Board Meeting

Wednesday, 28 October 2015
2:30pm

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

He Oranga Tika Mo Te Iti Te Rahi
Healthy Communities, Quality Healthcare

Published 22 October 2015
Agenda
Meeting of the Board
28 October 2015

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

Time: 2.30pm

Apologies Members:
Apologies Staff: Sue Waters

Karakia

Agenda
Please note that agenda times are estimates only

2:30pm 1. ATTENDANCE AND APOLOGIES

2. REGISTER OF INTERESTS AND CONFLICT OF INTERESTS
   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?

3. CONFIRMATION OF MINUTES 16 September 2015

2:40pm 4. ACTION POINTS
2:40pm  5.  CHAIRMANS REPORT – VERBAL REPORT

2:45pm  6.  EXECUTIVE REPORTS
   6.1  Chief Executive’s Report

2:55pm  7.  COMMITTEE REPORTS
   Manawa Ora Committee
   7.1  Ethnicity Data Audit Toolkit – Final Report

3:00pm  8.  PERFORMANCE REPORTS
   8.1  Financial Performance Report - September 2015
   8.2  Funder Report – September 2015

9.  DECISION REPORTS - NIL

10.  GENERAL BUSINESS

3:20pm  11.  RESOLUTION TO EXCLUDE THE PUBLIC

Next Meeting:  Wednesday, 09 December 2015 at 2.00pm
               A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare
# Attendance at Board Meetings

<table>
<thead>
<tr>
<th>Members</th>
<th>18 Feb. 15</th>
<th>1 Apr. 15</th>
<th>13 May. 15</th>
<th>24 Jun. 15</th>
<th>05 Aug. 15</th>
<th>16 Sep. 15</th>
<th>28 Oct. 15</th>
<th>09 Dec. 15</th>
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<td>Lee Mathias (Deputy Chair)</td>
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<td>Gwen Tepania-Palmer</td>
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Key: 1 = present, x = absent, # = leave of absence
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.

## Register of Interests – Board

<table>
<thead>
<tr>
<th>Member</th>
<th>Interest</th>
<th>Latest Disclosure</th>
</tr>
</thead>
</table>
| **Lester LEVY (Chair)**  | Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman)  
                       | Chairman - Auckland Transport  
                       | 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  
                       | Member – State Services Commission Performance Improvement Framework Review Panel  
                       | 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 | 16.09.2015 |
| **Jo AGNEW**             | Director/Shareholder 99% of GJ Agnew & Assoc. LTD  
                       | Trustee - Agnew Family Trust  
                       | Professional Teaching Fellow – School of Nursing, Auckland University  
                       | Appointed Trustee – Starship Foundation  
                       | Casual Staff Nurse – Auckland District Health Board | 15.07.2015 |
| **Peter AITKEN**         | Pharmacy Locum – Pharmacist  
                       | Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd  
                       | Shareholder/ Director - Pharmacy New Lynn Medical Centre  
                       | Shareholder/Director – New Lynn 7 Day Pharmacy  
                       | Shareholder/Director – Belmont Pharmacy 2007 Ltd  
                       | Shareholder/Director – TAMNZ Limited  
                       | Shareholder/Director – Bee Beautiful Limited | 07.10.2015 |
| **Doug ARMSTRONG**       | Shareholder - Fisher and Paykel Healthcare  
                       | Shareholder - Ryman Healthcare  
                       | Shareholder – Orion Healthcare  
                       | Trustee – Woolf Fisher Trust  
                       | Trustee- Sir Woolf Fisher Charitable Trust  
                       | Daughter is a partner – Russell McVeagh Lawyers  
                       | Member – Trans-Tasman Occupations Tribunal | 14.07.2015 |
| **Judith BASSETT**       | Fisher and Paykel Healthcare  
                       | Westpac Banking Corporation  
                       | Husband – Fletcher Building  
                       | Husband - shareholder of Westpac Banking Group  
                       | Daughter is a shareholder of Westpac Banking Group | 13.07.2015 |
| **Chris CHAMBERS**       | Employee - ADHB  
                       | Wife is an employee - Starship Trauma Service  
                       | Clinical Senior Lecturer in Anaesthesia - Auckland Clinical School  
                       | Member – Association of Salaried Medical Specialists  
                       | Associate - Epsom Anaesthetic Group  
<pre><code>                   | Shareholder - Ormiston Surgical | 26.01.2014 |
</code></pre>
<table>
<thead>
<tr>
<th>Name</th>
<th>Position Details</th>
<th>Date</th>
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</thead>
</table>
| Lee MATHIAS        | Chair - Counties Manukau Health  
                    Deputy Chair - Auckland District Health Board  
                    Chair - Health Promotion Agency  
                    Chair - Unitec  
                    Director - Health Innovation Hub  
                    Director - Health Alliance Limited  
                    Director/shareholder - Pictor Limited  
                    Director - Lee Mathias Limited  
                    Director - John Seabrook Holdings Limited  
                    Advisory Chair - Company of Women Limited  
                    Trustee - Lee Mathias Family Trust  
                    Trustee - Awamoana Family Trust  
                    Trustee - Mathias Martin Family Trust  
                    Director – New Zealand Health Partnerships | 10.07.2015 |
| Robyn NORTHEY      | Self-employed Contractor - Project management, service review, planning etc.  
                    Board Member - Hope Foundation  
                    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 | 21.07.2015 |
| Morris PITA        | Member – Waitemata District Health Board  
                    Shareholder – Turuki Pharmacy, South Auckland  
                    Owner and operator with wife - Shea Pita & Associates Ltd  
                    Wife is member of Northland District Health Board  
                    Wife provides advice to Maori health organisations | 13.12.2013 |
| Gwen TEPANIA-PALMER| Board Member - Waitemata District Health Board  
                    Board Member - Manaia PHO  
                    Chair - Ngati Hine Health Trust  
                    Committee Member - Te Taitokerau Whanau Ora  
                    Committee Member - Lottery Northland Community Committee  
                    Member - Health Quality and Safety Commission | 02.04.2013 |
| Ian WARD           | Board Member - NZ Blood Service  
                    Director and Shareholder – C4 Consulting Ltd  
                    CEO – Auckland Energy Consumer Trust  
                    Shareholder – Vector Group  
                    Shareholder / Director - Eltham Investments Limited  
                    Shareholder / Director - Cavell Corporation Limited  
                    Shareholder / Director - Ward Consulting Services Limited  
                    Trustee - LP Leasing Limited  
                    Trustee - Chris C Lynch Limited  
                    Son – Oceania Healthcare | 07.10.2015 |
Minutes
Meeting of the Board
16 September 2015

Minutes of the Auckland District Health Board meeting held on Wednesday, 16 September 2015 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 2:30pm

<table>
<thead>
<tr>
<th>Board Members Present</th>
<th>Auckland DHB Executive Leadership Team Present</th>
</tr>
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<tbody>
<tr>
<td>Dr Lester Levy (Chair)</td>
<td>Ailsa Claire  Chief Executive Officer</td>
</tr>
<tr>
<td>Jo Agnew</td>
<td>Simon Bowen Director of Health Outcomes – AHB/WDHB</td>
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<tr>
<td>Peter Aitken</td>
<td>Margaret Dotchin Chief Nursing Officer</td>
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<tr>
<td>Doug Armstrong</td>
<td>Joanne Gibbs Director Provider Services</td>
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<tr>
<td>Judith Bassett</td>
<td>Dr Debbie Holdsworth Director of Funding – ADHB/WDHB</td>
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<tr>
<td>Dr Chris Chambers</td>
<td>Dr Andrew Old Chief of Strategy, Participation and Improvement</td>
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<tr>
<td>Dr Lee Mathias (Deputy Chair)</td>
<td>Rosalie Percival Chief Financial Officer</td>
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<tr>
<td>Robyn Northey</td>
<td>Linda Wakeling Chief of Intelligence and Informatics</td>
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<td>Morris Pita</td>
<td>Dr Margaret Wilsher Chief Medical Officer</td>
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<td>Gwen Tepania-Palmer</td>
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<td>Ian Ward</td>
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<th>Auckland DHB Senior Staff Present</th>
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<tr>
<td>Fiona Barrington  Change Director</td>
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<tr>
<td>Jo Brown  Funding and Development Manager Hospitals</td>
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<td>Aroha Haggie  Māori Health Gain Manager</td>
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<td>Gil Sewell  Organisational Development Director</td>
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<td>Marlene Skelton  Corporate Business Manager</td>
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<td>Kate Sladden  Funding and Development Manager, Health of Older People</td>
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<tr>
<td>Karl Snowden  Programme Manager, Māori Health Gain Auckland DHB/Waitemata DHB</td>
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<td>Gilbert Wong  Director Communications Primary Care</td>
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(Other staff members who attend for a particular item are named at the start of the minute for that item)

1. **ATTENDANCE AND APOLOGIES**

That the apology from Sue Waters, Chief Health Professions Officer be received.

2. **CONFLICTS OF INTEREST**

Lester Levy advised that his register of interests was to be revised as he had stepped down as a Director of Orion Health and Orion Health Corporate Trustee Ltd.

There were no declarations of conflicts of interest with any items on the open agenda.
3. **CONFIRMATION OF MINUTES 05 August 2015** (Pages 8-13)

**Resolution:** Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the minutes of the Board meeting held on 05 August 2015 be confirmed as a true and accurate record.

**Carried**

4. **ACTION POINTS** (Pages 14)

There was no additional information to report.

5. **CHAIRMAN’S REPORT**

Lester Levy on behalf of the Board recognised the passing of:

Dr David Becroft - paediatrician and pathologist, ONZM, MD, FRCPA, FRACP, FRC Path, (hon) FRANZCOG, FRSNZ. From 1959 to 1992, David was Pathologist-in-Charge of the clinical laboratories of the Princess Mary Hospital for Children (now Starship Children’s Hospital) and perinatal pathologist at the National Women’s Hospital. Amongst other achievements, David was the first to make the link between severe adenovirus infection and subsequent bronchiectasis in children.

Don Gray – Deputy Director General of General Policy. Don had worked with the Ministry of Social Development since 2004. Most recently he was the Ministry’s Chief Policy Advisor, where he worked on building policy advice, capability and practice. Don had also spent time as a Ministerial Private Secretary, and has worked on international comparative social policy analysis with the OECD in Paris. Since 2009, he has also been Convener of the Officials Group (OSOC) supporting the Cabinet Social Policy Committee (SOC).

6. **CHIEF EXECUTIVE’S REPORT** (Pages 15-20)

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

- **Wellbeing Expo to be held 21 to 25 September 2015**
  A week of health and wellbeing activities is taking place between 21-25 September at Auckland City Hospital and Greenlane. This is aimed predominantly toward staff activities and includes; mindfulness, financial management workshops, yoga and Zumba. In addition there are a number of guest speakers including Dr Robin Youngson and Maria Tutaia. This is part of an overall programme to support the health and wellbeing of the Auckland DHB team.
• Long Service Awards to be held 21 and 22 October 2015
   Plans are in place for four Long Service Award ceremonies in October 2015. The events are the final ones of this year to catch up with those who have completed 20 years plus service. Board Members are encouraged to attend these ceremonies.

• A reminder that world Car Free day is to occur on Tuesday, 22 September 2015. Auckland Transport will be on site to promote alternative travel options.

• The difficult weekend experience dealing with acute flow patients. This has had an effect on the level of elective surgery able to be carried out.

• Grants totalling $400,000 for collaborative research projects between scientists and clinicians from the Faculty of Medical and Health Sciences and the Auckland DHB were announced in August. The Research Collaboration Fund is co-funded by the A+ Trust and the Faculty of Medical and Health Sciences and is designed to support joint research projects and develop relationships between Auckland DHB and FMHS staff. There were 50 applications, all of a very high standard, spread across services, with five successful projects being selected.

• The Information Management Service and the Performance Improvement Team have jointly sponsored the development of an Emergency Department Patient Facing Dashboard that will provide patients in the AED waiting room with real-time information about expected wait times. Two screens have been developed – the ‘Waiting for Doctor’ screen and the ‘Already in Treatment’ screen - to display real-time information about patients in the AED waiting to be seen, the expected wait time by urgency category, and the number of patients already in treatment. These screens can also be used for other types of messaging and can display in multiple languages.

• The Chief Medical Officer, Dr Margaret Wilsher accompanied by senior managers from People and Capability and the Strategy, Participation and Improvement teams, visited Queensland Children’s Services to discuss patient safety and reliability science as a safety tool. The visit was hosted by new CEO Fionnagh Dougan, formerly Director of Provider Services, Auckland DHB. These tools do appear to uplift patient safety and save money. This will be observed with interest to see what outcome is achieved over time.
   The group also spent time at the Cognitive Institute, a subsidiary of the Medical Protection Society, specialising in ongoing training of doctors.

That the Chief Executives report for August 2015 be received.

Carried

7. LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

7.1 Staff Well Being and Healthy Workplace Programme (Pages 21-30)
Simon Bowen, Director Health Outcomes spoke to the report, highlighting that:

- Auckland DHB has a key role in supporting healthy environments and healthy workplaces throughout Auckland. In order to be taken seriously Auckland DHB needs to lead by example and implement the changes within its own services that it would want to be adopted in other workplaces and settings.

- Staff well-being and a healthy workplace are fundamental to delivering on Auckland DHB’s vision and closely linked to its values. Significant progress has been made to re-establish the Committee and revitalise the Programme. A number of initial actions have been progressed and a work plan developed for 2015/16. Of particular note is the recently launched gym programme, proving very popular with staff, the Food policy and the Alcohol policy.

That the report on the Staff Well Being and Healthy Workplace Programme be received.

Carried

8. FINANCIAL OPERATIONAL PERFORMANCE

8.1 Financial Performance Report (Pages 31-36)

Rosalie Percival, Chief Financial Officer advised that the District Health Board 2014/15 financial performance was overall better than planned, with a surplus of $355K realised, against a planned surplus of $27k. This result was signed off by Audit NZ for purposes of Crown Financial Information System reporting completed early August.

For 2015/16, the planned financial result is a surplus of $2.3M. Financial performance for the first month of the year has started on budget, with a deficit of $683k recorded for the July month, against a planned deficit of $717k. August figures have just been released and the Board remains just on track however, it should be noted that there are significant pressures on this budget.

Resolution: Moved Ian Ward / Seconded Peter Aitken

That the Board receives this Financial Report for July 2015 and:

i. Notes the additional $2.3M revenue advised to the District Health Board by the National Health Board that has been included in the final 2015/16 District Annual Plan (DAP)

ii. Approves the revised annual plan budget for the 2015/16 DAP (summarised in this report) reflecting the above additional funding.

Carried
9. **MAORI HEALTH GAIN ADVISORY COMMITTEE RECOMMENDATIONS**

9.1 **Kaumatua Action Plan for Auckland and Waitemata DHBs** (pages 37-64)

Aroha Haggie, Manager, Maori Health Gain and Karl Snowden, Programme Manager, Māori Health Gain Auckland DHB/Waitemata DHB asked that the report be taken as read.

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

- Advice as to what had been changed within the plan since it had been considered at the last Manawa Ora Committee meeting. Carer and whanau stress was highlighted by Manawa Ora as an issue that wasn’t being addressed within the initial draft of the plan. As a result of this feedback activity has been added to investigate the level of stress for Maori/Whanau carers and identify options to address this (eg respite care, education, flexible packages of care).

**Resolution:** Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the Auckland District Health Board endorse the final draft Kaumatua Action Plan for Auckland and Waitemata District Health Boards (attached to this paper as Appendix 1).

**Carried**

9.2 **Waitemata and Auckland DHB 2015/2016 Maori Health Plans** (pages 65-69)

Aroha Haggie, Māori Health Gain Manager advised that this item had been referred from the Manawa Ora Committee to the Board and asked that the report be taken as read.

The Chair of Manawa Ora, Gwen Tepania-Palmer reminded members that this was a joint plan owned by both the Waitemata and Auckland District Health Boards. She urged staff to ensure that its contents fit within the District Annual Plan and commented that she expected to see a strong alignment between the two plans.

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

- Comment was made that teens did not appear to be receiving or taking up the oral health service that they were entitled to and what was being done to encourage their participation. Advice was given that access to dental services for this cohort had been increased by the availability of mobile bus units visiting schools.

**Resolution:** Moved Gwen Tepania-Palmer / Seconded Robyn Northey

That the report on the Waitemata and Auckland DHB 2015/2016 Maori Health Plans be received.

**Carried**
10 GENERAL BUSINESS

10.1 Centre for Patient and Whanau Participation and Experience – A Concept (pages 70-72)

Lester Levy commented that it was good to see this come before the Board at a conceptual stage allowing full Board participation.

Dr Margaret Wilsher, Chief Medical Officer asked that the report be taken as read.

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

- Advice that this was a concept only and that no consideration had been given to the determination of FTE requirements.
- Lee Mathias asked that the language employed in the document be more user friendly to aid public understanding of the concept.
- Jo Agnew asked whether this concept could be extended across the region and was advised that the team did actively network across the region. Regional take-up was dependant on what issue was being addressed and what importance it had to a Board.

Resolution: Moved Gwen Tepania-Palmer / Seconded Judith Bassett

That the Board endorses exploring the creation of a Centre for Patient and Whānau Participation and Experience.

Carried

10.2 Appointment of Electoral Officer for the 2016 Triennial Elections (pages 73-77)

Lester Levy advised that under the provisions of the NZ Public Health and Disability Act (2000) [Schedule 2, Section 9B] the person appointed by a District Health Board as its electoral officer must, “be a person who is also the electoral officer of a territorial authority in whose district the District Health Board is wholly or partly situated”. The Board is required, under the legislation, to appoint the Auckland Council’s Electoral Officer, as its Electoral Officer. That person is Dale Ofsoske of Election Services Ltd, who has most ably undertaken the role in elections prior to the 2013 election.

Resolution: Moved Jo Agnew / Seconded Ian Ward

That the Board appoints Election Services Ltd (designating Dale Ofsoske) Electoral Officer of the Auckland Council, as the Electoral Officer for the Auckland District Health Board to conduct the 2016 triennial election.

Carried
10.3 **Patient Experience Survey** (Pages 78-83)

This item was referred from the Hospital Advisory Committee meeting of 16 September 2015 for Board consideration.

**Resolution:** Moved Jo Agnew / Seconded Robyn Northey

**That the Board:**

1. **Endorses the creation of a composite Net Promoter Score based on existing Patient Experience Survey measures.**
2. **Approves Auckland DHB making its Patient Experience Survey results publically available.**

**Carried**

11 **RESOLUTION TO EXCLUDE THE PUBLIC** (Pages 84-88)

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:

**Resolution:** Moved Ian Ward / Seconded Robyn Northey

<table>
<thead>
<tr>
<th>General subject of item to be considered</th>
<th>Reason for passing this resolution in relation to the item</th>
<th>Grounds under Clause 32 for the passing of this resolution</th>
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</thead>
</table>
| 1. Confirmation of Confidential Minutes 05 August 2015 | **Confirmation of Minutes**
As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000. | 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 | **Confirmation of Action Points**
As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D | 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] |
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<tr>
<th>Section</th>
<th>Description</th>
<th>Exemption Clauses</th>
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| 3.1 | Funding of Eating Disorder Service | 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. | Health and Safety | 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] |
| 5. | Funder 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 sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| 6. | Lift the Health of People in Auckland City - NIL | N/A |
| 7.1 | Expansion of Secondary School Based health Services | 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)]
<p>|        |              | 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&amp;D Act 2000] |</p>
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<td>Authorised Banking Signatories</td>
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<td>Management and Administration FTE Cap</td>
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<td>7.4</td>
<td>Memorandum of Understanding Relating to the Collective Procurement of Office Supplies</td>
<td>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</td>
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<td>7.5</td>
<td>Draft 2014/2015 Annual Report</td>
<td>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</td>
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<td>Pharmaceutical Waste</td>
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<td>Addendum</td>
<td>Confidential Minutes 5 August 2015</td>
<td>Commercial Activities</td>
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<td>9.4</td>
<td>• Metro Auckland Community Pharmacy Waste Management Services</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
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<td>9.5</td>
<td>• NEHR Programme Update</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
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**Carried**

The meeting closed at 4.55pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 16 September 2015

Chair: ___________________________ Date: ___________________________

Lester Levy
## Action Points from 16 September 2015 Open Board Meetings

As at Wednesday, 28 October 2015

<table>
<thead>
<tr>
<th>Meeting and Item</th>
<th>Detail of Action</th>
<th>Designated to</th>
<th>Action by</th>
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</table>
| 9.3 18 February 2015 | **Rules of Sourcing**  
That the Chief Finance officer and Legal counsel undertake to ensure that the matter of development of a policy and supporting practises being put in place for rules of sourcing is placed on the agenda of the other Regional District Health Boards.  
The response has not addressed the issues raised. Bruce Northey, Legal Counsel is following this up and will update the Board with progress. | Rosalie Percival/Bruce Northey | When regional policy is developed.                                      |
| 4 1 April 2015    | 22 April 2015  
MBIE sent a letter to all District Health Board Chief Executives regarding issues raised about the Rules of Sourcing. Auckland DHB Legal Counsel is working with hA and the other District Health Board Lawyers in the region to develop a common procurement policy that incorporates this feedback. This policy will then be forwarded to Boards for approval.                                                                                                                                                                                                 |                             |                                                                         |
Chief Executive’s Report

Recommendation

That the report be received.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>APAC</td>
<td>Asia Pacific Forum on Quality Improvement</td>
</tr>
<tr>
<td>CETU</td>
<td>Clinical Education and Training Unit</td>
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<tr>
<td>CCDM</td>
<td>Care Capacity Demand Management programme</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>RACMA</td>
<td>Royal Australasian College of Medical Administrators</td>
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1. Introduction

This report covers the period from 28 August to 9 October. It includes an update on the management of the wider health system and is a summary of progress against the Board’s priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Patient and Community

Communications manages a generic communication email box. This is one of only two email addresses on the Auckland DHB website and acts as an unofficial online contact centre. Many of the requests are outside of the scope of the communication team’s duties, and actual communications requests. However, the team responds to all emails and connects people to the correct departments. From 28 August to 9 October 387 emails were received that required action.

2.2 External and internal communications

2.2.1 External

Auckland DHB has made public statements about:

- Electric bike taster sessions for staff commuters
- Seeking feedback on interpreter service
- Subsidised gym memberships for staff to promote health and wellbeing
- Give/Tukua theme for Mental Health Awareness Week
- Continuing updates on hospital occupancy

Auckland DHB made proactive pitches to media about:

- Hybrid operating theatre open for patients
- Starship branded app for paediatric anaesthesia available on iTunes
- Auckland City Hospital pharmacist Amy Chan wins $20,000 prize for research
- Co-design project wins Award at Australasian MS Nursing Conference

We received 66 requests for information, interviews or for access from media organisations in the period from 28 August to 9 October.

Media enquiries included interest in:

- Review of New Zealand organ donation rates announced by Minister
• Crohn’s disease research
• 19-month-old hit by car
• Man “king-hit” outside Denny’s Restaurant
• Norovirus in small number of patients at Starship (Initial inaccurate story was corrected)

Apart from those noted, 63 per cent of the enquiries over the period were enquiries about the status of patients hospitalised following crimes or accidents or who were of interest because of their public profile. We reviewed 38 Official Information Act requests and provided responses over this period.

2.2.2 Internal communications
• Three CE blog posts were published. These covered Wellbeing, a roundup of the last financial year, the impact of family violence and DHB values
• Hospital occupancy was updated daily on the Intranet.
• 20 news updates were published on the DHB intranet.
• six eNova (weekly electronic newsletters) were published.

2.3 Events and Campaigns

NZ Designers Institute Best Awards
Our Design for Health & Wellbeing Lab was in the NZ Designers Institute Best Awards on 9 October and came away with a Silver Award for the physical space itself and the coveted ‘Purple Pin’ supreme award in the inaugural Public Good category.

The wins have generated some very positive mainstream media attention in both the Herald and on TV3 prime time news. It’s also generated a lot of interest in the wider design community.

It’s been recognition for the team and their innovative work and in particular we acknowledge Justin Kennedy-Good, our co-Director for the Lab.

Health Excellence Award Applications
The fifth Health Excellence Awards will take place on 3 December 2015. Thirty-seven applications were received for this year’s awards. Judges are currently assessing these and winners will be announced at the Awards evening. Invitations will be sent out to Board members later this month.

Wellbeing Expo – 21 to 25 September 2015
A very successful week of health and wellbeing activities took place 21-25 September at Auckland City Hospital and Greenlane. The week was aimed predominantly at staff and activities include mindfulness, financial management workshops, yoga and hot hula. In addition we had a number of guest speakers including Dr Robin Youngson and Anna Friis. There were also cultural performances from the community – Mount Albert Primary School Tongan Group and St Peters College Kapa Haka Group. This is part of an overall programme to support the health and wellbeing of the Auckland DHB team. The project team worked hard to make the week a success.

Dementia Awareness Day
A stand and promotional posters were on display to raise awareness of dementia and the work taking place at Auckland City Hospital to become a Dementia Friendly Hospital.

Anaesthesia Day
A team of anaesthetic trainees and fellows led by Nigel Robertson coordinated a health promotion event at Auckland City Hospital on National Anaesthesia Day (16 October). The aim was to increase the public awareness of the risks of obesity when facing surgery.
**World Thrombosis Day**
Posters, videos and an information stand were available around our buildings to promote the risk of thrombosis. In addition patient stories were shared and an energetic team took part in a flash mob.

**Shake Out – 15 October**
Auckland DHB will be taking part in the National Shake Out Initiative and is encouraging all staff to part in the ‘Drop, Cover and Hold drill where it is safe to do so.

**APAC intensive at Auckland City Hospital**
Health professionals from around the world took a ‘behind the scenes’ tour at Auckland City Hospital to see first-hand innovation and improvement in practice. The ‘APAC intensive’ visit was day one of the 4th annual APAC Forum – Asia Pacific’s premier healthcare conference. The Intensive was a great opportunity to showcase some of the innovative work happening at Auckland DHB. Areas of focus included Releasing Time to Care, The Management Operating System and the Design Lab. Feedback from participants was very positive.

**Long Service Awards – 21 and 22 October 2015**
Four Long Service Awards take place in October 2015. The events are the final ones of this year to catch up with those who have completed 20 years plus service. We will be recognising more than 200 people at the four Long Service Awards events in the Marion Davis Library. From next year two events will be held annually in the continuing programme recognising long service.

**Values-based Leadership and Recruitment**
Tim Keogh from April Strategy came back to Auckland DHB in October. During the week more than 250 of our leaders attended values-based leadership sessions and 90 people attended the values-based recruitment sessions. This is a part of our next steps to embed our refreshed values into everything we do.

**Nurses Uniform Consultation**
A consultation and engagement process began in October for a new Nurses Uniforms. Three designs for men and three designs for women are being trialled by a group of 30 nurses for four weeks. The designs will be showcased at a ‘Fashion Show’ and a number of roadshows around our sites so that many nurses as possible can have a say on their future uniform.

**2.4 Social Media**
Facebook: 2,965 likes
Twitter: 1,914 followers
LinkedIn: 3,940 followers

The most popular posts on Facebook for this period were:
- Suicide awareness and helplines – Shared post from Mental Health Foundation
- Nursing uniforms throughout the ages
- Local Heroes
- World Pharmacist day – Pharmacy team photo
- Wellbeing Expo
- Thank you card for Trevor Anderson – Piano playing blue coat volunteer
- Design lab
- Fetal Alcohol Spectrum Disorder awareness day
- World Physiotherapy Day
- Prof Ed Gane – Chronic hepatitis research
- Dr Harold Coop – Painting donation
The most popular tweets for this period were:

- Nursing uniforms throughout the ages
- Electric Bikes – Free AT sessions
- Retweet about Big White Wall – Mental Health service
- Mental Health Awareness week
- Local Heroes
- International Day of Older Persons
- World Heart Day
- Tim Denison – APAC Improvement award
- Wellbeing Expo
- APAC Intensive
- Wayfinding project
- Thank you card for Trevor – Piano playing blue coat volunteer
- Sustainability tips
- #patienthighfives stories

2.5 People

Local Heroes
Twenty-seven people were nominated as ‘Local Heroes’ during August and September. Edith Scott, Student Nurse was presented with the September local hero.

Edith was nominated by a patient’s daughter who said: “My mum was transferred to Auckland City Hospital after three weeks in another hospital. She was pretty distraught and Edith built up a rapport with her, treating her with the patience and dignity that an 86-year-old deserves. After we left, Edith spent most of the evening with her. Mum ended up staying one week, and Edith popped up each time she had a shift. On the day of Mum’s second operation, Edith spent the whole day with her. Her actions gave me a feeling of being supported as many other things in my world were crashing down. I have come across many lovely staff in hospitals, but Edith was unique.”

The October hero was being selected at the time of writing.

Leading Sustained Quality Improvement Award goes to Auckland DHB staff member
Auckland DHB’s Improvement Programme Director, Tim Denison, has won the ‘Leading Sustained Quality Improvement’ award at the APAC International Excellence in Health Improvement Awards for his role in leading and improving acute flow at Auckland City Hospital since 2009.

Women’s Health anaesthetists, Dr Sharon Rhodes and Dr Matthew Drake, were also chosen as finalists in the ‘Promoting Clinical Research and Application to Practice’ category for their work in using a patient experience survey and clinical audit to introduce enhanced recovery after obstetric surgery.

Nurses honoured for their services
Auckland DHB nurses Abel Smith and Sonya Temata were honoured for their services to nursing at a NZ Nurses Organisation ceremony in Wellington in September. Abel Smith was recognised for his long commitment to the career development of Pacific nurses and health workers. Sonya Temata was acknowledged for her family-focused work in indigenous health and her voluntary work in women’s refuges and homeless shelters.
Pharmacist wins award for ‘smart inhaler’
Auckland City Hospital pharmacist Amy Chan has won a $20,000 Value of Medicines award for her world-leading study on a ‘smart inhaler’ for children with asthma. Amy’s PhD research, published in The Lancet in January, showed a 180 per cent improvement in preventive inhaler use in children who used a ‘SmartTrack Inhaler’.

The award, encouraging research into medicines and vaccines, was presented by Health Minister Hon. Jonathan Coleman at Medicine New Zealand’s annual Parliamentary Dinner in September. Amy plans to use the prize money researching how the tool could be applied to other chronic disease treatments.

Auckland DHB Pharmacy wins awards
Auckland DHB Pharmacy team took out five awards at the New Zealand Hospital Pharmacy Association annual conference. The award recipients are:

- Kiri Aikman – What The Clot?! RE-visiting Dabigatran
  **Best Paper from a Recently Graduated Pharmacist**
  *A review looking at emerging evidence surrounding the use of this new anticoagulant (Dabigatran) in obese individuals*

- Joe Monkhouse, Dr Robyn Toomath and Fiona Coulter – HARP@Discharge – A Pilot to Support Medicines Management at Patients’ Discharge
  **Best Paper in Medication Safety / Innovation**
  *A clinical pharmacy initiative to support patients with their medicines at discharge*

- Adele Print – Reaching Out Beyond the Hospital Walls: A New Clinical Pharmacy Service for People with Intellectual Disability in the Community
  **Best Poster – Medication safety/Innovation**
  *A clinical pharmacy initiative, in partnership with Spectrum Care (a charitable organisation), to conduct medication reviews for complex intellectual disability individuals in the community*

- Preetika Vareed, Rebecca Dean and Liz Oliphant – Oral Formulations
  **Best Overall Paper**
  *A project to raise awareness of the risks associated with incorrectly formulated liquid medicines for children*

- Congratulations also go to the PLAN team of Amy, Kiri, Ziyan, Natasha, Ricky, Sarah and Joe who won the Max Health Award, which Amy Chan presented at a plenary session
  *A clinical pharmacy initiative to promote health literacy and support patients to better understand their medicines*

Co-design project wins award at Australasian MS Nursing Conference
A multiple sclerosis co-design project run by Fiona d’Young and Hilary Boyd earlier in the year won the award for the best presentation and the overall conference award at the Australasian MS nursing conference over the weekend. As part of the prize, Fiona will be travelling to Maryland to present the project at the international MS conference in May 2016.

Dr Robin Norris
Dr Robin Norris, MD, FRCP, FRACP died recently following a short illness. Dr Norris was formerly director of the coronary care unit at Green Lane Hospital and an acknowledged international expert in the field of acute coronary disease. He led many clinical trials on myocardial infarct and was the
author of over 150 publications, many of them in leading medical journals. Our clinical practice today is influenced by his early trials of beta blockers in acute coronary syndrome.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary

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<th>Comment</th>
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<tr>
<td>![Yellow Triangle]</td>
<td>Sep 92%, Target 95%</td>
</tr>
<tr>
<td>![Yellow Triangle]</td>
<td>94% to plan for the year</td>
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<tr>
<td>![Green Circle]</td>
<td>Sep 100%, Target 100%, Year to Date 100%</td>
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<tr>
<td>![Green Circle]</td>
<td>Sep 95%, Target 95%</td>
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<td>![Green Circle]</td>
<td>Sep 79 patients, Target &lt; 104</td>
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<td>![Green Circle]</td>
<td>Jun Qtr 92%, Target 90%</td>
</tr>
<tr>
<td>![Green Circle]</td>
<td>Sep Qtr 95%, Target 95%</td>
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Key:
- Proceeding to plan
- Issues being addressed
- Target unlikely to be met

Commentary

Acute Patient Flow
Initiatives are underway to address the complex issues underpinning the increasing number of patients presenting at ED. These include:
- See and assess patients more quickly
- Increase flexibility to meet surges in demand
- Redesign our facilities to accommodate the growing numbers of patients

Primary Care – Better Help for Smokers to Quit
From 1 July 2015 the measurement for the Better help for smokers to quit target has been revised. The ‘seen by a health practitioner’ wording in the definition has been removed. This removes a historical adjustor to the measure and enables a more accurate target as it is now based on actual numbers not estimates. Secondly the numerator has changed from a 12 month to a 15 month coverage period. The impact of these changes is that the reported performance will drop. It may take time before the performance gets back to or above the target level of 90 per cent.

3.2 Financial Performance
The DHB financial performance for the month of September was favorable to budget of $18k, against a planned surplus of $577k for the month. The DHB financial performance for the year to date was favorable to budget of $151k, against a planned surplus of $1,045k for the year to date. We are awaiting final clearance from Audit NZ on the 2014/15 financial statements which is expected on 23 October 2015. The financial performance reported to the Ministry of Health for purposes of Crown Financial Information System in August has not changed. The overall result was
better than planned, with a surplus of $355K realised, against a planned surplus of $27k. For 2015/16, we are expecting to achieve the planned financial result with a surplus of $2.3M.

3.3 Clinical Governance

Care Capacity Demand Management report finalised

A Discovery Week to raise awareness of the principles of Care Capacity Demand Management (CCDM) was held in August. This coincided with an intensive process of one-on-one interviews at all levels of staffing and promotion of an online survey. CCDM arose out of the need for a programme to implement the recommendations of the Safe Staffing Healthy Workplaces Committee of Inquiry Report 2006. The Safe Staffing Healthy Workplaces Unit in partnership with DHBs, NZNO and the PSA have developed the programme, which has three main elements:

1. An evidence based method (mix and match) for setting the base staffing model in wards (numbers, skill mix and schedule) utilising validated patient acuity data.
2. Developing and supporting a system of multiple response strategies (Variance Response Management) within DHBs to manage short & midterm variance, so that demand can be met and safety and quality maintained.
3. Developing technical and social processes around a core set of data that is meaningful from the floor to the board, to ensure real time feedback and monitoring over time the demand-capacity match.

The findings of the Discovery Week report indicate that while Auckland DHB is going through a period of structural change, it is a good time to implement the CCDM programme. There is overt executive support and commitment from both the DHB and union partners to support the programme. The programme vision is of achieving quality patient care and a quality work environment and the best use of health resources is aligned with existing initiatives including:

- Releasing Time to Care
- the implementation of TrendCare
- formalising of variance management systems and processes for forecasting and
- the work in development to improve data management systems.

Successful accreditation

The Medical Council of NZ has accredited Auckland DHB as a provider of prevocational medical training. No corrective actions were required and several commendations were made. This is a tribute to Gill Naden and Dr Stephen Child of the Clinical Education and Training Unit who are responsible for the prevocational training programme.

Capability building in quality and safety

Dr Iwona Stolarek and Gillian Bohm from the Health Quality and Safety Commission have visited Auckland DHB to discuss the Commission’s paper on capability building in quality and safety, attend the clinical board meeting and meet with key clinical leaders to discuss patient safety initiatives. Drs Wilsher and Roberts together with performance specialist Justin Kennedy-Good attended the New Zealand chapter of the Health Round Table annual safety meeting. Auckland DHB presented its roll out of the Venous-thromboembolism risk identification tool and participated in a review of hospital mortality data and discharge statistics. As a follow-on from that meeting, a team from Auckland DHB will visit the Alfred Hospital which has recently completed a ‘hospital at night’ project. The Alfred is considered an exemplar hospital in respect of weekend mortality.

Auckland DHB hosts fellows of the Royal Australasian College of Medical Administrators

Auckland DHB hosted 20 visiting fellows of the Royal Australasian College of Medical Administrators at a workshop on acute flow, presenting the General Medicine bed day saving project and showing
the visitors the front of house facility. The College held its annual scientific meeting in Auckland for the first time, with the major theme being inequity in health care.

**Tamaki Support Hours Initiative**
The Tamaki Mental Health and Wellbeing Programme reached a key milestone last week, when the primary NGO support service was launched. This is a proof of concept initiative that aims to integrate NGO support services into the primary care team. The prototype service has been co-designed with primary care users, NGOs, GPs and the wider Tamaki community and will be trialled over the next six months, initially across two general practices. During the trial, we will be utilising a person-centred action/learning framework to identify and implement the optimum service solution for the people of Tamaki. The development of the service is the first of a set of initiatives that the Tamaki programme is developing and hopes to launch over the next 18 months.
Ethnicity Data Audit Toolkit – Final Report

Recommendation

That the Auckland District Health Board:

a. Receive this report which sets out highlights of the Ethnicity Data Audit Toolkit (EDAT) implementation, on the recommendation of the Chair of Manawa Ora.

b. Note the Māori Health Gain Team’s achievement on this piece of work.

c. Endorse the Māori Health Gain Team’s recommendations for ongoing work in this area to improve the quality of ethnicity data in primary care.

Prepared by: Aroha Haggie (Manager Māori Health Gain), Dr Karen Bartholomew (Public Health Physician), Micol Salvetto (Programme Manager, EDAT)

Endorsed by: Dr Debbie Holdsworth (Director Funding)

Glossary

BPAC - Best Practice Advocacy Centre
DHB - District Health Board
EDAT - Ethnicity Data Audit Toolkit
RFP - Request for Proposal
GP - General Practice
MoH - Ministry of Health
NES - National Enrolment Service
PHO - Primary Health Organisation
PMS - Practice Management System
The Protocols - Ethnicity Data Protocols for the Health and Disability Sector

1. Executive Summary

The Māori Health Gain Team (in collaboration with primary care colleagues and Primary Health Organisations (PHO)) has successfully completed implementation of the Primary Care Ethnicity Data Audit Toolkit (EDAT) in 98% of general practices in the Auckland and Waitemata DHB area.

This paper presents the highlights of the EDAT work and is provided to the Board on the recommendation of the Chair of Manawa Ora – the Māori Health Gain Advisory Committee.

This paper recommends the Board note the Māori Health Gain Team’s achievement in this area, in particular:

- We are the first in the country to have achieved EDAT implementation and have exceeded the 95% implementation target set by the Ministry of Health
- EDAT implementation is a key Māori Health Plan deliverable and means by which we can monitor and act on health disparities
• We have developed and led EDAT training across five other DHBs and in a variety of primary care settings
• We have shared resources and learnings with Counties Manukau DHB as they implement EDAT
• We have been able to provide reporting and technical commentary on EDAT issues to the Ministry of Health (MoH), and the MoH has acknowledged the quick and highly successful implementation of EDAT in the Auckland and Waitemata regions.

Finally, this paper recommends the Board endorse the Māori Health Gain Team’s ongoing work to improve the quality of ethnicity data in primary care, as set out in the ten recommendations in paragraph 8 below.

2. Background

EDAT is an audit package developed by the MoH to provide a baseline assessment of the quality of ethnicity data in primary care and practice level information on consequent quality improvement activities. Waitemata DHB and Waitemata PHO collaborated to pilot EDAT in 2012, prompting the Ministry of Health refined the EDAT before its release in 2013. Implementation began in Auckland and Waitemata DHBs in 2014.

Participating general practices implemented all three stages of the EDAT tool:

• **Stage one**: assesses whether the practice is collecting, recording and outputting ethnicity data in compliance with the Ethnicity Data Protocols (usually completed by practice manager).
• **Stage two**: assesses staff understanding of, and current processes for, the collection and recording of ethnicity data. This is also aimed at identifying specific staff training needs (staff surveys completed then marked by the practice manager).
• **Stage three**: assesses the quality of ethnicity data currently held in the PMS against a ‘fresh’ collection of self-identified patient ethnicity using the supplied audit form for 100 patients. This gives practices an indication of the quality of data, however it may not be representative of their enrolled practice population.

3. Implementation

Implementation was carried out jointly by the Māori Health Gain and Primary Care Teams in Auckland and Waitemata DHBs, in close collaboration with our five PHOs. EDAT toolkit packs were developed by the EDAT team in collaboration with the Best Practice Advocacy Centre (BPAC), and these were delivered to PHO liaison staff at train-the-trainer workshops. The EDAT team provided extensive training to PHO liaison and practice nurse advisor staff as part of the EDAT implementation. Some PHOs, after receiving the training, requested the training to be repeated to general practice staff directly. Communicating directly with the practices provided a useful insight into implementation issues, question interpretation, use of EDAT and current ethnicity data collection and recording practices. Regular implementation progress reports were provided to the Ministry of Health on technical details around issues identified, coding and PMS product variations including unavailability of the 2009 codeset change from the Ethnicity Data Protocols.

The Māori Health Gain team considered EDAT to be a useful opportunity to quantify ethnic specific misclassification in a primary care population and so requested the assistance of our PHO and general practices partners in providing anonymised evidence of completion of all three stages and a
further audit of a sub-sample of stage three results from each PHO (2,800; 12% of participating practices). The EDAT team reviewed and entered the results of the stage three forms on site at the PHO or practice. No identifiable data was transferred. The results were coded and their congruence assessed, and an estimate of the level of misclassification in the sample was calculated.

Once PHOs completed EDAT implementation exit interviews took place to discuss implementation procedures, PHO specific outcome of the audit and feasibility of quality improvement activities proposed by the DHB.

4. EDAT overall findings

All three stages of EDAT have been implemented in 235 general practices across Auckland DHB and Waitemata DHBs, corresponding to 98% implementation rate. The Ministry of Health have acknowledged the rapid and highly successful implementation of EDAT in our region, and have provided this feedback to our PHOs directly.

Table 1. EDAT implementation by PHO in Auckland DHB and Waitemata DHB

<table>
<thead>
<tr>
<th>PHOs</th>
<th>Number of practices</th>
<th>EDAT implemented</th>
<th>Implementation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Health Plus</td>
<td>25</td>
<td>25</td>
<td>100%</td>
</tr>
<tr>
<td>Auckland</td>
<td>24</td>
<td>24</td>
<td>100%</td>
</tr>
<tr>
<td>National Hauora Coalition</td>
<td>16</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td>Procare</td>
<td>130</td>
<td>126</td>
<td>97%</td>
</tr>
<tr>
<td>WPHO</td>
<td>44</td>
<td>44</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>239</strong></td>
<td><strong>235</strong></td>
<td><strong>98%</strong></td>
</tr>
</tbody>
</table>

Stage one: System compliance checklist
This was a relatively well received stage that practice administrators completed. Stage one is well designed and supports practices to clearly identify whether further attention is needed in the data collection stage or in the data recording stage. The last part of the checklist asks general practices about methods of data extraction. PHOs perform this function rather than general practices. This part of the score is therefore not meaningful in terms of data quality.

Stage two: Staff Survey
This was very well received by practice staff, managers and PHO representatives. Two PHOs in particular found the information emerging from this survey very useful and have decided to include this in their ‘yellow folders’ or welcome pack for new staff. One large PHO who was able to access all these results found the survey a useful tool to identify and support practices in need of training or support.

Stage three: Recollect 100 patients ethnicity
The EDAT tool stage three assesses the level of ‘match’ between the freshly collected ethnicity from 100 consecutive patients and the ethnicity recorded on the practice management system. The tool provides the following categories of assessment of ethnicity data quality at a practice level, which are linked to recommended quality improvement activities within the tool. For example practices with poor ethnicity data quality are recommended to recollect ethnicity data for their enrolled population over time.

- High data quality: Match score above 90%
- **Moderate data quality**: Match score between 70% and 90%
- **Poor data quality**: Match score below 70%

Table 2 shows that all PHOs had a wide range of practice data quality, with 35% of practices overall scoring a high data quality assessment. Twenty-two practices (10%) were assessed as having poor ethnicity data quality. More than half of the practices scored moderate quality. The level of partial matches and total mismatches have not been reported here.

**Table 2. Summary results of Stage 3 EDAT; ethnicity data quality assessment by PHO**

<table>
<thead>
<tr>
<th>PHO</th>
<th>Number of practices who completed EDAT</th>
<th>PHO Mediation score</th>
<th>PHO score range</th>
<th>Data Quality EDAT Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number (%) of practices scoring ≥ 90%</td>
</tr>
<tr>
<td>Alliance Health Plus</td>
<td>25</td>
<td>87%</td>
<td>62-100%</td>
<td>9 (36%)</td>
</tr>
<tr>
<td>Auckland</td>
<td>24</td>
<td>86%</td>
<td>67-100%</td>
<td>9 (48%)</td>
</tr>
<tr>
<td>NHC</td>
<td>16</td>
<td>85%</td>
<td>72-100%</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Procare</td>
<td>126</td>
<td>85%</td>
<td>37-100%</td>
<td>43 (34%)</td>
</tr>
<tr>
<td>Waitemata</td>
<td>44</td>
<td>84%</td>
<td>42-100%</td>
<td>15 (34%)</td>
</tr>
<tr>
<td>Totals</td>
<td>235</td>
<td></td>
<td></td>
<td>83 (35%)</td>
</tr>
</tbody>
</table>

It is important to note that the summary results regarding data quality are influenced by system level issues rather than issues at a general practice level. This is discussed in paragraph 5 below.

The EDAT tool does not state that where partial match or total mismatch was identified in stage three the PMS should be updated with the correct ethnicity. The EDAT project team considered PMS updating to be a central component of data quality improvement and established this as a standard part of EDAT implementation through all training and train-the-trainer forums, support to practice liaisons and practices. The EDAT tool does not require practices to share or keep their stage three results. Where the results of stage three were shared for the sub-analysis they were only shared as de-identified data. We were therefore not able to audit identifiable data to determine whether PMS changes were made by comparing the result with the PHO enrolment register. However, exit interviews and discussions with practice staff demonstrate that PHOs were supportive of PMS updating through EDAT and that PMS changes were made. For mismatches some practices scanned the forms into the PMS or asked patients to sign the audit forms to support making PMS changes related to enrolment (a MoH requirement). The changes to the EDAT tool that would support this key quality improvement component have been provided to the Ministry of Health and to other DHBs currently implementing EDAT.

### 5. Key issues identified

The Māori Health Gain Team was able to compile a detailed register of key issues that affect ethnicity data quality, based on the overall experience of implementing EDAT and working closely with primary care, PHOs and some Practice Management Systems (PMS) vendors. The issues can be grouped in three broad groups:
5.1 System issues

The primary cause of data quality issues were attributable to systems and process issues, largely related to the IT PMS vendor structure or processes. Even where frontline administrative staff, who collect and record ethnicity in most practices, are trained and aware of the Ethnicity Data Protocols they are fundamentally unable to record the data correctly if the PMS system they utilise does not contain the correct codes or facilitate easy and correct recording.

The different PMS all had a different interface for recording ethnicity data. Key PMS issues are:

- None of the PMS complied with the Ethnicity Data Protocols
- Incorrect ethnicity codes were available in some PMS
- Limited numbers of ethnicity codes were available in some PMS
- Practices had been allowed to make up their own ethnicity codes (often in response to patient request or confusion. These created codes are often invalidated when PHOs extract data resulting in missing data in PHO enrolment registers. This practice has now been stopped but data quality has already been compromised)
- Some PMS automatically pre-populate ethnicity for family members on enrolment (eg children); this is not supported by the Ethnicity Data Protocols
- The largest PMS has a front demographic screen requiring input of a ‘principle ethnicity’ (asking the patient to choose; this is not supported by the Ethnicity Data Protocols)
- The largest PMS then has optional second and third ethnicities on the third demographic tab. Most frontline administrative staff were not aware that this tab existed and only input the first ethnicity on the enrolment form. As the enrolment forms use the census question this often is New Zealand European, even when a prioritised ethnicity is listed on the form.
- No PMS included the new 2009 codeset at the time of EDAT. This has subsequently been made available in the two largest PMS systems after the conclusion of EDAT, although the PMS vendor transfer process has some issues noted.

5.2 Training and education

The second largest cause of ethnicity data quality issues was the education and training gap for frontline administrative staff, PHO liaison staff and wider PHO staff. There was evidence of lack of knowledge about the importance of ethnicity data, the uses of ethnicity data (outside of the practice setting), the correct form to collect data, the existence of the Ethnicity Data Protocols, and the nature of the codes for recording data. No frontline administrative staff were familiar with the Ethnicity Protocols and its minimum requirements.

Implementation of EDAT has met some of these training and education needs, however a more systematic and sustainable national approach needs to be developed to address this fundamental problem. The EDAT project team has proposed developing an electronic based training module on ethnicity data collection and recording for primary care, designed for the end user and developed to be short and focused.

5.3 Compliance issues

System and training comprised the majority of the reasons for ethnicity data quality issues. There was however also evidence of non-compliance with the Ethnicity Data Protocols of a more systematic nature. These were mostly found to be grounded in concern for patients – either respecting their ethnic identification choices or ensuring the provision of care. There was note made of deliberate changing of enrolment forms for this purpose. These issues are being followed up by the relevant PHOs.
• Not all practices have the correct ethnicity question (census 2001 in the correct order) in their enrolment forms. The MoH example enrolment form is not used in some practices, even if it is the policy of their PHOs.
• Systematic misclassification of the Fijian-Indian ethnic group. According to the Protocols this group is coded as 43_Indian (which codes up to Asian), however they are systematically coded as Fijian (36_Fijian which codes up to Pacific; which has funding implications and is likely to contribute to the overcount of Pacific peoples). Some practices have amended their enrolment forms so that there are two additional boxes for Fijian and Indian separately; so that when both are coded the Pacific code is prioritised above the Indian code as per the Protocols. Some patients and practice staff express a strong preference for this group to be coded as Pacific. There have also been changes to the definition of these groups in Fiji which has resulted in some confusion.
• Systematic misclassification of some Southeast Asian groups (e.g. Pakistani, Bangladeshi and Sri Lankan; currently coded as 44_Other Asian). The 44 code does not currently trigger an early (and funded) Cardiovascular Disease Risk Assessment, even though these groups are likely at high risk. There is evidence that some practices code these groups as a funded code in order to provide this care.

6. Sub-analysis

Table 3 presents the high level findings from the stage three sub-analysis (recollect of ethnicity from 100 consecutive patients and comparison with PMS records) of 2,800 (12%) patient forms. Of the 241 Māori patients 21 were misclassified in the PMS. Misclassification may result in under or over counting. In this sub-analysis a 9% undercount of Māori patients in the PMS was found. For Pacific there was a 5% over-reporting, and for Asian a 4% undercount.

Table 3. Quantification of ethnic specific misclassification for EDAT Stage 3 sub-analysis of 2,800 patients recollected ethnicity compared with PMS ethnicity

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Mismatch calculation</th>
<th>Misclassification interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients with mismatched ethnicity</td>
<td>Total number of patients</td>
</tr>
<tr>
<td>Māori</td>
<td>21</td>
<td>241</td>
</tr>
<tr>
<td>Pacific</td>
<td>19</td>
<td>400</td>
</tr>
<tr>
<td>Asian</td>
<td>26</td>
<td>586</td>
</tr>
</tbody>
</table>

Although there was a reasonable sample size for the sub-analysis, greater statistical confidence in the ethnic specific misclassification analysis can be generated by a larger sample size. This is being conducted in Counties Manakau DHB, where the Māori Health Gain Team are assisting with EDAT implementation and have requested all practices contribute anonymised stage three results.

Misclassification impacts many primary care indicators, for example the currently reported Māori-non Māori current gap in PHO enrolment of 10-15% would reduce to 0-5% if this level of misclassification is accurate. Although not required by the EDAT tool, during EDAT training Auckland DHB and Waitemata DHB PHOs, practice liaison staff and practices were advised to update their PMS where mismatched ethnicities were identified. This is an important data quality improvement activity that could be supported further by modification of the EDAT tool which has been recommended to the Ministry of Health.
An issue noted in EDAT implementation and the sub-analysis was the high level of use of the codes ‘54_Other’ and ‘99_Ethnicity not stated’. These two codes are meant to be used rarely, however there is evidence of frontline staff using the codes when they encounter ‘difficult’ ethnicities rather than selecting the correct code. There is also evidence that 99 codes have been applied to patients that do have an ethnicity recorded in their PMS. This may have been done in error or possibly to assist with the ethnicity data completeness requirement of the previous PHO Performance Programme (less than 2% missing ethnicities). Completeness has been a focus of ethnicity data previously, rather than ethnicity data quality. The previous Cervical Screening Ethnicity Data Audit determined that both 54 and 99 codes contain high levels of misclassified Māori patients.

From the exit interviews, discussions with practices and practice advisors and the sub-analysis of the 2,800 stage three forms (12% of the sample) it was found that EDAT tool level of match assessment did not provide a full picture of the quality of ethnicity data. Specifically:

- Lack of prioritised ethnicities are not counted in the EDAT tool as a high level of mismatch - for example where a patient records on their enrolment form or EDAT form New Zealand European and Māori and only New Zealand European is captured on the PMS. This issue is a significant cause of ethnic specific misclassification. The level of match assessment in EDAT is therefore likely to be an overestimate.

- There were issues with the interpretation of the tool where some match assignment was not done correctly. This may have been due to confusion about the tool, resistance to the level of match score – for example, where New Zealand European and Other European were a mismatch and the practice did not agree.

7. Discussion

EDAT provides a baseline assessment of ethnicity data quality and highlights for practices and PHOs some areas of potential quality improvement activity. Some quality improvement, as noted in the pilot evaluation report, can be generated from EDAT participation learnings (eg staff training needs), however significant and sustained ethnicity data quality improvement will require systematic data quality improvement initiatives.

Achievement of data quality improvement needs to address both the fundamental systems issues (to move these from barriers to enablers of high quality data recording) and the training issues. As well as the broad changes, EDAT has assessed a small number of practices (10%) having poor data quality. These practices require individual practice support, a quality improvement plan and repeat of EDAT. As noted EDAT does not provide a complete assessment of data quality for example the issue of missing prioritised ethnicities is not weighted as a key data quality issue in the tool itself. EDAT poor quality assessment, and adjunctive assessment such as 54 and 99 coding, may be used synergistically to identify a subset of practices that PHOs (assisted by the EDAT project team) can work more intensively with on quality improvement activities.

In addition to the systems and training issues the current Ethnicity Data Protocols minimum standard of Level 2 ethnicity does creates confusion where frontline administrative staff have to look up ethnicities in a table at their highest code (Level 4) and then work out their Level 2 code to input. Valuable granularity of information is lost in this process (for example Korean is classified as 44_Other Asian) and it creates confusion and the potential for errors. The Māori Health Gain Team have observed the Level 4 coding in Auckland City Hospital and consider that Level 4 recording of data, although substantially more codes (200+ compared to 20+) is simpler for those entering the
A standardised and intuitive Level 4 electronic recording system (interface) designed with end users could reduce the confusion and provide a platform for systematic training (including e-learning modules) and data quality improvement. The Ministry of Health has some work underway with PMS vendors which include ethnicity collection, and the Māori Health Gain Team has contributed to this work.

8. Recommendations

The Māori Health Gain Team’s makes ten recommendations for its ongoing work in this area to improve the quality of ethnicity data in primary care:

**PHOs**

1. Support all practices to undertake the quality improvement activities as indicated by individual practice EDAT results, including updating mismatched ethnicities identified in stage three.

2. Provide direct support (including training) to practices identified as having poor quality ethnicity data to undertake the quality improvement activities as indicated EDAT.

3. Provide direct support (including training) to practices identified as having high levels of 54 or 99 coding which may also indicate poor ethnicity data quality.

**Auckland DHB and Waitemata DHB EDAT Team**

4. Conduct a 54 and 99 code audit with PHOs and practices as an adjunctive assessment of ethnicity data quality.

5. Work with the Ministry of Health on technical issues identified through EDAT.

6. Continue to work with PMS vendors to ensure that the 2009 codeset change is robustly implemented.

**Ministry of Health**

7. Modify the EDAT tool to provide instructions to practices to update their PMS where partial and total mismatched ethnicities are identified.

8. Update the Ethnicity Data Protocols to provide guidance on the range of technical issues identified through EDAT, and to consider implementation of Level 4 ethnicity data collection and recording.

9. Consider the development of a standardised user interface (developed with end users) which could be a requirement of all PMS vendors.

10. Development of primary care training (designed to meet the needs of frontline administrative staff) on ethnicity data, for example an e-learning module.
Financial Performance Report

Recommendation

That the Board receives this Financial Report for September 2015

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

A year to date (YTD) surplus of $1M was realised for the first quarter of 2015/16, which was favourable to budget by $151k. Revenue is favourable by $2.9M with the main underlying revenue variances including: $1.3M additional MoH devolved funding, $613K additional MoH Sourced revenue for direct contracts and $2.4M additional other income. These are partially offset by adverse inter DHB & Internal and patient/consumer sourced revenue. YTD expenditure is unfavourable with significant variances including: unfavourable variances in outsourced personnel $2.2M, clinical supplies $540K and infrastructure and non-clinical supplies $580K. These are offset by favourable Personnel costs $1.44M (favourable in all employee groups except for nursing). Detailed analysis of variances is outlined in the financial commentary below.

Auckland District Health Board

Summary Results: Month of September 2015

<table>
<thead>
<tr>
<th>$000s</th>
<th>Month (Sept-15)</th>
<th>YTD (Sept-15)</th>
<th>Variance</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td>Actual</td>
<td>Budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOH Sourced - PBFF</td>
<td>92,819</td>
<td>92,819</td>
<td>0 U</td>
<td>278,456</td>
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<tr>
<td>MoH Contracts - Devolved</td>
<td>7,438</td>
<td>7,060</td>
<td>378 F</td>
<td>22,434</td>
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<tr>
<td></td>
<td>100,256</td>
<td>99,879</td>
<td>378 F</td>
<td>300,890</td>
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<tr>
<td>MoH Contracts - Non-Devolved</td>
<td>5,109</td>
<td>4,735</td>
<td>374 F</td>
<td>14,191</td>
</tr>
<tr>
<td>IDF Inflows</td>
<td>54,369</td>
<td>54,105</td>
<td>264 F</td>
<td>162,227</td>
</tr>
<tr>
<td>Other Government (Non-MoH, Non-OtherDHBs)</td>
<td>2,886</td>
<td>2,817</td>
<td>69 F</td>
<td>8,698</td>
</tr>
<tr>
<td>Patient and Consumer sourced</td>
<td>1,567</td>
<td>1,544</td>
<td>23 F</td>
<td>4,159</td>
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<tr>
<td>Inter-DHB &amp; Internal Revenue</td>
<td>1,147</td>
<td>1,279</td>
<td>132 U</td>
<td>3,343</td>
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<tr>
<td>Other Income</td>
<td>4,719</td>
<td>3,698</td>
<td>1,022 F</td>
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<tr>
<td>Donation Income</td>
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<td>221</td>
<td>128 U</td>
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<td>Financial Income</td>
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<td>643</td>
<td>145 U</td>
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<tr>
<td><strong>Total Income</strong></td>
<td>170,901</td>
<td>169,270</td>
<td>1,631 F</td>
<td>510,970</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
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<tr>
<td>Personnel</td>
<td>70,303</td>
<td>70,128</td>
<td>175 U</td>
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</tr>
<tr>
<td>Outsourced Personnel</td>
<td>5,961</td>
<td>5,306</td>
<td>654 U</td>
<td>18,148</td>
</tr>
<tr>
<td>Outsourced Clinical Services</td>
<td>2,074</td>
<td>1,884</td>
<td>190 U</td>
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</tr>
<tr>
<td>Outsourced Other Services (incl. ha/funder Costs)</td>
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<td>792</td>
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<tr>
<td>Clinical Supplies</td>
<td>20,123</td>
<td>20,528</td>
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<tr>
<td>Funder Payments - NGOs</td>
<td>45,464</td>
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<td>Funder Payments - IDF Outflows</td>
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<td>9,268</td>
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<tr>
<td>Infrastructure &amp; Non-Clinical Supplies</td>
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<td>11,200</td>
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<td>Finance Costs</td>
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<tr>
<td><strong>Total Expenditure</strong></td>
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<td>168,693</td>
<td>1,613 U</td>
<td>509,925</td>
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<tr>
<td><strong>Net Surplus / (Deficit)</strong></td>
<td>595</td>
<td>577</td>
<td>18 F</td>
<td>1,045</td>
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</table>
2. Result by Arm

<table>
<thead>
<tr>
<th>Result by Division</th>
<th>Month (Sept-15)</th>
<th>YTD (Sept-15)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Funder</td>
<td>318</td>
<td>194</td>
</tr>
<tr>
<td>Provider</td>
<td>219</td>
<td>383</td>
</tr>
<tr>
<td>Governance</td>
<td>59</td>
<td>0</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>595</td>
<td>577</td>
</tr>
</tbody>
</table>

The YTD $475K favourable Funder Arm result and $457K favourable Governance Arm result fully offset the unfavourable Provider Arm result.

- The Funder result reflects lower expenditure for demand type services, offset by adverse net IDF flows. Higher YTD revenue from funded initiatives is accompanied by equivalent expenditure and has a nil impact on the results.
- The Provider Arm unfavourable result is driven by net unfavourable expenditure – primarily Personnel Costs and one off/abnormal Infrastructure and Non Clinical Supplies costs. Overall, volumes are 98.1% of base contract - this equates to $5.5M below contract.
- The Governance Arm favourable result of $457K YTD reflects the slow uptake of joint funder costs in the first quarter. This result is a timing difference and will be offset by higher expenditure in the coming quarters.

3. Financial Commentary for September 2015

Month Result

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

Revenue for the month was favourable to budget by $1.6M with key variances as follows:

a) Favourable revenue was realised mainly in Other Income - $1M favourable mainly from $249k Research grants and one off revenue from settlement of a commercial contract.

Expenditure was higher than budget for the month by $1.6M with key variances as follows:

a) Personnel/Outsourced Personnel costs $0.8M (1.1%) unfavourable. FTEs were 33 (0.4%) below budget but this favourable variance is offset by cost per FTE targets not met, giving a net unfavourable variance.

b) Infrastructure and Non Clinical Supplies $0.5M (4.4%) unfavourable, with the key unfavourable variances being valuation losses in the DHB Trust investments and one off project costs $0.1M.

Year to Date Result

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

Revenue was higher than the budget by $2.9M, with significant underlying variances as follows:

a) MoH Devolved Contracts - favourable to budget by $1.3M mostly as a result of contracts finalised by the Ministry after budgets have been set and with equivalent additional expenditure requirements. The main cause of this variance is from new funding for Zero Fees for under 13s.

b) Other Favourable revenue variances:
o Haemophilia funding $0.4M favourable for abnormally high blood product usage, offset by additional expenditure.
o High Cost Treatment Pool revenue $0.3M favourable – one off revenue, largely offset by additional expenditure.
o Research Income $1.1M favourable, offset by equivalent expenditure and bottom line neutral.
o Pharmacy Retail sales $0.3M favourable, largely offset by additional cost of sales expenditure.
o $0.8M one off revenue related to settlement of a commercial contract and insurance claim.
c) Unfavourable revenue variances:
o Non Resident Income $0.5M unfavourable – this fluctuates from month to month.
o Inter DHB Revenue - $0.5M unfavourable, reflecting the end of the LabPlus MidCentral DHB contract – the reduction in income is partially offset by favourable Clinical Supplies costs in LabPlus.

Expenditure is adverse to budget by $2.8M with significant underlying variances as follows:
d) Net Personnel Costs and Outsourced Personnel Costs $0.8M unfavourable. YTD FTE for total Personnel/Outsourced are 85 below budget, but net costs are unfavourable due to cost per FTE targets not met.
o Personnel Costs are $1.4M (0.7%) favourable due to FTE 237 below budget – the FTE variance is spread widely with vacancies across all categories other than Nursing which is 19 above budget YTD.
o This favourable variance is offset by $2.2M (14%) unfavourable Outsourced Personnel costs (152 FTE above budget), primarily for contract Support and Administration staff covering vacancies.
e) Clinical Supplies $0.5M (0.9%) unfavourable – this variance primarily reflects abnormally high haemophilia blood product costs ($0.3M unfavourable), which are fully funded.
f) Infrastructure and Non Clinical Supplies $0.6M (1.7%) unfavourable, comprising three key variances (predominantly with offsetting income or phasing variances only, so expected to be bottom line neutral) – higher costs of goods sold for retail pharmacy $0.3M (offset by additional revenue), revaluation of financial derivatives $0.4M, and timing of facilities management costs $0.3M unfavourable.
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)

Figure 2: Consolidated Net Result (Cumulative YTD)

5. Efficiencies / Savings

The total savings target for 2015/16 is $26.9M and to be generated within the Provider Arm.

For the first quarter 2015/16 ending September, $4.4M savings were reported against the budget of $5.2M, resulting in an unfavourable variance of $794K. The unfavourable variance is primarily due to the timing of planned procurement savings which have been phased equally into the budget for the full year but actual savings are expected to be weighted towards the second half of the year by the time new contract pricing is implemented. The healthAlliance savings report is being reviewed for further monitoring. The provider arm services are close to budget with a minor unfavourable variance of $59K.
### 6. Financial Position

#### Statement of Financial Position as at 30 September 2015

<table>
<thead>
<tr>
<th>$'000</th>
<th>30-Sep-15</th>
<th>31-Aug-15</th>
<th>Variance</th>
<th>30-Jun-15</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Actual</td>
<td>Last Month</td>
<td>Actual</td>
</tr>
<tr>
<td>Public Equity</td>
<td>576,798</td>
<td>576,798</td>
<td>OF</td>
<td>576,798</td>
<td>OF</td>
</tr>
<tr>
<td>Reserves</td>
<td>-</td>
<td>-</td>
<td>OF</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>438,457</td>
<td>406,629</td>
<td>31,828F</td>
<td>438,457</td>
<td>OF</td>
</tr>
<tr>
<td>Cashflow-hedge Reserve</td>
<td>(4,155)</td>
<td>(4,107)</td>
<td>48U</td>
<td>(4,201)</td>
<td>46F</td>
</tr>
<tr>
<td>Accumulated Deficits from Prior Year’s</td>
<td>(464,047)</td>
<td>(461,199)</td>
<td>2,848U</td>
<td>(464,047)</td>
<td>OF</td>
</tr>
<tr>
<td>Current Surplus/(Deficit)</td>
<td>1,045</td>
<td>-</td>
<td>1,045F</td>
<td>450</td>
<td>595F</td>
</tr>
<tr>
<td></td>
<td>(28,693)</td>
<td>(58,677)</td>
<td>30,114F</td>
<td>(29,847)</td>
<td>462F</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td>548,099</td>
<td>518,122</td>
<td>29,978F</td>
<td>547,457</td>
<td>642F</td>
</tr>
</tbody>
</table>

#### Non Current Assets

| Fixed Assets | Land | 249,006 | 217,178 | 31,828F | 249,006 | OF | 249,006 | OF |
| Buildings | 578,914 | 555,902 | 23,012F | 580,948 | 2,034U | 585,033 | 6,119U |
| Plant & Equipment | 76,659 | 85,761 | 9,102U | 75,940 | 719F | 78,462 | 1,803U |
| Work in Progress | 56,179 | 56,934 | 755U | 49,061 | 7,118F | 39,821 | 16,358F |
| | 960,758 | 915,775 | 44,983F | 954,955 | 5,803F | 952,322 | 8,436F |
| Derivative Financial Instruments | - | - | OF | - | OF | - | OF |
| Investments | - | - | OF | - | OF | - | OF |
| - Health Alliance | 42,170 | 42,430 | 260U | 42,170 | OF | 42,170 | OF |
| - HBL | 12,420 | 12,420 | OU | 12,420 | OU | 12,420 | OU |
| - ADHB Term Deposits > 12 months | 10,000 | - | 10,000F | 10,000 | OF | - | 10,000F |
| - Other Investments | 462 | - | 462F | 462 | OU | 462 | OU |
| | 65,052 | 54,850 | 10,202F | 65,052 | OU | 55,052 | 10,000F |
| Intangible Assets | 788 | 1,625 | 837U | 828 | 40U | 910 | 122U |
| Trust Funds | 17,994 | 14,548 | 3,446F | 17,167 | 827F | 17,299 | 695F |
| | 83,833 | 71,023 | 12,810F | 83,047 | 786F | 73,261 | 10,572F |
| **Total Non Current Assets** | 1,044,591 | 986,798 | 57,793F | 1,038,002 | 5,689F | 1,025,583 | 19,008F |

#### Current Assets

| Cash & Short Term Deposits | 60,023 | 95,363 | 35,341U | 69,715 | 9,692U | 87,210 | 27,178U |
| Trust Deposits > 3 months | 7,500 | 7,700 | 200U | 7,000 | 500F | 8,500 | 1,000U |
| ADHB Term Deposits > 3 months | 5,000 | - | 5,000F | 5,000 | OF | - | 5,000F |
| Debtors | 26,251 | 25,299 | 953F | 25,877 | 374F | 28,509 | 2,258U |
| Accrued Income | 33,954 | 22,000 | 11,954F | 26,885 | 7,069F | 19,206 | 14,748F |
| Prepayments | 2,707 | 1,166 | 1,541F | 2,860 | 153U | 1,035 | 1,672F |
| Inventory | 13,353 | 12,723 | 630F | 13,184 | 169F | 13,154 | 199F |
| **Total Current Assets** | 148,789 | 164,251 | 15,462U | 150,521 | 1,732U | 157,614 | 8,825U |

#### Current Liabilities

| Borrowing | - | (4,026) | 4,026F | (54,840) | 54,840F | (52,454) | 52,454F |
| Trade & Other Creditors, Provisions | (146,163) | (120,404) | 25,759U | (134,893) | 11,720U | (121,299) | 24,864U |
| Employee Benefits | (163,315) | (170,254) | 6,939F | (165,533) | 2,118F | (176,735) | 13,420F |
| Funds Held in Trust | (1,217) | (1,169) | 48U | (1,215) | 2U | (1,208) | 9U |
| **Total Current Liabilities** | (310,695) | (295,853) | 14,842U | (356,481) | 45,786F | (351,696) | 41,001F |

#### Working Capital

| (161,906) | (131,602) | 30,304U | (205,960) | 44,054F | (194,082) | 32,176F |

#### Non Current Liabilities

| Borrowings | (304,500) | (304,500) | OF | (254,500) | 50,000U | (254,500) | 50,000U |
| Employee Entitlements | (30,085) | (32,575) | 2,490F | (30,085) | 0U | (30,085) | 0U |
| **Total Non Current Liabilities** | (334,585) | (337,075) | 2,490F | (284,585) | 50,000U | (284,585) | 50,000U |

#### Net Assets

| 548,099 | 518,121 | 29,978F | 547,457 | 642F | 546,916 | 1,183F |
Comments

- The full revaluation of land completed at 30 June resulted in an increase in revaluation reserve of $31.8M, increasing the year end Equity position.
- Buildings, plant and equipment variances are largely due to different opening balances set in the budget.
- Lower than budget cash and cash equivalents are offset by favourable investment term deposits. $5M matures within a year and $10M matures greater than a year.
- Trade & Other Payables timing differences in payments for creditors, capital charge and income in advance.
## Statement of Cash flows (Month and YTD September 2015)

<table>
<thead>
<tr>
<th></th>
<th>Month (Sept-15)</th>
<th>Year to Date (Sept-15)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash Received</td>
<td>163,347</td>
<td>169,148</td>
</tr>
<tr>
<td>Payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>(72,522)</td>
<td>(67,979)</td>
</tr>
<tr>
<td>Suppliers</td>
<td>(29,432)</td>
<td>(35,918)</td>
</tr>
<tr>
<td>Capital Charge</td>
<td>0</td>
<td>(3,358)</td>
</tr>
<tr>
<td>Funder payments</td>
<td>(54,758)</td>
<td>(53,356)</td>
</tr>
<tr>
<td>GST</td>
<td>(4,607)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(161,319)</td>
<td>(160,611)</td>
</tr>
<tr>
<td><strong>Net Operating Cash flows</strong></td>
<td>2,029</td>
<td>8,537</td>
</tr>
<tr>
<td><strong>Investing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Income</td>
<td>498</td>
<td>676</td>
</tr>
<tr>
<td>Sale of Assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purchase Fixed Assets</td>
<td>(8,953)</td>
<td>(8,235)</td>
</tr>
<tr>
<td>Investments and restricted trust fund</td>
<td>(1,328)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Investing Cash flows</strong></td>
<td>(9,782)</td>
<td>(7,559)</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Equity Movement</td>
<td>(0)</td>
<td>0</td>
</tr>
<tr>
<td>Equity Injections</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Loans</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans Repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Equity Repayment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(1,938)</td>
<td>(1,273)</td>
</tr>
<tr>
<td><strong>Net Financing Cashflows</strong></td>
<td>(1,938)</td>
<td>(1,273)</td>
</tr>
<tr>
<td><strong>Total Net Cash flows</strong></td>
<td>(9,691)</td>
<td>(295)</td>
</tr>
<tr>
<td><strong>Opening Cash</strong></td>
<td>69,715</td>
<td>95,660</td>
</tr>
<tr>
<td><strong>Total Net Cash flows</strong></td>
<td>(9,691)</td>
<td>(295)</td>
</tr>
<tr>
<td><strong>Closing Cash</strong></td>
<td>60,024</td>
<td>95,365</td>
</tr>
</tbody>
</table>

ADHB Cash
- 56,445
- 90,260
- 33,816U

A+ Trust Cash
- 1,038
- 0
- 1,038F

A+ Trust Deposits - Short Term < 3 months & restricted fund deposits
- 2,542
- 5,105
- 2,563U

ADHB - Short Term > 3 months
- 5,000
- 0
- 5,000F

A+ Trust Deposits - Short Term > 3 months
- 7,500
- 7,700
- 200U

ADHB Deposits - Long Term
- 10,000
- 0
- 10,000F

A+ Trust Deposits - Long Term
- 17,994
- 14,548
- 3,446F

Total Cash & Deposits
- 100,518
- 117,613
- 17,095U
FUNDER REPORT

Recommendation

That the Auckland DHB Board receive the report.

Prepared by: Jo Brown (Funding & Development Manager – Hospitals), Tim Wood, (Funding & Development Manager – Primary Care, Acting Funding & Development Manager – Mental Health & Addictions), Kate Sladden (Funding & Development Manager – Health of Older People), Ruth Bijl (Funding & Development Manager – Women, Children & Youth), Aroha Haggie (Manager – Maori Health Gain), Lita Foliaki (Manager – Pacific Health Gain, Samantha Bennett (Manager – Asian, Migrant & Refugee Health Gain)

Endorsed by: Dr Debbie Holdsworth, Director Funding

Glossary

ARRC - Aged Related Residential Care
BMT - Bone Marrow Transplant
DHB - District Health Board
EDAT - Ethnicity Data Audit Tool Plan
EOI - Expression of Interest
ESPI - Elective Services Patient Flow Indicators
FCT - Faster Cancer Treatment
FTE - Full Time Equivalent
Funder - the joint Auckland and Waitemata DHB funding team
HBHF - Healthy Babies Healthy Futures
HBSS - Home Based Support Services
HSC - High Suspcion of Cancer
ICS - Interim Care Scheme
IDF - Inter-District Flow
MBU - Mother Baby Unit
MOH - Ministry of Health
NHB - National Health Board
NIR - National Immunisation Register
NSU - National Screening Unit
ORL - Otorhinolaryngology
PHAP - Pacific Health Action Plan
PHO - Primary Healthcare Organisation
RhF - Rheumatic Fever
RFP - Request for Proposals
SIR - Standardised Intervention Rates

1. Introduction

This report provides a detailed overview of the Funder’s activity and areas of priority for the Auckland District Health Board (DHB) population. It includes an update on provider performance and funding arrangements. For the most part, it is limited to matters not already dealt with by other Board committees.
2. Primary Care

2.1 Community Pharmacy

The Pharmacy Audit Strategy 2015-2025 was commissioned by the Community Pharmacy Services Agreement (CPSA) to provide a balance between quality improvement, core assurance and probity activities for pharmacy audits. The strategic objectives supporting this strategy focus on funding, safe practice, quality improvement, enhancing auditing efficiencies & effectiveness and maintaining national consistency.

Audit tools developed based on the Strategy will be used to determine whether a community pharmacy is providing a high quality service aligned with the expectations of the funders. The CPSA will also use clearly articulated measures for each service that is provided by community pharmacies. These measures will be patient centred, quality focussed, targeted, and audit will operate on the basis of an integrated auditing programme which includes self-audit.

2.2 Diabetes

The Diabetes Service Level Alliance (DSLA) is working on developing a draft Work Programme for endorsement by the Alliance Leadership Team. It is envisaged that the Work Programme would have four key workstreams namely Systems Redesign, Self-Management and Care Planning, Workforce Development and Optimisation of Clinical Management. Once finalised, each workstream will be led by a working group who would be accountable to the DSLA for achieving the agreed deliverables.

2.3 Smoking Cessation

Two technical changes have been introduced to the primary care target for Brief Help for Smokers to Quit from 1 July 2015. Aim of these changes was to improve recording and reporting of the target.

This change takes away the need for an ‘adjuster’ in calculating the denominator of the targets’ indicator. By removing the adjuster, it improves the accuracy of the target as it is now based on actual numbers rather than estimates. This change also allows PHOs to better support all enrolled patients who smoke, regardless whether they have been seen by their health practitioner. This means that PHOs could reach enrolled smokers via a range of health promotion and public health activities.

Another technical change is related to ‘numerator cover period’ which has been extended from 12 months to 15 months. This change allows the practice/PHO to offer smokers’ help to quit for 12 months, with a three month follow up period to contact smokers who have not been in contact with their health practice.

The change has resulted in a decrease in performance in the target. With the revised target for the Better Help for Smokers to Quit, Auckland DHB’s 89% of the eligible population received Advice to Quit during July and August months. The Ministry have recognised the challenges with the new definition and removed any financial penalty for PHOs not achieving the target in 15/16 if they achieved it in Q4 14/15.

We have formally raised our concerns about the changes with the Ministry and requested a review of the target, particularly the period over which the performance is measure. The 15 month period doesn’t adequately reflect patient utilisation of general practice compared to a period of 18 or 24 months. 90% of the enrolled population would have visited their GP in 24 months compared with
70% for 15 months. In this context, the revised target still puts the reliance on a non face to face contact when the evidence is that brief intervention is most effective when delivered face to face.

2.4 Green Prescription

The Ministry of Health has extended the Green Prescription agreement with Auckland DHB to include Active Families for 2015-16. Active Families is a community based health initiative designed to increase physical activity and improve nutrition in children and young people aged five to eighteen years of age and their whanau/families. Activity and nutritional advice is provided to families through weekly group sessions and some home visits over a period of six months. Sport Auckland who provides the Green Prescription service for the DHB started delivering an Active Families programme in Glenn Innes in September. They plan to add further locations during the year.

3. Hospitals

3.1 Cancer target

Auckland DHB has established a number of initiatives to support the achievement of the 62 day Faster Cancer Treatment target for both the ADHB population and the regional populations who access cancer services at ADHB. These initiatives include the appointment of new staff across a number of services including the Regional Cancer and Blood service, and the development of a range of tools that will assist with the identification tracking and management of all patients with a high suspicion or evidence of cancer. New funding is available to ADHB from 1 October to augment the investment already prioritised in 2015/16 by the ADHB funder.

The rolling four month FCT indicator result for the period April – July 2015 is 65% compared with the Quarter 4 result of 55%.

3.2 Auckland DHB 2015/16 Surgical Health Target

In 2015/16 the Ministry has changed the definition of Surgical Health Target to include surgical activity discharged from a medical service and surgical events, discharged from a medical or surgical service, admitted within 1 – 7 days of a decision to treat (also known as acute arranged surgical activity). This is a change from the previous surgical health target definition which included surgical discharges admitted more than 7 days after the decision to treat.

The preliminary results for the 1st quarter show ADHB has achieved 92% of the surgical health target. This target has not been met due to a range of issues including the impact of high complexity acute demand and increased IDF elective activity within the ADHB provider associated with sustaining ESPI compliance, as well as reduced demand for Orthopaedic and Ophthalmology elective services at Counties Manukau for the Otahuhu population. The Director of Provider services has established a range of measures including additional capacity during the 2nd quarter to increase internal production and the funder is working with CMDHB to ensure the IDF plan is achieved through the appropriate substitution of other elective clinical services.

3.3 2015/16 IDF arrangements

A preliminary analysis of the last two years actual IDF inflows and the forecast 15/16 IDF volumes has been completed. A further refresh of the available data will occur at the end of October when cost and activity data for 2014/15 is finalised. This will be reviewed jointly by the funder, CFO and Director of Provider to establish whether there is a need to adjust revenue and cost budgets in this
financial year to reflect anticipated reduced demand for Auckland DHB services by other populations.

3.4 2016/17 IDF arrangements

The funder is working with the Directors of ADHB Directorates to review forecast IDF arrangements for 2016/17 with the intention of meeting the end of October deadlines to inform the Funding envelope. At the same time the funder is participating in regional processes to establish the IDF DHB provider and community provider outflow arrangements for the ADHB population.

3.6 Tertiary services review

The Tertiary Service review is progressing with a detailed schedule of service specific review meetings established to complete the Starship review by December 2015 and progress is now on track to achieve this. The following table provides a high level summary of the milestones and indicative timelines to complete the Starship review.

<table>
<thead>
<tr>
<th>Action</th>
<th>Progress</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework for service review established and tested</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>All Starship service descriptions signed off by Steering Group</td>
<td>On track</td>
<td>18-Dec-15</td>
</tr>
<tr>
<td>Preliminary update to other funders</td>
<td>On track</td>
<td>22-Dec-15</td>
</tr>
<tr>
<td>Final draft Starship Tertiary service review complete and local service specifications and recommendations agreed</td>
<td></td>
<td>31-Jan-16</td>
</tr>
<tr>
<td>Final financial analysis to inform annual plan budget allocations</td>
<td></td>
<td>05-Feb-16</td>
</tr>
<tr>
<td>Final advice to and engagement with other funders complete</td>
<td></td>
<td>26-Feb-16</td>
</tr>
<tr>
<td>Implementation of Starship Tertiary review recommendations</td>
<td></td>
<td>June 2016</td>
</tr>
<tr>
<td>Scope and commence Adult Tertiary service review</td>
<td>Timeline TBC</td>
<td></td>
</tr>
</tbody>
</table>

3.7 Policy Priority areas

Colonoscopy indicators

All waiting time indicators for colonoscopy are being met within internal capacity. Auckland DHB has provided a response to the Ministry of Health regarding future capacity planning and has indicated additional capacity will be available within the provider from 2017 to support a roll out of a National Bowel Screening programme.

Radiology Indicators

The Auckland DHB provider has made progress and is now meeting the national waiting time indicator for outpatient CT. There has been some improvement in performance against the outpatient MRI indicator in the last two months with an improvement to 47% achievement against the target of 80%. There has been marginal improvement in the outpatient ultrasound indicator with 49% compliance against a target of 75%. The provider continues to work to an established improvement plan.
Waiting Time Targets
As at the end of September Auckland DHB is achieving compliance with ESPI2 (outpatient FSA) waiting time targets and remains within the buffer for ESPI5 (booked for surgery).

Bone Marrow Waiting Times
Additional beds within the Haematology service have been commissioned in October for an interim period to address the waiting list backlog for Bone Marrow Transplant. At the time of the last report there were four patients waiting longer than the clinically recommended time of six weeks and this has reduced to only one patient waiting in excess of this time.

3.8 National services
The National Clinical Genetics service improvement project and the National Intestinal Failure service plan are on track. The funder is working with the Directors of Cardiac services and Child Health to provide further information to the National General Managers of Planning and Funding to enable decisions to be made regarding additional investment from 2016/17 to sustain these national services with a decision expected in early November.

3.9 Regional Service Review Programme
Work is occurring regionally to review the arrangements for a range of clinical services provided by ADHB including the Child and Family Unit service review, local Oncology services and the review of elective Urology services for the Counties-Manukau DHB population. The ADHB Executive leadership team will be meeting with CMH to agree a regionally integrated approach to local service delivery for the Counties population.

4. Women, Children & Youth

4.1 8 months Immunisation Health Target
ADHB achieved the Health Target of 95% fully immunised by 8 months of age. The end of quarter result saw coverage of 97% for Pacific infants and 98% for Asian infants achieved. The coverage rate for Maori was 88%.

The Funder is increasing attention on coverage at 5 years of age, following two further immunisations at 15 months and 4 years of age. Current performance shows significant improvements with little or no inequity. Results are Total 84%; Maori 85%; Pacific 83% and Asian 85%.

4.2 Inter-agency working
The Funder has a Youth Alliance with the PHOs. The DHB is required to provide nursing services to Alternative Education (AE) students. Through nursing services to AE students and other processes the Funder has identified unmet health needs, particularly mental health needs, in students attending AE. The Funder commissioned a brief report to better understand if the interventions being introduced as part of the enhanced school based health services (SBHS) programme (the visiting clinical psychologist service) could be extended in the same form to these young people (aged 13 – 16 years). The report, commissioned from clinical psychologist Epenesa Olo-Whaanga, suggested a navigator role would be more appropriate. The Funder has met and agreed with Ministry of Education (Director of Education – Auckland) and Ministry of Social Development (Regional Community Investment Manager – Auckland) to pilot and evaluate a navigator position for these vulnerable young people. The pilot will run during the 2016 academic year. The role will be
funded through the Youth Alliance during 2016, but funding is not sustainable and we have proposed that MSD should fund this role in future. MSD has indicated it will consider this. MSD and Ministry of Education will jointly fund the evaluation. The process has been very positive in terms of establishing closer working relationships. It is expected that working jointly on this small pilot will help with establishing effective working relationships that will be required for Children’s Teams.

4.3 School based health services in Auckland Girls’ Grammar School

Following approval from the Audit and Finance Committee, the Funder met with the Principal of Auckland Girls’ Grammar School (AGGS), Liz Thomson, and senior management to progress establishment of a SBHS in AGGS. The concept was received enthusiastically by AGGS. A contract will be entered into with the school to employ 2 FTE nursing staff who will undertake HEEADDSSS assessments and other services. The school is now exploring reconfiguring some space to accommodate these staff, the GP clinic and the visiting psychologist service and to provide a youth appropriate health service within the school setting. The student population is largely Pacific.

5. Health of Older People

5.1 Home and Community Support Services (HCSS)

The Joint Auckland and Waitemata Working Group on HCSS has agreed overarching principles for HCSS, a redesigned patient pathway and a single set of performance measures. However, due to different configurations and systems in each respective provider arm completed alignment has not been achieved and it has been proposed that different procurement processes are used at each DHB.

Recommendations from the Director General’s Report on HCSS are expected in the next few weeks and could have some bearing on the design of the HCSS models and the procurement processes.

5.2 Aged Related Residential Care (ARRC)

The annual review of the ARRC Agreements is underway and DHBs have until the end of October to identify issues, which will then be prioritised by the Review Group. The review will concentrate on those issues linked to the strategic priorities areas – palliative and end of life care, integration of services for ARRC residents (primary care, community pharmacy and ambulance services) and technology.

6. Mental Health & Addictions

6.1 Maternal Mental Health Acute Continuum

The joint Auckland and Waitemata DHB crisis respite and packages of care service was officially opened on 26 June by Minister Coleman. These services are specifically for pregnant women and mothers and infants where the mother is experiencing an acute deterioration in her mental health from the period of the 2nd trimester (13 weeks+) of pregnancy through to 12 months post birth. Operated by WALSH Trust, the residential respite service is based in Te Atatu in a rented property while the purpose-built 6 bedroom facility is under construction. The expected completion date is September 2016. To date, 17 women have used the residential respite service and 184 support hours have been provided in the community.
6.2 Suicide Prevention and Postvention Action Plan

Chief Coroner Judge Deborah Marshall released the annual provisional suicide statistics on the 6th of October, which show 564 people died by suicide in the 2014/15 year. This is the highest number since the provisional statistics were first recorded for the 2007/08 year. The Focus groups within the Suicide Prevention Advisory Committee continue with implementation phase of the SPPAP, and will update on regular basis.

6.3 Youth Innovation Forum

“Look up” Expo is taking place on the 16th of October at Te Oro Music and Arts Centre, Glen Innes. This innovative Expo is for young people and professionals to see, hear and learn new creative and technological ways to connect to achieve the best outcomes for young people’s mental health and wellbeing. The intention is to leave participants informed and inspired with new innovative ways of working. It is expected that between 150 and 200 youth people from the ADHB area will be attending.

7. Maori Health Gain

7.1 Smoking cessation

The Maori Health Gain Team is leading the development and implementation of an evidence based incentives programme to support pregnant mothers to become and stay smokefree. The programme offers pregnant mothers who smoke an incentive to quit smoking followed by further incentives to stay smokefree. The 20-week programme consists of 2 weeks focusing on initial engagement, 16 weeks focusing on key milestones to quit smoking during pregnancy and a further 2 weeks post-partum. The Programme was endorsed by Auckland DHB Board and was launched in early October.

7.2 Kaumatua Action Plan

The Kaumatua Action Plan outlines the activities Auckland and Waitemata DHBs will undertake over the next three years to improve health outcomes for Maori 65 years and over. The Plan was presented to both Auckland and Waitemata DHB Board’s and received endorsement. We are in the process of implementing year one actions.

7.3 Cardiovascular rehabilitation

The Maori Health Gain Team is leading the development of a framework for phase two cardiac rehabilitation in the community. The framework has been drafted and is being reviewed by the Northern Regional Alliance Rehabilitation Network.
8. Pacific Health Gain

8.1 Pacific Health Action Plan

The implementation of Pacific Health Action Plan (PHAP) is on target for Priorities 1 – 5, as follows:

Priority 1 – Children are safe and well and families are free of violence
The first Living Without Violence programme is being implemented in a Samoan church in Sandringham. A Tongan language version is being developed and will be implemented in this Quarter.

The new format for the nutrition and physical activity programme for pregnant women and young children, Healthy Babies Healthy Futures is being implemented through HealthWest, West Fono Health Trust and other Pacific providers, The Asian Network and the Chinese New Settlers Services Trust. The programme consists of six modules and the focus is on skills development.

Priority 2 – Pacific people are smoke-free
The WERO group smoke free competition is now facilitated by HealthWest. HealthWest has met with the Enua Ola health committees in West Auckland and they will be introduced to HVAZ churches as well. They are in a position to provide more practical support to groups who will join the competition.

Priority 3 – Pacific people are active and eat healthy
The third weight loss Aiga Competition for churches in the Enua Ola programme has now ended and the data is being processed. The HVAZ competition started on 21 September 2015. Data from both programmes will be analysed for the three years that the competition has taken place and it will be used to assess the success (or not) of the competition.

Participants who have lost or maintained weight over the previous three years will be identified and asked if they are willing to provide individualised support/mentoring for others who need/want to lose weight. The Funder intends to develop a programme to support mentors.

Priority 4 – Pacific people seek medical and other help early
The parish community nursing service is progressing well. A workshop is being organised for the four parish community nurses from ADHB and the three from WDHB to share learnings and this will be an ongoing forum.

Priority 5 – Pacific people use hospital services when needed
A project to better understand Pacific patient’s experience of hospital services has been initiated by the General Manager for Pacific Health Services. The Pacific Planning and Funding Team is involved and will focus specifically on the interface between hospital services and primary care/community services.

Priority 6 – Pacific families live in houses that are warm and adequate
The Ministry of Business, Innovation and Employment runs workshops on addressing the housing needs of Pacific people. The Pacific Team participates in the workshops and keeps the Enua Ola and HVAZ networks informed.
8.2 General Comments

Review of Enua Ola and HVAZ Programmes
A review of the HVAZ and Enua Ola programmes is being undertaken. A Review Working Group has been established and has had its first meeting. It consists of three people from the Enua Ola groups and three from HVAZ. The Review is being undertaken by the DHB Pacific Team and the community Working Group provides advice as to the questions being asked of the community and the methodology that is being used.

Consultation with the following will be undertaken:
- HVAZ and Enua Ola health committee members
- Pacific providers
- Individuals
- DHBs

The feedback from the consultation will be presented to the Working Group and draft recommendations will be developed. Those recommendations will be shared with the Enua Ola and HVAZ health committees and Pacific providers then presented to Director of Funding and Health Outcomes but the Director of Funding will be informed of issues that emerge as the review progresses.

It is intended that the review will be completed by April 2016.

Sugary Drinks Free NZ Conference
The Pacific HAVZ/Enua Ola Programme Manager and Rev Featuna‘i Liuana, Pacific CPHAC representative gave a joint presentation to the Sugary Drinks Free NZ Conference held on 7th September. The presentation was based on the HVAZ Healthy Eating Awards. The presentation was well received and a comment was made that more community people should be invited to participate in conferences that address obesity.

Input into Academic Courses
A paper on Pacific Health is part of the Bachelor of Health Sciences degree at AUT. Two of the lectures were presented by one of the Pacific programme managers and the Suicide Prevention Programme manager.

9. Asian, Migrant & Refugee Health Gain

The Asian & Middle Eastern, Latin American and African (MELAA) Health Governance Group agreed that the portfolio’s key goal is to increase health gain in targeted Asian, migrant and/or refugee populations where health inequalities impact on their health status in the Auckland and Waitemata District Health Boards (DHB). Key priorities for 2015-16 are set out below.

9.1 Increase the DHBs’ capability and capacity to deliver responsive systems and strategies to targeted Asian, migrant and refugee populations
As part of the Health Needs Assessment (HNA) cycle, an Asian International Benchmarking Report is underway comparing health outcomes for Asian subpopulations around the world, in order to identify potential emerging areas that may impact on the health of specific Asian groups in Waitemata DHB and Auckland DHB catchments. The analysis will aim to cover health outcomes, important risk factors, health service use, and policy framework.
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 80% (ADHB) and 84% (WDHB) targets by 30 June, 2016 (current rates 78% (ADHB) and 82% (WDHB) as at 30 June, 2015)

**Indicator:** Reduce admissions to the Emergency Department (ED) at Auckland City Hospital (ACH) for identified recent migrant and/or student populations

A scoping paper has been developed to explore ‘Utilisation of ED at ACH and primary care services for recent migrants and students (international and domestic) in the Auckland district’. Concurrently, a survey to students has been rolled out to identify their ‘Awareness of health services and health information in the Auckland district’ to guide better understanding of attitudes and behaviours to health service access for students. The survey is available online across the three Auckland University of Technology (AUT) campuses, and online and via hardcopies (Chinese and Korean languages) at the two New Zealand Management Academies (NZMA) campuses. The survey will be made available across other university and training platforms shortly. The findings for this Project will guide the development of targeted interventions to these identified groups, particularly those living in the central business district (CBD) and inner city suburbs on appropriate pathways to primary and acute care.

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

The Refugee Primary Care Wrap Around Service Agreements with PHOs are rolling out with identified general practices participating in the programme to offer subsidised culturally appropriate services to enrolled refugees within the practices. The Programme Manager - Asian, Migrant and Refugee (WDHB-ADHB) will provide onsite support to practices where necessary to address barriers to uptake of services experienced by the refugee populations or primary health workforce. An Operational Group for participating PHOs has been established to provide support and act as a platform for shared learnings and group discussion. Professional development opportunities were provided to frontline staff and primary health staff to upskill them on the soft skills and cultural competencies required to support refugee families at the practice level. They included:

- Two receptionists training to frontline staff delivered in March and June 2015 (25 attended)
- Three refugee health network forums on Women’s Health, Men’s Health and Youth Health delivered in May, August and November 2015 (120 attended)

**Indicator:** Increase the number of Indians who have a heart and diabetes check through targeted engagement

Intent is to engage with partners reaching out to Indian communities in Auckland and West Auckland to raise awareness about heart and diabetes checks, and healthy lifestyle messaging via partner platforms in Q2/Q3.
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:

<table>
<thead>
<tr>
<th>General subject of item to be considered</th>
<th>Reason for passing this resolution in relation to the item</th>
<th>Grounds under Clause 32 for the passing of this resolution</th>
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</thead>
</table>
| Confirmation of Confidential Minutes 16 September 2015 | Confirmation of Minutes  
As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000. | 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] |
| Register of Interest and Conflict 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] |
| Action Points 16 September 2015 | Confirmation of Action Points  
As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000. | 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 Health and Safety Responsibility Falling to the Funder/Planner in regard to contracted services | Commercial Activities  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(ii)]  
Negotiations  
To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)] | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| 4.1 | Health and Safety Performance Report September 2015 | **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] |
| 5. | Performance 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] |
| 6.1 | Approval for Auckland DHB to acquire further “C” Class Shares in healthAlliance NZ | **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] |
| 6.2 | Endoscopy Business Case | **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] |
| 6.3 | Birthcare Auckland Ltd – Contract Variation 1 July 2015 | **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 | Home Based Support Services Update | **Commercial Activities**  
To enable the Board to carry out, without prejudice or disadvantage, | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of |
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<td></td>
<td><strong>Commercial Activities</strong></td>
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<td><strong>6.5</strong></td>
<td><strong>Heart Lung Machine for Cardiovascular</strong></td>
<td>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&amp;D Act 2000]</td>
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<td><strong>6.6</strong></td>
<td><strong>Refurbishment of Fraser McDonald Unit</strong></td>
<td>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&amp;D Act 2000]</td>
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<td><strong>6.7</strong></td>
<td><strong>Perioperative Fleet – Bulk Instruments 2015/2016</strong></td>
<td>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&amp;D Act 2000]</td>
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<td><strong>6.8</strong></td>
<td><strong>Replacement Perioperative – Stealth Navigation System</strong></td>
<td>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&amp;D Act 2000]</td>
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<td><strong>6.9</strong></td>
<td><strong>Official Information Act Process and Policy</strong></td>
<td>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&amp;D Act 2000]</td>
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<td><strong>7.1</strong></td>
<td><strong>Obligation of Confidence</strong></td>
<td>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&amp;D Act 2000]</td>
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**Auckland District Health Board**  
Board Meeting 28 October 2015
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<thead>
<tr>
<th>Topic</th>
<th>Commercial Activities</th>
<th>Reason</th>
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<tr>
<td>Non Resident Debt Write Off Request</td>
<td>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)] Privacy of Persons To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)]</td>
<td>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&amp;D Act 2000]</td>
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<td>7.2 Capex Variation Request – Anaesthesia Machines and Monitors</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
<td>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&amp;D Act 2000]</td>
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<td>7.3 Annual Report</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
<td>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&amp;D Act 2000]</td>
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<td>8.1 Human Resources Report October 2015</td>
<td>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)]</td>
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<tr>
<td>9.1 Northern Electronic Health Record (NEHR) Programme Update</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
<td>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&amp;D Act 2000]</td>
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<td>10.1</td>
<td>Collaboration Governance Group Minutes 24 June 2015</td>
<td>Commercial Activities</td>
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<tr>
<td>10.2</td>
<td>Collaboration Governance Group Minutes 23 September 2015</td>
<td>Commercial Activities</td>
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<tr>
<td>11.1</td>
<td>Delegation of Authority – Contract Approval and Signing</td>
<td>Commercial Activities</td>
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<tr>
<td>11.2</td>
<td>CE at Risk Payment</td>
<td>Commercial Activities</td>
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