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

Time: 2:30pm

Agenda
Meeting of the Board
01 April 2015

Board Members
Dr Lester Levy (Chair)
Jo Agnew
Peter Aitken
Doug Armstrong
Judith Bassett
Dr Chris Chambers
Dr Lee Mathias (Deputy Chair)
Robyn Northey
Morris Pita
Gwen Tepania-Palmer
Ian Ward

ADHB Executive Leadership
Ailsa Claire Chief Executive Officer
Simon Bowen Director of Health Outcomes – AHB/WDHB
Margaret Dotchin Chief Nursing Officer
Christine Etherington Director of Strategic Human Resources
Naida Glavish Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Dr Debbie Holdsworth Director of Funding – ADHB/WDHB
Dr Andrew Old Chief of Strategy, Participation and Improvement
Rosalie Percival Chief Financial Officer
Linda Wakeling Chief of Intelligence and Informatics
Sue Waters Chief Health Professions Officer
Dr Margaret Wilsher Chief Medical Officer

ADHB Senior Staff
Bruce Levi General Manager Pacific Health
Auxilia Nyangoni Deputy Chief Financial Officer
Marlene Skelton Corporate Business Manager
Gilbert Wong Director Communications

(Other staff members who attend for a particular item are named at the start of the respective minute)

Apologies Members:

Apologies Staff: Linda Wakeling Chief of Intelligence and Informatics

Register of Interests
Does any member have an interest they have not previously disclosed?
Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

Karakia

Agenda
Please note that agenda times are estimates only

2:30pm

1. Attendance and Apologies

2. Conflicts of Interest

2:35pm

3. Confirmation of Minutes

3.1 Confirmation of Minutes – 18 February 2015

3.2 Confirmation of the Minutes of the Special Meeting of the Board – 11 March

Auckland District Health Board
Board Meeting 01 April 2015
2015

2:40pm  4.  **Action Points 18 February 2015**

2:45pm  5.  Chair’s Report

6.  **Chief Executive’s Report**

2:50pm  7.  Health and Safety Scorecard

* (This item is reported quarterly)

8.  Lift the Health of People in Auckland city - Nil

9.  Live Within Our Means

9.1  **Funder Report**

3:00pm 10.  General Business

10.1  **Te Kaunihera Kaumatua Terms of Reference**

11.  **Resolution to exclude the public**

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**Next Meeting:**  Wednesday, 13 May 2015 at 2:00pm  
A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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*Hei Oranga Tika Mo Te Iti Me Te Rahi*

*Healthy Communities, Quality Healthcare*
# Attendance at Board Meetings

<table>
<thead>
<tr>
<th>Members</th>
<th>18 Feb. 15</th>
<th>01 Apr. 15</th>
<th>13 May. 15</th>
<th>24 Jun. 15</th>
<th>05 Aug. 15</th>
<th>16 Sep. 15</th>
<th>28 Oct. 15</th>
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<td>Lester Levy (Chair)</td>
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Key: 1 = present, x = absent, # = leave of absence
Conflicts of Interest Quick Reference Guide

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

An “interest” can include, but is not limited to:

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

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

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

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

IMPORTANT

If in doubt – declare.

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

## Register of Interests – Board

<table>
<thead>
<tr>
<th>Member</th>
<th>Interest</th>
<th>Latest Disclosure</th>
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<tbody>
<tr>
<td>Lester LEVY (Chair)</td>
<td>Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman)</td>
<td>19.02.2015</td>
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<td></td>
<td>Chairman - Auckland Transport</td>
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<td>Independent Chairman - Tonkin and Taylor Ltd (non-shareholder)</td>
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<td>Director - Orion Health (includes Director – Orion Health Corporate Trustee Ltd)</td>
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<td>Professor (Adjunct) of Leadership - University of Auckland Business School</td>
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<td>Head of the New Zealand Leadership Institute – University of Auckland</td>
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<td>Member – State Services Commission Performance Improvement Framework Review Panel</td>
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<td>Director and sole shareholder – Brilliant Solutions Ltd (private company)</td>
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<td>Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder)</td>
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<td>Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder)</td>
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<td>Trustee – Levy Family Trust</td>
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<td>Trustee – Brilliant Street Trust</td>
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<tr>
<td>Jo AGNEW</td>
<td>Professional Teaching Fellow - School of Nursing, Auckland University</td>
<td>01.03.2014</td>
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<td>Appointed trustee Starship Foundation</td>
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<td>Casual Staff Nurse - ADHB</td>
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<td>Peter AITKEN</td>
<td>Pharmacy Locum - Pharmacist</td>
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<td>Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd</td>
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<td>Shareholder/ Director - Pharmacy New Lynn Medical Centre</td>
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<td>Doug ARMSTRONG</td>
<td>Fisher and Paykel Healthcare</td>
<td>11.03.2015</td>
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<td>Trustee – Woolf Fisher Trust</td>
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<td>Judith BASSETT</td>
<td>Fisher and Paykel Healthcare</td>
<td>14.05.2014</td>
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<td>Westpac Banking Corporation</td>
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<td>Chris CHAMBERS</td>
<td>Employee - ADHB</td>
<td>26.01.2014</td>
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<td>Wife is an employee - Starship Trauma Service</td>
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<td></td>
<td>Clinical Senior Lecturer in Anaesthesia - Auckland Clinical School</td>
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<td>Member – Association of Salaried Medical Specialists</td>
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<td>Associate - Epsom Anaesthetic Group</td>
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<td>Shareholder - Ormiston Surgical</td>
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Auckland District Health Board
Board Meeting [Click here to enter meeting date]
<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Experience</th>
<th>Date</th>
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<tbody>
<tr>
<td>Lee MATHIAS</td>
<td>Chair - Counties Manukau Health/Deputy Chair - Auckland District Health Board/Chair - Health Promotion Agency/Chair - Unitec/Director - Health Innovation Hub/Chair - Health Alliance Limited/Chair - Health Alliance (FPSC) Limited/Chair - IAC IP Limited/Director/shareholder - Pictor Limited/Director - Lee Mathias Limited/Director - John Seabrook Holdings Limited/Advisory Chair - Company of Women Limited/Trustee - Lee Mathias Family Trust/Trustee - Awamoana Family Trust/Trustee - Mathias Martin Family Trust</td>
<td>23.10.2014</td>
</tr>
<tr>
<td>Robyn NORTHEY</td>
<td>Self-employed Contractor - Project management, service review, planning etc./Board Member - Hope Foundation/Trustee - A+ Charitable Trust</td>
<td>20.06.2012</td>
</tr>
<tr>
<td>Gwen TEPANIA-PALMER</td>
<td>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</td>
<td>02.04.2013</td>
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<tr>
<td>Ian WARD</td>
<td>Board Member - NZ Blood Service/Director and Shareholder – C4 Consulting Ltd/CEO – Auckland Energy Consumer Trust/Shareholder – Vector Group</td>
<td>09.07.2014</td>
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Minutes
Meeting of the Board
18 February 2015

Minutes of the Auckland District Health Board meeting held on Wednesday, 18 February 2015 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 2:30pm

Board Members Present
Dr Lester Levy (Chair)
Jo Agnew
Peter Aitken
Doug Armstrong
Judith Bassett
Dr Chris Chambers
Dr Lee Mathias (Deputy Chair)
Gwen Tepania-Palmer
Ian Ward

Auckland DHB Executive Leadership Team Present
Ailsa Claire Chief Executive Officer
Simon Bowen Director of Health Outcomes – ADHB/WDHB
Margaret Dotchin Chief Nursing Officer
Christine Etherington Director of Strategic Human Resources
Naida Glavish Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Dr Debbie Holdsworth Director of Funding – ADHB/WDHB
Rosalie Percival Chief Financial Officer
Linda Wakeling Chief of Intelligence and Informatics
Sue Waters Chief Health Professions Officer

Auckland DHB Senior Staff Present
Jo Brown Funding and Development Manager Hospitals
Julie Helean Assistant Director Strategy
Bruce Levi General Manager Pacific Health
Bruce Northey Legal Counsel
Marlene Skelton Corporate Business Manager
Gilbert Wong Director Communications

(Other staff members who attend for a particular item are named at the start of the minute for that item)

1. APOLOGIES

That the apologies of Board Member Morris Pita be received.

That the apologies of Executive Leadership Team Members, Dr Andrew Old, Chief of Strategy, Participation and Improvement and Dr Margaret Wilsher, Chief Medical Officer be received.

2. CONFLICTS OF INTEREST

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

3. CONFIRMATION OF MINUTES 10 December 2014 (Pages 8-20)

Resolution: Gwen Tepania-Palmer / Seconded Judith Bassett

That the minutes of the Board meeting held on 10 December 2014 be confirmed as a true and accurate record.

Carried
4. **ACTION POINTS 10 DECEMBER 2014** (Page 21)

There was no discussion.

5. **CHAIR'S REPORT**

Lester Levy drew Board Members attention to the Letter of Expectation recently released by the Minister of Health. He commented that it signalled a subtle change in direction for healthcare and that any change would likely occur over time.

Lester Levy advised that the shift from Health Benefits Ltd to another organisation was under investigation and that a report on this situation was due at the end of March.

6. **CHIEF EXECUTIVE'S REPORT** (Pages 22-29)

The Chief Executive asked that her report be taken as read, highlighting:

- Auckland District Health Board celebrated the achievements of early career researchers at the Young Investigator Awards 2014 held at the Grafton Campus of the Faculty of Medical and Health Sciences. The winners received prizes donated by A+ Charitable Trust. First place winner, Kylie Russell (Nutrition Services) won the award for her presentation "Effect of Preoperative Immuno-nutrition on Outcome in Patients Undergoing Liver Resection: A Randomised Pilot Study. Nicholas Gow (LabPlus) received the second place award for his presentation "The role of echocardiography in Staphylococcus aureus bacteraemia at Auckland City Hospital."

- Forty seven people were nominated as ‘Local Heroes’ during December and January. Local hero awards were presented to Ann Verbeemen and Lynley Frame.

- Auckland City Hospital was affected by a waste water leak on Auckland Anniversary Weekend that affected part of Level 5 and Level 6 of the Support Building. No inpatient areas were affected. It did however, lead to a range of out-patient clinics being permanently relocated to Greenlane Clinical Centre. The staff café has been opened to the public with the temporary closure of Muffin Break. Engagement with staff and visitors is being undertaken to determine views about this being a permanent move. Thanks to good organisation and goodwill, the inconvenience for patients has been kept to a minimum.

- In January, Starship Children’s Hospital admitted eight patients who had serious complications following traditional circumcision in the Pacific community.

- Auckland DHB is currently not achieving the ED target for Adult Acute Patient Flow. The target has not been met due to unprecedented numbers of adult and child patients presenting to the emergency departments. This level of activity appears to be the new norm and the solution is likely to require additional resource to solve.

- Plans to develop a service centre in Tamaki are coming together in discussion with Ngati Whatua Orakei. The centre proposals include a new community renal dialysis centre and discussions are underway with the Women’s Health, Community and Long Term Conditions and Mental Health directorates to develop new models of care.
for key services that could be delivered from such a centre. This partnership is about how to best serve the health needs of this local population.

- Our savings program is on track to achieve an overall target of $49.6m with YTD savings to November of $20.7m versus a budget of $19.8m, supporting our year-end breakeven target.

- The Alliance Leadership Team (ALT) met again on 12 February to consider a diabetes CVD performance framework to measure how well diabetic care is delivered. The Auckland Regional Clinical Governance Group have reviewed and endorsed the framework. This framework is based on the Ministry of Health quality framework released last year. The ALT has agreed that all Service Level Alliance will report up to the Alliance to enable consistency of approach and alignment of outcomes and work programmes.

That the report be received.

7. LIFE THE HEALTH OF PEOPLE IN AUCKLAND CITY

7.1 Health Needs Assessment (Pages 30-110)

Simon Bowen, Director of Health Outcomes, Jean Wignall, Health Outcomes Analyst and Peter Sandiford, Clinical Director, Health Gains were in attendance to answer questions in relation to the Health Needs Assessment 2015.

Simon Bowen asked that the report be taken as read and briefly outlined key points as follows:

- The self-reported health status of our population is overall very good. The mortality rates from cardiovascular disease and cancer, the two biggest causes of avoidable deaths, have declined steadily over the last decade.

- The children in our region are experiencing a great start to life with a much lower rate of infant mortality than is observed nationally and our immunisation rates are very high, with nearly 95% of our 8 month old children and 96% of our two year old children, fully immunised.

- Smoking, the largest cause of preventable ill health, declined substantially between 2006 and 2013, with rates falling from 16.5% to 11% of adults. We now have the lowest rate of smoking of any DHB in the country.

- The key health challenges come from inequalities in health outcomes particularly with the Māori and Pacific population who live on average six to seven years less and have hospitalisation and mortality rates from many chronic diseases two to three times higher than our European/Other population. The main drivers of this equity gap are circulatory disease, cancer, diabetes and injuries. Nearly 20% of our population live in areas ranked as highly deprived, concentrated in
Rosebank/Avondale in the west, Mt Roskill and the CBD and the eastern and southern areas from Glen Innes to Mt Wellington and Otahuhu. These people experience poorer health outcomes than those in more affluent areas.

- In 2011, there were 620 potentially avoidable deaths of Auckland residents (26% of the total), 33% of which were amongst the Maori and Pacific populations. Of these deaths, half could have been avoided through primary prevention, for example through adopting healthier lifestyles; a quarter could have been prevented by identifying and managing problems like hypertension before they caused illness; and a quarter could have been avoided through prompt identification and treatment.

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

- Lester Levy commenting that the suicide rate for Auckland DHB was slightly lower than the national average and questioning what it was like in relation to other major international cities. He advised that the rate was still a cause for concern.

- Simon Bowen advised that a review of the current Auckland DHB plan around suicide and the development of one for Waitemata DHB were underway.

- Advice was given that this document would be disseminated to the wider public by placing it on the external website but that it was not planned to do an extensive hard copy print run of the document. Board members felt that it should be brought to the media’s attention and that they be encouraged to produce a factual in depth article.

- Robyn Northey commented that Auckland Council had produced a health needs assessment and wanted to know if collaboration had occurred and if it had not, she saw this was an opportunity to develop a further working relationship with the Council.

That the Health Needs Assessment 2015 report be received.

Carried

8. **LIVE WITHIN OUR MEANS**

8.1 **Funder Report (Pages 111-121)**

Debbie Holdsworth, Director Funding advised that:

- This is the first Funder report to the Board providing an overview of funder activity and areas of priority where these matters are not already being dealt with in other Board committees. Over time this report will provide a more detailed funder view of provider performance and funding arrangements for the Auckland DHB population.

- The new cancer target requiring 85% of patients referred with a high suspicion of cancer to be treated within 62 days of referral by June 2016 is a very challenging target. The Cancer Service has implemented significant service improvement to achieve and sustain 100 per cent compliance with the historical cancer target relating to waiting times for chemotherapy and radiotherapy. However, the new FCT
target relates to the whole system of delivery from referral to treatment and encompasses a range of specialist services beyond the Cancer Service including diagnostic and surgical. Auckland DHB’s current performance against the FCT is 54.5 per cent and a structured whole of organisation approach will be needed to achieve the required level of increased performance by year end.

- The Funder has initiated planning to support the Auckland DHB Tertiary Services Review (TSR) and there is an expectation that this process will be accelerated to be completed prior to the scheduled August timeframe. It has been agreed that the TSR will commence in Child Health services.

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

- Confirmation that the Auckland Funder cannot afford the forecast in growth and that there is a need to make decisions about activities undertaken and how best to reprioritise funding. Ailsa Claire advised that a focussed discussion had begun around activity that could be removed from services.

- Advice that the new cancer target will be a challenge to achieve in light of the fact that Auckland DHB receives a large number of patients from other District Health Boards too.

Action

That Dr Richard Sullivan, Director Cancer and Blood provide a report to the next meeting of the Board detailing strategies to meet the new cancer target.

That the Auckland District Health Board receives the Funder Report dated February 2015.

Carried

9. GENERAL BUSINESS

9.1 Strategy and Values for Auckland DHB (pages 122-138)

Julie Helean, Assistant Director Strategy and Christine Etherington, Director of Strategic Human Resources asked that the report be taken as read, noting that what was before the Board was an updated version of the Strategy and Values previously considered at the December Board meeting.

Board members were invited to comment.

The Feedback for noting is as follows:

General comment

- Lee Mathias felt that the word Mana” did not adequately convey the additional
concept of being able to “establish and know my place in the world”. Naida Glaavish was asked whether the word “Manaaki” covered that concept. Naida explained that Mana had several streams of meaning; inherited and undisputed personal prestige and secondly the ability of an individual to increase or decrease one’s personal prestige based on personal behaviour.

- Lester Levy felt that the challenge would lie with getting a large number of people to reach a common understanding of what were quite simple concepts that were being made too complex. There is a need to consider the practical application of the values and to keep the concepts simple enough to effectively work with.

- There was general consensus that the words sound like those used by any other organisation and don’t necessarily clearly identify Auckland DHB as a health organisation with a distinctive place and role in the community. There needs to be an emotional resonance with staff so that behaviour displayed matches that which is written down.

- It was agreed that the rollout needs to be led by an active modelling of the required change in behaviour which is then observed by the wider staff within the organisation. This will come from the executive team, directors, managers and team leaders.

- There was an acknowledgement that it takes time to fully embed Values in a large organisation, in a way that has a positive impact on organisational culture.

Specific Comment

- Page 125 - A word other than “commissioning” and not “Planning and Funding Planning be found to describe the funding activity.

- Page one of strategy, last paragraph: The board is not comfortable with the assertion that, “By 2020 we will be delivering truly world-class health, healthcare and disability services that are cohesive, equitable and, most importantly, sustainable over the long term.” The Board acknowledges that it is important to be aspirational but would like a goal that is realistic in the timeframe given.

- There was some debate and a divergence of opinion over the use of the expression, “We need to get tough on the right problems”. It was agreed to leave as is.

- Page 129 (6 of strategy) Link the statement about autonomy to evidence. As it is now it sounds very opinionated.

- Page 138 (15 of strategy) The purpose is not inspiring. It needs to be rewritten so that it captures the imagination. There is nothing in particular that links it with Auckland DHB.

- Place more comment throughout the document that differentiates Auckland DHB as a centre that offers specialist care and profiles its ability to offer consistent and quality 24 hour, seven day a week care.
Make changes to the strategy on the basis of the feedback given today, and proceed to consultation.

Make changes to the values on the basis of the discussion and send the re-work back to board members (by email with a 24 hour turn around).

**Resolution**: Moved Lester Levy / Seconded Doug Armstrong

That the Board; subject to the comment made at this meeting and a further 24 hour opportunity being provided for Board member comment to be collected and added,

- approve the Strategy for Auckland DHB to be taken out for stakeholder feedback
- approve that the set of Values be adopted as final.

**Carried**

9.2 **Waitemata DHB and Auckland DHB Maori Workforce Strategy 2014** (139-169)

Margaret Dotchin, Chief Nursing Officer, and Tereki Stewart, (Manukura Hauora, Te Rūnanga o Ngāti Whātua) were in attendance to speak to the report highlighting that:

- The key objective of the strategy is to increase the number in the Māori health and disability workforce from 3-5% to 13% everywhere by 2020. It addresses a significant issue where the current percentage of Maori in the health workforce is extremely low and in fact has remained stagnant over the last five years.
- The strategy is designed to maximise the contribution of all health care providers in achieving health equity for Māori and is about doing something new and different to stimulate the required growth.

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

- Comment from Judith Bassett applauding the approach as a sensible one but cautioning staff to not underestimate the difficulty in finding candidates. She suggested that the Board should look to and actively market the strategy with the current District Health Board Maori workforce, encouraging them to own it and push it with family and friends.
- Gwen Tepania-Palmer on behalf of the Board acknowledged the great amount of work that had been undertaken, commenting small steps led to a solid development in the future.
- Lee Mathias commented that there was a lot of work to be done with schools to ensure they were providing the right encouragement and information to students intending to enter tertiary education focused on the health sector.

**Resolution**: Moved Judith Bassett / Seconded Doug Armstrong
That the Board approve the Waitemata – Auckland DHB Maori Health Workforce Development Strategy 2014-2017 and that the Board be provided with quarterly reports on progress against the strategy.

Carried


Bruce Northey, Legal Counsel was in attendance and advised that the directive issued by the Minister of State Services and the Minister of Finance is the equivalent of a statute in relation to compliance obligations. If District Health Boards do not comply then that is tantamount to instigating a judicial review. Therefore, there is an urgent need to have a policy and supporting practices in place for rules of sourcing.

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

- Advice that a regional approach would be adopted to the development of a policy and supporting practices in place for rules of sourcing. The issue had been discussed at the regional CFO’s meeting and would be put before other Regional District Health Boards.

Action

That the Chief Finance officer and Legal counsel undertake to ensure that the matter of development of a policy and supporting practices being put in place for rules of sourcing is placed on the agenda of the other Regional District Health Boards.

Resolution: Moved Robyn Northey / Seconded Lee Mathias

That the full Board notes:

- The mandating of the application by all District Health Boards from 1 February 2015 of the Government Rules of Sourcing (“the Rules”) in respect to procurement.
- The on-going health sector consultation with the Ministries of Health and Business Innovation and Employment over the application of the Rules.
- The obligation in the Rules for each agency to have procurement policies in place that incorporate compliance with Rules; District Health Boards will also need to incorporate compliance with PHARMAC and Health Benefits Ltd managed procurement arrangements.
- Agree to proceed to document a procurement policy which interprets the Rules:
  - Not applying to Funding, being service agreements issued under s26 of the New Zealand Public Health and Disability Act.
  - As being subject to any specific statutory or similar obligations applying to District Health Boards in respect to procurement.
  - Definition of ‘health services’ and ‘welfare services’ as aligned to the same or similar definitions in the New Zealand Public Health and Disability Act.
10. **RESOLUTION TO EXCLUDE THE PUBLIC** (Pages 173-177)

**Resolution:** Moved Chris Chambers / Seconded Jo Agnew

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

<table>
<thead>
<tr>
<th>General subject of item to be considered</th>
<th>Reason for passing this resolution in relation to the item</th>
<th>Grounds under Clause 32 for the passing of this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confirmation of the Public Excluded Minutes of the Board Committee Meeting 10 December 2014</td>
<td>Confirmation of Minutes As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&amp;D Act 2000.</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>2. Action Points 10 December 2014</td>
<td>Confirmation of Action Points As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&amp;D Act 2000.</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>3.1 Auckland DHB Health and Safety Audit Report</td>
<td>Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>3.2 Critical Risk – Escalation Report</td>
<td>Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which</td>
</tr>
</tbody>
</table>
3.3 Critical Risk – Management Response

Obligation of Confidence
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]

That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

3.4 Health and Safety Report

Obligation of Confidence
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]

That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

3.5 Health and Safety Scorecards

Obligation of Confidence
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]

That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
| 4.1 | Financial 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] |
| 5.1 | CPHAC Recommendations - Nil |  |
| 6.1 | Anaesthesia Machines | Commercial Activities  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| 6.2 | Clinical Sterile Supply Department Tracking System | Commercial Activities  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| 6.3 | Purchase of Replacement Gamma Camera | Commercial Activities  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| 6.4 | Fleet Echo Machines 2014/2015 Business Case | Commercial Activities  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
<table>
<thead>
<tr>
<th>Section</th>
<th>Commercial Activities</th>
<th>Official Information Act 1982 s9(2)(i)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.5</td>
<td>Hybrid Theatre Additional Funding Request</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
</tr>
<tr>
<td>7.1</td>
<td>Human Resources Report</td>
<td>Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]</td>
</tr>
<tr>
<td>8.1</td>
<td>Annual Plan</td>
<td>Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]</td>
</tr>
<tr>
<td>9.1</td>
<td>Quality Account Report – Verbal Update</td>
<td>Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]</td>
</tr>
<tr>
<td>10.1</td>
<td>Commercial Activities</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
</tbody>
</table>
### Community Laboratory Services Transition Update

To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]

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]

### 10.2 Palliative Care Funding

Commercial Activities
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(ii)]

Obligation of Confidence
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]

### 10.3 Confirmation of Addendum Confidential Minutes 10 December 2014

Confirmation of Minutes
As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000.

That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

---

**Carried**

The meeting closed at 5.25pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 18 February 2015

Chair: ___________________________ Date: ___________________________

Lester Levy
Minutes of the Auckland District Health Board special meeting held on Wednesday, 11 March 2015 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 7:30am

<table>
<thead>
<tr>
<th>Board Members Present</th>
<th>Auckland DHB Executive Leadership Team Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jo Agnew</td>
<td>Ailsa Claire Chief Executive Officer</td>
</tr>
<tr>
<td>Peter Aitken</td>
<td>Simon Bowen Director of Health Outcomes – AHB/WDHB</td>
</tr>
<tr>
<td>Doug Armstrong</td>
<td>Margaret Dotchin Chief Nursing Officer</td>
</tr>
<tr>
<td>Judith Bassett</td>
<td>Dr Debbie Holdsworth Director of Funding – ADHB/WDHB</td>
</tr>
<tr>
<td>Dr Lee Mathias (Board Deputy Chair)(Chair)</td>
<td>Rosalie Percival Chief Financial Officer</td>
</tr>
<tr>
<td>Robyn Northeay</td>
<td>Linda Wakeling Chief of Intelligence and Informatics</td>
</tr>
<tr>
<td>Morris Pita</td>
<td>Dr Margaret Wilsher Chief Medical Officer</td>
</tr>
<tr>
<td>Ian Ward</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Auckland DHB Senior Staff Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marlene Skelton Corporate Business Manager</td>
</tr>
<tr>
<td>Gilbert Wong Director Communications</td>
</tr>
</tbody>
</table>

(Other staff members who attend for a particular item are named at the start of the minute for that item)

APOLOGIES

Resolution: Moved Robyn Northeay/ Seconded Peter Aitken

That the apologies of Dr Lester Levy (Chair), Dr Chris Chambers and Gwen Tepania-Palmer be received.

That the apologies of Auckland DHB Executive Leadership Team members, Christine Etherington, Director of Strategic Human Resources, Dr Andrew Old, Chief of Strategy, Participation and Improvement and Sue Waters, Chief Health Professions Officer be received.

Carried

CONFLICTS OF INTEREST

Lester Levy because of his interest relating to Orion Health does not receive Board papers that relate to matters that may include Orion Health. As the Northern Region Electronic Health Record (NEHR) Project involves Orion Health, Dr Levy has tendered his apology for this meeting.

Doug Armstrong advised that he is a trustee of Woof fisher Trust which holds shares in Orion Healthcare. Advice from Bruce Northeay, Legal Counsel is that as this is an investment by the Trust itself where the declarant is not a beneficiary and therefore is no personal advantage and no conflict of interest.
Robyn Northey advised that her son worked within the software industry but had no affiliation with Orion Healthcare.

Resolution to exclude the public from the meeting

Resolution: Moved Robyn Northey/ Seconded Peter Aitken

Recommendation

That in accordance with the provisions of Clauses 32 and 33, Schedule 4, of the New Zealand Public Health and Disability Act 2000 the public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

<table>
<thead>
<tr>
<th>General subject of item to be considered</th>
<th>Reason for passing this resolution in relation to the item</th>
<th>Grounds under Clause 32 for the passing of this resolution</th>
</tr>
</thead>
</table>
| 1. Northern Region Electronic Health Record Project | Commercial Activities  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]  
Obligation of Confidence  
The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] | That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |

The meeting closed at 9am.

Signed as a true and correct record of the Special Board meeting held on Wednesday, 11 March 2015

Chair: _______________________________ Date: _______________________________

Lee Mathias
### Action Points from Previous Board Meetings

As at Wednesday, 18 February 2015

<table>
<thead>
<tr>
<th>Meeting and Item</th>
<th>Detail of Action</th>
<th>Designated to</th>
<th>Action by</th>
</tr>
</thead>
</table>
| 8.1 18 Feb 2015  | **Funder Report – Cancer Targets**  
That a report be provided to the next meeting of the Board detailing strategies to meet the new cancer target. | Richard Sullivan       | (Transferred to HAC Agenda) 1 April 2015 |
| 9.3 18 February 2015 | **Rules of Sourcing**  
That the Chief Finance officer and Legal counsel undertake to ensure that the matter of development of a policy and supporting practises being put in place for rules of sourcing is placed on the agenda of the other Regional District Health Boards. | Rosalie Percival/Bruce Northey | Verbal Report                     |
Chief Executive’s Report

Recommendation

That the report be received.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. **Introduction**
   This report covers the period from 30 January to 13 March 2015. 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 External and internal communications

2.1.2 External

Auckland DHB has made public statements about:
- Publication of the 2013/14 Quality Account
- Increase in organ donation and transplantation
- DHB clinicians engaging in Health Quality and Safety Commission forum with Dr Atul Gawande

We received 177 requests for information, interviews or for access from media organisations in this period.

Media enquiries included interest in:
- Missing mother Laura Singh located in Warkworth
- Guardian application for medical care sought by a DHB to provide medical care to boy with HIV
- Employment Relations Authority claim against Auckland DHB by Service and Food Workers Union
- Request for interview on claims made by patient of the Regional Eating Disorders Service

Apart from those noted, 62 per cent of the enquiries over the period were routine enquiries about the status of patients hospitalised following crimes or accidents or who were of interest because of their public profile.

We received 28 Official Information Act requests in this period as opposed to 10 in the same period in 2014.
2.1.3 Internal

The Auckland DHB Intranet had a makeover with a new homepage design bringing it in line with the Auckland DHB branding. It also provides a more organised structure to make information easier to find. Next steps are to clean up existing content and move more information into the new style. Longer term this work prepares us for moving towards to a more functional platform.

A Welcome poster with multilingual greetings has been placed on level 4 at ACH. Contributions were asked for by staff to celebrate Mother tongue language day.

Two blog posts were published by the CE to celebrate excellence, a thank you for going the extra mile during the waste water leak and keeping an eye on the big picture how we are performing against the health targets.

Three Teamtalk blogs were published:
- A new year, a new you by Physiotherapist Laura Rensford – providing healthy lifestyle tips and advice.
- Unlocking the transport puzzle by Clare Thompson, General Manager Commercial Services – inviting people to take part in the transport survey.
- Peak Moments by Project Manager Hilary Boyd – encouraging involvement in patient experience week.

- 16 news updates were published on the DHB intranet.
- Six eNova (weekly electronic newsletters) were published.
- The February/March edition of Nova magazine was published.

2.1.4 Social Media

Our social media channels have the following audience size:
- Facebook – 2,680
- Twitter – 1,468
- Linkedin – 3,129

Most popular items of content during this period were:
- Our People – recognitions, Local Heroes, Starship doctor invents faster-to-build orthotics from 3D printer, Meet our waste orderlies
- Partnerships – Design Lab
- Participation campaigns – #ADHBtransport, #patientexperience
- Health campaigns – P.L.A.N for better care - pharmacy
- Events – Pharmacy Aseptic Production Unit celebrates 3rd anniversary
- Patient stories – Patient #highfives (compliments)
- Careers - Weekly job postings, Care Navigation
- Values – Welcome to recent starters, new welcome wall banner
- Sustainability tips
2.1.5 Events

Quality Grand Round: The spaces in which we deliver care matter
The first quality grand round for 2015 took place in February. Attendees heard what other health providers, including the Mayo Clinic and Utrecht Emergency Department, are doing to improve patient, family and staff experience through creating patient centred spaces.

Transport Survey
Staff were asked to take part in a survey to drill down and capture more details on how they travel to our sites, the challenges and the barriers they face in using alternative transport options like public transport, carpooling or cycling to work.

The survey ran from 16 February to 2 March 2015 with more than 2500 people taking part.

Medicine safety campaign
This campaign helped to ensure greater quality control in the use of medication. Messaging was targeted at both staff and patients. The campaign was part of a national campaign run by the HQSC.

2.1.6 People

Local Heroes
Seventeen people were nominated as ‘Local Heroes’ during February. The Local hero award was presented to Dr Chanel Prestige. Dr Prestige was nominated by the parent of a Starship patient who told us:

“My daughter received a successful kidney transplant in 2014 at Starship. As a result, we were able to travel to the USA to see relatives for the first time in several years. While we were in Hawaii, my daughter came down with some potentially transplant-related symptoms requiring attention. We ended up at a small US hospital late at night. Despite the hour, the US doctors were easily able to contact Chanel - who was on call for Ward 26B back in NZ. Likewise, Chanel called us personally late at night to reassure us that all was well and to provide follow up. Over the next few days, we sent her lab results by email and had at least one more phone call. Her advice was, as usual, spot on - and it made us all feel good to know that we could so easily contact one of our NZ doctors while in the USA and during the holidays. Chanel’s care and concern for my daughter and our family last month deserves of special mention as an Auckland DHB "local hero".

New Zealander of the Year
Dr Susan Parry, Clinical Director for Familial Gastrointestinal Cancer was included in the list of New Zealander of the Year. Dr Brian Broom, practicing physician and health educator in immunology and psychotherapy was included in the finalists list for the Metlifecare Senior New Zealander of the Year.

The annual New Zealander of the Year awards recognise, encourage and reward New Zealand’s most vital asset - its people. It is open to all New Zealanders and celebrates the contributions of Kiwis from all walks of life.

3. Strategy and Values

At the February meeting of the Board, members discussed the final Auckland DHB values and the process for helping staff and leaders put these into practice. In order to help staff remember the
four values, the order of the words has been changed so that English word is first, followed by its translation to Māori. Design students in the Design Lab are working on graphics to complement the values and help make them memorable. The Director of Strategic Human Resources has finalised a behaviour framework that explains, with examples, what each value looks like in action. A Grand Round on Values was held on 17th March and included a presentation by Tim Keogh, the UK based member of April Strategy who has been helping with us on this project. The February meeting of the Board also offered feedback on the Auckland DHB Strategy, indicating it should be modified and sent back to members for a quick turnaround. The changes were made and further comments have been received from the Board Chair. These points are still under discussion and relate to the feasibility of the ambitions expressed in the strategic plan. Meetings are taking place with Auckland health partners to achieve a system wide strategic intent.

The strategy team and the performance improvement team are assisting with the Commissioner Strategy map under development. The strategy map shows the programmes that are being put in place to achieve the There is similar strategic work occurring with primary care and iwi partners through the Alliance, in primary nursing and across the provider arm where the business plan will reflect the strategic programmes and business requirements of the provider arm. Help is provided to teams and directorates who are involved in planning. The immediate attention has been on completing the section on Strategic Intentions that is a part of our Annual Plan.

Achievement of the strategy is a core responsibility of the commissioning arm and work is being undertaken to develop a framework describing the scope and competencies. This will result in a development programme for commissioning which will also involve the Board.

4. Performance of the Wider Health System

4.1 National Health Targets Performance Summary

<table>
<thead>
<tr>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute patient flow (ED 6 hr)</td>
<td>Feb 94%, Target 95%</td>
</tr>
<tr>
<td>Improved access to elective surgery</td>
<td>99% to plan for the year</td>
</tr>
<tr>
<td>Shorter waits for radiation therapy &amp; chemotherapy</td>
<td>Feb 100%, Target 100%, Year to Date 100%</td>
</tr>
<tr>
<td>Better help for smokers to quit</td>
<td>Feb 95%, Target 95%</td>
</tr>
<tr>
<td>Cardiac bypass surgery</td>
<td>Feb 66 patients, Target &lt; 104</td>
</tr>
<tr>
<td>More heart &amp; diabetes checks</td>
<td>Dec Qtr 92%, Target 90%</td>
</tr>
<tr>
<td>Increased immunisation 8 months</td>
<td>Dec Qtr 94%, Target 95%</td>
</tr>
</tbody>
</table>

Key: Proceeding to plan, Issues being addressed, Target unlikely to be met
Commentary
Auckland DHB met the revised Ministry of Health target of providing patients with their First Specialist Assessment (FSA) or elective surgery within 120 days in December. The target is a challenge and only achieved by a team effort that involved people working right up to 31 December. The ongoing challenge will be to maintain Auckland DHB’s performance in meeting this target. The Adult Surgical team have made a pledge to beat the target by aiming to give all patients a date for their FSA or surgery within 90 days of being added to the waiting list.

Reducing waiting times is always difficult as we have to do more on top of our current activity to make the reduction. The Acute patient flow target has not been met due to unprecedented numbers of adult and child patients presenting to our emergency departments and others in the Auckland region. Work is underway to address the issues and to meet the target. This involves changing the model of care and changes to acute flow across the whole organisation.

Achievement of the cancer waiting times is also a priority and the Cancer director is coordinating a range of activities across the organisation to ensure its achievement. Both targets have been reported on in the HAC report.

The PHOs have continued to maintain achievement of two of the primary care health targets. Auckland DHB was first and second in the country for More Heart and Diabetes Checks and Smoking Brief Advice targets respectively for quarter 2. We were ninth for the immunisation target with a result of 94%

4.2 Financial Performance
For February 2015, we recorded a year-to-date net surplus of $2.23M, which is $0.15M higher than budget. Year-to-date income is higher than budget primarily due to additional funding received to cover the increase in capital charge resulting from the revaluation of land at the end of the previous financial year. While expenditure is overall close to budget for the year-to-date, underlying this result are significant adverse variances in outsourced and financing costs which were offset by favorable variances in personnel costs and funder payments to external providers. Our savings program is on track to achieve an overall target of $49.6M with YTD savings to February of $33.4M versus a budget of $32.3M, supporting our year-end breakeven target.

4.3 Clinical Governance Commentary
NEAC review
Auckland DHB (CMO and Research Office Manager) has recently provided submissions to the National Ethics Advisory Committee which sought feedback on the current health and disability research ethics arrangements, issues with these arrangements and ideas for enhancing them. A particular focus of the ADHB feedback was the challenge in defining clinical audit from observational research, and the difficulty in determining which studies required ethical review as opposed to institutional sign off. Legal Counsel provided feedback to the Law Society which in turn provided a submission.

The Ministry of Business, Innovation and Employment and Ministry of Health are jointly conducting a strategic refresh of the Health Research Council (HRC). The refresh will look at ways the government can maximise the contribution of HRC in line with broader health and economic goals. Over the next month, Ministry officials will meet with a range of stakeholders such as medical and health researchers, District Health Boards, clinicians, medical technology firms, Māori and Pacific stakeholders and other funding agencies. The refresh findings are expected to be reported to Ministers in June.
4.4 Primary care and community services
The Alliance Leadership Team (ALT) have approved the diabetes CVD performance framework to measure how well diabetic care is delivered. The Auckland Regional Clinical Governance Group have reviewed and endorsed the framework. This framework is based on the Ministry of Health quality framework released last year.

The group also considered the proposed programme of work in the Tamaki locality. This is a multifactorial programme with a primary focus on mental health and wellbeing with linkages to other agencies such as the Tamaki Redevelopment Company. The health hub project is progressing in parallel utilising the community engagement and partnership linkages from the Tamaki project.
Funder Report

Recommendation:

That the Auckland DHB Board receive the report.

Prepared by: Dr Debbie Holdsworth, Director Funding

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance</td>
<td>Auckland and Waitemata DHB District Alliance</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drug</td>
</tr>
<tr>
<td>AWHHI</td>
<td>Auckland Wide Healthy Homes Initiative</td>
</tr>
<tr>
<td>ARC</td>
<td>Aged Residential Care</td>
</tr>
<tr>
<td>CADS</td>
<td>Community Alcohol and Drug Service</td>
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<tr>
<td>CCP</td>
<td>Cost Pressure Adjustment</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CFA</td>
<td>Crown Funding Agreement</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CMH</td>
<td>Counties Manukau Health</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>CPHAC</td>
<td>Community and Public Health Advisory Committee</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>EDAT</td>
<td>Ethnicity Data Audit Tool Plan</td>
</tr>
<tr>
<td>EDS</td>
<td>Eating Disorder Service</td>
</tr>
<tr>
<td>ELT</td>
<td>Executive Leadership Team</td>
</tr>
<tr>
<td>Enula Ola</td>
<td>the name of Auckland DHB’s Pacific church health promotion programme of which 42 churches are a part</td>
</tr>
<tr>
<td>HVAZ</td>
<td>Health Village Action Zones, the name of Auckland DHB’s Pacific church health promotion programme of which 42 churches are a part</td>
</tr>
<tr>
<td>IDF</td>
<td>Inter district flow – describes service provided to DHB population by another DHB provider or NGO</td>
</tr>
<tr>
<td>IPIF</td>
<td>Integrated Performance and Incentive Framework</td>
</tr>
<tr>
<td>FCT</td>
<td>Faster Cancer Treatment</td>
</tr>
<tr>
<td>Funder</td>
<td>Term used to describe the joint Auckland DHB/ Waitemata DHB funding team established in July 2013</td>
</tr>
<tr>
<td>HBSS</td>
<td>Home Based Support Services</td>
</tr>
<tr>
<td>MHBU</td>
<td>Maori Health Business Unit</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>PBF</td>
<td>Population Based Funding</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Healthcare Organisation</td>
</tr>
<tr>
<td>PVS</td>
<td>Price Volume Schedule – the detailed funding arrangements for all provider services for the financial year. This includes the level of funded volumes to be provided by the Auckland DHB Provider for each DHB population served</td>
</tr>
</tbody>
</table>
1. Introduction

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

2. Hospitals

2.1 Cancer target

FCT indicator performance was published at the end of February and Auckland DHB performed poorly overall. Richard Sullivan has been confirmed as the Cancer Outcomes leader for Auckland DHB and the Funder will work with provider services to ensure the infrastructure is in place to support improvement in faster cancer treatment times.

2.2 Elective target

Auckland DHB provider is currently meeting the health target requirements however detailed effort is being required to sustain ESPI compliance.

2.3 Auckland DHB production plan

The first draft of the 2015/16 Auckland DHB production plan has been finalised and submitted to the National Health Board. The Auckland DHB provider price volume schedule (PVS) is a significant component of the Auckland DHB production plan. The starting point for the PVS is the current year’s forecast volume adjusted for expected service change including demographic growth and acute demand. After confirming the additional 2015/16 revenue available to the provider it was apparent that the 2014/15 forecast volumes being delivered by the Auckland DHB provider were not affordable in 2015/16 using new national prices. A review of all volume and non-volume related purchase units identified that few opportunities exist to reduce the demand for services.

Following further discussion with the Executive Leadership Team (ELT) and the Director of Funding and Director of Health Outcomes (Directors) it has been agreed that the provider teams will undertake service by service reviews of outpatient clinics. Services will be required to implement a range of alternative methods to change the way in which clinic services are provided and in so doing reduce the total cost of providing these services. This may include the increased use of virtual assessment and follow-up and the use of nurse follow-up instead of medical specialist follow-up. The savings to the Funder associated with these changes has been estimated at $5.9m.

2.4 Auckland DHB electives

Auckland DHB has been advised the elective target uplift for the Auckland DHB population in 2015/16 is an additional 499 discharges and the Funder has started to develop a draft plan to be considered by provider services.
2.5 IDF inflow management
Auckland DHB is a substantial provider of services to the Auckland metro DHBs and all three DHBS are under additional financial pressure in 2015/16 as a result of the level of increased funding available and the affordability of current volume forecasts. The Waitemata Funder and CFO have commenced a discussion with the Auckland DHB CFO regarding opportunities to work jointly to reduce the cost of services in 2015/16. Discussions will need to be progressed with the Chief Executive Officer (CEO) and Directors to agree a feasible work plan that is likely to be mutually beneficial for both DHBs.

Counties Manukau Health (CMH) have advised of their intention to review inter-district flow (IDF) costs and have signalled volume change relating to service repatriation (refer below). The IDF volume and service levels are established as part of an annual planning process timed to inform the Funding Envelope revenue allocations. National technical reference prices are used for all IDF arrangements with wash up arrangements supported by national business rules. In an increasing constrained environment, all DHBs are looking at their outflows as a means of managing overall financial risk. Often there is a perception that IDF outflow is an issue and the mechanism needs to change. Appendix 1 outlines a review of the IDF management processes undertaken by the joint Funder which was agreed by both the ADHB and Waitemata DHB CEs. It provides background detail regarding the IDF planning process and payment arrangements.

2.6 Tertiary services review
The Funder has initiated a tertiary services review in Paediatric Respiratory and Paediatric Surgery with recommendations regarding Paediatric Respiratory being due to the Sponsor Group within the next two weeks. The methodology of the review has been validated through these initial reviews. The process requires a high degree of engagement with the clinical service leaders and the directors of the directorate and there is a significant impact on business intelligence resource throughout the process. For both of these reasons it is not feasible to undertake more than two service reviews simultaneously. This will continue to be reviewed over time.

2.7 Colonoscopy capacity planning
The Auckland DHB Gastroenterology service has a number of short and long term issues relating to the provision of Endoscopy procedures including colonoscopy that need to be addressed and these matters are detailed in a paper to the Hospitals and Advisory Committee this month. There are short term issues relating to facility and service capacity which means that the service is unable to provide sufficient training for medical trainees. In the long term the service needs to provide sufficient capacity to respond to a roll out of a national bowel screening programme.

2.8 National services
The national Funding General Managers have agreed to fund additional resources in Paediatric Rheumatology and Paediatric Metabolic services from 2015/16. A recovery plan is in place to address longstanding issues relating to waiting times for Clinical Genetics services and the Auckland DHB service is performing well against this plan. There has been a slow start to the development of the integrated Auckland DHB National Intestinal Failure coordination service and concerns identified by the National Health Board are being addressed through an updated Auckland DHB service implementation plan.

Further consideration is currently being given to the request for additional funding for the Paediatric Cardiac service to address issues of service capacity currently impacting on service quality. There is a national meeting of Funding General Managers on 23 March 2015 and a decision regarding the additional funding request is expected on that day. This issue is covered in more detail elsewhere on the agenda.
2.9 Regional Service Review Programme

There is a prioritised regional list of service reviews currently underway and the Regional Service Review Advisory group oversees the associated work plan. Included on the list are service reviews that are likely to have an impact on the financial position of Auckland DHB including:

- **Urology** – CMH have signalled their request to repatriate up to $4m of elective Urology services to enhance the services currently already being provided at CMH for the CMH population. The Auckland DHB service has yet to complete an impact analysis of this proposal.

- **Chemotherapy** – CMH have requested that chemotherapy services are provided locally at CMH for their population. Volume information has been requested by CMH and further details of their request will be provided once the volume data has been reviewed.

- **Acute Spinal Cord Impairment** – in August 2014 the Northern region DHBs agreed that CMH would be provider of acute spinal cord impairment services for the Northern region DHB populations. Since that time CMH has identified issues regarding the cost providing the service and have initiated discussions nationally seeking additional funding for this service. The Funder will continue to provide input to the proposal through the national pricing mechanism and will refer any formal request for increased funding to the regional CEO forum for consideration.

3. Primary Care

A comprehensive report was provided to the Community and Public Health Advisory Committee (CPHAC) in March 2015, outlining progress against National Health Targets, the Integrated Performance Incentive Framework and the 2014/15 annual plan deliverables. Key points from that are noted below.

3.1 PHO s

Primary Health Care Organisations (PHO) continue to be on track with achievement of the More Heart and Diabetes Health Checks and Smoking Brief Advice health targets.

Maintaining and improving system capability and capacity is an important aim of the Integrated Performance and Incentive Framework (IPIF) programme. Along with setting standards and expectations for measures and performance, a mechanism is required to assess capability and capacity. The first phase is implementing a self-assessment framework to demonstrate how Primary Healthcare Organisations (PHO) meet the Minimum Requirements of the PHO Services Agreement. PHOs are in the final stages of completing the self-assessments. A nationally led peer review process of the self-assessments will follow.

3.2 Afterhours Services

A procurement subgroup with PHO and DHB representation has undertaken the development of a procurement process to identify suitable service provider(s). A procurement plan has been finalised and released to all interested parties. The Register of Interest process is in the final stages of development and due for release March 2015. This will be followed by a Request for Proposal process. This process has and continues to receive oversight from independent probity advisors with a focus on the process, documentation and the management of conflict of interests. It is planned that new Agreements will be in place this year.
3.3 Alliance
The Auckland and Waitemata DHB District Alliance (Alliance) has identified diabetes and cardiovascular disease (CVD) as key areas on which to focus. The vision of the Alliance is that people living with diabetes and/or CVD are enabled to be leading partners in their own care within systems that can ensure they can manage their condition effectively with appropriate support from proactive care teams.

A working group was convened and an intervention logic model for diabetes was developed. The overarching goals were identified as to improve the health of people with diabetes and CVD and reduce the prevalence of these conditions in the population. A list of clinical indicators and measures were then developed that mapped into the domains of the intervention logic model. It is envisaged that using these clinical indicators to measure performance will enable DHBs and PHOs to optimise progress towards the goals.

The Funder will be able to identify areas in which Auckland and Waitemata DHBs are doing well and areas that require additional input. The diabetes and cardiovascular disease clinical indicators have been endorsed by the Auckland Waitemata District Alliance Leadership Team and by the Metro Auckland Clinical Governance Group and following this, a comprehensive paper was provided to CPHAC in March 2015 requesting endorsement of the clinical indicators.

4. Health of Older People

4.1 HBSS
A joint working group across Auckland DHB and Waitemata DHB is working on a revised Home Based Support Service (HBSS) model. The redesigned model will be presented to both Boards for approval prior to procurement in 2015/16. The model focuses on optimising function within the realities of an individual’s condition.

4.2 In-between Travel Time
The Settlement Agreement for In-between Travel Time (that is, paying HBSS support workers for their time travelling between clients) will become effective on 1 July 2015 the Funder is awaiting implementation details from the Ministry of Health.

4.3 interRAI
All Auckland DHB aged residential care (ARC) facilities are engaged in interRAI (standardised clinical assessment) training. This will become the primary assessment tool for ARC in 2015/16.

4.4 Asian owned and operated ARC facilities
The first forum was held for Asian owned and operated ARC facilities. The aim of this forum is to better understand the issues faced by these providers so appropriate support can be provided and to increase their engagement in Auckland DHB ARC programmes, for example cluster groups and study days.
5. Mental Health

A comprehensive report was provided to CPHAC in March 2015, outlining progress against the 2014/15 annual plan deliverables. Key points from that are noted below.

5.1 Suicide Prevention and Postvention Planning

The MOH has stated that the role of all DHBs in Suicide Prevention & Postvention is “to implement the New Zealand Suicide Prevention Strategy 2006-2016 and Suicide Prevention Action Plan 2013 - 2016”. Specifically, DHBs are expected to co-ordinate suicide prevention activities. This includes implementing a district suicide plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention and where necessary, implementing a suicide postvention plan and a coordinated response to clusters/contagions. Suicide prevention and postvention activities are now included in the National Service Coverage Schedule expectations and in DHB Annual Planning requirements.

A DHB Suicide Prevention Advisory Committee was formed in late 2014 and has met on three occasions to work on formulating a Suicide Prevention and Postvention Action Plan for 2015 – 2017 (SPPAP). It was agreed that the SPPAP be jointly developed to provide Waitemata and Auckland DHBs as well as the wider community, guidance for action on the Suicide Prevention Action Plan 2013 - 2016.

The Waitemata and Auckland DHB SPPAP highlights priority actions for suicide prevention and postvention in the Funder’s districts. The SPPAP notes specific work to be undertaken alongside at-risk groups in our district including Māori, Pasifika, people who are lesbian, gay, bisexual, transgender or intersex, older people, migrants and the rural community.

The SPPAP was presented to CPHAC on the 18th March 2015 for approval. Subject to any changes recommended by CPHAC, the SPPAP will be submitted to the MOH by 20 April 2015 for review and approval. A verbal update will be provided to the ADHB board on the 1st of April following CPHAC’s receipt of the SPPAP.

Once approved by the MOH, the plan will become the guiding document not only for the Waitemata and Auckland DHBs but also community postvention groups, suicide prevention agencies and the wider community. It focuses on priorities for the next two years, which aim to reduce the impact of suicide in our Waitemata and Auckland communities.

5.2 Maternal mental health services/enhanced acute continuum:

In March 2014 Auckland DHB signed a Crown Funding Agreement (CFA) with the Ministry of Health to provide a Maternal Mental Health Acute Continuum. The “Northern Region Perinatal and Infant Mental Health Model of Care Guideline” was developed and a range of DHB and NGO services are in the implementation stage. These services include:

- **Acute responsiveness enhancement to DHB maternal mental health services providing additional clinical and medical staffing** - Auckland DHB has recruited to 2.6 FTE clinical positions and a further 0.4 FTE is currently being recruited to. A 0.5 FTE Senior Medical Officer has been appointed and commenced employment in March.

- **NGO Crisis Respite Beds and Packages of care services** - following a joint Auckland DHB/Waitemata DHB RFP process a successful provider has been identified. A contract with the provider is being drafted. Support hours services will commence in April 2015. The 6 bed respite house requires a new build on a site in Te Atatu already owned by the provider. It is estimated
that the build, and the consent processes will take 6 to 12 months. As an interim measure the provider is sourcing a rental property, and will open with 4 beds initially.

- **Mother and baby acute mental health care inpatient beds** - 3 mother and baby acute mental health care inpatient beds commenced operating in October 2014, based at the Child and Family Unit at Starship Hospital. The beds were well utilised in the first four months of operation, although there was a dip in utilisation in February.

These services are to work collaboratively and strong linkages will be developed and maintained between the services and maternal mental health services, crisis mental health services, midwives and other lead maternity carers, Well Child providers, Maori Health advisors, Pacific health providers, General Practice teams and local health and social services for mothers and infants.

### 5.3 Regional Eating Disorders Service

The current Northern and Midland supra-regional Eating Disorders Service (EDS) provides specialist care for adults and children with eating disorders from the nine supra-regional DHBs. The services include:

- A tertiary level service providing professional support, clinical review and consult liaison based in the ADHB Regional Eating Disorder Service (REDS)
- A specialist paediatric inpatient service in Starship Hospital
- Residential beds and a day programme (Thrive) provided by a contracted NGO service

Following an evaluation of a proposed EDS model of care presented in 2014, the MOH provided a series of recommendations to help further develop equitable and sustainable services for the supra-region. At the same time, planning had commenced to transition supra-regional service funding from a top-sliced CFA to a Population Based Funding (PBF) arrangement with agreed IDFs.

A project, overseen by a supra-regional Steering Group, was started to progress development of a revised service delivery model in accordance with the Ministry recommendations; and develop agreed IDFs to manage the transition to an alternative funding arrangement.

In December 2014 a paper was presented to the Northern Region CE/CMO Group and the Midland CE/GM Group outlining the revised service delivery model and the implications of the proposed 2015/16 IDFs. The key elements of this paper were:

- The findings of the service delivery model review process which endorsed retention of a “hub and spoke” model with key changes to improve service access and delivery for the supra-region
- An overview of central EDS hub based service utilisation with Auckland and Waitemata DHB populations showing the highest access rates and Northland and Midland DHBs the lowest
- The proposed 2015/16 IDFs resulting in an overall reduction in funding for the Auckland based EDS hub services (REDS, Thrive and Starship) of $1.2m
- Recommendations for improving service appropriateness and delivery under a revised service model

A subsequent paper to the Northern CE/CMOs resulted in endorsement of a work plan to facilitate service change discussions between hub based service providers. Work undertaken since has involved facilitated discussions between REDS, Thrive, Starship and regional funders to progress the
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plan to achieve the required service changes in the available timeframe. Service providers have engaged effectively with these discussions and two provider/funder meetings have been held as well as a joint provider/funder workshop on 26 February 2015 to review possible options. The outcomes of this workshop provided a short list of preferred options and a detailed risk analysis, which were presented to the Northern Region Funding Forum for discussion on 3 March 2015. A further workshop was held on 9 March 2015, to refine the options analysis in preparation for presentation to the CE/CMO forum on 20 March 2015. A verbal update will be provided to the ADHB board on the 1st of April following this.

5.4 NGO sustainability

National perspective - in July 2014 Platform, who are the national representative body for the Mental Health and Addictions NGO sector, launched their Fair Funding Campaign. The expressed expectations of the campaign were that:

- CCP must be passed on to NGOs each and every year it is received by DHBs
- Nationally acceptable and consistent pricing for services must be determined
- DHBs must reduce the burden of compliance for NGOs in areas like reporting and auditing
- Good health and wellbeing is reclaimed and sustained in the community and NGOs are essential to a contemporary health system

In response to this campaign, the MOH undertook detailed analysis of NGO funding, from a national and local DHB perspective. In addition, in the 15/16 annual planning guidance notes the MOH required DHBs to include an action to outline an approach to ensuring NGO services are an integral part of the continuum of services, and processes to ensure NGO sustainability.

Regional Perspective - currently the contracts with the Mental Health and Addictions NGO sector in the Northern region are of a three year term. These contracts are due for renewal as of 1 July 2015. Navigate who is the representative body for the Northern NGO sector is negotiating terms for the renewed contracts. Navigate has requested a 5 year contract term and a 2% price increase, to redress perceived inequity across the Northern region DHBs in the application of CCP in preceding years. The Deputy Director of Funding, Auckland and Waitemata DHB and the GM Funder from Counties Manukau DHB are leading the negotiations with Navigate, on behalf of the region. The intention is to reach a regionally consistent offer in the negotiations. Advice on this will be provided to the Board as negotiations unfold.

5.5 Alcohol and other Drugs

TRANX is a small AOD NGO contracted to provide support to people withdrawing from benzodiazepine. ADHB host the contract on behalf of the metro DHBs.

As of December 2014, there were internal staff related issues that TRANX was working through. Also, as a back-drop to this, there was some early indications that the authorisation of benzodiazepine prescribing requirements could change, and the TRANX Board were considering the long term future for the organisation. For both these reasons, exit from contract was one possible outcome. As the contract holder TRANX had kept the Funder informed of these issues. The Community and Alcohol Drug Service (CADS) was also kept informed, so that there could be a contingency plan for client care should this occur.

In late January 2015 the TRANX board chair updated the Funder that the mechanisms in place to address the internal staff issues had been unsuccessful. As a result the CEO chose to resign. With the resignation of the CEO, the board indicated they did not wish to continue, and contemplated service closure. Consultation with the staff began, with the intention to close the service.
The situation escalated quickly, and on 13 February 2015 TRANX decided to suspend service delivery. Unfortunately the Funder was informed of this after the fact. On 19 February the TRANX board met and decided to close the service.

The Funder is now in communication with TRANX to agree a formal exit date from the contract. Dr Susana Galea (Clinical Director, CADS) has been working with the TRANX board chair and two staff who have been seconded in to the service to manage the client handover. All the current clients and those on the waiting list, are personally phoned and offered referral to CADS. A standard letter is also being sent to all clients and their GPs. To date approximately 20 people have taken up the offer of referral to CADS.

A metro Auckland process will be embarked upon to decide on future delivery of this type of service. Expert advice will be sought from CADS.

**Social Detoxification Beds for Methamphetamine Users** - as part of the Prime Minister’s Methamphetamine Action Plan the MOH directly purchases five social detoxification beds in the Northern region (two in Northland DHB and three in Auckland based with the Salvation Army).

The MOH propose to devolve this funding for withdrawal management services to the Northern region DHBs as of July 1 2016.

Potentially, the Northern region DHBs may want to use their share of this funding to continue to support the existing providers of social detoxification services for methamphetamine users. Alternatively the DHBs are able to explore how this funding could be used to better integrate social detoxification services for methamphetamine users with other withdrawal management services within the region. Alternatively this funding could be used to assist DHBs to respond to updated compulsory addiction assessment and treatment legislation anticipated to be introduced in 2015. The new legislation will improve the ability to compel people to receive treatment for serious drug and alcohol problems, and may well increase demand for residential treatment beds.

A regional process will be used to determine the best use of this resource, with advice from the alcohol and drug sector, including CADS.

### 5.6 Funding & Development Manager - Mental Health and Addictions

Finally, the Funder continues to recruit to the Mental Health and Addictions manager position. The Mental Health work programme is being led by the Deputy-Director Funding until such time as a permanent appointment is made.

### 6. Women, Children and Youth

#### 6.1 Immunisation

Achieving the immunisation health target and maintaining coverage at the 2 year milestone age continues to be a priority with particularly intensive focus in Waitemata as the notion of a whole of systems approach is adopted. Equity for Maori infants continues to be of concern. Most recent rates at the 8 month milestone (target 95%) were:

- Auckland DHB – 94% (All); 88% (Maori)
Focusing on the timeliness of immunisation is a key to achieving the target as is the continuing focus on declines. The DHB is working with primary care to increase skills in having conversations with families who are reluctant to vaccinate. Early newborn enrolment with primary care is central to immunisation timeliness. An evaluation of the Waitemata DHB immunisation approach has been commissioned from UniServices and the Immunisation Advisory Centre. This will identify if there are any other actions that we could take to achieve the target.

6.2 Rheumatic Fever
The Funder continues to work toward the Rheumatic Fever target. The most recent MOH hospitalisation discharge data for Waitemata DHB indicates an increase in first incidence hospitalisation for Rheumatic Fever (from 9 cases in 2013 to 13 cases in 2014). However this data does not correlate with the Funder’s information as it includes query Rheumatic Fever cases on discharge and also due to reporting timeframes. It would appear from the Funder’s information that the rates have remained stable (11 cases in 2013 and 11 cases in 2014). Rates in Auckland DHB may have decreased slightly, but it is likely the decrease is within the confidence interval; as such it is too soon to say whether an improvement in hospitalisations is being achieved.

In respect of primordial prevention activities, a review has recently been undertaken by the MOH of the Auckland Wide Healthy Homes Initiative (AWHI). It identified that improved housing outcomes for families was very low. For example in 2013, of the 246 families referred to AWHI, 8 families received housing related interventions. As a result, significant changes have been made, and/or are in progress, in terms of changes to personnel, systems and processes in AWHI. The AWHI Review and requirements in the February Omnibus for integration between different parts of the Rheumatic Fever programme have supported improved information flow at both the governance and operational levels from AWHI to the DHBs. The DHBs are responsible for referring to AWHI and continue to monitor and refine referral processes. The vast majority of children/young people on the school based sore throat management programme, the bicillin programme and those being admitted to hospital with the medical diagnostic criteria have been assessed and, where appropriate, referred to AWHI. The District Nursing service now has systems in place to assess whether adults on the bicillin programme meet the AWHI eligibility criteria and, if so, to refer to AWHI.

6.3 Other IPIF targets
Other IPIF targets are also managed through the Women, Children and Youth (WCY) team including cervical screening, early engagement with LMC and newborn enrolment. The latter two sit under the governance of the Pregnancy and First Year of Life Service Alliance which is beginning to better understand the complexity of this area and lend its support to addressing these. The RFP for pregnancy and parenting (curriculum and mobile apps) is out with seemingly good interest from the market.

The WCY scorecard will be updated to include oral health utilisation at 2 years, following input from the Pregnancy and First Year of Life Alliance. This will be presented again to CPHAC in late April.

Cervical Screening
In cervical screening a number of changes are anticipated with the Ministry devolving funding for independent service providers to the DHB. This should result in better leverage with providers who are funded to engage with harder to reach groups of women. The Funder also plans to pilot a coordination role in primary care, devolving it from Auckland DHB Women’s Health where it has been hosted.
Cervical Screening IPIF measure
With the change in the census population the December coverage for the cervical screening programme has increased for Auckland DHB from 75.2% to 78.9%, there has been little impact of the census changes for Waitemata DHB.

National Cervical Screening Programme (NCSP) 3 year coverage, women aged 25-69 years, by DHB

<table>
<thead>
<tr>
<th>DHB</th>
<th>Jun-13</th>
<th>Sep-13</th>
<th>Dec-13</th>
<th>Mar-14</th>
<th>Jun-14</th>
<th>Sep-14</th>
<th>Dec-14</th>
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<tbody>
<tr>
<td>National</td>
<td>77%</td>
<td>77%</td>
<td>77.0%</td>
<td>77.0%</td>
<td>76.6%</td>
<td>76.5%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Auckland</td>
<td>77%</td>
<td>77%</td>
<td>76.9%</td>
<td>76.2%</td>
<td>75.3%</td>
<td>75.2%</td>
<td>78.9%</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>69%</td>
<td>70%</td>
<td>69.8%</td>
<td>70.0%</td>
<td>69.8%</td>
<td>69.6%</td>
<td>71.5%</td>
</tr>
<tr>
<td>Waitemata</td>
<td>76%</td>
<td>76%</td>
<td>76.2%</td>
<td>76.4%</td>
<td>76.3%</td>
<td>76.5%</td>
<td>76.1%</td>
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Cervical screening coverage can be presented and compared as DHB coverage (NCSP programme) coverage and as primary care coverage (measured as PHO performance by funded DHB, calculated by DHB Shared Services (DHBSS)). The PHO Performance target was only changed from the old NCSP programme target of 75% in January 2014 to the new target of 80%, an increase in activity at that time can be seen. The 80% target has been set in IPIF for achievement in July 2015, with interim performance targets set to reach this. The trend performance graphs for Auckland DHB and Waitemata DHB are shown below.

- For Auckland DHB it can be seen that initial performance <75% in December 2012 has improved from December 2013 to above NCSP programme performance, and sits just above 78%.
- For Waitemata DHB PHO performance has consistently been higher than NCSP programme performance overall, and since December 2013 performance has been at or close to the 80% target.
Cervical screening coverage can also be presented by PHO (as in the IPIF Primary Care results) and by PHO by funding DHB for a further breakdown. Auckland PHO and Waitemata PHO PHOs have met the target for Q2 IPIF. ProCare sits at 78%.

ProCare has approximately 225,000 women in the age range to be eligible for cervical screening. Approximately 50,000 of these women are overdue or never screened according to the datamatch with the NCSP Register. That is demonstrating the scale of the lists that have gone back to general practices for action, to invite and recall as many of those women as possible, in addition to maintaining their current volume of smears.
IPIF has resulted in reinvigoration of primary care activity for cervical screening. The Metro Auckland Cervical Screening Advisory Group (MACSAG) has prepared two platforms to assist PHOs in reaching the target – a data matching pilot and implementation of the ‘How To’ guide. The ‘How To’ Guide implementation is delivered by a nurse smear taker providing practical tailored practice level support. PHOs are implementing a range of additional activities to support general practices including Saturday and after hours clinics, receptionist training for invitation and recall activities, PMS alerts for opportunistic smears, and additional nurse smear taker training.

While IPIF is an important factor in coverage improvement MACSAG needs to maintain a focus on overall NCSP coverage and coverage for priority group women, as the women who develop cervical cancer are more likely to be underscreened or neverscreened, and priority group women, and these are the very women least likely to be enrolled in primary care. MACSAG continues to work closely with PHOs and Independent Services Providers (ISPs) on the issue of unenrolled women and improvements to ISP referral pathways from primary care.

7. **Maori Health**

7.1 **Maori Health Outcomes Framework**

The Maori Health Gain team are working with Sir Mason Durie to develop a Maori Health Outcomes Framework. The aim of the Framework is to measure the contribution the health system is making to improving health outcomes for Maori. As part of the development process the Funder will be engaging with its Memoranda of Understanding partners and Maori providers. The Framework will support the development of multiyear integrated contracts for Maori providers and support more flexible service delivery.

7.2 **Planning**

The first draft of the 2015/16 Auckland Maori Health Plan was endorsed by the Audit and Finance Committee and submitted to the National Health Board on 13 March 2015 with the Annual Plan. The Funder is expecting feedback from the Maori Health Business Unit (MHBU) in late April. The Funder will continue to engage with its Memorandum of Understanding (MOU) partners, Primary Health Care organisations, Māori providers and key internal stakeholders to refine the Maori Health Plan in conjunction with MHBU feedback.

7.3 **Ethnicity Data Audit Tool**

Implementation of the Ethnicity Data Audit Tool (EDAT) Project is progressing well with all of the DHB led training requirements having been delivered. To date, EDAT has been implemented in 159 general practices. This represents an implementation rate of 70%. The Funder is confident that it will reach 95% implementation rate by the end of the project (June 2015) as stipulated by contract with the Ministry of Health.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of EDAT</td>
<td>70%</td>
<td>95% of General Practitioner Practices have implemented EDAT</td>
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7.4 **Healthy Babies Healthy Futures**

The Healthy Babies Healthy Futures Programme continues to build momentum with support from the Maori Health Gain team. The Collective implementing the programme continues to be a leader nationally in service delivery. The Funder is in the process of organising the Healthy Babies Healthy Futures National Conference which will be held on 27 March 2015. The Conference will provide an
opportunity for the various Collectives to come together and be up-skilled and share learning and information. Current service delivery stands at:

<table>
<thead>
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<th>Activity</th>
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<tbody>
<tr>
<td>Number of people in the HBHF programme</td>
<td>511</td>
</tr>
<tr>
<td>Number of people on TextMATCH</td>
<td>229</td>
</tr>
<tr>
<td>Number of staff trained in Healthy Conversations Skills Training</td>
<td>29</td>
</tr>
<tr>
<td>Number of activities/workshops delivered</td>
<td>35</td>
</tr>
<tr>
<td>Number of media events delivered</td>
<td>24</td>
</tr>
</tbody>
</table>

7.5 Workforce Strategy
The Waitemata DHB and Auckland DHB Māori Workforce Development Strategy has been officially endorsed by all major stakeholders including Te Runanga o Ngati Whatua, Manawa Ora (the Māori Health Gain Advisory Committee) and both Waitemata and Auckland DHBs.

The Runanga is currently in discussion with key DHB leaders to help identify appropriate people to lead implementation.

7.6 Maori Nurse Leadership
The Associate Director of Nursing - Maori role at Auckland DHB has become vacant, and a plan is in place to create a new role across both Waitemata and Auckland DHBs. Resourcing and a position description are being negotiated and need to be finalised before recruitment can begin. The Maori Workforce Development Consultant has coordinated a group of senior Waitemata DHB nurses to have input into negotiations, to ensure the role meets the needs of the Maori nurse workforce.

7. Pacific Health
A detailed update was provided to CPHAC in March reporting progress against the priority areas of the Pacific Health Action Plan 2013-2016.

Priority 6 - Pacific families live in houses that are warm and are not overcrowded
Of note is the development of an implementation plan for Priority 6 of the Pacific Health Action Plan which states that Pacific families live in houses that are warm and are not overcrowded.

Like the first priority of families being free of violence, Priority 6 requires strong inter-sectoral collaboration. The Ministry of Business Innovation and Employment, the Ministry of Social Development and the Ministry of Pacific Island Affairs and the Commission for Financial Capability are all working together on addressing the issues of the housing needs of the Pacific population, specifically in Auckland. The Funder has attended meetings to discuss the government’s social housing policy and how Pacific churches and non-government organisations are involved; the Pacific community increasing their influence in the development of housing policy; and working with banks to allow for inter-generational loans and other options. These government agencies are conducting conversations directly with Pacific communities and the Funder will participate in those discussions as well.

The Commission for Financial Capability are training fifty facilitators who will provide education to improve Pacific people’s financial capability (and literacy) and the Funder will ensure that some of this training is delivered to Healthy Village Action Zones (HVANZ) and Enua Ola churches / groups.
Appendix 1

Inter district flows and wash-up arrangements between Auckland and Waitemata DHBs

Recommendation

That the Auckland and Waitemata District Health Board Chief Executives:

a) Note the Funder values inter-district flows as a mechanism for the Funder and provider of services to set service level expectations and to manage the actual service levels provided.

b) Note the management of financial risk in inherent in the inter-district flow volume setting process and this requires both Funder and provider engagement.

c) Note volumes agreements must be made by February in the preceding financial year and cannot be re-litigated.

d) Approve no change is made to wash-up arrangements between Waitemata and Auckland DHBs for acute inpatient services.

e) Approve the recommended change to wash-up arrangements between Waitemata and Auckland DHBs for 14/15 onwards with respect to elective inpatient services:

   i. caseweights less than 100% of plan are paid at 100% of the actual value
   ii. an additional $200k penalty payment for under-delivery of elective discharge volumes (not caseweights) which contribute to the health target is applied to both Auckland and Waitemata DHB providers
   iii. caseweights between 100 to 102% of plan are paid at 100% of the actual value
   iv. caseweights above 102% of plan are paid at 50% of the actual value
   v. no payment for actual caseweights at greater than 105% of plan.

f) Approve no change is made to wash-up arrangements between Waitemata and Auckland DHBs for non-diagnostic related group services.

Prepared by: Joanne Brown (Funding and Development Manager - Hospitals), Dr Debbie Holdsworth (Director Funding)

Endorsed by: Dr Debbie Holdsworth (Director Funding), Cliff La Grange (Manager – Finance & Support Services), Tim Wood (Deputy Director Funding)

Glossary

DHB - District Health Board
DRG - Diagnostic Related Groups - refers to inpatient services which are subject to case-weight (WIES) coding, these include inpatient medical, surgical and maternity services
ESPI - Elective Service Performance Indicators
IDF - Inter-district Flow
KPI - Key Performance Indicator
MoH - Ministry of Health
Non-DRG - Non-Diagnostic Related Groups Description - services that are not inpatient services or are not WIES coded, sometimes referred to as "outpatient", “non-inpatient” or ‘not admitted’ activity
PBF - Population Based Funding - funding which is provided to a DHB based on population factors which are calculated as a percentage of the overall NZ population

PBF share - Population Based Funding Share - a method of allocating shares of IDF costs in line with a DHB’s population based funding percentage

Wash-up - Process by which the actual cost of services provided is compared with the funded cost and a payment is made to the DHB of service for services provided in excess of the funded plan and funding is returned to the DHB of domicile when the level of service provided is less the funded plan

WIES - Weighted Inlier Equivalent Separation - the unit of measure applied to coding of inpatient activity and allows the relative resource utilisation of an inpatient event to be compared across all inpatient events, also known as “caseweights”

1. Purpose

One of the intentions of merging the Funder of both Waitemata and Auckland District Health Boards (DHB) was to leverage economies of scale and deliver financial benefits to both DHBs. A key focus has been inter-district flows (IDF) which have historically created ongoing tension between both DHBs due to the financial risk to each party. A Chair key performance indicator (KPI) was established to review the current IDF arrangements to ensure they are appropriate in the context of a single Funder and enable both DHBs to set and manage appropriate budgets. This paper is the delivery against this KPI. It outlines the principles the Funder believes should be maintained and recommendations for Board consideration.

2. Introduction

Historically there has been tension between Auckland and Waitemata DHBs when one or other has an unexpected financial risk associated with IDFs. For Waitemata DHB this is a greater than expected IDF outflow, that is, more Waitemata DHB patients are receiving services than budgeted for. Waitemata DHB has the greatest exposure to IDF outflow of any DHB in the country and this risk must be managed. For Auckland DHB this is a less than expected IDF inflow, that is, fewer patients from other DHBs are being treated than budgeted for.

The party with the negative financial impact usually seeks to resolve their financial situation by attempting to settle outside the nationally agreed rules. This has resulted in a view by some stakeholders that the current rules are no longer fit for purpose. There has also been an increasing view that in a collaborative environment between the two DHBs IDFs and associated wash-up arrangements could be done away with. The aim of this would be to provide greater financial certainty for both DHBs and remove any tension around year end negotiations.

The joint Funder has considered the current arrangements and opportunities for improvement. These are presented in this paper.

3. Context

IDFs and associated wash-up arrangements are complex. The key elements are described in this section to provide a greater understanding of the Funder and provider roles, the mechanisms and processes in
place in the sector, and developments over the last ten years that have resulted in the current approaches to IDFs. A key factor in setting volumes which are realistic and reflect the nuances of patient demand and service delivery is the experience and knowledge of those involved in the process.

3.1 Current annual process

IDF volume planning process (setting the budget)

The annual planning process for inter-district flow arrangements occurs between July and October each year. This timing is so the associated funding can be included in the Funding Envelope advice provided to DHBs every December for the subsequent financial year.

In most instances the level of IDFs to be paid to a DHB of service for the future financial year is based on actual population use of those services in the previous financial year with some adjustments for known service change and demographic growth. This means the baseline data informing the future year’s level of service is based on historical activity data that may be up to two years old. For example the 2014/15 volumes were agreed using the 2012/13 volumes as a baseline.

These volumes are set following a systematic review of activity and discussions between providers and Funders. The volumes are generally agreed based on a common understanding of what level of service is expected to be provided in the subsequent financial year. It is worth noting the default baseline for IDF volumes, in the absence of agreement between Funders and providers, is the prior full financial year actuals plus two years demographic growth.

There are natural tensions between Funders and providers in this process. Where there is no wash-up the provider is paid for the agreed plan regardless of actual delivery. The favourable position for the provider of a service is therefore an agreed volume plan as high as possible, with the provider gaining the benefit of any under-delivery. The Funder of the service is seeking the reverse, that is, to have the agreed volume set at a threshold as low as possible with no obligation to pay for over-delivery.

Where there are wash-up provisions, that is, where the provider is paid for actual service delivered, there is less tension around negotiation as both parties are assured of either being paid what they deliver or only paying for what is delivered. The risk for the provider is where the volume agreed is artificially too high and they are unable to reduce cost when the revenue doesn’t flow. For the Funder, again the risk is in reverse, setting a plan that is too low and not providing for the financial risk of when the plan is exceeded.

Reaching agreement can be challenging particularly if the default volumes suit one party. This is predominantly in the non-areas which are not subject to wash-up. It is recognised that for service change and/or revenue shifts in non-diagnostic related groups description services (non-DRG) it is often difficult to estimate volumes with what is usually limited information. Therefore agreements are usually for non-DRG services to have wash-up provisions for the 12 months following the service change. This provides both parties with reassurance that in the event the volumes do not shift as planned that appropriate funding will follow. Historically volume and revenue calculations have landed within 3% or less.

The accuracy of the budgets for IDFs and therefore the ability to manage against them is dependent on the level of engagement by both Funders and providers in this process. The Funder observation is that historically this is sometimes treated as an administration process rather than being seen as a budget setting process. This results in a default position which establishes the financial risk.
Current wash-up business rules – national default arrangements

The payment arrangements for the above volumes are supported by a set of national default business rules relating to over and under delivery of expected volumes.

Since population based funding and IDFs were implemented the sector has deliberately moved from an approach of funding IDF services on a population based share to funding services on the basis of utilisation wherever possible. This has occurred as utilisation data has become increasingly timely and robust to support improved planning and supports the principle that a DHB is expected to fund services its population receives. Currently there are very few regional and national arrangements funded on a population based funding (PBF) basis.

Wash-up arrangements support the principle of payment for services on a utilisation basis. Wash-up generally occurs where there are high volume, high value and highly variable flows that are affected by a number of factors unable to be fully managed or controlled by either the Funder or the provider (such as acute and elective inpatient services).

The current national default wash-up arrangements have been established over a long period of time and there is a mechanism to review these arrangements annually during the IDF planning process. It is noteworthy that there has been minimal change to the national default rules since 2003 with changes in recent years only to Cancer and renal outpatient purchase units (2012/13) and community pharmacy arrangements (2013/14). The national default rules represent collective views of all stakeholders across the sector routinely engaged in IDF funding matters. These are summarised in Appendix A.

Currently Auckland DHB and Waitemata DHB operate under the national default business rules for all IDF services except inpatient services for Health of Older People. The DHBs have jointly opted out of the national default arrangement for this service to incentivise the appropriate management of planned admissions and to remove any perceived funding barriers to providing the right clinical services for the patient circumstances.

In addition to the national default arrangements, Waitemata and Auckland DHB have annually jointly reviewed the year end results. On a case by case basis activity that has occurred that is unfunded has been considered, and in certain circumstances payments outside of the default rules have been agreed and implemented. Cancer outpatient activity is an example where the Waitemata DHB Funder has recognised growth is appropriate and paid for over-delivery when these volumes have historically not been in wash-up. The national rules have changed to now wash-up on these purchase units.

While there have been times of strong disagreement between the two DHB parties in this process, in every year there has been a negotiated payment outside of the national default rules.

3.2 National price

Inpatient activity is coded and assigned to a DRG. The principle behind DRGs is that all diagnoses and procedures can be classified into about 745 groups, based on similarities in clinical nature and resource consumption. Each DRG has a "weight" that represents the cost of treating such a patient relative to the average of all patients; for example, tonsillectomies have a lower case-weight than heart surgery.

The value or price of a case-weight is established annually through the national pricing programme. An efficient provider makes money on each patient and an inefficient provider loses money on each patient.
3.3  No wash-up arrangement

There is on-going debate as to whether or not “no wash-up” arrangements are preferable to the current (national default) arrangements. IDF arrangements where there is no provision for wash-up provide DHBs with certainty of revenue or expenditure and for some stakeholders this is considered to be the position of least financial risk.

As described above, the challenge with the current process is that for either party this relies on getting the volumes as accurate as possible. The annual IDF volume plans are established using historical data from the most recent previous financial period and therefore for the forecast financial period there is up to a 21 month period within which a range of variables have an impact on the expected volumes.

For example, the base data from the most recent historical financial period that informs the volume plan’s start point may include aberrant activity within any number of services which will be non-recurring, for example, additional electives in a particular year to clear a waiting list for elective service performance indicators (ESPI) compliance. Equally, on-going volume variations occur at any point given the nature of acute service presentations and population health demand unable to be managed or mitigated in a timely manner by either the provider or the Funder.

The range and unpredictably of acute or demand driven service utilisation is such that in a “no wash-up” arrangement there might be many points in time over a 21 month period where either the provider or the Funder may wish to re-negotiate funding arrangements as a result of actual volume variation.

The volume and range of services provided through bilateral IDF arrangements between Auckland DHB and Waitemata DHB and the level of variation that occurs on a month to month and year to year basis is such that there could quite easily be a case for constant discussion regarding the re-setting of volume plans. This proposition provides no more certainty for Funders or providers than the current national default wash-up arrangements.

3.4 Wash-up arrangement with maximum wash-up risk agreed

In the case of any current or future wash-up arrangement consideration might be given to establishing an agreed maximum wash-up risk to enable budgeting of a risk pool and allocation of revenue to occur at the beginning of the financial period.

The current total value of the IDF Waitemata DHB outflow to Auckland DHB is shown below with the value of percentage variance for reference.

<table>
<thead>
<tr>
<th></th>
<th>Annual Value (000)</th>
<th>1% (000)</th>
<th>2% (000)</th>
<th>3% (000)</th>
<th>4% (000)</th>
<th>5% (000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>$80,500</td>
<td>$805</td>
<td>$1,610</td>
<td>$2,415</td>
<td>$3,220</td>
<td>$4,025</td>
</tr>
<tr>
<td>Elective</td>
<td>$34,700</td>
<td>$347</td>
<td>$694</td>
<td>$1,041</td>
<td>$1,388</td>
<td>$1,735</td>
</tr>
<tr>
<td><strong>subtotal</strong></td>
<td><strong>$115,200</strong></td>
<td><strong>$1,152</strong></td>
<td><strong>$2,304</strong></td>
<td><strong>$3,456</strong></td>
<td><strong>$4,608</strong></td>
<td><strong>$5,760</strong></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$63,000</td>
<td>$630</td>
<td>$1,260</td>
<td>$1,890</td>
<td>$2,520</td>
<td>$3,150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$178,200</strong></td>
<td><strong>$1,782</strong></td>
<td><strong>$3,564</strong></td>
<td><strong>$5,346</strong></td>
<td><strong>$7,128</strong></td>
<td><strong>$8,910</strong></td>
</tr>
</tbody>
</table>
4. Proposed future wash-up arrangements

4.1 Proposed wash-up principles
When considering the use of wash-up arrangements the following principles should be taken into account:

- Within a PBF context, DHBs expect to pay for services that their populations’ use
- PBF funding is used to fund services to improve health outcomes for the DHB population it was provided for
- The right clinical and management behaviour from service providers needs to be incentivised and the avoidance of arrangements that encourage ‘revenue optimisation’ behaviour
- Funding arrangements need to facilitate rather than discourage reviewing models of care and ensuring best use of scarce resources
- Funding arrangements should incentivise disciplined planning and implementation by service providers to deliver services in line with the available funding
- Services that are demand driven and services where the provider is unable to decline services or be reasonably expected to manage demand growth should be adequately funded
- We need to be mindful of the extent to which hospital services can be reasonably expected to reduce budgeted costs as a result of volume reduction variations
- We need to know the extent to which additional volumes result in additional costs in the knowledge that additional volumes may occur at marginal additional cost.

4.2 Recommended wash-up arrangements
There are three groups of services that form the basis of the majority of IDF provider arrangements between Waitemata and Auckland DHB - acute inpatient services, elective inpatient services and outpatient services. The focus is therefore on these three areas.

Acute inpatient services
Current arrangement
Currently these services are in full wash-up at national price. The current value of acute inpatient activity at Auckland DHB for the Waitemata population is $80m.

Considerations
Factors that need to be taken into account when considering this wash-up arrangement include:

- The Funder does not want acute volume growth
- The Funder is buying volumes of services requiring a certain level of provider capacity and the provider establishes capacity for that volume at a cost
- The mechanism to establish the level of services to be provided needs to be undertaken on a fair and reasonable basis by both Funder and provider and the engagement in this process must avoid default volumes (last year’s actuals plus demographic growth) being established
- Caseweights are indicative of cost/resource utilisation
- In the case of under delivery of services against the planned volume there is a question as to who should benefit from the financial upside - noting both that the provider has limited ability to remove costs, but also that the volumes have been established sometime in the past and up to 21 months of time can lapse between the volume start point and actual services being delivered
- In the case of over delivery of services against the planned volume additional costs are incurred by the provider without either party knowing the actual extent of these additional costs.
For acute services the lead in time for establishing an annual volume plan and the level to which volumes and weighted inlier equivalent separation (WIES) vary on a month to month basis makes it very difficult to establish a plan for a financial period that is up to 21 months into the future from the agreed start point. Varying the price for these services where under-delivery or over-delivery occurs, while technically possible, would require a process to establish the level of fixed versus variable costs across a range of different clinical services. This would need substantial time, effort and expertise to be available.

While reduction in growth of acute activity is desirable, internationally this remains unachievable to any great degree. The risk to the provider of under-delivery of acute inpatient activity is lower when there has been engagement in setting an appropriate baseline rather than accepting the default position. Consideration was given to a no wash-up on a percentage of under-delivery to create an incentive to reduce acute growth as the provider would benefit from under-delivery. On balance it wasn’t useful as the provider has little ability to control acute risk and potentially creates a perverse incentive to not engage constructively in setting the baseline.

The financial risk therefore should lie with the Funder who needs to both provide for this and also be incentivised to engage system wide activity to introduce alternative models of care. The value of establishing a marginal price is felt to be outweighed by the resources required to implement and the desire not to create an incentive to shift coding between acute and elective activity.

It is therefore recommended there is no change to the current IDF rule which is full wash-up on national price.

**Recommendation**

That the Auckland District Health Board approve no change is made to wash-up arrangements between Waitemata and Auckland DHBs for acute inpatient services.

**Elective inpatient services**

**Current arrangement**

Currently these services are in full wash-up at national price. The value of elective inpatients at Auckland DHB for Waitemata population is $35m annually.

**Considerations**

Factors that need to be taken into account when considering this wash-up arrangement include:

- The Funder is supportive of robust production planning activity that enables providers to develop the required capacity to deliver to a maximum contracted volume and WIES for elective services
- The Funder wants an agreed level of volume delivered in accordance with a prioritised plan however it is understood that it is difficult for the provider services to achieve precisely 100% of the planned volume and WIES at each clinical specialty level.
- Equally the Funder does not want to pay for planned clinical services provided in excess of budget that are unaffordable and not identified as a priority for the population in the annual period
- The Funder values delivery to the annual prioritised elective plan and generally under delivery has a negative impact for the population and the DHB noting that there needs to be sufficient demand to achieve the plan
The elective plan is established using the rules of the national purchasing framework including rules of counting and coding. It is assumed that the provider acts in accordance with all rules and there is no perverse counting and coding of activity to achieve the required level of the plan.

For elective services the Funder establishes a population plan for elective interventions based on a range of information. The plan is prioritised according to what meets the needs of the population and what is affordable for the DHB. It is very important for clinical services to establish the right level of capacity using a robust production plan. It is also important the plan is met as a minimum as these volumes form the electives plan agreed with the Ministry and contribute to the health target. The Funder also recognises it is very difficult for providers to achieve exactly 100% volumes and 100% WIES plan and therefore a degree of over-delivery is the preferred position over under-delivery.

There is evidence the payment arrangement does influence provider behaviour in the elective domain. Historically there has been little ability to effect elective volume growth at Auckland DHB for Waitemata residents. In 2011/12 in a full wash-up position there was $3.7m elective inpatient activity more than contracted (12.2% over-delivery). In 2013/13 an agreement was put in place to not automatically wash-up on electives. This had an immediate impact on reducing overproduction and the Auckland DHB provider was on track to deliver to plan. However with one month of the year to go and the organisations health target at risk, the Funder had to modify the plan with Auckland DHB to mitigate the Waitemata DHB provider under-delivery. The Auckland DHB provider was able to deliver to 102.7% of plan ($880k) which was paid in full thereby ensuring the health target was met.

Payment for inpatients is always on the case-weights as this reflects the cost of the activity delivered. The electives health target is however based on discharge volumes. Given the organisational risk of not meeting health targets it is felt there is a need for provide sufficient disincentive to ensure there is 100% delivery to the electives discharge plan. While it has never happened, it is theoretically possible to under-deliver volumes however the Auckland provider will not be financially disadvantaged if it delivers a higher than plan average case-weight. Depending on the level of production of its own provider, the Waitemata health target could be at risk. It is therefore proposed to include a $200k financial penalty should the volumes not be delivered regardless of the case-weight delivered to provide an appropriate financial disincentive. The Funder is of the view this should apply to both providers. In an environment where there should be robust communication about activity and clear mitigation plans where under-delivery occurs, it is hoped this penalty payment would not be required.

**Recommendation**

That the Auckland District Health Board approve the recommended change to wash-up arrangements between Waitemata and Auckland DHBs for 14/15 onwards with respect to elective inpatient services:

**Under-delivery** -

1. **Case-weights less than 100% of plan are paid at 100% of the actual value**
2. **An additional $200k penalty payment for under-delivery of elective discharge volumes (not case-weights) which contribute to the health target is applied to both Auckland and Waitemata DHB providers**
Over-delivery –

1. Case-weights between 100 to 102% of plan are paid at 100% of the actual value
2. Case-weights above 102% of plan are paid at 50% of the actual value
3. No payment for actual case-weights at greater than 105% of plan.

Impact of Recommendation

The following table shows the past four years actual Auckland DHB performance of elective inpatients against plan for Waitemata DHB as they relate to the electives plan with the Ministry. The impact of the proposed payment compared with the current payment is shown. These figures are not inclusive of all elective activity for Waitemata at Auckland DHB however are very close approximation.

<table>
<thead>
<tr>
<th>Over-delivery (case-weight)</th>
<th>Proposed Payment</th>
<th>Value Of Proposed Payment</th>
<th>Current Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 - 102%</td>
<td>100%</td>
<td>up to $700k</td>
<td>Up to $700k</td>
</tr>
<tr>
<td>102.1 - 105%</td>
<td>50%</td>
<td>$700k to $1.2m</td>
<td>$700k to $2m</td>
</tr>
<tr>
<td>&gt;105%</td>
<td>0%</td>
<td>$1m</td>
<td>$1m to $3.7m*</td>
</tr>
</tbody>
</table>

*Upper range based on maximum historical over-delivery

Outpatient services

This group of services include a broad range of activities most of which are planned (elective) and volume delivery is considered able to be controlled when working to a robust annual production plan providing capacity to the funded level of volumes.

Considerations

Currently most of these services are not in wash-up. Factors that need to be taken into account when considering this wash-up arrangement include:

- The volume start point has been established using best information to identify the required level of service for the population taking into account the relative priority of each of the services and the affordability of the total plan
- The services are schedulable with some ability to defer and therefore production is able to be managed to a contracted volume level
- Thresholds and clinical pathways are able to be established to enable management of patients to the required level
- Volume variation is minimal over time or trends are able to be established to support sound volume forecasting
- Service capacity fixed and a level of volume variation able to be accommodated within the fixed capacity with minimal additional variable cost being occurred associated with additional volumes.

What are we trying to achieve

In 2012/13 new exclusions to “no wash-up” for outpatient services were established in purchase units relating to Cancer and Renal services, Haematology chemotherapy, Pharmaceutical Cancer Treatment (PCT) and CT PET. The new agreement to wash-up nationally in these services was in response to requests from providers and agreed by Funders in response as there were considered to
be limitations in the ability to forecast volume demand and equally little ability to manage or control presentations to these services.

In the case of all outpatient services the Funder, in discussion with the provider, uses the best information available across a broad range of services to establish a total level of funding. This enables the provider to establish a fixed capacity. While variation may occur at a unit level during an annual period across a large number of purchase units, the historical pattern in the IDF arrangements between Auckland and Waitemata DHBs show that the total variance to plan has been consistently less than 1% per annum. Where services that provide volumes that are either difficult to predict or difficult to control (such as Cancer and Renal services) a current national wash-up rule applies.

Within this group of activity, the largest component which is not in wash-up are follow ups. These continue to grow at a rate greater than demographic and are consistently over-delivered. This is activity where there is general acceptance there is non-value activity which needs to be removed from the system. While reducing growth is challenging, the span of control lies with the provider. Payment arrangements remain the strongest lever to effect change.

It is recommended Auckland DHB and Waitemata DHB continue with the current national wash-up arrangements for non-DRG services with a joint review of year end actual costs providing the opportunity to address unique issues.

**Recommendation**

*That the Auckland District Health Board approve no change is made to wash-up arrangements between Waitemata and Auckland DHBs for non-DRG services.*

5. **Conclusion**

The Funder is of the view that IDFs serve a useful purpose to ensure:

- **PBF integrity**, that is, monies for a population are used for that population
- The Provider has clear signals of service level requirements
- There are consequences for not delivering the service or delivering more than required
- There is consistency with the NGO sector where there is claw back money for under-delivery and in many cases, except the demand services, no payment for over-delivery.

The Funder is also of the view that the current national wash-up arrangements for payment generally work well for both providers and Funders. This is dependent on both parties acting reasonably when either party has concerns relating to the outcome of applying the national default rules in any annual period. It is important that payment arrangements do not substitute for good contracting arrangements.

It is also important that both Waitemata and Auckland DHB continue to support and contribute time and intellect to the national processes that support fair and reasonable funding arrangements for IDF services. This includes participation in the national pricing programme including common counting and common costing activities.
Appendix A: National Wash-up Rules

The current national default rules are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Wash-up arrangements</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute inpatient services (DRG)</td>
<td>Full national wash-up on all over and under delivery at full national price</td>
<td>Inpatient stay for acute heart attack</td>
</tr>
<tr>
<td>Elective inpatient services (DRG)</td>
<td>Full national wash-up on all over and under delivery at full national price</td>
<td>Inpatient stay for elective surgical procedure such as cholecystectomy</td>
</tr>
<tr>
<td>Outpatient services (Non DRG)</td>
<td>No wash-up except for national wash-up on Cancer, Renal, PET scan, Haematology chemotherapy PUC – wash-up on national prices and actual volumes</td>
<td>First specialist appointments, Follow-ups, Emergency Department attendances and procedures such as colonoscopy, renal dialysis and day stay IV therapy such as chemotherapy treatments</td>
</tr>
<tr>
<td>Pharmaceutical Cancer Treatments</td>
<td>Full national wash-up on all over and under delivery at full drug price</td>
<td>Drugs used for chemotherapy which are not included in national price for the treatment.</td>
</tr>
<tr>
<td>NGO services</td>
<td>No wash-up</td>
<td>Fertility Treatment, primary maternity</td>
</tr>
<tr>
<td>Health of Older People (HOP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Full national wash-up on all over and under delivery at full national price</td>
<td>ATR bed day stay</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>No wash-up</td>
<td></td>
</tr>
<tr>
<td>NGO services</td>
<td>No wash-up</td>
<td></td>
</tr>
<tr>
<td>Aged Residential Care</td>
<td>Full national wash-up</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider services</td>
<td>No wash-up</td>
<td></td>
</tr>
<tr>
<td>NGO services</td>
<td>No wash-up</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Health Organisation (PHO) capitation</td>
<td>National wash-up on actual enrolments calculated quarterly</td>
<td></td>
</tr>
<tr>
<td>PHO - FFS</td>
<td>National twice yearly wash-up</td>
<td></td>
</tr>
<tr>
<td>General Medical Subsidy</td>
<td>No wash-up</td>
<td></td>
</tr>
<tr>
<td>Immunisations</td>
<td>No wash-up</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Laboratory services</td>
<td>No national wash-up (Regional wash-up on capped volumes)</td>
<td></td>
</tr>
<tr>
<td>Community Pharmacy services</td>
<td>National wash-up on actual volumes where NHI is known</td>
<td></td>
</tr>
</tbody>
</table>
Te Kaunihera Kaumatua

Waitemata and Auckland DHBs Terms of Reference

Recommendation

That the Board approves the terms of reference for Te Kaunihera Kaumatua and that these terms of reference be referred back to Manawa Ora for information.

Prepared by: Jesse Taylor (Corporate Committee Administrator)

1. Background

This item was first introduced by Naida Glavish, Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB to the July 2014 meeting of Manawa Ora. (See item 7.1)

The terms of reference were in draft form at that time and required further minor amendment which has subsequently been undertaken.

The Manawa Ora Committee resolved:

1. That the Tikanga GM Māori Performance Report be received.
2. That terms of reference for Te Kaunihera Kaumatua be submitted to both Boards for adoption and then referred back to Manawa Ora.

The terms of reference are now ready for approval and adoption.
1 Purpose & Brief

Purpose
The purpose of the Committee is to ensure Ngati Whatua tikanga is upheld across the Waitemata and Auckland DHBs.

Scope
The Committee:
• advises the Board, through the Chief Advisor Tikanga, General Manager, Māori Health, on matters relating to Ngati Whatua tikanga.
• acts strategically, through the Chief Advisor Tikanga, General Manager, Māori Health, to ensure Ngati Whatua tikanga is reflected in all policies and plans emerging from the Waitemata and Auckland DHBs.
• oversees the development of operational policies across both DHBs.
• identifies and manages risk associated with breaches in tikanga or Te Tiriti o Waitangi.
• provides support to tuoro (patient) and staff.

Accountability
Te Kaunihera Kaumatua is accountable to the Chief Advisor Tikanga and General Manager, Maori Health.

2 Structure

Membership / Composition
Committee membership will include:
• The Chief Advisor Tikanga/General Manager, Maori Health.
• Kaumatua direct reports to the Chief Advisor Tikanga.
• Kaumatua from the Auckland and Waitemata DHB Memorandum of Understanding partners.
• The Personal Assistant for the Chief Advisor Tikanga/General Manager, Maori Health.
• Any person/s may be invited at the discretion of the Chief Advisor Tikanga.

All committee membership will be signed off by the Chief Advisor Tikanga and General Manager, Maori Health.

Other committee members may be co-opted by the Chief Advisor Tikanga and General Manager, Maori Health as required.

Membership changes may occur from time to time. At such times appointment and resignation procedures will be set by the Auckland and Waitemata DHB Human Resources processes.
Te Kaunihera Kaumatua  
Waitemata and Auckland DHBs Terms of Reference

Current list of Committee Members

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair person</td>
<td>Naida Glavish</td>
<td>WDHB/ADHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>Pita Pou</td>
<td>WDHB/ADHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>Louise Elia</td>
<td>WDHB/ADHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>Pio Jacobs</td>
<td>WDHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>Takawai (Kiri) Jacobs</td>
<td>WDHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>David Hillman</td>
<td>WDHB/ADHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>Ronald Baker</td>
<td>WDHB/ADHB</td>
</tr>
<tr>
<td>Committee member</td>
<td>Heta Tobin</td>
<td>Te Kahu Pokere, Ngati Whatua</td>
</tr>
<tr>
<td>Committee member</td>
<td>Tihema Ripi</td>
<td>Auckland Corrections</td>
</tr>
<tr>
<td>Committee member</td>
<td>James Hamiora</td>
<td>Auckland Corrections</td>
</tr>
<tr>
<td>Committee member</td>
<td>Fraser Toi</td>
<td>WDHB/ADHB</td>
</tr>
<tr>
<td>Committee Support</td>
<td>Vanessa Watene</td>
<td>WDHB/ADHB</td>
</tr>
</tbody>
</table>

Appointment & Term of Office
Committee members are nominated by existing committee members and signed off by the Chief Advisor Tikanga and General Manager, Māori Health.

3 Meetings

<table>
<thead>
<tr>
<th>Chair</th>
<th>Naida Glavish or her nominate delegate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quorum</td>
<td>50% of the Committee</td>
</tr>
<tr>
<td>Frequency</td>
<td>Once a month, dates may change if required</td>
</tr>
<tr>
<td>Minutes &amp; Agenda</td>
<td>To send out three days before each meeting</td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
</tr>
<tr>
<td>Meeting Fees</td>
<td>N/a</td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Member Requirements

Committee membership skills will include:
- Whakapapa to Ngati Whatua and or;
- Expertise in Ngati Whatua tikanga in practice;
- Expertise in Waitemata and Auckland DHB tikanga in practice
- fluency in te reo me nga tikanga; and
- Have the time to commit to reading meeting papers and attending meetings on a monthly basis.

3.2 Decision Making / Escalation

- If an agreement can not be met the issue will be escalated to the CEO.
- All issue of Tikanga within Waitemata and Auckland DHBs **must** be signed off by the Chief Advisor Tikanga.

3.3 Additional Membership

The Chief Advisor Tikanga, General Manager, Māori Health may invite Kaumatua from external organisations. The external organisations must have similar kaupapa to Ngati Whatua and Waitemata and Auckland DHB.

3.4 Set agenda items

- Karakia timatanga
- Mihi
- Attendance
- Apologies
- Agenda setting
- Matters arising
- Conflicts of interest
- Guest speakers
- General business
- Details for next hui
- Karakia whakamutunga
- Kai

Both Te reo Maori and English may be used in the meeting but correspondence and minutes will normally be drafted in English.
Resolution to exclude the public from the meeting

**Recommendation**

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

<table>
<thead>
<tr>
<th>General subject of item to be considered</th>
<th>Reason for passing this resolution in relation to the item</th>
<th>Grounds under Clause 32 for the passing of this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Confirmation of Minutes 18 February 2015</td>
<td>Confirmation of Minutes As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&amp;D Act 2000.</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>2. Action Points 19 February 2015</td>
<td>Confirmation of Minutes As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&amp;D Act 2000.</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>3.1 Health and Safety – Critical Incident – Site Services Security Review</td>
<td>Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>4.1 Financial Report February 2015</td>
<td>Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
<td>That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&amp;D Act 2000]</td>
</tr>
<tr>
<td>Section</td>
<td>Topic</td>
<td>Commercial Activities</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.2</td>
<td>Home Based Support Services Contracting Arrangements for 2015/2016</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
</tr>
<tr>
<td>5.1</td>
<td>DISAC Recommendation – Proposed Appointment of a Pacific Representative to DiSAC</td>
<td>Negotiations To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obligation of Confidence The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]</td>
</tr>
<tr>
<td>6.1</td>
<td>Preventative Maintenance</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
</tr>
<tr>
<td>6.2</td>
<td>LabPlus PC3 Laboratory Construction Contract</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
</tr>
<tr>
<td>6.3</td>
<td>Ultrasound Machine Fleet Replacement</td>
<td>To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]</td>
</tr>
</tbody>
</table>

Auckland District Health Board
Board Meeting 01 April 2015
Page 2
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **6.4** | **New Agreement for Services under the Age Related Residential Care Agreement** | **Negotiations**  
To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]  
That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| **6.5** | **Audit Engagement Letter and Management Letters** | **Commercial Activities**  
To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]  
That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| **7.1** | **Human Resources Report** | **Negotiations**  
To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]  
That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |
| **9.1** | **HealthAlliance New Zealand Limited – Resolution in Lieu of an 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] |
| **9.2** | **Confirmation of the Minutes of the Special Meeting of the Board 11 March 2015** | **Confirmation of Minutes**  
As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000.  
That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000] |