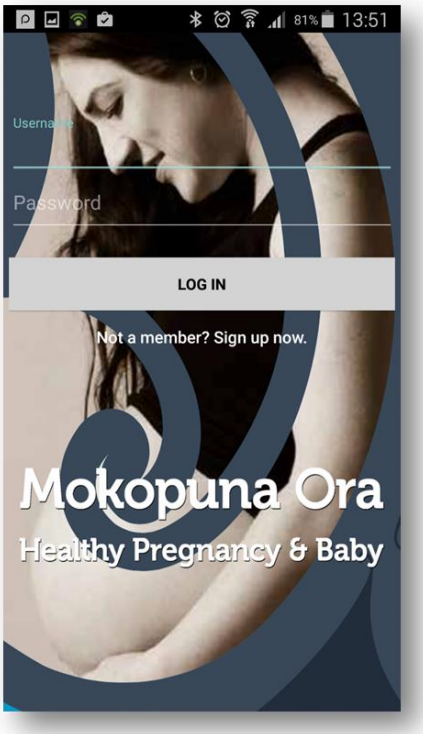
The community Lactation Consultant is now established in Auckland DHB. The service delivers support from community locations (Ngati Whatua and Mt Roskill Union) as well as providing a home visiting service. The key focus for the service is providing additional breastfeeding support in the first 6 weeks following the birth.

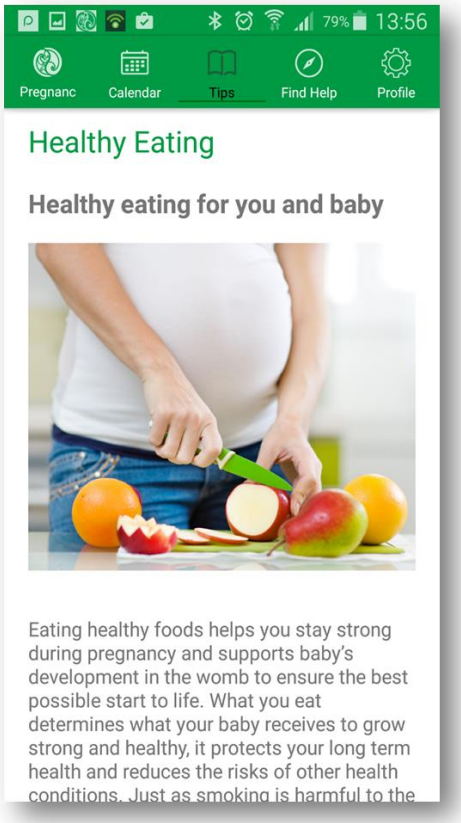
5.9 Pregnancy and Parenting Information and Education

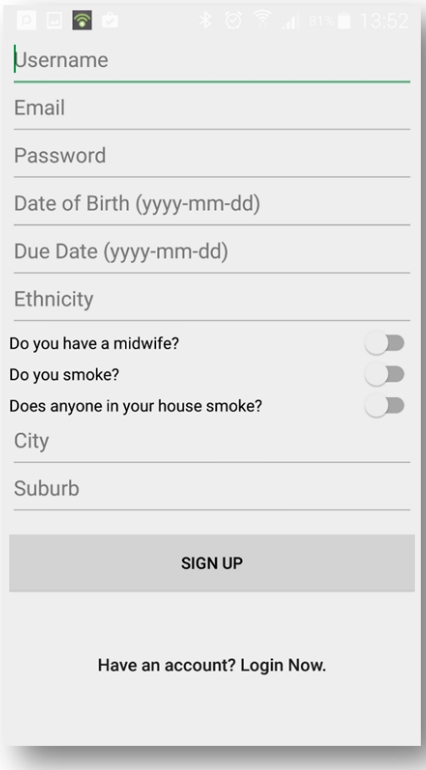
Auckland DHB has implemented the revised Pregnancy and Parenting Service. A key feature of the new service is the availability of evidenced based pregnancy and parenting information via an App and Website (www.mokopunaora.nz) commissioned from the University of Auckland. The content is linked, so updates made to the website automatically populate on the App. A range of information is provided on the website as indicated in the screen shot below.

This new resource provides women and their family and whanau information including how they can access pregnancy and parenting education including on-line booking for more traditional antenatal classes. The following images are taken from the app and show that a woman can enter her pregnancy details and then receive information relevant to the stage of her pregnancy which includes reminders regarding actions such as ensuring she has a midwife. Messages are framed as positive encouragement to action.


13:49
Mokopuna Ora
Netbyte Digital Agency
3+
INSTALL
Health & Fitness
Similar
Healthy Baby and Pregnancy.
An app to help young mothers through pregnancy
READ MORE


13:51
Password
LOG IN
Not a member? Sign up now.
Mokopuna Ora
Healthy Pregnancy & Baby


13:56
Pregnanc
Calendar
Tips
Find Help
Profile
Healthy Eating
Healthy eating for you and baby
Eating healthy foods helps you stay strong during pregnancy and supports baby's development in the womb to ensure the best possible start to life. What you eat determines what your baby receives to grow strong and healthy, it protects your long term health and reduces the risks of other health conditions. Just as smoking is harmful to the


Username
Email
Password
Date of Birth (yyyy-mm-dd)
Due Date (yyyy-mm-dd)
Ethnicity
Do you have a midwife?
Do you smoke?
Does anyone in your house smoke?
City
Suburb
SIGN UP
Have an account? Login Now.

The more traditional face to face sessions remain and are available at a variety of community locations including Glenn Ines, Mt Roskill, Parnell and Avondale. Women can access information regarding the service and register for classes on-line via the website, Healthpoint.

Additional information sessions are also being provided within the Greenlane maternity clinics and the inpatient antenatal and postnatal wards at Auckland Hospital. This is proving to be a positive opportunity to increase access to information for priority women.

An evaluation of the Auckland DHB service is currently being commissioned. The evaluation will be specifically tasked to review the implementation, reach, effectiveness and maintenance of the new Auckland DHB Service.

6 Mental Health and Addictions

6.1 Innovate

Innovate members are contracted and funded Auckland DHB providers of mental health and addiction services (including DHB services, NGO, Funders and Primary Care). The group provides an opportunity for providers and funders to collaborate and work together from a 'whole of sector' and integrated systems framework. The work plan for the collaborative for 2016_17 year (also linked to the annual plan) is to focus on:

- Tamaki Project as primary care initiative;
- Equally Well initiatives: People experiencing challenges with mental health and/or drug and alcohol use also often experience physical health problems. This group is developing strategies and interventions to improve physical health outcomes for people who experience mental illness and/or addictions.
- Shifting of services closer to home and the community: as a strategy to actively use current resources more effectively and deliver the right care, in the right place, at the right time and by the right people.

6.2 Look-Up 2016 Exploring Wellbeing around Alcohol and Other Drugs

Look Up is a free youth innovation forum to be held on 11 August 2016 for Auckland youth to explore wellbeing around alcohol and other drugs. The event aims to equip young people with access to good information, skill building opportunities and partake in conversation that they can share with their communities. Programme themes are balance, tough conversations, keeping safe and youth leadership. Look Up project manager is a youth being supported and guided by a predominantly youthful action team.

6.3 Auckland DHB's Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot started with three NGOs linked with two GP practices and more recently expanded to a third Mt Wellington practice. Next steps will be expanding (NGO provided) support services into GP practices in Mt Albert, the CBD and further practices in Tamaki. There is on-going evaluation of the initiative using person-centred approach, with people telling the evaluators that support should be designed around "what matters to me" as opposed to "what is the matter with you'. Here is an example of this principle in action:

> *Sometimes what feels trivial is actually key with people in the community telling Tamaki initiative evaluators that texting is a great way to get in touch to begin support relationships. It's easier first up to have a text conversation with a support worker. Texting to arrange to talk or meet a support worker gives a person more control as they can respond to the text when it suits them. If mobility is an issue it can be hard to get to a ringing phone and for many people the cost of picking up voice messages left on mobiles can be a real barrier. The evaluators have also found that the time it takes a support worker to respond to a person's texts is an early measure*

of trust. Texting back quickly lets people know they matter, and goes a long way to getting a support relationship off to a good start.

7. Maori Health Gain

7.1 Cervical Screening HPV Self-Sampling

Auckland and Waitemata DHBs have two projects approved to provide access to cervical screening Human Papilloma Virus (HPV) self-sampling to priority group women over the next three years. The intention of both projects is to clarify the participation rate for priority women using self-sampling in order to inform national policy as the National Cervical Screening Programme (NCSP) moves to changing the screening test from a pap smear to an HPV test in 2018. HPV self-sampling is not currently included in the NCSP programme change; however the NCSP is very supportive of research evidence to inform further policy development.

1. A HPV self-sampling feasibility and acceptability project for 200 Māori women in West Auckland, commencing in August 2016 (DHB led project; a partnership between Māori health, women's health, Te Whānau O Waipariera, primary care, colposcopy service, laboratory, and HPV experts).
2. A HPV-self sampling study comparing mail-out and clinic-based invitation strategies with usual care across both Auckland and Wellington, for Māori, Pacific and Asian Women (Massey University led project with DHB partnership, recently announced funding by the Health Research Council). Anticipate start of recruitment September 2017.

The feasibility project has recruited a Māori smear-taker nurse and is in the process of recruiting a project manager. One PHO has approved participation in the project and two further PHOs have agreed to participate in principle. Health Literacy New Zealand have been commissioned to localise the information for women and to develop an education package for providers. Project documentation is being prepared for approval by the ethics committee and local research committees, with an anticipated start to recruitment of women in August 2016.

7.2 Kaumatua Action Plan

The Kaumatua Action plan was signed off in 2015 and the first year of activity is currently being implemented. The current Kaumatua Action plan was developed by the DHBs as a mechanism that would support the improvement of older Māori health and well-being while also addressing the inequities that still exist between older Māori and Non-Māori within health. These inequities and the rapid growth of the older Māori population will have a significant impact on the health sector in the near future. We know this because the costs of health and disability support services increase significantly with age (Health of Older people Strategy, 2002) and therefore developing alternative approaches to delivering services to older Māori that are efficient and cost effective is essential.
In order to achieve this we are working on and have completed the following:

Project	Progress
1. Collaborate with Te Rūnanga o Ngāti Whātua to develop Tikanga Best Practice Guidelines for Aged Residential Care (ARC) that align with the District Health Boards ARC Quality Framework	• Draft version of Tikanga Best Practice Guidelines for Aged Residential Care (ARC) completed • Review process underway
2. Work in partnership with ADHB Rapid Response Team to link Māori clients with Māori services within the community	• Developed information package for Māori providers detailing services available, referral pathways and main contacts within the services • All Māori providers within the ADHB region now have this package • We will follow up with Rapid response services and Māori providers to gauge the uptake.
3. Complete a comprehensive analysis of the Māori workforce within Health of Older people provider arm services	• Completed an analysis of Māori workforce and Māori clients 65 plus across both DHBs • Information will be supplied to the Māori workforce development consultant to help inform specific areas of need within the Health of older persons workforce development area

Further work is needed to continue to build on these activities which can be sustained through the continual implementation of the Kaumatua Action plan. However there have been some factors outside the control of the project that have impacted on the progress of some activities (i.e. Notification to DHBs to roll over HCSS contracts for the 2016/17 year).

7.3 Māori Alliance Leadership Team (MALT)

The Māori Alliance Leadership Team (MALT) governs the implementation of the Workforce Strategy action plan across Auckland and Waitemata DHBs. The first meeting was held in February 2016. Key areas of focus were to:

- Develop a new data dashboard for regular reporting and integration into the Manawa Ora scorecard.
- Update the Maori workforce strategy to include a:
  - "Keeping People" section which is focused on retention of staff.
  - Set of differential targets for priority occupations reflecting the working age population
- Determine priorities for the workforce section of the Māori Health Plan.
- Review programmes to support Maori students in the tertiary component of the pipeline.
- Complete a stocktake of current DHB workforce development programmes.

At the second meeting held in June, immediate actions for the MALT were:

- Improve the methods used for gathering and recording ethnicity data.
- Improve the accuracy and completeness of the existing ADHB/WDHB ethnicity data set.
- Design the first year projects to be focussed on.
- Develop a business case to provide the infrastructure needed.

7.4 16/17 Māori Health Plans

The finalised 16/17 Māori Health Plans for Auckland and Waitemata DHB have been signed off by the Ministry of Health and are now available on the DHB and MOH websites.

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 *Incredible Years (IY)* parenting programme in the Tongan Methodist Church in Ponsonby has been completed and one *Living Without Violence* programme has been completed in the Congregational Church of Samoa, Sandringham.

The second training of *Living Without Violence* facilitators was held on 10th and 11th June in the Onehunga area and about 40 people participated. The next training workshop will be held on 17th September

Negotiations with Te Whanau o Waipareira Trust to train Pacific Triple P facilitators have been completed and these facilitators will deliver Triple P parenting programmes for Enua Ola churches in West Auckland. The *Incredible Years* programme will continue to be delivered on the North Shore and ADHB as the Ministry of Health contract with Wai Health for training and delivery of Triple P is only for West Auckland.

8.2 PHAP Priority 2 –Pacific People are smoke-free

West Fono Health Trust is the new provider for quit smoke services for Pacific people in the Auckland and Waitemata DHB areas. We will support West Fono in setting up this service.

8.3 Priority 3 – Pacific people are active and eat healthy

Negotiations are progressing with Healthy Families, Waitakere for WDHB and Healthy Families to work together to support Pacific early childhood centres in West Auckland to develop and implement healthy food policies in the centres.

The analysis of the survey of Aiga Challenge participants who have maintained weight loss in the last three years have been completed. Results will be disseminated to Enua Ola and HVAZ churches to inform the next Challenge.

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

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.

Self Management Education (SME)

The Stanford Chronic Disease Self Management Education Programme Leader's Manual into Samoan was launched on 3rd June. National MP, Alfred Ngaro was present as well as the Chief Adviser of Pacific Health from the Ministry of Health, Procare management as well as many members from the Samoan community.

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.

No further progress has been made in this area.

8.7 New Pacific Health Action Plan

Community consultation on the new Plan will start on 22nd July on the North Shore. Five meetings in total will be held. An online line version of the consultation is also being developed as an attempt to reach younger Pacific people who don't normally attend community meetings. This would be the first time that we have made the consultation available on- line.

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

The Asian International Benchmarking Report (Auckland and Waitemata DHBs) has been finalised and will be forwarded to the CEs by end of July and will be presented to CHPAC in August.

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% as at April, 2016)

'Healthcare- where should you go?' multilingual ADHB targeted campaign in Chinese, Korean, Hindi and English has rolled out to promote culturally appropriate messaging to Asian students and new migrants living in the Auckland City Centre and inner city fringe suburbs with the intent to increase awareness of the:

- appropriate healthcare options of where to go for urgent, less serious health concerns, and when to go to the hospital emergency department (ED) for emergency care
- benefits of enrolling with a local family doctor, or seeing one regular doctor who can manage one's overall health (for those who are not eligible or entitled to enrol).

A Hindi video on the NZ health & disability system has been finalised and will be added to the suite of online English and Mandarin resources available on the revamped Your Local Doctor website www.yourlocaldoctor.co.nz

Multilingual leaflets on the NZ health system have been finalised in English, Simplified Chinese, Korean, Japanese and Hindi and uploaded to the www.yourlocaldoctor.co.nz

Engagement has occurred with Plunket and targeted Central Auckland libraries to reach out to Asian parents (Chinese, Indian and Other Asian) about the role of a family doctor and benefits of primary care for their family.

Directorships - healthAlliance

Recommendation

That the Board:

1. **Note that Waitemata DHB wishes to appoint Russell Jones to become a director of healthAlliance NZ Ltd (hANZ) and healthAlliance (FPSC) Limited (FPSC) in the place of Andrew Brant, Chief Medical Officer - WDHB.**
2. **Note that Northland DHB has proposed that Meng Cheong, CFO - NDHB be appointed as a Director of (hANZ) and (FPSC), to replace Anthony Norman.**
3. **Note that the Constitution of hANZ and the Shareholders' Agreement provides that all shareholders jointly appoint directors. Auckland DHB is a shareholder in hANZ.**
4. **Resolve that Russell Jones and Meng Cheong be appointed as Directors of hANZ and FPSC and that the Chief Executive be delegated authority to execute all related documentation.**
5. **Resolve that the Constitution of hANZ and the Shareholders' Agreement be modified to allow each shareholder to appoint a director and that the Chief Executive be delegated authority to execute all related documentation to affect this change.**

Prepared by: Bruce Northey (General Counsel)

Endorsed by: Endorsed by: Rosalie Percival (Chief Financial Officer)

Background

The Constitution of hANZ and the Shareholders Agreement provides that all shareholders appoint Directors. This approach was adopted when Health Benefits Limited was a shareholder in hANZ and the consensus was that the DHBs would jointly appoint shareholders who were independent of any DHB. The current practice is that each DHB appoints a representative; this should be recognised by implementing a new Constitution and Shareholders' Agreement

Following the resignation of Anthony Norman as a Director of hANZ and FPSC as of 1 July 2016, Northland DHB have proposed that Meng Cheong, NDHB CFO be appointed as a Director of both these companies. NDHB is suggesting Meng Cheong should join the Boards until such time as a newly constituted NDHB Board reviews the position.

Waitemata DHB has proposed that Russell Jones become a director of hANZ in the place of Andrew Brant, CMO at WDHB. A copy of his CV is available.