AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 26 October 2016

10:00am

Note:

- **Public Excluded Session 10:00am to 12 noon**
- **Open Meeting from 12:45pm**

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

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Published 20 October 2016

Agenda
Meeting of the Board
26 October 2016

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

Time: 9:45am

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

Apologies Members:

Apologies Staff: Sue Waters

Karakia

Agenda

Please note that agenda times are estimates only

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

2. **RESOLUTION TO EXCLUDE THE PUBLIC**

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

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

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

12:45pm **4.** **CONFIRMATION OF MINUTES 7 SEPTEMBER 2016**

12:50pm **5.** **HEALTH AND SAFETY**

	5.1	Rehabilitation Policy
	6.	**ACTION POINTS 7 SEPTEMBER 2016 - NIL**
1:10pm	**7.**	**CHIEF EXECUTIVE'S REPORT**
	7.1	Chief Executive's Report
1:20pm	**8.**	**PRESENTATIONS**
	8.1	"Nurses Rising to the Challenge" - Margaret Dotchin, Chief Nursing Officer
1:40pm	**9.**	**PERFORMANCE REPORTS**
	9.1	Financial Performance Report
	9.2	Funder Update Report
	10.	**DECISION REPORTS - Nil**
	11.	**DISCUSSION PAPERS**
1:50pm	11.1	Auckland DHB Strategy Supports New Zealand Health Strategy Themes
	12.	**GENERAL BUSINESS**

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

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Attendance at Board Meetings

Members	17 Feb. 16	30 March.16	11 May. 16	22 Jun. 16	03 Aug. 16	07 Sep. 16	26 Oct. 16	07 Dec. 16
Lester Levy (Chair)	1	1	1	1	1	1		
Joanne Agnew	1	1	1	1	1	1		
Peter Aitken	1	1	1	1	1	1		
Doug Armstrong	1	1	1	1	1	1		
Judith Bassett	1	1	1	x	1	1		
Chris Chambers	1	1	1	1	1	1		
Lee Mathias (Deputy Chair)	x	1	1	1	1	1		
Robyn Northey	1	1	1	1	1	1		
Morris Pita	1	1	1	1	1	1		
Gwen Tepania-Palmer	1	1	1	x	1	1		
Ian Ward	1	1	1	1	1	1		
		Key: 1 = present, x = absent, # = leave of absence						

Resolution to exclude the public from the meeting

Recommendation

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Confirmation of Confidential Minutes 7 September 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
1.1 Confirmation of Circulated Resolution – Starship Children's Hospital Upgrade Projects – Construction Contract Approval	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	
2. 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 7 September 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety Performance Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not	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

	be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.2 Presentation – Journey of Incidents through the Management and Reporting System	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Provider Arm Recovery Plan	**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]
5.2 Orthopaedic Update	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 2015/2016 Annual 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]
8.1 Business Case – Improving Adult Acute Flow at Auckland Hospital Level 2, AED Redesign	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act

		1982 [NZPH&D Act 2000]
8.2 All of Government Electricity Contract	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.3 Detailed Capital Expenditure Budget for 2016/2017	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.4 Amended Delegated Authority Policy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.5 Audit of PHOs – Qualification of Statement of Performance	**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]
8.6 Contract Extension for Taxis	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the	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

	greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	1982 [NZPH&D Act 2000]
9.1 Human Resources Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Annual IEA Increases	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(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]
9.3 At Risk Performance Pay Component	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(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]
9.4 Chief Executive's 2015/2016 Remuneration Review	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Eating Disorder Supra	**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

Regional Services – Implications of and Response to Midland Proposal to Exit	commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.2 Regional Working Arrangements – Clarifying roles, Accountabilities and Working Arrangements for Regional Groups	**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]
11.1 Primary Maternity Facility	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 Commercial Agreement with IBM re National Infrastructure Platform	**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]
11.3 New Zealand Health Innovation Hub Ltd – Stakeholder 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]
11.4 After Hours Update	**Commercial Activities** To enable the Board to carry out,	That the public conduct of the whole or the relevant part of the meeting would

	without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.5 healthAlliance NZ Limited – Resolution in Lieu of AGM	**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]
12.1 Board Resolution Status – Quarterly Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act Board members must disclose all interests, and the full nature of the interest, as soon as practicable after the relevant facts come to his or her knowledge.

An "interest" can include, but is not limited to:

- Being a party to, or deriving a financial benefit from, a transaction
- Having a financial interest in another party to a transaction
- Being a director, member, official, partner or trustee of another party to a transaction or a person who will or may derive a financial benefit from it
- Being the parent, child, spouse or partner of another person or party who will or may derive a financial benefit from the transaction
- Being otherwise directly or indirectly interested in the transaction

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out duties under the Act then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

Gifts and offers of hospitality or sponsorship could be perceived as influencing your activities as a Board member and are unlikely to be appropriate in any circumstances.

- When a disclosure is made the Board member concerned must not take part in any deliberation or decision of the Board relating to the transaction, or be included in any quorum or decision, or sign any documents related to the transaction.
- The disclosure must be recorded in the minutes of the next meeting and entered into the interests register.
- The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if the majority of other members of the Board permit the member to do so.
- If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

IMPORTANT

If in doubt – declare.

Ensure the full **nature** of the interest is disclosed, not just the existence of the interest.

This sheet provides summary information only - refer to clause 36, schedule 3 of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004 for further information (available at www.legisaltion.govt.nz) and "Managing Conflicts of Interest – Guidance for Public Entities" (www.oag.govt.nz).

Register of Interests – Board

Member	Interest	Latest Disclosure
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	09.02.2016
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Peter AITKEN	Pharmacy Locum - Pharmacist Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd Shareholder/ Director - Pharmacy New Lynn Medical Centre Shareholder/Director – New Lynn 7 Day Pharmacy Shareholder/Director – Belmont Pharmacy 2007 Ltd Shareholder/Director – TAMNZ Limited Shareholder/Director – Bee Beautiful Limited	07.10.2015
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare (no personal beneficial interest as it is held through a Trust) Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter is a partner – Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	10.10.2016
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Group Daughter is a shareholder of Westpac Banking Group	13.07.2015
Chris CHAMBERS	Employee - ADHB Wife is an employee - Starship Trauma Service Clinical Senior Lecturer in Anaesthesia - Auckland Clinical School Member – Association of Salaried Medical Specialists Associate - Epsom Anaesthetic Group Shareholder - Ormiston Surgical	26.01.2014

Lee MATHIAS	Chair - Counties Manukau Health Deputy Chair - Auckland District Health Board Chair - Health Promotion Agency Chair - Unitec Acting Chair - Health Innovation Hub Director - Health Alliance Limited Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships	11.05.2016
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation	24.08.2016
Morris PITA	Member – Waitemata District Health Board Shareholder – Turuki Pharmacy, South Auckland Shareholder – Whanau Pharmacy Limited Director and Shareholder of Healthcare Applications Ltd Owner and operator with wife - Shea Pita & Associates Ltd Wife is member of Northland District Health Board Wife provides advice to Maori health organisations	17.02.2016
Gwen TEPANIA-PALMER	Board Member - Waitemata District Health Board Board Member - Manaia PHO Chair - Ngati Hine Health Trust Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Member - Health Quality and Safety Commission	02.04.2013
Ian WARD	Deputy Chair - NZ Blood Service Director and Shareholder – C4 Consulting Ltd Shareholder – Vector Group Shareholder / Director - Eltham Investments Limited Shareholder / Director - Cavell Corporation Limited Shareholder / Director - Ward Consulting Services Limited Trustee - LP Leasing Limited Trustee - Chris C Lynch Limited Son – Oceania Healthcare	18.07.2016

Minutes
Meeting of the Board
07 September 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 07 September 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:45am.

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Lester Levy (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Simon Bowen	Director of Health Outcomes – Auckland and Waitemata DHB's
Peter Aitken	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Dr Debbie Holdsworth	Director of Funding – Auckland and Waitemata DHB's
Judith Bassett	Fiona Michel	Chief of People and Capability
Dr Chris Chambers	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Dr Lee Mathias (Deputy Chair) (not present after item 5)	Rosalie Percival	Chief Financial Officer
Robyn Northey	Linda Wakeling	Chief of Intelligence and Informatics
Morris Pita (not present after item 5)	Sue Waters	Chief Health Professions Officer
Gwen Tepania-Palmer	Dr Margaret Wilsher	Chief Medical Officer
Ian Ward		
	Auckland DHB Senior Staff Present	
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Sir Graeme Douglas

Dr Lester Levy acknowledged the passing of Sir Graeme Douglas, pioneering founder of Douglas Pharmaceuticals, which today employs some 450 staff.

"On behalf of the Board, I would like to express our sadness and condolences to the Douglas Family."

"Sir Graeme and Lady Ngaire are renowned for their generosity and philanthropy, and in particular their gift to Starship Children's Hospital in 2010 of $3m. This helped pay for a new medical scanner to ensure its own MRI facility and remains the single largest personal donation in the hospital's history."

"Thousands of children and their families have benefited as a result."

"Sir Graeme is remembered for his significant contribution to health in so many ways, his kindness and his generosity."

"The quote, 'what we have done for ourselves alone dies with us; what we have done for others and the world remains and is immortal', sums up Sir Graeme – a man with great vision and compassion."

1. ATTENDANCE AND APOLOGIES

That the apologies for Lee Mathias and Morris Pita for early departure be received.

2. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 5-7)

Resolution: Moved Gwen Tepania-Palmer / Seconded Peter Aitken

That in accordance with the provisions of Clauses 32 and 33, Schedule 3, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Confirmation of Confidential Minutes 3 August 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. 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]
3.1 Health and Safety Performance Report – July 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points 3 August 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding

		would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 NEHR Programme Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Capex Variation Request – Auckland DHB ePrescribing Early Adopter Implementation Project	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Public Spaces Refurbishment	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Variation Request for the Workforce Central Time and Attendance Project (RiTA)	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

7.1 Human Resource Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Auckland DHB Provider Arm Financial Position: Implementing the Get on Track Initiative	**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]
9.1 Reporting available from healthAlliance	**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]
9.2 Deloitte Auckland DHB financial Review	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

3. CONFLICTS OF INTEREST (Pages 8-10)

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

4. CONFIRMATION OF MINUTES 3 AUGUST 2016 (Pages 11-23)

Resolution: Moved Robyn Northey / Seconded Jo Agnew

That the minutes of the Board meeting held on 3 August 2016 be confirmed as a true and accurate record.

Carried

5. HEALTH AND SAFETY REPORT

5.1 The Next Steps – From Safety to Health and Safety

Ailsa Claire made a presentation on progress made in reducing exposure to physical harm, provided details on programmes of work being undertaken to support this, and covered what was required of a measurement system to monitor success [see attachment 5.1.1.]

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

- Morris Pita commenting that the information given provided a broader lense over health and safety issues and was consistent with the requirements and intentions of the new Act.

That the Next Steps – From Safety to Health and Safety presentation be received.

Carried

6. ACTION POINTS 3 AUGUST 2016 (Pages 24)

There were no current action points to report on.

7. CHIEF EXECUTIVE'S REPORT (Pages 25-37)

7.1 Chief Executive's Report

Ailsa Claire, Chief Executive asked that her report be taken as read highlighting as follows:

- The MP for Tamaki and Chair of the Health Select Committee, Mr Simon O'Connor, Paul Goldsmith, Minister of Commerce and Consumer Affairs and Associate Minister for ACC and Melissa Lee, Parliamentary Private Secretary for Ethnic Communities and Chair of the Commerce Select Committee; visited Auckland DHB in August. They met with Lester Levy and Ailsa Claire, as well as heads and staff of the Adult and Children's emergency department and students from the Design Lab involved in the acute flow work.
- At the request of Tauranga lung transplant patient Nikki Reynolds-Wilson, Auckland DHB enabled her three hours of admission and pre-operative procedures (and a post-op interview) to be filmed for *Attitude* which screens on TV One at 8.30am on Sunday mornings. Together with her sister Kristie Purdon, they are known as the 'cystic sisters', who tell their inspirational story of positivity in the face of cystic fibrosis.

- To continue the sustainability journey, connections are being made with the wider community and other organisations to share insights at a series of Sustainability Forums. Auckland District Health Board are partnering with The Energy Efficiency and Conservation Authority (EECA) in a three year programme to implement energy efficiency measures at Auckland DHB sites. The DHB uses energy equivalent to 14,500 NZ houses. It is predicted energy cost savings of almost $400,000 can be made, along with reduce the carbon footprint.
- In August we received a certificate of recognition for our work recycling PVC intravenous bags, oxygen masks and oxygen tubes which have been made into 170 playground mats.
- There were a large number of nominations for Local Heroes during July and August.
- Plans are underway to recognise 140 people across the organisation in three Long Service Award events on Monday 10 October 2016. The backlog of staff members to recognise has now been reduced and fewer events will be required in the future. Staff value Board Member attendance and it would be nice to continue to see Board Members present.
- The "Faster Cancer Treatment" national health target shows a significant improvement and there is optimism about reaching this target. The "Increased immunisation 8 months" target has been more difficult to reach but it is worth noting that the Starship Hospital has reported that for those diseases immunised against, a reduction in numbers presenting at ED has been seen. The "Raising Healthy Kids" target is currently showing historic data and it is expected that by quarter three the target will be met.
- On a quarterly basis DHB performance is assessed by the Ministry of Health against a set of data quality measures [see page 34 of the agenda]. These measures have been consistently rated as achieved or higher. Auckland DHB has been given an overall rating of Outstanding for 2015/16.

That the Chief Executives report for August 2016 be received.

Carried

8. COMMITTEE REPORTS

Audit and Finance Committee

8.1 Sub-Committee Recommendations Arising from Risk Management Discussion (Pages 38-58)

Ian Ward, Chair, Audit and Finance Committee presented the report.

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

- Advice that the appointment of members to the sub-committees would rest with Ian Ward and Lester Levy. Any person appointed must have the time and appropriate capacity to undertake these roles.

- Lester Levy explained that he saw the requirement for these sub-committees as a result of the increasing complexity of business being undertaken and that transparency in decision making would be retained as all decisions would be reported through to the Finance, Risk and Assurance Committee. He acknowledged a point made by Chris Chambers around the necessity to have appropriate membership to provide a clinical viewpoint saying that if this did not exist, then the ability to appoint to ensure it was present was available.

Resolution: Moved Peter Aitken / Seconded Jo Agnew

That the Board:

1. **Approve the renaming of the current Audit and Finance Committee to be the Finance, Risk and Assurance Committee.**
2. **Approve the amended Terms of Reference for the renamed Finance, Risk and Assurance Committee.**
3. **Approve the proposed Terms of Reference for the Facilities and Capital Sub Committee.**
4. **Approve the proposed Terms of Reference for the Finance and Reporting Sub Committee.**
5. **Approve the proposed Terms of Reference for the Health and Safety Sub Committee.**
6. **Delegate authority to the Board Chair and Chair of the Audit and Finance Committee to appoint the Members and the Chair of the Sub-Committees.**
7. **Approve the proposed changes outlined in section 5 of the report to the delegation of authority scheme.**

Carried

9. PERFORMANCE REPORTS

9.1 Financial Performance Report (Pages 59-63)

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

- Overall, for the first month of the 2016/17 year the DHB has performed on budget, with the result for the month of July 2016 being favourable to budget by $76K. Revenue is unfavourable by $4.3M, offset by favourable expenditure of $4.4M. Funder and Governance Arms fully offset the unfavourable variance in the Provider Arm.
- The Provider Arm result for the month is $3.7M unfavourable. Two thirds of this is driven by revenue not being earned reflecting the under delivery to contract for Auckland DHB population elective volumes and IDFs, both of which are subject to wash-up. The remaining third is due to under delivery of planned efficiency and savings initiatives. A detailed explanation can be found on page 60 of the agenda.

That the Board receives the Financial Report for July 2016.

Carried

9.2 Funder Performance Report (Pages 64-78)

Dr Debbie Holdsworth, Director of Funding – Auckland and Waitemata DHB's asked that the report be taken as read, highlighting as follows:

- The table on page 65 of the agenda provides a breakdown of the different elements of the health target including the surgical elective theatre events versus other activity included in the health target count. There is a requirement to reconfigure elective surgery services to limit the non-theatre events to a maximum percentage of the overall electives discharge volume. In 2015/2016 these were 18.7% of the overall target and will need to reduce to fewer than 16% for the current year.
- Acknowledging the results gained against the national health targets. The efforts of the PHO's in the area of "More Heart and Diabetes Checks" was mentioned in particular as all PHOs within Auckland DHB reached the 90% target allowing Auckland DHB to post 92.6% against a target of 90% and rank first in the country.
- Board members attention was also drawn to the information provided on systems level measures framework, pharmacy waste management [page 70], and the metro Auckland collaborative for training Primary Care Nurses in Mental Health and Addictions [page 72].

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

- Advice given that the use of electronic cigarettes was still subject to some diversity of opinion around the health value. Some see it as a tool to affect a reduction approach to smoking; such as the Royal College Physicians in the UK, others are against it. It is not currently legal to sell electronic cigarettes in New Zealand therefore Auckland DHB's policy toward them is the same as for regular cigarettes.
- Judith Bassett commented that it appeared that a public campaign to inform about waste collected by community pharmacy's had been slow to transpire. She was advised that this was being worked on now and that the idea of using advertising on Auckland Transport services was being followed up. There would be an update report to CPHAC in 6 months on the success of the campaign.

That the Funder Performance report for August 2016 be received.

Carried

10. DECISION REPORTS

10.1 Safe Staffing and Healthy Workplaces Unit Care Capacity Demand Management Programme (Pages 79-95)

Margaret Dotchin, Chief Nursing Officer presented the report which provided an update on a proposed Letter of Agreement between Auckland DHB, the national Safe Staffing Healthy Workplaces Unit (SSHW Unit) and the relevant unions (New Zealand Nurses Organisation and the Public Service Association) to support delivery of the Care Capacity Demand

Management programme within Auckland DHB inpatient services.
Margaret sought approval for the Chief Executive to sign the Letter of Agreement on behalf of the Board.

The programme has been delivered in the majority of DHBs within New Zealand utilising a partnership model with health unions and the Safe Staffing Healthy Workplaces Unit. This partnership model provides a mechanism for the DHB, unions and the SSHW Unit to work collaboratively to deliver and embed the programme and to share relevant data and information.

Care Capacity Demand Management (CCDM) is an organisational approach to ensuring that the demand for patient care is matched accurately and effectively with the resources required (staff, knowledge, equipment, facilities). It has three main elements as outlined in detail on page 80 of the agenda. It supports District Health Boards to achieve the appropriate balance, improve the quality of care for patients, enhance the working environment for staff and increase organisational efficiency.

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

- Doug Armstrong commented that an optimistic view had been promoted and that he wanted assurance that this would not lead to another avenue for industrial action to occur.
  Ailsa Claire responded, saying that this provided a mechanism for an open and transparent interaction with the unions. It provided the data required which enabled the opportunity to have conversations take place around the redeployment and the skill mix of staff. She felt that it would help build a more positive relationship with unions.
- Chris Chambers asked if any simulation exercises had been undertaken and was advised that this would be difficult as Trendcare data was the foundation data used to enable a patient by patient decision to be made in respect of accurately and effectively matching demand with the resources.
- Doug Armstrong and Lester Levy questioned the fiduciary risk, drawing attention to particular wording in the document; “apparent” and “does not appear”, asking that a legal review be undertaken before it was signed.
- Doug Armstrong asked what happened when agreement for staffing levels was not reached and was advised that the data provided related directly to staffing ratios and skill mix that allowed a transparent conversation to take place based on a scientific approach to staffing. Fiona Michel added that it made it easier for unions as the evidence was clear and they were not placed in the middle of a disagreement.

Resolution: Moved Ian Ward / Seconded Jo Agnew

That the Auckland District Health Board, subject to clear legal signoff, approves the Auckland DHB Chief Executive Officer to sign the Safe Staffing Healthy Workplace DHB Care Capacity Demand Management Programme Letter of Agreement on behalf of Auckland District Health Board.

Carried

11. GENERAL BUSINESS

Uniforms

Lester Levy expressed appreciation to Margaret Dotchin and her team for the work undertaken in introducing a new uniform. He commented that this had been time well spent as the uniforms were excellent and had been introduced at the right time when the old uniform was in short supply, making it a good economic solution.

Business Leave and Other Absences

Lester Levy reminded the Board that in his absence on Board business between 10 and 22 September 2016 and because Lee Mathias, Deputy Chair was also on business leave, that Ian Ward would be acting Board Chair.

Ailsa Claire would also be on leave from 8 to 30 September 2016 and during that period Rosalie Percival would be Acting CEO between 8 and 19 September 2016 and Margaret Dotchin between 20 and 30 September 2016.

Lester Levy extended his best wishes to all those that were standing in current district health board elections.

The meeting closed at 1.30pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 07 September 2016

Chair: _____ Date: _____

Lester Levy

Health and Safety Policy Approval: Rehabilitation of Staff

Recommendation

That the Board approve the publication of the Rehabilitation of Staff Policy

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Prepared by: Denise Johnson (Manager OH&S)
Endorsed by: Sue Waters (Chief Health Professions Officer)
Endorsed by Executive Leadership Team: Friday, 14 October 2016

Glossary

Acronym/term	Definition
ACCPP:	**ACC Partnership Programme**

1. Executive Summary

This report is seeking the approval of the re-publication of the Rehabilitation of Staff Policy. The policy has been reviewed as per the requirements of Document Control. The Policy is required to provide guidance to managers and staff in relation to supporting staff through the recover what they have experience injuries or illness that reduce capability and work attendance. The risks associated with not having this policy include great level of sick time, delays in return to full duties and inequitable treatment of injured/unwell staff. It is recommended that the Board approve the re-publication of this policy under the Chief Health Professions Officer.

2. Introduction/Background

The rehabilitation of Staff Policy is one of a number of Health and Safety Policies that form the framework for Health and Safety services at Auckland DHB.
The purpose of the Rehabilitation of Staff policy is to provide information to manager and staff on the processes in place to enable the organisation to support the return to full duties following an injury to a staff member. The aim of the processes are to:
- Reduce the duration and extent of the incapacity of the injured worker
-Ensure rehabilitation is available for those who need it
-Enable Auckland DHB to be compliant with the current legislation

The policy supports all workers directly employed by Auckland DHB and has rehabilitation support processes for work related, non- work related accidental injuries and incapacity due to personal health issues.

3. Risks/Issues

As Auckland DHB is in the ACC Partnership Programme for work related injuries there are a number of policy requirement that ensure the organisation meets the ACCPP audit standards and maintains its accreditation in the programme.

Early and safe return to work is only possible if managers are familiar with the rehabilitation processes and commence them at the earliest opportunity. Delays in early intervention lead to high levels of sick leave for the organisation.
All staff need to have the same opportunities for support while they are recovering from incapacity. This policy advocates fair and equitable support.

4. Approach/Methodology/Analysis/Justification

All Health and Safety policies are reviewed as per the document control requirements. This is a routine policy review.
The key change in the document is a change from Human Resource Portfolio to Chief Health Professions portfolio. This occurred because the reporting lines for Health and Safety have been re-assigned.

5. Consultation/Engagement

Consultation, as per the requirements of Document Control, was undertaken. As this is not a new policy it has been reviewed to meet current practice and re published without additional organisation wide consultation.

6. Conclusion

A Routine review of the policy was conducted to ensure it still met the requirements of the ACC Partnership Programme and the needs of the organisation. Minor changes were made and it was submitted to document control for publication.

It is recommended that the Board approve the re-publication of this policy under the Chief Health Professions Officer.

REHABILITATION OF STAFF

Overview

Document Type	Policy
Function(s)	Corporate Services; Workforce Services
Health Service Group (HSG)	Auckland District Health Board (Auckland DHB) Organisation Wide
Department(s) affected	All Auckland DHB departments, services and units
Patients affected (if applicable)	n/a
Staff members affected	All Auckland DHB staff members
Key words	Work-related injuries, ACC Claim, Rehabilitation, Dispute, Claimants rights
Author – role only	Manager Occupational Health & Safety (OH&S)
Owner (see ownership structure)	Owner: Chief Executive (accountable) Issuer: Chief Health Professions Officer (responsible)
Edited by	Document Controller: • Copy edit • Formatting • Proofreading
Date first published	December 1995
Date this version published	August 2016
Review frequency	3 yearly
Unique Identifier	PP01/STF/083

Content

This policy covers the following topics relating to the safe and effective rehabilitation of staff back into full duties following illness or injury.

REHABILITATION OF STAFF

Introduction

Purpose

The purpose of this policy is to:

- Reduce the duration and extent of incapacity associated with work or non-work-related injuries and illness
- Ensure rehabilitation is available to those who need it
- Establish processes for prompt recovery and safe return to work
- Ensure that Auckland DHB is compliant with the current legislation.

Scope

This policy applies to all Auckland DHB employees in relation to work-related and non-work-related injury and illness.

Background

Auckland DHB is committed to the prevention and management of injury and illness of its employees. Auckland DHB is an accredited employer in the Accident Compensation Corporation (ACC) Partnership Programme. This means that Auckland DHB will provide an appropriate injury management services for work-related injuries and illness. This will have active involvement by managers, supervisors and other relevant personnel in recovery, rehabilitation and workplace-based return-to-work programmes as a standard approach.

Interventions for rehabilitation of staff involve three main types of programmes:

- **Work-related injury** managed under the ACC Partnership Programme.
- **Non-work related accidental injury** managed by ACC and facilitated by OH&S Department.
- **Return-to-work capacity** for employees experiencing health impairment affecting their work performance managed by area managers and supported by the OH&S Vocational Wellbeing Advisor

Continued on next page

REHABILITATION OF STAFF

Introduction, Continued

Associated Documents

The table below indicates other documents associated with this policy.

Type	Document Titles
Board Policies	• Human Resource Principles • Leave
Health & Safety	• Health & Safety Hazard Identification & Risk Assessment (was Hazard Management) • OH&S Occurrence
Legislation	• ACC Act 2001 • Code of Health & Disability Services Consumers' Rights (1996) • Health & Safety at Work Act 2015 • Health Information Privacy Code (1994) • Human Rights Act (1993) • Injury Prevention, Rehabilitation and Compensation Act (2001) • Privacy Act (1993)

Continued on next page

REHABILITATION OF STAFF

Introduction, Continued

Auckland DHB Commitment

Auckland DHB is committed to:

- Meet it's obligations in accordance with all work-related legislation and the standards of the ACC Partnership Programme.
- Ensure that the process of workplace rehabilitation is commenced at the earliest appropriate opportunity.
- Monitor the rehabilitation process and provide advice on procedures to ensure that employees receive meaningful involvement.
- Promote the expectation that a return to work as soon as is possible after the injury or illness is normal practice.
- Provide clear accountabilities and responsibilities for all parties involved including Auckland DHB third party administrator (TPA) and all other stakeholders.
- Keep all personal medical information confidential with only appropriate information provided to Auckland DHB management.
- Provide appropriate and safe alternative duties / hours for employees when recommended by health provider.
- Reserve the right to request a second opinion from appropriate health professionals.
- Ensure employees receive their legal rights and entitlements.
- Be committed to continuous improvement.

Manager's Responsibility

The manager is responsible for all management of employees who report directly to them. Therefore the manager maintains their normal relationship with the injured / ill employee and is the key driver of the rehabilitation process for an individual episode of rehabilitation for that employee.

All parties directly involved in the rehabilitation process will liaise with the employee through the manager and ensure that the manager is kept updated with information related to the rehabilitation intervention at all times.

Continued on next page

REHABILITATION OF STAFF

Introduction, Continued

Principles of Rehabilitation

All Rehabilitation episodes should be guided by the following principles:

- Early intervention
- Confidentiality and consent
- Rehabilitation plans as appropriate
- Regular review
- Cooperation of all parties
- Employee must perceive as a benefit
- Good employer

Work Injury Claims

The work-related injury management and rehabilitation process is governed by the requirements of the ACC Partnership programme which in turn are governed by the ACC Act. They are prescriptive and specific and outlined in the section titled "Work-related Rehabilitation Process".

Whenever an ACC claim results from a work-related accident, a completed Occupational Health & Safety Occurrence report will be used by Occupational Health & Safety to confirm injury details provided by the employee.

In the absence of a completed Occupational Health & Safety Occurrence report, a claim decision (accept / decline) of the work-related ACC claim may be declined on the basis of lack of documentation.

Non-work Related ACC

- Auckland DHB facilitates return to work for employees who have had a non-work accident covered by ACC.
- ACC provides all entitlements and will liaise with Auckland DHB to co-ordinate elements of vocational rehabilitation.
- OH&S will support managers in management of non-progressive cases as required. (refer to Rehabilitation Type Summary)

Continued on next page

REHABILITATION OF STAFF

Introduction, Continued

Return to Work / Workplace Rehabilitation

Where an employee's personal health issues are affecting their performance the OH&S Vocational Wellbeing Advisor can provide assistance and advice to the manager. This may involve a fitness to work assessment and workplace accommodation advice from the OH&S Doctor. (refer to Rehabilitation Type Summary)

Communication & Training

Auckland DHB will ensure that:

- Managers responsible for involvement in rehabilitation process will receive training, guidance, support and ongoing advice from OH&S.
- All employees are informed of the responsibilities and the accountabilities of all parties involved in rehabilitation policy
- Communication and training will emphasise a quality improvement focus of rehabilitation management and promote a "just culture" within Auckland DHB.
- Information for managers is available from the H&S Intranet site.

Co-Operation

Willing participation of all parties involved in determining and executing a meaningful rehabilitation plan and workplace accommodation is required in order to expediently achieve the optimum outcome.

Continued on next page

REHABILITATION OF STAFF

Introduction, Continued

Audit & Review

- Data from the work-related rehabilitation case management database will be reported to the board & senior management monthly.
- Review of work-related cases open more than 6 months will be reviewed regularly.
- Review of work-related rehabilitation outcomes and service provision for the previous fiscal year will be reviewed annually by the Chief Health Professions Officer. Auckland DHB's Manager OH&S will review progress updates of all open work-related claims bi-weekly.
- Yearly audits of the work-related rehabilitation management will be undertaken by an external auditor as a condition of ACC Partnership Programme membership.
- Periodic assessment of Third Party Administrator will occur by Auckland DHB to ensure that service level agreement and ACC standards are met.

REHABILITATION OF STAFF

Work-related Rehabilitation Process

Procedure & Accountability

The following process details the responsibilities of employees, the Manager, and other parties involved in determining and implementing a rehabilitation plan for work-related injuries in accordance with the standards of the ACC Partnership Programme.

Injured Person

The **injured person** is responsible for the below steps in the rehabilitation process.

Step	Action	When
1.	Inform their manager / team leader of injury or illness as soon as practicable.	Within 24 hours or ASAP
2.	Provide copy of all medical certificates to manager	ASAP
3.	Complete an OH&S Occurrence report	Within 24 hours or ASAP
4.	Invite a nominated support person to attend rehabilitation meetings if desired	As required
5.	Participate in rehabilitation programme and prompt return to work	As required

Continued on next page

REHABILITATION OF STAFF

Work-related Rehabilitation Process, Continued

Manager

The **manager** is responsible for the below steps in the rehabilitation process.

Step	Action	When
1.	Contact employee for initial needs assessment	Within 48 hours of injury report
2.	Investigate OH&S Occurrence that resulted in the work-related injury / illness and complete the process required by the OH&S Occurrence policy.	Within 7 days of report
3.	Attend meetings and cooperate with the composition of a rehabilitation plan, acknowledging operational priorities and any limitations stipulated on the medical certificate.	As required
4.	Liaise with Employee whilst off work to update and document action plan.	Weekly
5.	Liaise with case manager & OH&S.	As required
6.	Provide appropriate alternative duties within the capabilities of the employee's rehabilitation.	Ongoing
7.	Monitor and support the employee when at work.	As required
8.	Promote a clear understanding of the objectives and principles of the rehabilitation policy to all staff.	As required
9.	Identify and implement strategies to prevent injuries to other employees.	Ongoing

Continued on next page

REHABILITATION OF STAFF

Work-related Rehabilitation Process, Continued

Occupational Health & Safety

Occupational Health & Safety is responsible for the below steps in the rehabilitation process.

Step	Action	When
1.	Provide support and advice to manager regarding injury management of a claimant and obligation under the ACCPP.	As required
2.	Maintain work-related claim data base	Monthly
3.	Provide monthly statistical data and trends to Auckland DHB	Monthly and as requested
4.	Facilitate communications between ACC, TPA and the Auckland DHB	as required
5.	Ensure external providers (TPA, health providers) maintain standards as per the service level agreement requirements	Annually

Case Manager

The **Case Manager** is responsible for the below steps in the rehabilitation process.

Step	Action
1.	Co-ordinate the process of the employee returning to his / her duties in a gradual, safe manner.
2.	Consult with the work area to identify safe alternative duties according to the employee's job description.
3.	Provide a written & signed rehabilitation plan for the employee, supervisor / manager to follow.
4.	Monitor the effectiveness of the programme with agreed objectives and timeframes with the employee and manager.
5.	Ensure the employee is aware of their obligations and entitlements under the ACC Act 2001.
6.	Involve other 'support professionals' or agencies where necessary to aid the early return to work.
7.	Give appropriate information with regard to the dispute resolution process

Continued on next page

REHABILITATION OF STAFF

Work-related Rehabilitation Process, Continued

General Practitioner

The **General Practitioner** is responsible for the below steps in the rehabilitation process.

Step	Action	When
1.	Remains the person's primary health care provider. Issue Medical certificate to appropriate party (ACC non-work-related, TPA work-related injury / illness)	Immediately
2.	Assess person's fitness for work, and outlines capability limitations including time constraints	Immediately and as required

Injured Person's Nominated Support Person

The **injured person's nominated support person** is responsible for the below steps in the rehabilitation process.

Step	Action	When
1.	Attend meetings with the injured person if requested	As required
2.	Take notes at the meetings if requested by the injured person	As required
Note	the nominated support person could be a colleague, friend, family member, H&S Rep, or a union representative	

REHABILITATION OF STAFF

Disputes – Work-related ACC

Background

Auckland DHB encourages an open and consultative approach to rehabilitation, workplace injury management and safety. This includes a willingness to work co-operatively with complaints or dissatisfaction about the services provided to our employees.

In most cases, managers are directly responsible for dispute resolution. Auckland DHB Disputes Manager is the Chief Health Professions Officer. The Auckland DHB Disputes Manager is formally informed about any dispute and asked to intervene directly when an employee is not satisfied with an action proposed by the manager.

Please note that the Auckland DHB uses a Third Party Administrator (TPA), to provide services in the processing of work accident claims.

Note: This section is related to complaints and disputes for work-related ACC claims only. Complaints and disputes resulting from illness rehabilitation interventions to be managed in accordance with the Human Resource Principles policy (see Associated ADHB documents section)

Continued on next page

REHABILITATION OF STAFF

Disputes – Work-related ACC, Continued

Dispute Process

In the case of disagreement about work injury claims, the following three stage process is to be followed:

Stage	Description
Initial Discussion	• Formal discussion of the problem or dispute with the employee, manager, case manager or service provider concerned. The aim of the discussion is to jointly agree a resolution. Auckland DHB Disputes Manager is able to facilitate this meeting if required. • If agreement reached, it should be recorded, in brief, in writing. • If the problem is not resolved by discussion, then the issue is formally referred to the Auckland DHB Disputes Manager. The Auckland DHB Disputes Manager is then responsible for seeking an agreed resolution in the most appropriate manner. • Where the dispute or complaint is about a work injury claim decision made by a case manager, the employee should go directly to the formal review process outlined in the Review Process stage
Review Process – Internal & Administrative	• The case manager will provide the prescribed form required to lodge a formal request for review of case decisions made. If desired, the employee may request that the review be conducted by an independent party. • The employee will also receive from the TPA written information about what to do throughout the review process. The information will include details of all work injury decisions made, the employee's entitlements to ACC cover and benefits, and all relevant legislation will be cited. • Written decision letters must always explain to the employee their rights to formally review any decision and the process involved. • An administrative review will be undertaken by a TPA manager to take a fresh look at all the facts and decide whether the decision made was the correct one. • All relevant people will be consulted, including those at the workplace. The TPA will notify the Auckland DHB Disputes Manager of the outcome. If an employee is still not satisfied then they may proceed to the External Review stage

Continued on next page

REHABILITATION OF STAFF

Disputes – Work-related ACC, Continued

Stage	Description
External Review	• If the decision made by the TPA is not changed following the administrative review, the next step is to proceed to an external review, conducted by an independent professional. Reviews are undertaken by an external dispute resolution service. All relevant parties (including employee support people or nominated representatives) must be consulted to make sure the selected reviewer is acceptable. • Following the hearing, the reviewer has 28 days to issue a Review Decision (unless further information such as more detailed medical information is required or information is presented by one of the parties that has not been reviewed by the other party prior to the meeting). • Once the decision is issued, the claimant has 28 days to appeal to the District Court if they wish to do so.

REHABILITATION OF STAFF

Code of ACC Claimant Rights

Introduction

The ACC Code encourages positive relationships between:

- ACC
- Accredited Employer
- Third Party Administrator and
- Claimants

For ACC, the Accredited Employer and Third Party Administrator to assist Claimants a partnership based on mutual trust, respect, understanding and participation is critical.

Claimants and ACC, Accredited Employer, and Third Party Administrator need to work together, especially in the rehabilitation process.

This code is about how ACC, Accredited Employer, and the Third Party Administrator will work with Claimants to make sure they receive the highest practicable standard of service and fairness

The Claimant's Rights

Claimants have the right to:

- Be treated with dignity and respect
- Be treated fairly, and to have views considered
- Have their culture, values and beliefs respected
- A support person or persons present at meetings
- Effective communication
- Be fully informed
- Have their privacy respected
- Complain

Accredited employers, and persons acting as agents of ACC or on behalf of ACC, must also comply with this Code in their dealings with claimants.

Continued on next page

REHABILITATION OF STAFF

Code of ACC Claimant Rights, Continued

A Concern

- A concern or issue should be raised by the claimant with their Manager, case manager, OH&S or TPA.
- The concern should be addressed on the spot by the accredited employer or TPA, or may escalate into a complaint.
- A concern is not a formal complaint lodged with ACC's complaints service.

A Complaint:

- A complaint is lodged with ACC's Complaints Service – this is a formal process
- The complaint is investigated by the Complaints Service using the formal complaint process contained in the ACC Code, resulting in a decision by ACC's Complaints Service that carries review rights.

REHABILITATION OF STAFF

The Complaints Process – Work-related ACC

Complaints Process Follow the steps below to process ACC work-related complaints.

Step	Action
1.	Claimant lodges a complaint either in writing or by phone to ACC's complaints service.
2.	ACC Complaints Service obtains the necessary complaint detail and confirms whether or not the complaint relates to matters dealt with under the ACC Code.
3.	Impartial investigation conducted, seeking information from the different parties involved.
4.	The complaints service provides a list of facts to check.
5.	ACC complaints service makes a formal decision.

REHABILITATION OF STAFF

Definitions

Term	Definition
ACC45 (Medical Certificate)	Initial medical treatment form, completed by a registered medical practitioner (ie GP, Physiotherapist). This form is required by ACC (non-work-related cases), TPA (work-related cases)
ACC18 (Medical Certificate)	Subsequent medical treatment forms, completed by a registered medical practitioner (ie GP, Physiotherapist). This form is required by ACC (non-work-related cases), TPA (work-related cases)
Code of ACC Claimant's Rights	The code encourages positive relationships between ACC, Auckland DHB,TPA and the employee
Cover Decision	A written decision that accepts or declines the employer's liability for a work-related ACC claim.
Gradual Process Injury	An injury resulting from the prolonged or multiple exposures to a task or hazardous environmental factor. For example: Noise induced hearing loss, muscle pain and swelling.
ACC Act or Legislation	Accident Compensation Act 2001
Lost time Injury	Any injury that involves a staff member losing one full shift of work and there is an ACC45/ACC18 medical certificate provided by the medical practitioner confirming the need for time off work.
Medical Certificate of Work Capability	A form for the employee to take to the Doctor so that appropriate alternative or selected duties can be provided at their work place.
Non-work Injury	A personal injury which occurs as a result of activity which is not related to work tasks or the work environment this may be related to a non-work ACC claim.
Manager	The person with management responsibilities for the injured or ill employee to which any cost related to leave will be allocated.
PICBA Injury	Personal Injury Caused by Accident – otherwise known as a sudden onset injury
Rehabilitation Plan	Is a structured, written process to facilitate active change and support the goal of restoring the employee's health and independence
Return-to-Work Programme	A programme instituted by the employer and medical providers to return an injured employee safely to work as quickly as possible. This is often a gradual process that includes transitional duties and hours of work.

Continued on next page

REHABILITATION OF STAFF

Definitions, Continued

Term	Definition
Review – Formal	An employee may review any decision made by Auckland DHB in relation to the work-related injury management process. Application to review must be completed on a prescribed form available from the TPA.
TPA **Third Party Administrator**	This is the company that is contracted to provide the Auckland DHB with injury and claims management expertise. May also be referred to as Third Party Provider (TPP)
Treatment or Medical Provider	A treatment provider may include (but is not limited to) a general practitioner, physiotherapist, dentist, orthopaedic surgeon, occupational physician, osteopath and the like.
Work-related Injury	A personal injury which occurs within Auckland DHB facilities and / or as a direct result of specific work tasks

REHABILITATION OF STAFF

Rehabilitation Type Summary

	Work-related Injury/Illness	Non-work ACC Injury	Health Impairment
Action initiated because of:	OH&S Occurrence Report and ACC 45	Employee absence due to non-work ACC injury	Employee absence or performance issues due to personal health.
Manager's action	Call OH&S case manager Complete initial needs assessment if time off work taken	Call OH&S Vocational Wellbeing Advisor for advice if needed	Discuss with HRC Call Vocational Wellbeing Advisor Complete request for OH&S assistance
Case manager	OH&S in house case manager	ACC case manager	Employee's manager
Case manager assigned	If 4 or more days off work or if considered high risk	Variable as per ACC protocol	Manager initiated
OH&S support	OH&S in-house case manager	OH&S Vocational Wellbeing Advisor	OH&S Vocational Wellbeing Advisor
HRC	Involved if non progressive injury more than 6 months	Involved if long absence	Always involved
OH&S Occurrence report	Required to support workplace accident claim	Not required	may be used to report pain and discomfort at work but not caused by work
Medical Certificates	ACC 45, ACC 18	ACC45, ACC 18	Medical certificate from doctor may be provided in some cases if requested

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REHABILITATION OF STAFF

Rehabilitation Type Summary, Continued

	Work-related Injury/Illness	Non-work Injury	Non-work Illness
OH&S Referral documents	Not required	Not required unless OH&S referral for non progressive case is requested by manager	Referral from manager required (OH&S forms)
Consent document	Obtained by TPA (WorkAon)	Not required unless OH&S referral is requested by manager	Required as part of referral to OH&S
Case managers action	OH&S: Liaise with injured employee Develop Individual Rehabilitation Plan and regular review of same Co-ordinates treatments required	ACC: Liaise with injured employee Develop Individual Rehabilitation Plan and regular review of same Co-ordinates treatments required	Manager: obtain advice from OH&S Vocational Wellbeing advisor and co ordinate action plan as required.
Funding for care	Auckland DHB administered by TPA (WorkAon)	ACC	Funded by employee (public health or private insurance) and in some cases by Auckland DHB
Salary (Leave)	First week paid by Auckland DHB (ACWK) Ongoing: Entitled to 80% Earning related compensation paid by Auckland DHB	First week paid by Auckland DHB (Sick leave) Ongoing: Entitled to 80% Earning related compensation paid by ACC	Sick time, annual leave taken as sick, special leave
Primary Health care provider	Employee's GP	Employee's GP	Employee's GP

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REHABILITATION OF STAFF

Rehabilitation Type Summary, Continued

	Work-related Injury/Illness	Non-work Injury	Non-work Illness
OH&S Occupational Medicine Physician	referred to external providers only	Not used, ACC to provide all care and assessment	Referral through OH&S OH&S Doctor will liaise with employee's GP
Workplace accommodation	Required under the ACC Partnership Programme. Alternative duties may be required	Auckland DHB as a good employer and guided by operational needs	Auckland DHB as a good employer and guided by operational needs
Alternative duties	May be outside of normal work unit and duties, but salary will still be paid by the unit paying the employee at the time of the injury.	Within normal unit and duties, but there are some exceptions.	Within normal unit and duties
Rehabilitation meetings	Monthly to update IRP	As required by ACC	As required by Manager

Action Points from 7 September 2016 Open Board Meeting

As at Wednesday, 26 October 2016

6

Meeting and Item	Detail of Action	Designated to	Action by
	NIL		

Chief Executive's Report

Recommendation

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

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 15 August – 14 October, 2016. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

2.1.1 Tribute to Sir Graeme Douglas

The Board acknowledged the passing of Sir Graeme Douglas, pioneering founder of Douglas Pharmaceuticals, which today employs some 450 staff.

On behalf of both the Auckland DHB and Waitemata DHB boards, Dr Lester Levy expressed sadness and condolences to the Douglas Family. He acknowledged that Sir Graeme and Lady Ngaire are renowned for their generosity and philanthropy, and in particular their gift to Starship Children's Hospital in 2010 of $3m. This helped pay for a new medical scanner to ensure its own MRI facility and remains the single largest personal donation in the hospital's history. Thousands of children and their families have benefited as a result.

Sir Graeme is remembered for his significant contribution to health in so many ways, his kindness and his generosity. The quote, 'what we have done for ourselves alone dies with us; what we have done for others and the world remains and is immortal', sums up Sir Graeme – a man with great vision and compassion.

2.1.2. Tribute to Dave Davies, former CEO of Waitemata DHB

The Board would also like to express its condolences to the family of Dave Davies, who was CEO of Waitemata DHB from 2006-2011. Mr Davies was born in Wales, studied Nursing in the UK and came to New Zealand in the mid-80s, where he completed a Bachelor of Arts degree in Social Sciences from Massey University, including a strong focus on anthropology, which he built into his philosophy on psychiatry.

Passionate about delivering high quality sustainable health services to the population, he held key funding and General Management roles in Mental Health Services prior to his appointment as CEO, including the Regional Health Authority, Transitional Health Authority and the Northern District Health Board Support Agency. Dave had a reputation for being gentlemanly and principled and it is with great sadness that we note his passing.

2.1.3. Visits

Hon Paul Goldsmith, MP Simon O'Connor and MP Melissa Lee

Minister Goldsmith visited Auckland DHB on 26 August, along with MP for Tamaki and Chair of the Health Select Committee Mr Simon O'Connor and MP for Mt Albert, Melissa Lee.



Cheng Keung National University

Together with the University of Auckland Faculty of Medical and Health Sciences, Auckland DHB hosted a brief visit by a delegation from the Cheng Kung National University from Tainan, Taiwan.

The delegation was led by Professor Jin Ding Huang, Vice Dean, College of Medicine and included another professor, an associate professor and four assistant professors.

The delegation, which toured Starship Children's Hospital with Associate Professor Cameron Grant, was here to explore research internships, clinical electives and research collaborations.

2.2 DHB Elections

District Health Board Elections 2016 took place on Saturday 8 October. The seven elected Board members include Jo Agnew, Lee Mathias, Michelle Atkinson, Judith Bassett, Douglas Armstrong, Robyn Northey and Zoe Brownie. They will take office on Monday 5 December 2016. Refer http://www.adhb.health.nz/about-us/adhb-election-2016/

2.3 Patient and Community

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 193 emails were received. Thirty-six were not communications-related and where appropriate were referred to other departments and services at Auckland DHB.

2.4 External and Internal Communications

2.4.1 External

We received 102 requests for information, interviews or for access from media organisations between 15 August – 14 October. Media queries included requests for information about Auckland DHB's neonatal intensive care unit capacity, the emergency departments' winter load and research.

Approximately 30 per cent of the enquiries over this period sought the status of patients admitted following road accidents and other incidents or who were of interest because of their public profile.

The DHB responded to 29 Official Information Act requests over this period.

2.4.2 Internal

- Two CE blog posts were published, talking about *why change is good* and *the dedication of our people.*
- 47 news updates were published on the DHB intranet.
- 12 eNova (weekly electronic newsletters) were published.
- Three '*In the know*' sessions took place on 16 September, with approximately 60 managers attending.
- The refresh of the DHB intranet (internal resource) continues with the soft launch due to take place in October. The new intranet will provide a much better managed approach to information with a more powerful search function.

2.4.3 Events and Campaigns

Security Awareness week

The Security for Safety programme hosted a Security Awareness Week for Auckland DHB employees to provide useful advice and information on working together to create a safe workplace. NZ Police joined the stands to share information and employees had the opportunity to check their access card was activated ready for go live.

Allied Health, Scientific and Technical Awards

Applications are open for the first Allied Health, Scientific and Technical Awards. The Awards take place on 22 November 2016 at the Maritime Museum where around 200 people will celebrate the great and varied contribution this part of the workforce make to Auckland DHB. The Awards have been generously sponsored by A+ Trust.

Sustainability forum

To continue on our sustainability journey we have reached out to connect with the wider community and organisations to share their insights at a series of Sustainability Forums.

In August Lesley Stone, Sustainability Manager at the University of Auckland shared the challenges of sustainability in a large organisation. Bradley Keam, Sustainability Manager for Baxter's Australia and NZ shared his sustainability story with us in September and Rod Oram, New Zealand journalist and broadcaster, will present on 28 October.

Partnership with Energy Efficiency and Conservation Authority

EECA
Energy Efficiency and Conservation Authority
Te Tari Tiaki Pūngao

Auckland DHB is working towards fulfilling the first milestone in its partnership with the Energy Efficiency and Conservation Authority (EECA). We are currently evaluating the best system to monitor energy consumption at our sites with the new system in place by the end of November.

This system will give us an accurate baseline of energy consumption as well as show us real time energy savings.

Health Excellence Grand Round

The Health Excellence Grand Rounds are an opportunity to share and learn from improvement and transformation taking place here at Auckland DHB, as well as providing a great platform to learn from external speakers.

The next Health Excellence Grand Round takes place on 27 October. Dr Zena O'Connor will present on the use of colour in a hospital environment and the impact that can have on wellbeing.

Auckland City Mission

As part of our commitment to alleviate food poverty in our neighbourhood, we are exploring ways for Auckland DHB staff to donate non-perishable food items to the Auckland City Mission at regular intervals throughout the year (rather than just at Christmas as part of our *Ka pai whānau* programme) which is referred to later in this report.

We are also working closely with the Mission's Calder Medical Centre to offer increased dietary advice and mental health care services to Auckland's most marginalised residents. The service is set up as a very low cost General Practice and is closely integrated with the Mission's social services.

The Calder Centre specialises in providing accessible, affordable care to the homeless, families and individuals in crisis, clients with mental health concerns and those with alcohol and other drug addictions. Due to barriers such as a lack of finances, trust issues, cultural issues and very chaotic lifestyles, many of these patients would not otherwise have regular access to a GP. All children and teenagers up to the age of 18 are free of charge.

2.4.4 Social Media

Facebook likes: 4,098
Twitter followers: 2,635
LinkedIn followers: 5,240
Instagram followers: 125

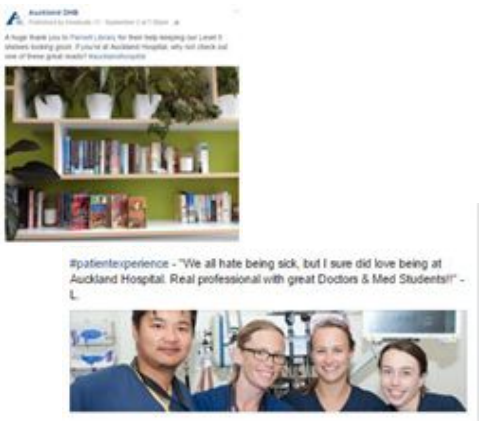
Most popular posts:

Our people

- Local Heroes
- Happy World Physio Day
  (photos of Auckland DHB physios)
- Grand Round – Auckland DHB nursing strategy
- NOVA story about reducing our carbon footprint
- Security Awareness Week

Patient experience

- #patientexperience letters
- Thank you to Parnell Library for donations to level 5 public library



Public health alert or education

- Green Prescription – story about a DHB staff member being prescribed
- News story – Pacific children most at risk of ear infection

Campaigns

- Stroke and heart health awareness campaigns
- Rheumatic Fever campaign
- Measles immunisation
- Sit Less – HPA campaign about getting up from your desk

Recruitment

- Weekly round-up of new job postings

2.4.5 Our People

In memory of Cathryn George

Sadly, Cathryn George who worked at Auckland DHB for more than 20 years as part of the phlebotomy team, passed away recently. A memorial service was held on 22 September for Cathryn at Auckland City Hospital Chapel. She will be sadly missed by many people.

Employee engagement survey

Auckland DHB's employee survey goes live on 3 October and will remain open for six weeks. The survey is an opportunity for everyone to say what it is like to work here. The survey will be sent out via emails with survey clinics planned for those who don't have a DHB email.

Local Heroes

There were 13 people nominated during August for local hero. Congratulations to our September Local Hero: Yvonne Kaepelli, Clinical Effectiveness Advisor.

Yvonne was nominated by a team member who said, "*Yvonne is unflappable in the most stressful situations and works as a wonderful mentor and support person for the people within her Team. She is the person who most people in the department turn to as she has a mountain of knowledge and is always kind, compassionate, caring and is an amazing listener.*

The Department is very, very lucky to have such a wonderful, clear headed, professional, supportive team member."

Long Service Awards

(Post reporting date) This year approximately 340 people across the organisation achieved milestones of 20, 30, 40 and even 50 years of service. Their commitment was acknowledged at three Long Service Events held on 10 and 11 October. The events were an opportunity for these people to celebrate with their colleagues and family and were very well received by those attended.

"Thank you for the lovely evening last night to celebrate the long service employees. I really enjoyed the event, so did my husband, and thought it was appropriately and beautifully organised and delivered."

Thank you to Board Members – Gwen Tepania Palmer, Lee Mathias and Jo Agnew who attended the Awards events and acknowledged the people who have made Auckland DHB their life. The Long Service Events are generously funded by the A+ Trust.
and we will continue to profile some of their stories across our social and digital communication platforms.

Small selection of photos from the Long Service Awards – congratulations to all



Health Excellence Awards

Finalists for the 2016 Health Excellence Awards will be announced at the end of October. Winners will be announced at the 2016 Health Excellence Awards evening on 1 December at Auckland Museum. More than forty applications have been received across five categories.

Staff musical performance, *The Committed*

Auditions for the staff musical performance, *The Committed* took place in early August. The cast is made up of the talented Auckland DHB team and the show will take place on 12 and 13 December.

Ka pai whānau – saying thank you to our people, and giving thanks

Planning is underway for events, celebrations and other activity for staff and patients throughout December. As part of our commitment to alleviate food poverty in our neighbourhood, Auckland DHB staff wanting to donate to the Auckland City Mission will be able to drop gifts and non-perishable food items at our main reception desks on level five at Auckland City Hospital and in Building Four at Greenlane Clinical Centre. Unwrapped gifts of toys or other items and donations of non-perishables such as tinned food will be accepted and collected by reception staff and passed along to Auckland City Mission to distribute.

At the Auckland Hospital site, for each gift given, a wrapped cardboard box will be placed under the Christmas tree on level five at reception to demonstrate how the collection is progressing. Gifts will be accepted up until early Christmas week when they will be collected in time for distribution. We are also considering best ways to facilitate a regular programme for food donations throughout the year.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary[1]

	Status	Comment
Acute patient flow (ED 6 hr)		Aug 95%, Target 95%
Improved access to elective surgery		89% to plan for the year
Faster cancer treatment		Jul 86%, Target 85%
Better help for smokers to quit:		
• Hospital patients		Aug 95%, Target 95%
• PHO enrolled patients		Jun Qtr 92%, Target 90%
• Pregnant women registered with DHB-employed midwife or lead maternity		Jun Qtr 100%, Target 90%
Raising healthy kids		Aug 52%, Target 95%
Increased immunisation 8 months		Jun Qtr 94%, Target 95%

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

[1] Note that effective July 2016, ***Raising Healthy Kids*** has replaced More Heart & Diabetes Checks.

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

3.1.2 National Health Targets – YOY comparison Auckland region DHBs

	Auckland Region	2015/16				2016/17			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours.	**Auckland DHB**	**93**	**95**	**95**	**95**				
	Waitemata DHB	93	95	96	95				
	Counties Manukau	95	95	96	96				
	All DHBs	92	94	94	94				
 The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**93**	**98**	**98**	**101**				
	Waitemata DHB	101	101	102	106				
	Counties Manukau	99	103	105	109				
	All DHBs	104	105	106	108				
 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.	**Auckland DHB**	**66**	**70**	**75**	**77**				
	Waitemata DHB	74	68	70	75				
	Counties Manukau	70	72	70	74				
	All DHBs	69	75	75	74				
 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.	**Auckland DHB**	**95**	**94**	**94**	**94**				
	Waitemata DHB	93	95	93	92				
	Counties Manukau	95	95	94	95				
	All DHBs	93	94	93	93				
 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. (Other targets also exist)	**Auckland DHB**	**85**	**86**	**88**	**91**				
	Waitemata DHB	85	88	90	91				
	Counties Manukau	87	88	89	92				
	All DHBs	83	85	86	88				
 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.	**Auckland DHB**	**92**	**92**	**92**	**92**	Note this target is replaced by ***Raising Healthy Kids*** *from July 2016*			
	Waitemata DHB	91	90	91	91				
	Counties Manukau	92	92	92	92				
	All DHBS	**90**	**90**	**90**	**91**				

Q1 2016/17 targets not published as at 19 October 2017.
Source: http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing

3.2 Financial Performance

The financial performance for the three months of the 2016/17 financial year (September) was a deficit of $1.7M which was unfavourable to budget by $4.3M. Within this result the Provider Arm was unfavourable to budget by $9M offset by a favourable performance to budget in the Funder of $4.7M. Significant unfavourable variances result from the under delivery of electives volume $1.9M, the under delivery of IDF inpatient services provided to other DHB populations $1.5M, unfavourable other government revenue $1.2M, unfavourable Personnel/Outsourced Personnel costs $1.4M and higher than budget clinical supplies $3.4. These are offset by favourable NGO expenditure $6.4M and favourable other income revenue of $1.4M.

The full year plan signed off by the Board is for a surplus of $4.5M that will be achieved through additional funding advised by the Ministry of Health. Underlying that plan was an initial savings target in excess of $37M. Subsequent to Board approval of the plan, further changes have been made primarily in relation to electives volumes. We have held discussions with the Ministry and finalised the additional electives volumes for the year and other matters. A final savings target of $42M has been set in the final Annual Plan.

The 2015/16 financial audit is almost complete with no major issues identified so far. The preliminary result previously advised to the Board remains at a surplus of $2.9M, against a planned surplus of $2.4M. The full Annual Report including the Financial Statements is presented to the Board for approval in this meeting as another agenda item.

4.0 Clinical Governance

4.1 Development and recognition

4.1.1 2016 Junior Doctor of the Year Awards nomination

Dr Margot Mulcahy, Renal House Officer, has been nominated by the Medical Council of New Zealand to represent New Zealand at the Confederation of Prevocational Medical Education Councils 2016 Junior Doctor of the Year Awards in Hobart in November. Margot was nominated on the basis she regularly demonstrates professionalism, altruism and is notable for being active on the House Officer Curriculum Committee and the Regional Prevocational Training Committee. We wish Margot every success in the award process.

4.1.2 Stem Cell Transplant Programme accreditation

Auckland City and Starship Children's Hospitals' Stem Cell Transplant Programme received accreditation to 12 July 2019 from FACT (Foundation for the Accreditation of Cellular Therapy), University of Nebraska Medical Center on 23 September. Congratulations to the team involved.

4.1.3 Southern Hemisphere Influenza and Vaccine Effectiveness (SHIVERS)

Auckland DHB's contribution to the global fight against flu was formally recognised by ESR. Starship paediatrician and University of Auckland Associate Professor Cameron Grant received the certificate of recognition on our behalf at the annual SHIVERS science meeting in Wellington. SHIVERS which is led by ESR, is a five-year multi-million dollar project funded by the United States Centers for Disease Control and Prevention (CDC).

4.1.4 Farewell to Dr Tony Baird

Dr Tony Baird retired after a dedicated service of over 42 years. He was farewelled by Auckland DHB Women's Health and other colleagues on 30 September.

4.1.5 Releasing Time to Care

Ward 71 recently celebrated completion of the Releasing Time to Care programme. The team have consistently achieved greater than 60 per cent direct care time. Contributing to this have been a renovated and organised medication room, bedside handovers and intentional rounding now embedded into practice. All the team on the ward have engaged in improving processes to make life better for patients and better for staff. The ward atmosphere is calm and well organised, and patient feedback is very positive in the care they receive.

4.2 New Services

4.2.1 National Intestinal Failure (NIF) Service

Chair of the National Intestinal Failure Service Clinical Governance Board, Stephen Streat, has formally conveyed congratulations to Auckland DHB's NIF team on the hard work that has occurred to implement this important new national service. In a letter to me, Mr Streat advised that the team was very well prepared, cohesive and collaborative. He said his board were "most impressed with the collegial relationships on display and evidence of the outward-facing service and relationships that have been developed."

4.2.2 Level 8 Day of Surgery Admissions (DOSA) pilot

On Monday 26 September Auckland DHB started a pilot for Level 8 Day of Surgery patients to check in at the Transition Lounge on their day of surgery, rather than the day before. This change will also provide an opportunity to carry out pre-operative activities earlier in the Transition Lounge where clinical staff are based. We will be seeking feedback to further improve the patient experience, and positively impact patient flow in level 8 theatres.

4.2.3 Electronic Prescribing and Administration (ePA)

(Post reporting date) On 12 October, ePA went live in the Awatea ward in Older People's Health. The project has had excellent clinical engagement and is a key digital health initiative to improve medication chart legibility, reduce transcription errors, improve communication between departments, provide real-time clinical decision support and easier access to information, and faster fulfilment of prescriptions.

Pictured: first patient Mr Robin Osbourne, House Officers Jinny Koon, Jenika Patel and Sam Paula

All of these factors can positively impact patient safety and help reduce Adverse Drug Events (ADEs).

ePA is a national priority and Auckland DHB is the fifth DHB in New Zealand to implement the solution. Waitemata DHB was the agreed early adopter DHB for the Northern Region, and we have worked closely with them to learn from their experience.

5.0 Funding

5.1 Applications open

5.1.1 Starship Foundation funding

The Foundation's application process has been updated and funding for projects under $2,000 is now open year round. Funding for training and conferences is available quarterly.

5.2 Research funding received

5.2.1 AAHA Collaborative Research Grants

The 2016 Auckland Academic Health Alliance Collaborative Research Grant round has awarded a total of $300,000 to four research projects being jointly led by university and hospital professionals. The projects promise enhancements in prevention, diagnosis and therapies and are jointly funded by the A+ Trust, Auckland DHB and the University of Auckland Faculty of Medical and Health Sciences.

- Dr Susann Beier and Associate Professor Mark Webster receive funding of $100,000 for "Coronary Artery Atlas", a study of coronary artery flow assessment in normal and pathological cases to improve stent strategy.

- Another grant of $100,000 has been awarded to Dr Raida Al-Kassas and Dr Mark O'Carroll for "New and effective method for the treatment of cystic fibrosis using nanotechnology", an investigation into delivering sodium chloride therapy using inhaled albumin nanoparticles.

- Professor Merryn Gott and Dr Andrew Old receive funding of $49,000 for "End of Life Care Provision by Auckland DHB", an extensive survey into the end of life circumstances of terminal patients dying under the care of the Auckland District Health Board.

- Professor Mike Dragunow and Dr Clinton Turner receive funding of $50,000 for "Immune Cells in Meningioma", a retrospective observational analysis of the prognostic significance of tumour-infiltrating lymphocyte and macrophage subsets. The particular focus is on the 7-year recurrence-free survival of patients with meningioma in Auckland.

Financial Performance Report

Recommendation

That the Board receives the Financial Performance Report for September 2016

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for September 2016 was a deficit of $1.9M which was unfavourable to budget by $2.5M. For the Year to Date (YTD), a loss of $1.7M was realised, unfavourable to budget by $4.3M. Favourable Funder arm and Governance results are offset be unfavourable variances in the Provider arm.

YTD revenue is unfavourable to budget by $6.2M. Underlying this revenue variance are significant movements including: $1.8M for the under delivery of additional electives revenue; $1.5M under delivery of hospital inpatient services for other DHB populations and $1.2M other government revenue is below budget offset by $1.4M favourable variances in other income. YTD expenditure is favourable to budget by $1.9M. Significant variances include: $1.4M higher Personnel/Outsourced Personnel costs; $3.5M unfavourable Clinical supply costs in relation to high transplant activity and high blood costs offset by $6.4M lower than budgeted demand in Community Pharmacy and Aged Related Residential Care services and therefore related NGO costs.

The full year financial plan is forecasting a surplus of $4.5M. This is expected to be achieved by realising our planned IDF Revenue, by resolving the IDF pricing issues, and stepping up the realisation of the savings identified in our 2016/17 savings programme.

Auckland District Health Board
Summary Results: Month of September 2016

$000s	Month (September-16)			YTD (3 months ending 30 Sept-16)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	98,862	98,860	2 F	296,585	296,581	3 F	1,188,138	1,186,325	1,813F
MoH Contracts - Devolved	7,743	8,555	812 U	25,176	27,033	1,857 U	108,142	108,134	8F
	106,605	107,415	810 U	321,761	323,615	1,854 U	1,296,280	1,294,459	1,821F
MoH Contracts - Non-Devolved	4,704	4,960	257 U	14,114	14,906	792 U	59,040	59,538	498U
IDF Inflows	52,020	52,772	751 U	156,797	158,315	1,519 U	638,778	633,262	5,516F
Other Government (Non-MoH, Non-OtherDHBs)	2,480	3,104	624 U	8,203	9,451	1,248 U	36,714	37,738	1,024U
Patient and Consumer sourced	1,889	1,573	317 F	4,433	4,704	271 U	19,478	19,207	271F
Inter-DHB & Internal Revenue	1,258	1,249	9 F	3,456	4,003	547 U	15,244	15,791	547U
Other Income	4,304	4,164	140 F	13,991	12,599	1,392 F	51,700	48,721	2,979F
Donation Income	490	593	103 U	982	1,792	810 U	8,483	8,907	424U
Financial Income	343	643	300 U	1,265	1,853	588 U	7,830	7,606	224F
Total Income	**174,092**	**176,473**	**2,380 U**	**525,002**	**531,237**	**6,235 U**	**2,133,547**	**2,125,229**	**8,318F**
Expenditure									
Personnel	72,275	73,511	1,236 F	219,244	220,672	1,429 F	900,183	889,213	10,970U
Outsourced Personnel	2,141	1,120	1,021 U	6,202	3,384	2,818 U	18,914	13,402	5,512U
Outsourced Clinical Services	2,033	1,622	411 U	5,714	6,256	542 F	25,428	24,923	505U
Outsourced Other Services (incl. hA/funder Costs)	5,187	5,041	147 U	15,129	15,122	7 U	60,493	60,488	5U
Clinical Supplies	22,055	21,403	651 U	67,023	63,571	3,452 U	259,945	254,983	4,962U
Funder Payments - NGOs	46,498	47,642	1,144 F	136,550	142,927	6,376 F	557,812	571,707	13,895F
Funder Payments - IDF Outflows	9,567	9,567	0 F	28,554	28,700	146 F	114,653	114,800	147F
Infrastructure & Non-Clinical Supplies	11,665	11,329	336 U	34,520	34,168	352 U	135,841	135,452	389U
Finance Costs	1,018	1,052	34 F	3,118	3,155	37 F	12,622	12,621	1U
Capital Charge	3,568	3,568	0 F	10,704	10,704	0 F	43,140	43,140	0
Total Expenditure	**176,006**	**175,854**	**153 U**	**526,757**	**528,659**	**1,902 F**	**2,129,031**	**2,120,729**	**8,302U**
Net Surplus / (Deficit)	**(1,914)**	**619**	**2,533 U**	**(1,755)**	**2,578**	**4,333 U**	**4,516**	**4,500**	**16 F**

2. Result by Arm

Result by Division	Month (September-16)			YTD (3 months ending 30 Sept-16)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	1,414	375	1,039 F	5,790	1,125	4,665 F	16,500	4,500	12,000F
Provider	(3,105)	244	3,349 U	(7,564)	1,453	9,017 U	(12,016)	0	12,016U
Governance	(223)	0	223 U	19	0	19 F	0	0	0
Net Surplus / (Deficit)	**(1,914)**	**619**	**2,533 U**	**(1,755)**	**2,578**	**4,333 U**	**4,484**	**4,500**	**16 U**

The Funder arm result was $5.8M favourable and for Governance, $19k favourable, offsets the $7.6M unfavourable result realised in the Provider arm, resulting in an overall $1.7M unfavourable position YTD:

- The favourable full year Funder result of $5.8M reflects lower than budgeted demand in Community Pharmacy and Aged Related Residential Care services which continue to be significant contributors to the favourable NGO expenditure variances for both the month and year to date. Other contributions to the favourable variance are from budgeted services and funded initiatives not yet contracted or expensed. These were offset unfavourable provisions for the under delivery of additional electives revenue, and the IDF wash-up provision for the under delivery of hospital inpatient services for other DHB populations.
- The unfavourable Provider Arm Result of $7.6M for the year to date is $9M unfavourable to budget. This result reflects a combination of revenue below budget due to volumes under contract and unfavourable expenditure due primarily to savings targets not fully achieved. These variances are described further in section 3 below.

3. Financial Commentary for September 2016

Month Result

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

Revenue was less than budget by $2.4M, mainly driven by:

- The MoH Contracts – Devolved $812K (9.5%) adverse variance for the September month is mainly due to a $750K wash-up provision for the under delivery of additional electives revenue.
- The IDF Inflows $751K (1.4%) adverse variance for the month is due to a $750K wash-up provision for the under delivery of hospital inpatient services for other DHB populations.

Expenditure was greater than budget for the month by $153K. Significant variances are described below:

- Personnel/Outsourced Personnel costs are close to budget at $215K (0.3%) favourable. Total FTE at 8,532 remain consistent with the trend throughout the calendar year, but are 200 above budget due to FTE savings targets incorporated into the budget. While total FTE numbers are unfavourable, total costs remain close to budget due to lower cost per FTE (reflecting reductions in overtime and other premium payments).
- Clinical Supplies $651K (3%) unfavourable – comprising one off costs for loss on disposal of assets $0.2M and $0.3M unfavourable for Cardiovascular implants - $0.1M ICD implants is phasing only (year to date is on budget) and $0.2M due to high volume of TAVI implants.
- Funder Payments – NGOs $1.1M (2.4%) favourable to budget as a result of lower than budgeted demand activities in Community Pharmacy and Aged Related Residential Care services, which continue to be significant contributors to the favourable NGO expenditure variances. Other contributions to the favourable variance are from budgeted services and funded initiatives not yet contracted or expensed.

Year to Date Result

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

Revenue was less than the budget by $6.2M. Significant movements underlying this included:

Favourable revenue variances:

- Other income is $1.4M (11%) favourable YTD which is mainly due to $467K gain on financial assets in relation to the A+ Trust investment portfolio and $1M favourable research income.

Unfavourable revenue variances:

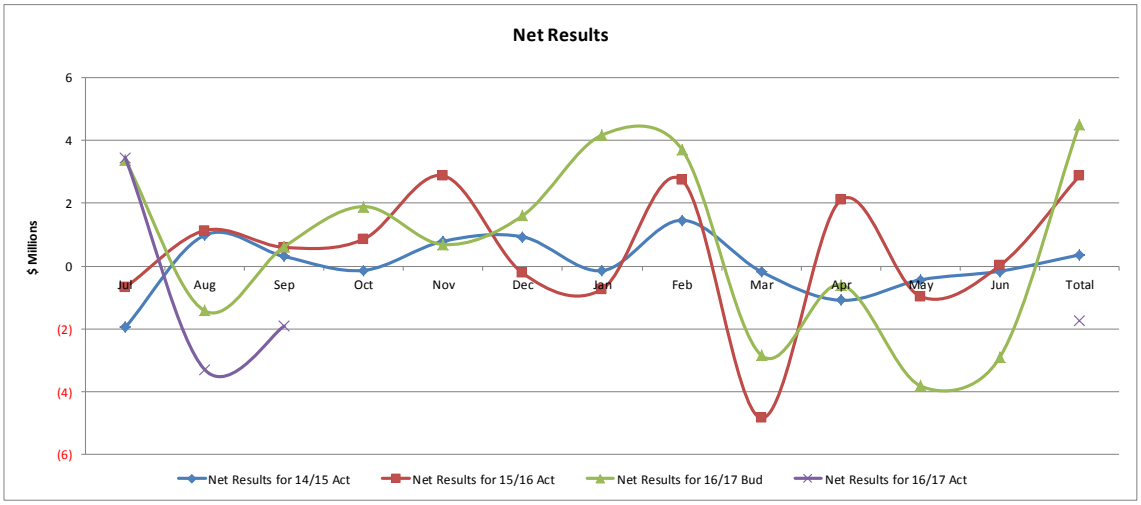
- The MoH Contracts – Devolved $1.9M (6.9%) adverse variance YTD is mainly due to a wash-up provisions for the under delivery of additional electives revenue.
- The IDF Inflows $1.5M (1%) adverse variance YTD is due to wash-up provisions for the under delivery of hospital inpatient services for other DHB populations.
- Other government revenue is $1.3M (13.2%) unfavourable mainly due to:
    - ACC revenue $0.7M unfavourable – primarily lower elective surgery volumes combined with budget including growth over last year actuals, not achieved to date;
    - Haemophilia funding $0.4M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure; and
    - MOH Public Health Funding $0.6M unfavourable, in line with services delivered – this revenue is expected to be on budget by year end.
- Donations $810K unfavourable – revenue fluctuates from month to month, depending on timing of key projects, with the full year budget still expected to be achieved.

Expenditure was less than budget for the YTD by $1.9M, with significant underlying variances as follows:

- Personnel/Outsourced Personnel costs $1.4M (0.6%) unfavourable reflecting total FTE 97 (1.2%) above budget due to FTE savings targets incorporated into the budget, partially offset by lower cost per FTE (reflecting reductions in overtime and other premium payments).
- Clinical Supplies $3.5M (5.4%) unfavourable, comprising the following key variances - high transplant activity - there have been a total of 62 heart, lung, liver and renal transplants for the year to date, compared to the average of 45 for a three month period over the last year and these have very high drug and clinical supplies costs - $0.4M unfavourable, Cardiovascular $0.9M unfavourable reflecting volume growth over the same period last year for both Cardiology and Cardiothoracic combined with a small number of patients with very high blood costs, Perioperative $0.8M reflecting theatre minutes 4.8% above year to date budget assumption, Depreciation $0.5M unfavourable due to timing of capitalisation of projects (expected to be on budget for the full year), one off costs for loss on disposal of assets $0.2M.
- Outsourced Clinical Services $0.5M (8.7%) favourable, reflecting no Orthopaedic elective surgery outsourcing, and offset by an unfavourable revenue/volume position.
- Funder Payments – NGOs $6.4M (4.5%) favourable to budget as a result of lower than budgeted demand activities in Community Pharmacy and Aged Related Residential Care services, which continue to be significant contributors to the favourable NGO expenditure variances. Other contributions to the favourable variance are from budgeted services and funded initiatives not yet contracted or expensed. The variances related to funded initiatives expenditure are offset by equivalent revenue variance.

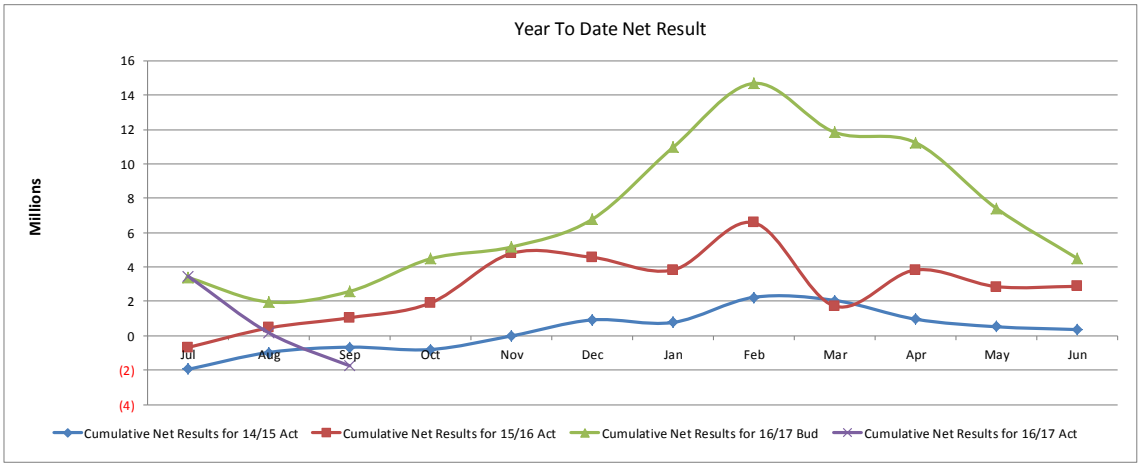
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Total
Net Result for 14/15 Act	(1.957)	0.984	0.306	(0.137)	0.790	0.931	(0.147)	1.462	(0.179)	(1.093)	(0.441)	(0.164)	0.355
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747	(4.850)	2.101	(0.967)	0.015	2.871
Net Result for 16/17 Bud	3.385	(1.426)	0.619	1.897	0.686	1.610	4.182	3.727	(2.844)	(0.600)	(3.819)	(2.916)	4.500
Net Result for 16/17 Act	3.462	(3.302)	(1.914)										(1.755)

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Cumulative Net Results for 14/15 Act	(1.957)	(0.973)	(0.668)	(0.804)	(0.014)	0.916	0.770	2.232	2.053	0.960	0.519	0.355
Cumulative Net Results for 15/16 Act	(0.683)	0.450	1.045	1.904	4.785	4.557	3.824	6.571	1.721	3.822	2.855	2.871
Cumulative Net Results for 16/17 Bud	3.385	1.959	2.578	4.476	5.161	6.772	10.953	14.681	11.836	11.236	7.417	4.500
Cumulative Net Results for 16/17 Act	3.462	0.159	(1.755)									
Variance to Budget for 2016/17	0.076	(1.800)	(4.333)									

5. Efficiencies / Savings

For the 3 months to 30 September 2016, $5.5M savings were reported against the target of $10.5M, resulting in an unfavourable variance of $5M. An additional $4.9M savings (FTE initiatives) has been included in the overall savings target and increased from $37M target to $42M.

With the exception of Funder all Directorates are reporting an unfavourable position for September YTD. There are 21 key MOH-related actions of which 19 show an unfavourable variance. The Funder achieved its target of $1.2M and Outpatients reports a favourable variance of $12K.There were however some offsets totalling $1.6M. These were mainly found to be in personnel and clinical supplies and have helped to mitigate the unfavourable variances. The unfavourable variance of $5M is mainly related to personnel & revenue. The services report they are progressing towards implementation on the programme of savings. Some services are also identifying other opportunities for savings in addition to the original target to help offset unfavourable variances. Two services (Surgical and Perioperative) have identified further pipeline projects totalling $3M to mitigate any shortfall in the original programme of initiatives.

Overall, the first quarter to September position continues to be unfavourable and although services are indicating that their programme of savings/initiatives are in start-up mode there is a risk that other service demand pressures may result in further delays and the savings target not being realised in 2016/17.

6. Financial Position

Statement of Financial Position as at 30 September 2016

$'000	30-Sep-16			31-Aug-16	Variance	30-Jun-16	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0U
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	508,995	438,457	70,538F	508,995	0F	501,626	7,369F
Cashflow-hedge Reserve	(3,604)	(3,603)	1U	(3,650)	46F	(3,742)	138F
Accumulated Deficits from Prior Year's	(461,173)	(461,652)	479F	(461,173)	0F	(464,047)	2,874F
Current Surplus/(Deficit)	(1,755)	2,572	4,327U	160	1,915U	2,873	4,628U
	42,463	(24,226)	66,689F	44,332	1,869U	36,710	5,753F
Total Equity	**619,261**	**552,572**	**66,689F**	**621,130**	**1,869U**	**613,508**	**5,753F**
Non Current Assets							
Fixed Assets							
Land	282,803	249,006	33,797F	282,803	0F	282,517	286F
Buildings	620,099	587,788	32,311F	620,868	769U	618,915	1,184F
Plant & Equipment	82,674	87,581	4,907U	84,187	1,513U	85,564	2,890U
Work in Progress	51,831	50,492	1,339F	49,031	2,800F	45,236	6,595F
	1,037,407	974,867	62,540F	1,036,889	518F	1,032,233	5,174F
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	53,103	53,103	0F	53,103	0F	53,103	0F
- HBL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	-	5,000	5,000U	-	0F	5,000	5,000U
- Other Investments	503	503	0F	503	0F	503	0F
	66,026	71,026	5,000U	66,026	0F	71,026	5,000U
Intangible Assets	611	944	333U	657	46U	762	151U
Trust Funds	15,462	14,494	968F	14,925	536F	14,495	967F
	82,099	86,464	4,365U	81,609	490F	86,283	4,184U
Total Non Current Assets	**1,119,506**	**1,061,331**	**58,175F**	**1,118,498**	**1,008F**	**1,118,515**	**991F**
Current Assets							
Cash & Short Term Deposits	48,796	47,709	1,086F	48,833	36U	34,461	14,335F
Trust Deposits > 3months	10,000	10,000	0F	8,500	1,500F	11,500	1,500U
ADHB Term Deposits > 3 months	15,000	11,500	3,500F	15,000	0F	15,000	0F
Debtors	28,773	29,872	1,098U	24,248	4,525F	29,869	1,096U
Accrued Income	42,983	32,179	10,804F	44,232	1,248U	32,179	10,804F
Prepayments	2,448	1,679	769F	3,319	870U	1,679	769F
Inventory	14,548	14,239	309F	14,258	290F	14,239	309F
Total Current Assets	**162,549**	**147,178**	**15,371F**	**158,389**	**4,160F**	**138,928**	**23,621F**
Current Liabilities							
Borrowing	(429)	(429)	0U	(429)	0F	(429)	0F
Trade & Other Creditors, Provisions	(152,892)	(144,501)	8,391U	(148,908)	3,984U	(133,316)	19,576U
Employee Benefits	(165,615)	(167,050)	1,435F	(162,493)	3,122U	(166,232)	617F
Funds Held in Trust	(1,246)	(1,239)	7U	(1,244)	2U	(1,239)	7U
Total Current Liabilities	**(320,182)**	**(313,219)**	**6,963U**	**(313,075)**	**7,108U**	**(301,217)**	**18,966U**
Working Capital	**(157,634)**	**(166,041)**	**8,407F**	**(154,685)**	**2,948U**	**(162,289)**	**4,655F**
Non Current Liabilities							
Borrowings	(304,958)	(305,065)	107F	(305,030)	72F	(305,065)	107F
Employee Entitlements	(37,653)	(37,653)	0F	(37,653)	0F	(37,653)	0F
Total Non Current Liabilities	**(342,611)**	**(342,718)**	**107F**	**(342,682)**	**72F**	**(342,718)**	**107F**
Net Assets	**619,261**	**552,572**	**66,689F**	**621,130**	**1,869U**	**613,508**	**5,753F**

Comments

Category	Comment
Fixed Assets	The full revaluation of land abd buildings completed at 30 June 2016 resulted in an increase in revaluation reserve of $70.5M ($33.8M for land and $36.7M for buildings), these revaluation adjustments were not accounted for in the 2016/17 budget.
Accrued income	Accrued income variance is mainly due to the timing of invoices to MoH and invoices accrued by the Funder
Creditors	Trade & Other Payables reflect timing differences for creditors' payments, accruals and income in advance.

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

$000's	Month (September-16)			YTD (3 months ending 30 Sept-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	168,375	175,829	7,454U	518,308	529,383	11,075U
Payments						
Personnel	(69,153)	(73,238)	4,085F	(219,860)	(219,855)	5U
Suppliers	(37,066)	(37,147)	81F	(116,654)	(111,168)	5,486U
Capital Charge	0	0	0F	0	0	0F
Funder payments	(56,065)	(57,209)	1,144F	(165,104)	(171,627)	6,523F
GST	670	0	670F	551	0	551F
	(161,614)	**(167,594)**	5,980F	**(501,067)**	**(502,650)**	1,583F
Net Operating Cash flows	**6,761**	**8,235**	**1,474U**	**17,241**	**26,733**	**9,492U**
Investing						
Interest Income	343	643	301U	1,265	1,852	587U
Sale of Assets	(59)	0	59U	0	0	0F
Purchase Fixed Assets	(4,579)	(5,905)	1,326F	(9,635)	(17,716)	8,081F
Investments and restricted trust funds	(2,000)	0	2,000U	6,000	5,000	1,000F
Net Investing Cash flows	**(6,295)**	**(5,262)**	**1,034U**	**(2,369)**	**(10,864)**	**8,495F**
Financing						
Other Equity Movement	0	1	1U	1	0	1F
Interest paid	(501)	(446)	55U	(537)	(472)	65U
Net Financing Cashflows	**(501)**	**(445)**	**56U**	**(536)**	**(472)**	**64U**
Total Net Cash flows	**(35)**	**2,528**	**2,564U**	**14,336**	**15,397**	**1,061U**
Opening Cash	48,833	45,183	3,651F	34,461	32,314	2,147F
Total Net Cash flows	(35)	2,528	2,564U	14,336	15,397	1,061U
Closing Cash	**48,797**	**47,711**	**1,086F**	**48,797**	**47,711**	**1,086F**

ADHB Cash	45,207	**45,176**	31F
A+ Trust Cash	1,526	**479**	1,047F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	2,064	**2,056**	8F
	48,797	**47,711**	**1,086F**
ADHB - Short Term > 3 months	15,000	**10,000**	5,000F
A+ Trust Deposits - Short Term > 3 months	10,000	**11,500**	1,500U
ADHB Deposits - Long Term	0	**5,000**	5,000U
A+ Trust Deposits - Long Term	15,462	**14,494**	968F
Total Cash & Deposits	**89,259**	**88,705**	**554F**

Funder Update

Recommendation

That the October 2016 Funder Update report be received.

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

Glossary

AH+	-	Alliance Health Plus
AOD	-	Alcohol and Other Drugs
ARC	-	Aged Residential Care
CAYAD	-	Community Action Youth and Drugs Auckland City Council
DHB	-	District Health Board
DNA	-	Did Not Attend
DSLA	-	Diabetes Service Level Alliance
ED	-	Emergency Department
HCSS	-	Home and Community Support Services
MACGF	-	Metro Auckland Clinical Governance Forum
MSD	-	Ministry of Social Development
NHC	-	National Hauora Coalition
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
PMHII	-	Primary Mental Health Innovation and Initiative
PUC	-	Purchase Unit Code
SACAT	-	Substance Addiction Compulsory Assessment and Treatment

Summary

This report updates the Auckland District Health Board (DHB) Board on planning and funding activities and areas of priority, since its last meeting on 14 September 2016.

1. Planning

1.1 Annual Plans

Both Annual Plans have recently been resubmitted to Ministry of Health and we are awaiting Ministerial sign off.

1.2 Annual Reports

Final drafts of the Auckland and Waitemata DHBs' 2015/16 Annual Reports have been prepared and are in the process of being presented to Board and Audit and Finance for review and sign off.

2. Hospitals

2.1 Cancer target

The Auckland DHB provider has reported the FCT 62 day indicator result at 15 September as 78.6%. This is a continued improvement, and the provider reports they are on track to achieve the 85% target by the end of October.

2.2 Auckland DHB 2016/17 Surgical Health Target

2.2.1 2016/17 ADHB Surgical Health Target

A revised 2016/17 Auckland DHB Surgical Health Target plan, including a revised provider phasing plan has been confirmed with the Ministry of Health and this revised plan reduces the total Auckland DHB population discharge plan by 364 Orthopaedic discharges. These Orthopaedic volumes have been reallocated, with the associated funding to the Waitemata, Counties Manukau and Northland DHB populations. As a result of the reduction in Orthopaedic discharge volumes, the Auckland DHB provider is ESPI 5 non compliant and this is expected to continue for six months until a planned increase in internal provider production in the 3rd and 4th quarters. The Ministry has agreed to a dispensation from financial penalties as a result of this non-compliance for a period of six months based on an agreed recovery plan. This dispensation applies to Orthopaedics only. The recovery plan outlines actions being taken and the associated timeframe to achieve both ESPI 5 compliance and the Health Target.

2.2.2 Year to Date Performance

Year to date August, Auckland DHB provider performance has been lower than planned with 18% of this provider shortfall due to Adult Orthopaedic under delivery against the adjusted (reduced) volume plan, 20% due to under delivery in Gynaecology, 42% in Child Health surgical services and the balance of the shortfall occurring across a range of other elective surgical services. The IDF volumes are tracking to plan however the provider performance evident in the year to date August position has not substantially improved in September. As a result, the 1st quarter result for the DHB is expected to be 91% against the target. Internal provider recovery plans are currently being established and this will enable the DHB to forecast when the provider is expected to achieve compliance with the Health Target.

2.2.3 Outsourcing Arrangements

The cataract outsourcing arrangements commenced in the 1st quarter have been successful with the planned volume being achieved and work is underway presently to ensure ongoing supply agreements are in place with a number of providers. The provider is expected to confirm the volume requirements for 2nd quarter cataract outsourcing in the next two weeks.

2.2.4 ESPI Compliance

At the end of August, Auckland DHB was moderately non-compliant (yellow) for ESPI 2 (outpatient specialist appointments) and non-compliant (red) for ESPI 5 (booked for surgery) waiting time targets. As previously discussed the DHB is expected to remain ESPI 5 non-compliant as a result of Orthopaedic service issues (adult and paediatric). While the Ministry of Health has agreed to a six month dispensation from financial penalties associated with this Orthopaedic non-compliance, this agreement is associated with an expectation that all other ESPI 2 and ESPI 5 services will be compliant.

2.3 IDF Arrangements

2.3.1 2015/16

The year end national wash up position has been finalised with the Counties Manukau DHB/Auckland DHB bilateral washup in the process of being finalised. In late August 2016 Counties Manukau DHB identified an error in their discharge data relating to an unidentified Auckland DHB discharge event that occurred in August 2015 and are seeking payment for this case. Discussions are ongoing at this time. The shortfall in the Midland DHB IDF funding arrangements for Eating Disorder services in 15/16 and 16/17 remains unresolved with no response having been received from Midland DHBs on these matters. However, the Midland region DHBs have written to the Northern region CEOs to give notice of their intention to withdraw from the Supraregional arrangement for Eating Disorder services from July 2017. An Auckland DHB and Northern region impact analysis has been prepared for consideration by the Auckland DHB Board and the Northern region CEOs in October. The Ministry of Health has been advised this letter has been received by Auckland DHB.

2.3.2 2016/17

Work continues within Auckland DHB and regionally and nationally to plan for the implementation of the Clot Retrieval service. This includes establishing appropriate payment for the current services being provided and the development of a proposal to invest in a sustainable service arrangement at Auckland DHB. This, together with associated activity in the Northern region Hyper acute stroke pathway planning will require increased investment in Auckland DHB capacity and an associated increase in funding from the Auckland DHB funder and other funders. Work continues to quantify the unfunded costs of delivery of Gynaecology Oncology services for the Northern and Midland region populations.

The service improvement plan for Ophthalmology is likely to be progressed within the next two months with the recruitment of a service improvement project resource. Auckland DHB and Waitemata DHB funder have yet to agree the increased funding proposal for 16/17 Ophthalmology volumes.

2.3.3 2017/18

Planning is underway regionally and locally to establish IDF forecasts for the next financial year with an expectation that IDF agreements will be finalised by the end of October.

2.3.4 Other

The Auckland DHB provider has received a number of requests over the last few months to undertake tertiary services for DHBs outside the Northern region as a result of changes in service and workforce capacity and capability in other secondary and tertiary providers. These requests include referrals for complex elective Cardiac interventional procedures, Paediatric Orthopaedic spinal procedures, Neurosurgical procedures and complex General Surgery procedures. These increased service demands impact on the capacity available to provide elective surgery for the Auckland DHB population to meet the surgical health target and meet existing funding commitments to the Northern region population for the provision of tertiary services. Further consideration needs to be given to Auckland DHB's obligations to provide these additional tertiary services due to current capacity constraints and the limitations of the current IDF payment mechanism which results in the tertiary adjustor payment associated with these cases not being automatically paid to Auckland DHB.

2.4 Tertiary services review

No new update as we are waiting for feedback from the Ministry of Health in relation to the financial analysis before confirming the consultation plan.

2.5 Policy Priority areas

Colonoscopy Indicators
Auckland DHB achieved all colonoscopy waiting time indicators in July and this has been validated by Ministry of Health reporting. The service continued to improve performance in all indicators. The service is facing ongoing challenges in the recruitment of Specialist Medical Staff, however there is no indication at this stage that the DHB will not stay on track for the rest of the year. Discussions are due to be held with the Waitemata DHB funder regarding ongoing volumes for the Waitemata DHB population between January and June 2017.

Radiology Indicators
The Auckland DHB provider reports CT performance as achieving target in August at 96%, MRI improved at 82% and the outpatient ultrasound indicator performance also improving from 84% reported in July to 86%, against the DHB target of 95%. There has been substantial improvement in the Paediatric MRI waiting list position with more than 150 children waiting for MRI in July 2016 and 50% of these children waiting more than six weeks. At the end of September there are only 52 children on this list with only three of those waiting more than six weeks.

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

2.6 National services

The DHB is reporting quarterly to Ministry of Health regarding the recruitment and appointment of new staff to further increase capacity in Paediatric Cardiac and Adult Congenital services in line with the agreement for additional funding in 2016/17. The increased funding in 2015/16 has led to a sustained position within the service of reduced elective cancellations and reduced elective operating outside of working hours. The provider reports this is having a very positive impact for both children and their families and for the specialised workforce providing this service.

The funder is working with the Child Health Directorate to submit a proposal to the National Services Governance Board seeking additional investment in the national metabolic service in 2017/18 in response to increased survival into adulthood of children with Metabolic diseases.

The Auckland DHB National Intestinal Failure (NIF) Coordination service has received very positive feedback from the NIF Governance Group following significant progress exceeding expectations of stakeholders and this has been formally communicated to the Auckland DHB CEO. The DHB has been advised the funding for National Intestinal Failure (Coordination) Services is to be continued for a further year from 1 July 2017 pending the completion of an evaluation.

2.7 Regional Service Review Programme

The regional work plan is continuing with no new priorities identified for inclusion. The Head and Neck regional review process is expected to be initiated within the next six weeks with early priorities being an emphasis on the tumour pathways within this service.

3. Primary Care

3.1 Health Targets

Better Help for Smokers to Quit
PHO performance on this target has dropped once again with a number of PHOs below target as the first quarter comes to an end. Work continues to have all PHOs hitting this target each and every quarter. However, we still have some way to go in achieving this.

More Heart and Diabetes Checks
All PHOs within Auckland DHB continue to meet the 90% target. Focus remains on ensuring we reach the target for the eligible Maori population where there is a very small gap to close. From 1 July 2016 'More Heart and Diabetes Checks' is no longer a national health target. PHOs will continue to offer More Heart and Diabetes Checks to the eligible population and overall incorporate this activity as business as usual.

3.2 Auckland Waitemata Alliance

There are two key priorities within the work programme; improving diabetes care under at Diabetes Service Level Alliance (DSLA), and development of an improvement plan for the new System level measures that have been introduced this year.

The DSLA has recently completed a review of retinal screening services and recommendations on service improvements are to be presented to the Alliance in October. A review of community based podiatry services is progressing to agreed timeframes and is due to report later this year. A revised stocktake of investment is in the final stages of completion. The stocktake will help inform decision about opportunities for revised investment. Finally, Innovate Change is working with the DSLA on a co-design approach. This co-design is particularly working with high needs people to better understand how they seek care and what prevents them from seeking care.

The System Level Measures (SLM) are being introduced for 2016/17 to replace the primary care Integrated Performance and Incentive Framework (IPIF) with a whole-of-system outcomes focused approach. This approach aligns with District Health Board outcomes frameworks.

The SLM Framework is a development process for activities over the next five years, with a focus on the current year. The metropolitan Auckland DHBs and the two ALTs (Auckland and Waitemata ALT and the Counties ALT) have undertaken a regional approach to the development of the SLM framework. The Ministry of Health requires submission of an improvement plan, which is agreement on the quantitative achievement of the four year one SLM, and agreement on a set of associated contributory measures and their quantitative targets for achievement. Improvement milestones and contributory measures should be based on a district's trend data and baseline and be appropriate for the needs and priorities of local communities and health services.

The joint DHBs and ALTs have established a Steering Group to provide oversight for Working Groups for each of the SLMs. PHO leads have been agreed for each of the SLM Working Groups, with support from Auckland and Waitemata DHB public health physicians in each group. Working Group membership consists of key representatives / experts from the sector (primarily from primary care and DHBs).

The System Level Measures from July 2016 are:

- Ambulatory Sensitive Hospitalisations (ASH) rates for zero to four year olds
- Acute hospital bed days per capita

- Patient experience of care
- Amenable mortality

The development of the plan is on track and full report on the plan will be presented to CPHAC.

4. Health of Older People

4.1. Home and Community Support Services (HCSS)

Part B of the Inbetween Travel Settlement Agreement focuses on achieving a regularised HCSS workforce, which incorporates guaranteed support worker hours, staff training and safe staffing ratios. Auckland DHB HCSS providers are participating in a virtual pilot starting on 3 October where data will be collected on support workers' rostered hours and cancelled client visits. This is a significant area to understand and quantify when preparing for guaranteed hours and the funding implications of guaranteed hours. Information collected from the pilot will be used to inform a budget bid the Ministry of Health is preparing. The Settlement Agreement requires guaranteed hours to be rolled out across the workforce from 1 April 2017.

Auckland DHB HCSS providers are working with Maori Health Services to develop a project aimed at making the HCSS pathway and service more responsive to Maori. The project will streamline discharge planning and transition from hospital for Maori patients who are to receive HCSS.

4.2. Aged Residential Care (ARC)

The annual review of the Aged Residential Care Agreements for 2017/18 is starting earlier than in previous years. DHBs are required to identify issues they wish to have considered and submit these through their regional HOP Forum by the end of September. An area of concern we will raise is how the supply of standard rooms will be maintained with many new builds focusing on premium rooms and associated premium charges.

We have undertaken a review of the ARC Deed of Assignment and new Agreement process. This process is managed by the Northern Regional Alliance (NRA) and is robust in ensuring that ARC providers have completed all required documentation. However, there can be significant delays in having the Deed of Assignment ratified and activated, which poses risks for the DHB. We are working with the NRA to achieve a more streamlined process.

4.3. Falls Prevention

The Partnering Agreement between Auckland DHB and ACC for the falls prevention programme has been finalised and is ready for sign off. Work is progressing on setting up the expansion of the Fractured Liaison Service and the In-Home Strength and Balance exercise programme.

5. Women, Children & Youth

5.1 Health and Better Public Service Targets

5.1.1 Immunisation

As of 28 September 2016, Auckland achieved 94% coverage of all 8 month old infants fully immunised. This represents a 1% improvement compared with the previous quarter (Q4 2015/16). However, we are not likely to achieve the Immunisation Health Target of 95% of 8 month old infants fully immunised in Q1 2016/17.

In July - September 2016:

- 1,401 children are eligible for vaccination before they turn 8 months of age
- 94.0% of the eligible cohort are fully immunised
- A further 7 children need to be vaccinated to reach the 95% target (by 30 Sept 2016)
- 6 children may be immunised and are on active follow up by General Practice and the outreach immunisation service.

Our evidence suggests delays and declines remain a significant challenge for Māori, particularly at this time of year as families manage winter illnesses. The Māori Health Gain Team will develop and support the implementation of an action plan to eliminate inequity between Māori and non-Māori 8-month immunisation coverage. This involves conducting a barriers and solutions workshop with key stakeholders which are scheduled in October. The outcomes will be used to identify appropriate strategies going forward to support the achievement of the National 8-month immunisation target for Māori of 95%.

The 1% improvement in coverage overall suggests the new action plan with a focus on connecting earlier is achieving some traction. We aim to engage during pregnancy so women have time to consider immunisation earlier and to help predict decliners/hesitant families earlier.

Joint DHB/PHO education sessions are underway for primary care practice staff and lead maternity careers (LMCs) across the Auckland region and we are working with PHOs to support practices in sites with high decline rates.

5.1.2 Childhood Obesity

The B4 School Check is a health assessment completed on four year old children in the year prior to them starting school. One of the primary purposes of the check is to make sure children have no impediments to learning and have appropriate supports from their first day at school. The 'Raising Healthy Kids' Target requires the B4 School Check Nurses to establish whether a child is over the 98th BMI percentile, refer the child/family to the GP, and receive acknowledgement of the referral within 30 days. The August results released earlier this month from the Ministry of Health indicate Auckland DHB (Figure 1) being one of the top two DHBs in the country (with Waitemata) for meeting this target at 63%. In Auckland DHB, 66% of children have had their referral acknowledged. This is up from 38% in the last report. This steady improvement can be seen clearly and will continue to climb as we move closer to the entire cohort being measured having been part of the intervention (Figure 2).

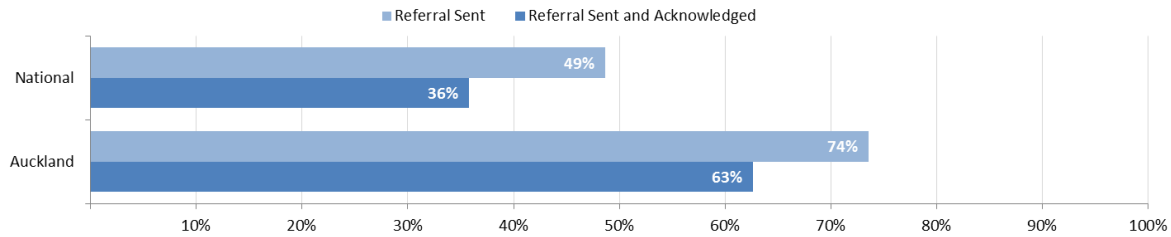


Figure 1. Auckland DHB Referral acknowledged compared with national average.

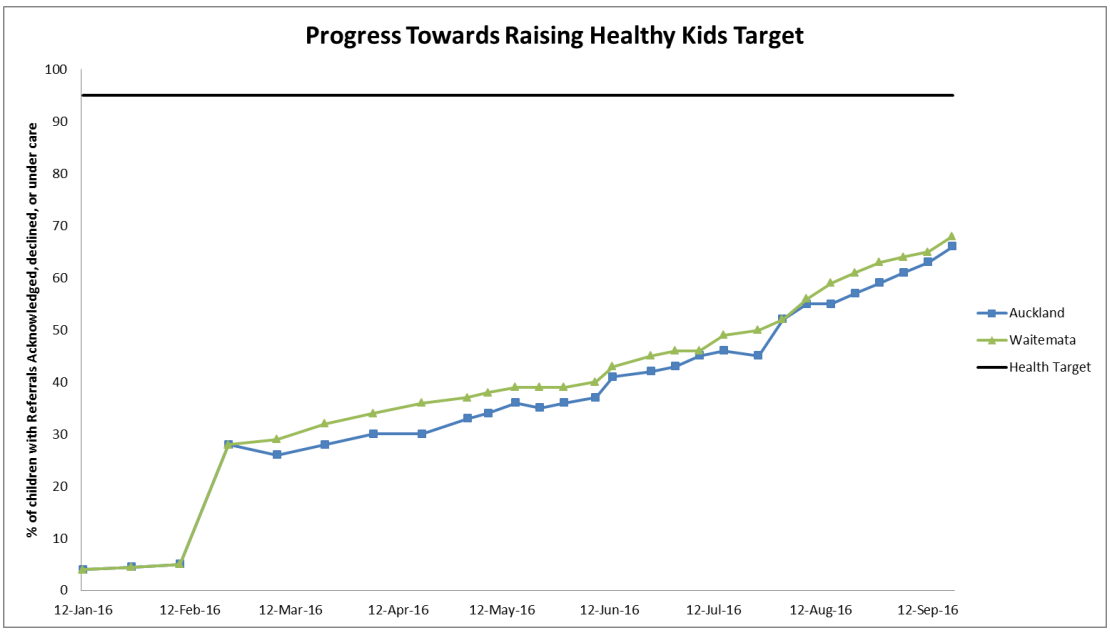


Figure 2. Auckland and Waitemata DHB – Raising Healthy Kids

A Northern Regional Pathway has been drafted and is progressing through the approval process. The 'BeSmarter' resource (developed in Waikato) is now being used as part of our Plunket's health worker's brief intervention for children identified as over the 98th percentile. For consistency of message, General Practices are also being trained in the use of the 'BeSmarter' resources. The Dietetics Departments in Auckland and Waitemata DHBs have been contracted to provide Raising Health Kids training to General Practitioners and Practice Nurses, along with general information on healthy weight in children. The Primary Health Organisations have each identified a Raising Healthy Kids Target champion.

Work has begun on designing a service model for the family-based community programme which is due to be implemented from 2017/18 financial year. This includes regular and ongoing collaboration from diverse interest groups within the DHBs. As previously signalled, the DHB will under-take a procurement process in 2016/17.

We are making solid progress against this important new health target and will continue to report progress routinely to Community and Public Health Advisory Committee through this scorecard.

5.1.3 Rheumatic Fever

The Community and Public Health Advisory Committee have been informed that we did not achieve the Rheumatic Fever target. Results for 15/16 were 19 cases (a rate of 3.9 per 100,000).

The Ministry stated that "case numbers in Auckland have remained virtually unchanged since the beginning of the Rheumatic Fever Prevention Programme: 20 cases in 2013, 17 in 2013/14, 13 cases in 2014; 15 cases in 2014/15; 14 cases in 2015; 19 cases in 2015/16."

Overview of target and current position

In June 2012, the MoH set Rheumatic Fever targets of 1.1 new RhF cases per 100,000 total populations by 2016-17. As at end 15/16, Auckland DHB had achieved the Better Public Service Target results as shown in Tables 1-2.

Table 1: ADHB Rheumatic Fever Better Public Service Target for rate of new cases of RhF

	2009/10–2011/12 Baseline rate	**2012/13** Remain at baseline	**2013/14** 10% reduction	**2014/15** 40% reduction	**2015 /16** 55% reduction	**2016/17** 2/3 reduction
Target rate	3.2	3.2	2.9	2.0	1.4	1.1
Actual rate	2.8	2.8	3.7	3.2	3.9	

Table 2: ADHB Rheumatic Fever Better Public Service Target for numbers of new cases RhF

# of cases	**2009/10–2011/12** Baseline	**2012/13** Remain at baseline	**2013/14** 10% reduction from baseline	**2014/15** 40% reduction from baseline	**2015 /16** 55% reduction from baseline	**2016/17** 2/3 reduction from baseline
Target	15	15	14	9	7	5
Actual	15	17	17	15	19	

9.2

Figure 3 shows the same information regarding number of notifications over time, including results for Counties Manukau. It is important to note that, unlike Counties Manukau DHB, both Auckland and Waitemata DHBs have limited population coverage through the primary school programme. CMDHB has sufficient population coverage (over 80%) through the school programme to target the vast majority of the at risk community.

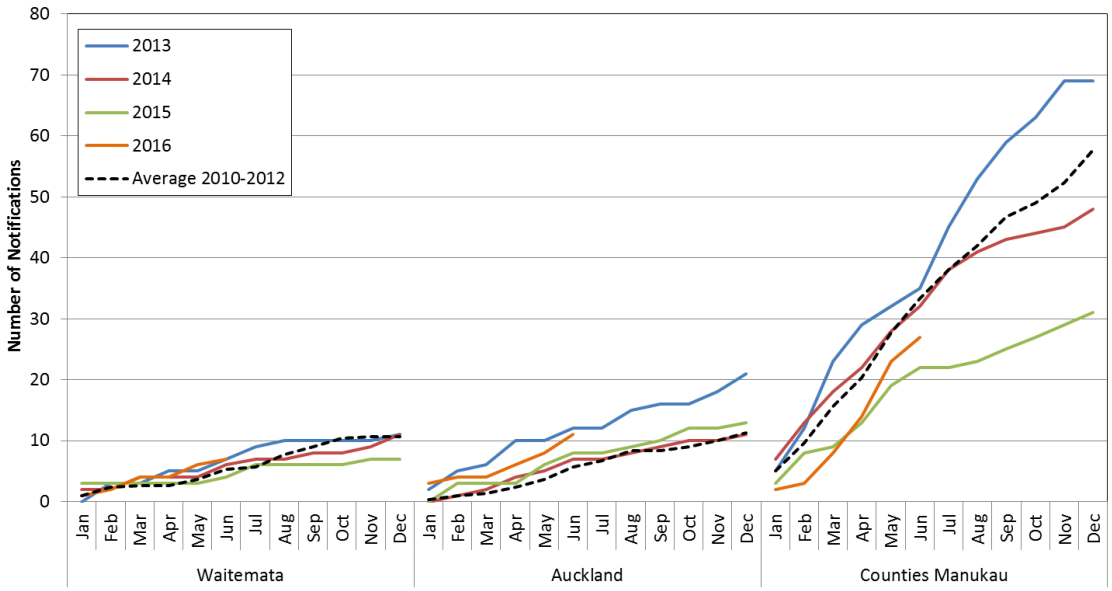


Figure 3: ARF Initial Attack Total Notifications by DHB and Admission Month, 2010-2016 Auckland Region prepared by Dr Catherine Jackson (ARPHS)

The actions we have taken to date in Auckland DHB include:

- Establishing a Steering Group which was re-shaped for 2016 to include membership from across Auckland and Waitemata DHBs.
- Developing initial and Annual Plans for approval by the Ministry of Health
- Identifying DHB Champions.
- Entering an Alliance Agreement in Auckland DHB with PHOs and DHB.

- A Pacific Engagement Strategy delivered by Alliance Health Plus (through a MoH contract).
- The Auckland Wide Healthy Housing Initiative (AWHI) led by the Ola Coalition (AH+ and NHC) (through a MoH contract).
- Raising community awareness through a variety of means such as the HYPE event, school community RhF awareness raising and localised events.
- Implementing a RhF Community and Sector Engagement Team to work with frontline staff across the DHB.
- Recently, adding targeted face to face messaging to the B4SC for Māori, Pacific and Q5 about the importance of getting sore throats checked, antibiotic compliance and tips for a warmer, drier, healthier house.
- The school-based throat swabbing and treatment programme which was implemented in 16 primary schools (with high incidence of RhF).
- Trialling a Community Health Worker (CHW) in secondary schools where we have DHB funded services.
- Providing education on RhF guidelines to secondary school-based nurses.
- Establishment through primary care of Rapid Response (RR) clinics in practices with a high proportion of Māori, Pacific and Q5. This included the addition of pharmacy in locations where practices were not engaged.
- Reviewing the Bicillin programme and implementing systems improvements to ensure compliance with 28 day antibiotic requirement.
- A major review of the adult community nursing service re Bicillin administration.
- Development of a Fight the Fever App to assist with getting Bicillin on time.
- Working actively on improving disease management including setting up a primary care group to examine coding, recall systems etc. for RhF management.
- Case finding in paediatric wards for referral to Healthy Housing Initiative (HHI).
- Case review – all cases systematically reviewed and feedback to providers.
- Establishing a process for primary care review of new RhF cases.

Some of the learnings, planned actions and new initiatives underway are summarised below:

- RhF is strongly associated with the social determinants of health. Having discussed with Ministry staff and based on self-reflection, we consider that we still have work to do particularly in relation to housing, primary care and community awareness. We consider that the primary school programme is unlikely to have delivered significant benefits to reducing disease (though there are other benefits) but may have curbed an increase in disease.
- We are in discussion with the MoH regarding the expanded Healthy Housing Initiative (HHI) (see below). A draft plan has been prepared. The Plan aims to leverage off existing workforces (DHB social work) as well as housing/social NGOs. We met with Te Puni Kokori (TPK) to discuss engagement and feedback loops with Whanau Ora providers.
- Community awareness – the recent change to the B4SC looks worth maintaining. We consider we need increase community awareness and improve linkages across community awareness raising activities. We met with the Chief Pacific Advisor at MoH to explore what we can do differently. The Community Engagement plan will be reviewed.
- Primary care – information regarding achievement against target was shared with the Governance Group. An extraordinary meeting was held to discuss the target and, specifically, what needs to be done in primary care and across the system. This information has been used to inform the draft resolution plan. PHOs have identified a named medical and nursing lead for RF in each PHO.

Healthy Homes Initiative Expansion
The Ministry of Health (MoH) has expanded the Healthy Homes Initiative (HHI), broadening the original objective of preventing rheumatic fever by reducing household crowding to focus more broadly on warm, dry, healthy housing for 0 to 5 year old children and pregnant women.

The HHI service will systematically identify and refer eligible families/whānau to the HHI Service. Actions include:

- Engaging with eligible families/whānau.
- Coordinating interventions to deliver warmer, drier and healthier homes.
- Building and facilitating the supply of interventions (such as curtaining).
- Ensuring greater understanding among families/whānau about the relationship between living in cold, damp and unhealthy homes and preventable illness, such as infectious respiratory conditions, rheumatic fever, or meningitis.
- Providing targeted tips for a warmer, drier and healthier home.

A HHI plan has been presented to and accepted by the Ministry of Health. The plan is a whānau centred approach, with health social work taking a lead and tailoring support as appropriate to meet individual whānau needs, alongside the Māori and Pacific Teams. Referals to Whānau Orā providers and Non-Government Organisations (NGOs) may be made as appropriate.

To date there have been positive discussions with the health social work leads across both DHBs and with Te Puni Kōkiri (Whānau Orā). The next steps in the HHI expansion include formulating a service level agreement with the provider arm (Health Social Work across child and women services) and asking for expressions of interest of the NGO sector to deliver components of the HHI service. As part of the MoH contract there are significant reporting requirements. A robust reporting system is being developed to capture all the data and show outcomes for whānau. The aim is to begin accepting referrals to the new service in December this year after promoting the new eligibility criteria and referral pathway.

Auckland and Waitemata DHBs have been working with the Southern Initiative (Auckland Council) to address the supply of interventions for the Health Homes Initiative through a co-design process. Findings indicate community willingness to engage and availability of a range of supplies, however coordinating these around families/whanau could be improved.

5.2 Children

Newborn Enrolment 'Free Health Services for Your Baby' flyer launched (see Appendix)
The Annual Plan and Manawa Ora Plan require Auckland and Waitemata DHBs to develop a multi enrolment/notification process for newborn infants. This project sits under the Pregnancy and First Year of Life Alliance – Auckland and Waitemata DHBs.

The aim is for every child to be offered the full universal package of care from 0 to 5 years of age. Currently many children miss out or are late for essential health services, sometimes due to parents not being aware of these opportunities or from delayed communication between health care providers. The multiple new-born enrolment/notification project will help bridge some of those gaps.

The Privacy and Security groups of both DHBs have been advising the project team. The advice was to develop a method to inform parents about what was planned, why and develop business processes.

A collaborative working group across Auckland and Waitemata DHBs included representatives from Maternity Services, Newborn Hearing Screening, Primary Care Organisations (PHOs), Oral Health (ARDS), National Immunisation Register (NIR), Plunket, Well Child Tamariki Ora (WCTO) providers, Auckland Regional Public Health Service (ARPHS) and the Māori and Pacific Health Gains Teams. The group developed the attached flyer for parents and obtained extensive feedback over a 12 month period including two rounds of consumer testing with young Māori and Pacific mothers. The final feedback was strongly positive. *'These mums love the poster and the information provided. The language poster will be very useful for most of our pacific mums.'*

Due to the urgent need to improve oral health enrolments for infants the local project to start sharing patient's contact information has been accelerated. The first phase of the project, to inform parents and launch the information sheet is scheduled for October 2016. The intention of this work is not to divulge any clinical information but to share patient contact details with the relevant services. Mothers can choose to opt off.

Lead maternity carers (LMCs) will continue to provide information to mothers about choices of well child providers in the antenatal period. They will be provided with funded posters of these free baby health services to give to women ante-natally. LMCs will still refer mothers and babies to well child providers and GPs at 4-6 weeks postpartum. The next phase is to engage with Primary birthing units to make the pamphlet available through them.

5.3 Youth

HPV vaccine

Planning is well advanced for the 1 January 2017 implementation of the 2-dose HPV vaccine programme. Offering the funded vaccine for males is a welcome opportunity to re-dress the previous gender bias in access to this highly effective vaccine.

In 2015/16 the target requires 65% of 12 year old girls fully immunised with 3-doses. The Ministry of Heath has signalled incremental increases in the target for all ethnicities to reach 70% in 2016/17, and 75% in 2017/18. HPV immunisation coverage results are measured once annually on 30 June due to the cycle of the school year. The results are presented here.

Nationally, 65% of 12 year old girls have received three doses of HPV vaccine. In this region both DHBs are showing strong gains in performance. Auckland is the top ranked DHB in the country this year with 83% of girls fully vaccinated. All ethnicities are exceeding target with Māori the highest at 91%, Pacific 86%, Asian 80% and Other 82%.

5.4 Women

5.4.1 Maternity

Breastfeeding

The draft Obesity Plan has identified increasing breastfeeding rates as a key priority. To support this, Plunket have been contracted to provide a pilot Breastfeeding Peer Support programme across Auckland DHB and Waitemata DHB. The sites for this pilot will be Glen Innes and Panmure. Peer support counsellors have received training through the completion of a La Leche peer support training programme. Women will be supported to access the service through their Lead Maternity Carer (LMC) or Well Child Provider. The aim of the programme is to increase breastfeeding rates at 3 months and beyond.

Implementation of the National Gestational Diabetes Guidelines

The Ministry of Health (MoH) has required all District Health Boards (DHBs) to implement the new Gestational Diabetes Guidelines by June 2016. Reports from both DHBs have been submitted to the Ministry of Health to outline progress on implementation. Education regarding HbA1C testing is being provided to Primary Care at a Women's Health seminar run by the Goodfellow Institute.

The Auckland DHB and Waitemata DHB Annual Plans require pregnant women at risk of, or with gestational diabetes to be referred to a Green Prescription provider for support with exercise and healthy eating in pregnancy. To ensure Green Prescription providers support pregnant women appropriately and are familiar with techniques to engage priority pregnant women, a training workshop is being organised. The workshop will be provided by a multidisciplinary team to the three Metro-Auckland Green Prescription providers. Following the workshop, active promotion of the Green Prescription service will be provided to LMCs.

Pregnancy and Parenting Information and Education

The independent evaluation of the Auckland DHB and Waitemata DHB Pregnancy and Parenting Services has begun. Synergia have been commissioned to complete this evaluation and have been meeting with key stakeholders to inform the development of the evaluation framework. The evaluation will run for 12 months and will focus on the implementation of the Auckland DHB Service and the reach and effectiveness of the Auckland DHB and Waitemata DHB Services. Both services are continuing to identify strategies to engage priority women and Synergia will provide regular feedback from the formative evaluation to ensure key findings are implemented in a timely manner.

A key focus of the new Auckland DHB service is the emphasis on supporting Māori women and their whanau to access the Pregnancy and Parenting Service. Ngati Whatua are now contracted to provide this Service, alongside their Well Child Tamariki Ora and Midwifery services. Their programme provides women with different options, women can attend four, four hour classes or attend a 2 day waananga (optional overnight) class. The courses incorporate the key pregnancy and parenting messages from the Mokopuna Ora curriculum and, in parallel, explore Te Ao Māori in relation to pregnancy. Including information on the status of waahine hapuu (pregnant women), whakapapa, ancestral stories, traditional birthing and parenting practices, karakia, waiata and kupu Māori (Māori language/words) in relation to pregnancy and parenting. Participants also make their own ipu whenua (a container for the afterbirth), and learn the significance of the afterbirth.

An example of the success the Ngati Whatua programme has experienced is detailed in the following case story.

> *A wahine Māori was having her first baby. She was referred for pregnancy and parenting services by an ADHB Māori social worker. She suffered depression and anxiety and had no transport, there were financial issues and she had been homeless with her partner for a period of time but had recently secured accommodation. Growing up she had little contact with her father, and her mother experienced addiction issues and has since passed away.*
>
> *The ADHB Māori child birth educator visited her at home. The wahine was very anxious and their budget was stretched (they had been living off noodles for some time). The educator invited her to the Ngati Whatua classes and waananga. The wahine was reluctant to attend the waananga. She felt ill equipped in the Māori world and commented "I'm not a real Māori." The educator explained the majority of the waananga would be in English and te reo Māori would be used mainly for the powhiri, karakia, waiata and as part of general conversation and discussion. She also explained that it would be a good opportunity to meet other mothers and learn about pregnancy and birthing, and traditional birthing practises.*

There would also be activities she could participate in (she made her own ipu whenua and took it home), and there would be lovely kai. The educator picked her up Friday evening to attend the first part of the waananga. The wahine thoroughly enjoyed the programme and especially commented on the whanaungatanga, the manaakitanga and aroha extended to her. It was a special experience for this wahine and she closed the evening with karakia. The next morning the educator went to pick her up to find that she and her partner had attended the waananga and had stayed overnight for the full day. Again, a rich experience for them both. They have now engaged with ongoing health care through Ngati Whatua and are connected to other support services to meet their needs.

5.4.2 Cervical screening

There has been a decline in coverage across all ethnicities for Auckland DHB in Q4. Māori coverage has dropped by 2.7% (59.1% to 56.4%), Pacific by 2.4% (77.7% to 75.3%) and Asian by 4.3% (66.1% to 61.8%). European coverage remains above the 80% target at 82.9%.

We have been waiting for the outcome of the NSU review of the Independent Service Providers (ISP). During this period of uncertainty (from April 2016) it has been difficult for the DHBs to engage with ISP providers to drive initiatives to increase coverage rates for priority group women. We have recently been informed that Well Women and Family Trust will be the ISP for Auckland. The DHB has a strong working relationship with this provider and will now pursue strategies to develop a comprehensive cervical screening outreach service, whilst also working in collaboration with primary care. The new contract comes in to affect from 1 November 2016.

The Auckland and Waitemata Coordination service has continued to focus on supporting PHOs to interpret the monthly NSU data match lists and to translate them in to easily interpretable lists for practices. This activity is essential for ensuring invitation and recall is prioritised by clinical need. The invitation and recall letters that practices use to send women from their Patient Management System (PMS), have been reviewed and translated in to 11 different languages. These can be accessed by practices along with all other resources developed by the Coordination service, from the Metro Auckland Cervical Screening website, http://nationalwomenshealth.adhb.govt.nz/health-professionals/auckland-regional-cervical-screening-project. Opportunistic screening also remains a key focus and cervical screening is regularly offered in conjunction with the Breast Screen mobile vans.

Table 3: Three year cervical screening coverage

Ethnicity	Auckland DHB	Additional women to screen to reach 80%
Māori	56.4%	2,373
Pacific	75.3%	598
Asian	61.8%	8,288
European/Other	82.9%	
Total	73.4%	

Source: National Screening Unit (NSU) June 2016

5.4.3 Breast screening (50-69 years: 2 year coverage)

The Auckland coverage has largely remained stable for Māori women and other ethnicities, with only a slight drop in Q4 compared to Q3 data, 0.4% and 0.3% respectively. Pacific coverage has dropped by 1.5% but still remains above target at 74.4%.

Of note from June 2016, the NSU began reporting using the latest 2013 domicile codes and a daily data loading process, compared to previous reports which used a monthly data loading process and based reporting on 2006 domicile codes. This has resulted in variances with coverage reports that are unrelated to actual screening activity.

The identification of unscreened and under screened women through a national NHI data matching process remains the key strategy to increase coverage. To support this activity and the associated increase in coverage it has been proposed that breast screening be recognised as a contributory measure under the new System Level Measure of amenable mortality. This will support renewed focus and activity on breast screening by Primary Care.

Collaborative activity to provide joint health promotion for cervical and breast screening has also been pursued, this activity has also incorporated smoking cessation messaging and Green Prescription activity.

Table 4: Two year breast screening coverage

	Ethnic Group	Eligible women	2 year coverage 50-69 years %	2 year coverage actual number of women	Number of women needed to reach 70% target
Auckland	Māori	3400	59.9%	2,035	345
	Pacific	4,520	74.4%	3,365	
	Other	42,710	63.8%	27,270	2,627

Source: National Screening Unit (NSU) June 2016 Quarterly Report. BreastScreen Aotearoa only report coverage by Māori, Pacific and Other (including New Zealand European).

6 Mental Health and Addictions

6.1 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

There have been two sector-wide workshops to gain collective energy to progress the service map of what Northern Region DHBs provide including NGO services. A technical advisory group has been established to review current Managed Withdrawal (including detoxification) service provision in Northern Region DHBs and develop a regional response based upon this. Ministry of Health are expecting the development of a proposed Northern Regional continuum of care in response to SACAT impact. Workshop 1 (15 September 2016) identified that under the current service configuration, Northern Region DHBs do not have all the service(s) and/or structures in place to provide an effective SACAT response. Workshop 2 held on 29 September 2016 worked on the development of a draft service delivery model aligned to SACAT processes.

The Ministry initially estimated that 200-300 people annually will come under the new legislation nationally; 154 of these people will be in the Northern Region and 10% (15) will require on-going support either in the home or in recovery housing. Feedback to MoH from Workshop Participants based upon New South Wales (Australia) experience with a similar Act and regional experience estimated the demand to be significantly higher with unmet need sitting behind the Ministry's original estimates, resulting in revised estimates from the MoH (refer to table 1 Estimate of Demand in NR for meeting SACAT criteria and need for services).

Table 1: Estimate of demand in Northern Region Workshop 2

Assessment	Meet SACAT criteria	Need home support (post SACAT)	Need recovery housing (post SACAT)
580 people	270 people	45 people (17%)	35 people (13%)

The workshops highlighted that this group may require different services to those currently available under existing AOD contracts. Many of these people will have cycled in and out of various treatment services, residential rehabilitation, detox facilities, homelessness services and prison repeatedly with little or no change or change that is not enduring. The treatment services currently available have not worked for this group and it is predicted that the range, intensity and therapeutic models may need to change in order to effect long lasting change in patterns of consumption. In addition, it is likely that some people placed under compulsory treatment orders may have developed cognitive related brain damage from which they may not recover sufficiently to be able to live independently. Therefore it is likely that they may need to be placed under the PPP&R Act with longer term supported accommodation provided for their care. In some cases despite the significant health and social impacts of their drug and alcohol use, some people once they regain competence may choose to continue to use substances at harmful rates. There may therefore need to be additional investment in services that provide safe and secure accommodation which allows people to continue to use substances in a controlled way while their health and other essential needs are met. The intent of these services would be to reduce harm rather than achieving abstinence.

A further workshop is required to develop the model of care in sufficient detail to identify resourcing. The third workshop will have an emphasis on specifying the requirements of the detoxification service and the range of therapeutic interventions required to support people both while they are under compulsion and; in the development of suitable aftercare options.

6.2 Perinatal Infant Mental Health Contract Service Review Project Update

The project is progressing well to review the objective of development of a regionally consistent specialist perinatal and infant mental health services for mothers with babies and/or infants who are at risk. Extensive stakeholder feedback includes consumers, NGOs, community and also the DHB provider services and other services accessing the maternal mental health services and the acute perinatal continuum of care. A first draft of the Review along with the qualitative report has been sent to the Governance Group for comment. The intention is for this report to be finalised by the Governance Group by the end of October.

6.3 Ministry Project – Fit for The Future: a systems approach to primary and community MHA services

The Ministry of Health is leading a project called “Fit For the Future – A systems approach to primary and community MHA services”. Fit For the Future aims to better understand how to improve outcomes for those who are not easily managed in primary care but do not meet the threshold for specialist services. The Ministry held two workshops (31 August and 21 September 2016) where over 60 representatives started to co-develop appropriate responses to better address the needs of this group. ADHB was well represented within the group discussion with representatives from DHB Service Provider and Funding and Planning, NGOs and PHOs members, Family/Whanau and Consumer Advisors. The Minister of Health asked the Ministry to set aside $5 million for investment into primary and community MHA services. The Ministry wishes to invest this money into existing initiatives in the sector to build an evidence base about integrated models that work well to improve outcomes for this group. Evidence gathered will inform both “Fit Fort the Future – A Systems Approach” and the longer term strategic plan to reshape the health system to focus on outcomes.

The Ministry invited DHBs to submit a Registration of Interest (ROI) for consideration in the allocation of a $5 million investment into primary and community mental health services. ADHB prepared a response to the Registration of Interest (ROI): Existing Initiatives for Investment in Building an Evidence Base (People with moderate mental health issues. The process itself only allowed an 17 day turnaround of the application. The Ministry expects to be ready to enter into discussions with preferred providers in October 2016.

6.4 Auckland DHB's Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot has linked three NGOs with two GP practices and is preparing to link a third GP practice. A review of this pilot developed seven principles of practice to guide future integration:

1. Be in, and of, the place where you are working
2. Be highly connected
3. Establish shared understanding and language
4. Give people choice including cultural choice in the services required
5. This will take time and need a network of people
6. This is a 'point in life'
7. An outcome focus: Moving from existing to thriving

Please refer to 'Awhi Ora – Supporting Wellbeing' for further information.

The pilot working group is currently focused on the development of primary care/NGO integration in further ADHB sites. A further four NGO support hours providers and ten GP practices have agreed to be involved in the next phase. This includes practices from Auckland PHO, Alliance Health Plus and National Hauora Coalition. On the evening of the 19th September an information evening was held to present the principles of practice and begin linking NGOs with practices. This meeting was well attended and the feedback from was very positive. The working group is currently finalising the pairings and discussing the prioritisation of NGO support hours for this expansion.

7. Maori Health Gain

7.1 Smoking cessation

The Māori Health Gain Team is working with our MOU partner, Te Rūnanga o Ngāti Whātua to implement a pilot programme for the delivery of communication and marketing initiatives that are developed by youth/rangatahi to promote stopping the initiation of smoking and for smoking cessation. We have partnered with selected secondary schools/institutions to promote these positive healthy lifestyle and choice options. In the Auckland DHB rohe we are working with Tamaki College and we are engaging with two other schools with high needs populations. The schools will develop social media based initiatives to promote staying and becoming smokefree.

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

The Māori health team are working with the Auckland Cancer and blood service to evaluate the Māori and Pacific Faster Cancer Treatment pilot undertaken in 14/15. The pilot was funded through Ministry of Health Faster Cancer Treatment project funding via the Northern Regional Alliance Cancer Network. The intent of the pilot was to deliver a Māori & Pacific Cancer Navigation based services to improve timeliness and ease of access, reduce DNA's and improve health literacy. The evaluation seeks to understand the effectiveness of the implementation and operationalisation of the pilot and whether it was able to improve performance against faster cancer treatment indicators and reduce DNAs. It is expected that we will be able to take these learnings and inform future practice, service improvements and investment. The report has been completed and will be

presented to the North Cancer Network in October and a paper will be presented with the findings from the evaluation to the Māori Health Gain Advisory Committee in January.

7.3 Mental Health Act 1992 Community Treatment Orders Consultation

The Māori Health Gain Team is working with Auckland DHB Mental Health Services to support improved health outcomes for Māori on a Community Treatment Order (CTO) under section 29 of the Mental Health Act 1992. This work supports one of the nationally set indicators from the 16/17 Māori Health Plan to reduce the rate of Māori treatment orders made under section 29 of the Mental Health Act 1992. We undertook a consultation with 16 Tangata Whai I te Ora on a CTO and their whānau to get a better understanding of the positive and negative effects of CTOs and to gain some insight into the effects client choice had on the use of CTOs by Māori. The preliminary results show that Tangata Whai I te Ora want to:

- be independent
- connected to their whānau
- be able to manage their illness without medication
- have secure employment
- access to more recreational activities
- be less stigmatised
- build new skills
- receive more culturally appropriate supports

Additional analysis will be undertaken with the final report and recommendations expected to be presented at the next Māori Health Gain Advisory Committee Meeting.

7.4 Cervical Screening HPV Self-Sampling

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

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

Both projects are progressing.

8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)

Consultation meetings regarding the refresh of the Pacific Health Action Plan, both face to face and online, were completed on 31st August. Meetings with other agencies were also progressed but meeting with the Early Childhood Education part of the Ministry of Education and Housing did not occur but we commit to making them happen.

A total of 290 responses were received. More attended the meetings, but not all completed and submitted the questionnaires that were given out at the meetings. The six priorities of the current plan were confirmed with over 70% supporting an additional focus on oral health and childhood obesity as part of the first priority which is children being safe and well and families being free of violence. Two new priorities were suggested by the PHAP Working Group and they are a focus on health of older people, supported by 87% and mental health promotion, supported by 89% of respondents. The renewed plan is currently being developed and will be submitted to CPHAC at its November meeting.

The implementation of Pacific Health Action Plan 2013 - 2016 (PHAP) is on target for Priorities 1 – 5.

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

This priority was strongly supported by the recent consultations that we undertook with additional support for work on oral health and childhood obesity.
The consultation that we undertook with Ministry of Social Development (MSD) and ACC made it clear to us that those agencies are not funding any programmes similar to those that we are delivering in the community and churches. MSD has a focus on training practitioners and community leaders but they do not have a focus yet on delivering programmes in the community.

ACC is currently working with a Pacific provider to develop e programme with a focus on violence prevention amongst youth.

We had envisaged MSD and ACC funding or co-funding the current programmes that Auckland and Waitemata DHBs are currently funding, but that is not likely to happen in the current financial year.

8.3 PHAP Priority 2 –Pacific People are smoke-free

The consultation that Waitemata DHB and West Fono undertook with Tongan men, using the kava drinking forums that Tongan men participate in, have been completed. The information that has been collected is rich and is currently being collated. The men that took part in the conversations expressed gratitude that the DHB and West Fono *took note of* us *and came to talk with us*. They encouraged the health workers to *not give up on us,* and the strongest suggestion they made is to approach smokers as a group. They said that a commitment to a group provides stronger motivation to stop smoking than individual commitment. The intention is to invite the men who took part in the consultation to work with West Fono to design a group approach to addressing their attempts to stop smoking. The experience and knowledge gained from the WERO programme will be utilised.

8.4 Priority 3 – Pacific people are active and eat healthy

The 4th Aiga Challenge (annual 8 week weight loss competition) is currently being implemented. Workshops with Dr Fizz were held for Enua Ola and HVAZ co-ordinators as well parish community nurses with the purpose of adding a component on preventing intake of fizzy drinks by young people

(and adults) and reducing sugar intake in general, as a focus of this Aiga Challenge. We will also have a stronger focus on analysing data, for the 4 year period, at the end of the Challenge.

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

The *Fanau Ola* Integrated Services contract with AH+ has had a focus on validating data collected by front-lines workers in the periods Q4 2015/16 and Q1 2016/17. This is progressing well and the result is that the number of families confirmed as receiving the service is not as high as initially thought, based on initial data. Now that the data is reliable, we are focusing on outcomes of the services delivered. The current contract was renewed till 31 December 2016. We are confident that we will be better informed about input/volumes, amount of work delivered, outcomes and funding levels, when we renew the contract from January 2017.

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

The Pacific GM for Hospital Services reports on this priority.

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

The recent consultation that we undertook, for renewing PHAP, strongly supported the need to continue to focus on housing. This was priority number 6 in the last plan, but it became priority number 4 in the consultation. This is perhaps no surprise in the current housing crisis in Auckland.

9. Asian, Migrant and Refugee Health Gain

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

The Final draft of the Asian International Benchmarking Report has now been completed and is currently going through internal review processes before final sign off with the two new Boards at the December 2016 meetings.

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 75% (Auckland DHB) and 85% (Waitemata DHB) targets by 30 June, 2017 (current rates 73% (Auckland DHB) and 83% (Waitemata DHB) as at Q3 2016)

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

- As a member of the Auckland Agency Group led by the Ministry of Education (MoE), inputs have been added to the development of a draft New Zealand International Student Wellbeing Strategy with a key focus on: 1) increasing awareness of the NZ health & disability system, and 2) access to, and utilisation of health services. A pilot model of care that is student centric is being explored with a general practice in the Central Business District (CBD), as well as a inclusion of Health's response to a Critical Response Workflow
- A small working group has been established with membership by key DHBs across the country and MBIE, led by Ailsa Claire and tasked to explore issues related to utilisation of health services by migrant communities for high use services such as mental health, termination of pregnancy, neonatal care and ED.

Indicator: 80% of eligible Asian women have completed a cervical smear by 2020 (current rate 66.1% (ADHB) as at June, 2016)

Funding has been secured for the HPV self-sampling feasibility study of 200 Māori women in West Auckland and the larger cohort (7000 invited, 1750 women screened) for the HRC funded study of Māori, Pacific and Asian women (Auckland and Wellington). We are in the paperwork development phase and recruiting Asian partners to sit on an Advisory group, with the aim of implementation early 2017.

Appendix 1- Free Health Services for Your Baby - Information for parents

*Free** Health Services for Your Baby

Congratulations on your new baby!

The following services are free and help you to keep your baby healthy. It is important that you 1. Choose a family doctor (GP) 2. Choose a Well Child provider 3. Tell us who you've chosen. We will share your basic contact information with the services below so they know you have a new baby and can contact you if needed.

Family Doctor (GP)
Your GP team provides a range of free services for children from birth to 13 years of age. Please contact your GP team to confirm that your baby is enrolled before their 6 week check.

Well Child Tamariki Ora
Well Child Tamariki Ora providers give you information and advice about caring for your new baby. They provide regular checks to make sure your baby is growing and developing well. Please let your midwife know which provider you chose.

Newborn Hearing Screening
Your baby will be offered a hearing screening test to check whether they can hear well. If your baby has hearing loss they can get expert help which is important for language, learning and social development.

Oral Health
Your baby's first teeth appear about 5 to 6 months of age. Information about how to care for your baby's teeth and basic dental treatment is free for all children. Dental care and advice in baby's first year can help protect their teeth for life.

National Immunisation Register
The National Immunisation Register records childhood immunisations. This helps your GP team ensure your baby has all their immunisations on time. Immunisations protect new babies from serious diseases.

BCG Vaccination - Tuberculosis
Tuberculosis (TB) is an infectious disease. Some babies risk getting TB if they live with people from countries where TB is common. Your midwife will discuss it with you your if your baby is eligible for a free BCG vaccination.

Classification number: 010-02-01-043 (Review date: June 2019)

Your midwife and your Well Child Tamariki Ora health book has more information on all these services. If you do not want these services you can decline when you are contacted.

You have the right to see your information and to ask for your information to be corrected if you do not believe it is accurate. **Some services may incur a cost if your baby is not a New Zealand citizen.*

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Waitemata District Health Board
Best Care for Everyone

Auckland DHB Strategy Supports New Zealand Health Strategy Themes

Recommendation

That the Board:

1. **Endorse the initial examples of DHB activity against the five national strategic themes**
2. **Note how the Auckland DHB strategic themes align and support the New Zealand Health Strategy**
3. **Note that quarterly reporting to the Ministry of Health must now include information on DHB activity that progresses the New Zealand Health Strategy.**

Prepared by: Julie Helean, Assistant Director Strategy
Approved/Endorsed by: Dr Andrew Old, Chief of Strategy, Participation and Improvement and ELT

1. Auckland DHB Strategy Supports the National Health Sector Strategy

The New Zealand Health Strategy was released by Minister Coleman in April 2016. At the time of release Auckland DHB was also finalising our longer term strategy. Both local and national strategies contain strategic themes which focus activity on critical areas to develop in future. Focusing attention on longer-term health outcomes helps health providers across the whole system to concentrate effort in areas where we face the greatest challenges. The strategies help us to see how the shorter-term outputs covered in our annual plan contribute to improved health outcomes over time.

2. Changes to Quarterly Reporting

Following the release of the New Zealand Health Strategy, DHB Chief Executives committed to progress the actions outlined in the roadmap attached to the strategy. Our Auckland DHB Annual Plan for 2016/17 shows how our local activity supports the future direction set for the New Zealand health sector. The Ministry of Health has added a new deliverable to DHB quarterly reporting for 2016/17 in order to capture information on how DHBs are supporting delivery of the strategy. As part of the new reporting requirement, each DHB will provide an example to highlight an action, initiative or activity delivered against each of the five strategic themes. These highlights will be included on the DHB quarterly dashboards for the Minister.

The following tables show how Auckland DHB intends to report for the first quarter of 2016/17. We will show how our seven strategic themes (and our 42 priority actions) align to the five national ones. We also add an example that shows tangible activity in support of the five strategic themes. The executive leadership team is currently gathering examples of activity and highlights to report for this first quarter. Draft examples are included and these will be finalised by the deadline of October 20.

The first table presents the NZ Health Strategy themes in five columns. In each column we have mapped where Auckland DHB activity (themes and priority actions) is best aligned to the national themes. There is considerable overlap between our themes and the national ones, and many of our priorities (numbered below) could be placed in several columns. The table below simply shows the main and most direct link between our strategic themes and government themes.

Aligning the seven Auckland DHB strategic themes to those in the New Zealand Health Strategy

Auckland DHB strategic themes are aligned to the NZ Health Strategy				
People-powered	**Closer to home**	**Value and high performance**	**One team**	**Smart system**
Community, family/whānau and patient-centric model of healthcare *Auckland DHB priorities:* **1.** Continuous connections and partnerships with local populations, to achieve shared health service planning and delivery, and with a focus on areas and groups with the highest need (our localities approach). **2.** Improve the experience and choice that patients have when they use our services, by partnering with people and service users in the design, delivery and evaluation of services, with an initial focus on diabetes and mental health. **3.** Reorient services so there are seamless pathways across settings, and navigation services for patients trying to coordinate complex or multiple treatment pathways, with a focus on Māori, Pacific, older people and those managing diabetes. **4.** Invest in a greater range of supports for services which 'stand beside' patients and families/whānau, for example care navigation. **5.** Support people to manage their own care record and care plan with specific measures to judge how well we respond. **6.** More people have Advance Care Plans, with supports to ensure plans get actioned when the person is unable to. **Emphasis and investment on treatment and keeping people healthy** *Auckland DHB priorities:* **7.** Implement programmes across the whole health system that help people to make the lifestyle changes needed to drive down rates of smoking, heart disease, diabetes, cancer and mental health problems. **8.** Advance child health through the Child Health Plan, taking a focus on vulnerable children and	**Service integration and/or consolidation** *ADHB priorities:* **13.** Enhance the quality and integration of services available to the whole Auckland DHB population, while making sure that resources are directed to those with greatest need, with a focus on reducing inequity. **14.** Where indicated, move less complex care into community settings and reserve expensive hospital facilities for complex care, and include more options for acute care in the community. **15.** Implement a Community Nursing Strategy that gets the best use of community nursing skills for patients and family, and for people with long term conditions. **16.** Implement the Whānau Ora Network and related model of care, accelerating work across services and sectors that achieves the greatest gain for Maori, Pacific and other communities with unequal health outcomes. **17.** Transition plans and other recovery supports in place for people receiving help for mental health and addiction problems, with a special focus on children and young people. **18.** Develop a Diabetes Model of Care that aligns services across Auckland and Waitemata DHBs using a whole-of-system approach. **19.** Support primary care development through capacity and capability development programmes (for example Safety in	**Emphasis on operational and financial sustainability** *Auckland DHB priorities:* **35.** Increase productivity and the best use of resources by using hospital services more wisely, with an initial focus on discharge planning, improved patient pathways, and day services. **36.** Develop our people so we get the best from our workforce. **37.** Develop a 10-25 year facilities plan for all DHB sites including improving the data on our capital assets. **38.** Redesign the model of care for outpatients so this is more patient-centric, freeing up staff and patients' time and reducing costs **39.** Review processes for procurement of goods and services to ensure value. **40.** Complete a review of our tertiary services to get the right mix of service and volume of service available to patients outside our DHB with a focus on ensuring the revenue covers the treatment of patients referred from other DHBs. **41.** Identify opportunities for public/private work which increases efficiency and/or generates revenue. **42.** Identify other opportunities for revenue through maximising our retail offerings, investigating judicious use of advertising and exploring our 'exportable' commodities, for example training.	**Outward focus and flexible service orientation** *Auckland DHB priorities:* **31.** Strengthen the health workforce by developing healthier workplaces, promoting cultural diversity and programmes that empower workers to be proactive. **32.** Develop more skills training and mentoring for staff in leadership positions and use these skills to build better staff engagement and sense of satisfaction. **33.** Explore opportunities to partner with businesses, both to enhance our internal capability through learning from others and to enable us to do more and faster, through co-investment, public/private partnerships or similar. **34.** Expand the range of rehabilitation and support services through a 'needs assessment' process which makes sure all the services needed are well coordinated.	**Intelligence and Insight** *Auckland DHB priorities:* **21.** Work with our neighbour DHBs to develop a regional patient IT system that integrates medical records and gives patients access to these. **22**. Improve the quality of the data we collect, to better understand trends, to gain accuracy in ethnicity data, and to improve how we manage risks in the provider arm. **23.** Develop a baseline for diabetes and cardiovascular disease indicators to track progress on these diseases. **24.** Explore the use of technology for the development of virtual medicine and personalised healthcare. **25.** Link the systems that collect data and use this to better understand, track and drive down DNA rates for Māori and for Pacific and other underserved groups. **26.** Collaborate with the Auckland metro DHBs to advance clinical developments, investigating where to extend use of, or invest in, electronic technology, in order to make it easier for patients to get the care and support they need within their homes, or within their community. **Consistent evidence-informed decision making and practice** *Auckland DHB priorities:* **27.** Address every issue that compromises our ability to guarantee world-class health services, with a goal of the provider being a leader in the quality and safety of specialist care. **28.** Continue to support the patient safety and clinical governance activities of both our provider and our primary care and community partners, through a stronger focus on

Auckland DHB strategic themes are aligned to the NZ Health Strategy				
People-powered	**Closer to home**	**Value and high performance**	**One team**	**Smart system**
those who are currently missing out on services and supports. **9.** Improve Māori health through increasing engagement with iwi, Primary Health Organisations, and by expanding access to other culturally appropriate health care and whānau ora supports in the community. **10.** Focus on timely access to early interventions and to effective treatments, with an emphasis on elective surgery, 'high risk individuals' in the community, and people with a high risk of cancer. **11.** Work with other sectors and with communities to address the factors that contribute to morbidity and mortality associated with mental health problems and mental illness. **12**. Improve the management of long term conditions such as cardiovascular disease, diabetes and mental illness, by providing more of the required support in community settings.	Practice) and support for the Healthcare Home model. **20.** Work with the northern region DHBs to consolidate regional services and agree: the standards and consistency of care delivery across our region; the models of care that will get the best clinical outcomes; and the best use of the region's health resources.			applied research, on quality IT systems, on reduced variation in clinical practice, and better benchmarking, for example Health Round Table. **29.** Standardise care and benchmarking by reducing clinical variation, improving diagnostic testing, and making better use of the Regional Clinical Practice Committee to guide decision making. **30.** Develop plans and service options based on evidence, specifically: - improve the safety of care provided to inpatients after-normal working hours - programme for people with dementia and their family/whānau carers - managing deteriorating patients - redesigning our outpatient model - critically reviewing our acute and elective models of care.

11.1

Examples of DHB activity against the five national strategic themes

Delivery of the NZ Health strategy – Auckland DHB highlights for the quarter				
People-powered	**Closer to home**	**Value and high performance**	**One team**	**Smart system**
The Design for Health and Wellbeing Lab In collaboration with AUT, our in-hospital design lab involves patients, DHB staff, AUT designers and students to create solutions that improve various aspects of the healthcare experience of patients, families and staff at Auckland City Hospital.	**The national community Falls Prevention Programme** Developed in conjunction with ACC and Waitemata DHB, this programme focuses on providing in-home and community support to minimise falls risk in people aged over 65 years.	**Formation of a workgroup to focus on savings.** A working group has been formed to concentrate on efficiencies that will ensure the organisation runs to budget. Many initiatives from this group are already in play, specifically efficiencies around the smooth transfer of patients to our transition lounge which expedites a safe discharge for patients.	**The Stroke Rehabilitation Unit** A more integrated system where primary and secondary care clinicians work collaboratively with clear and open lines of communication will ensure that appropriate healthcare services are delivered in the right place at the right time. We continue to work with our Alliance Leadership Team (ALT) to improve the integration and optimal configuration of services, including shifting services, to ensure patients receive more effective and co-ordinated services closer to home and provided by one team.	**CareConnect web eReferrals** Together with Counties Manukau and Waitemata DHBs, Auckland DHB introduced an electronic referral system in 2012. This system replaces the traditional paper-based referral system, providing faster and more accurate transfer of information between primary and secondary care providers.