Auckland District Health Board

Board Meeting

Wednesday 7 December 2011

2:00pm

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

Venue

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare

1

KARAKIA

Karakia

E te Kaihanga e te Wahingaro

E mihi ana mo te ha o to koutou oranga

Kia kotahi ai o matou whakaaro i roto i te tu waatea.

Kia U ai matou ki te pono me te tika

I runga i to ingoa tapu

Kia haumie kia huie Taiki eee.

Creator and Spirit of life.

To the ancient realms of the Creator

Thank you for the life we each breathe to help us be of one mind
As we seek to be of service to those in need.
Give us the courage to do what is right and help us to always be aware
Of the need to be fair and transparent in all we do.

We ask this in the name of Creation and the Living Earth.

Well Being to All.

2

ATTENDANCE AND APOLOGIES

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CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.
Ensure the full nature of the interest is disclosed, not just the existence of the interest.

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

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

ADHB BOARD INTERESTS REGISTER

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY (Chair)	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board A+ Trust	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman Trustee			31 May 2011
Jo AGNEW	Professional Teaching Fellow, Scholl of Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		9 September 2011
Peter AITKEN	Pharmacist Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	Nil				9 December 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Susan BUCKLAND	Writing, editing and public relations services Medical Council of NZ Occupational Therapy Board Northern Regional Ethics Committee	Self-employed Professional Conduct Committee member Professional Conduct Committee member Member	Fees Fee Fee Fee		7 September 2011
Dr Chris CHAMBERS	Employee, Auckland District Health Board Wife employed by Starship Trauma Service Clinical Senior Lecturer in Anaesthesia Auckland Clinical School Associate, Epsom Anaesthetic Group Member, ASMS Shareholder, Ormiston Surgical				20 April 2011

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee	Advisory	
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust Fee (to Ngati Hine Health Trust	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust		
	Waitemata District Health Board	Member			
Lee MATHIAS	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting	1 November 2011
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited	Provider of business and professional services to midwives and other maternity services providers	
	Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products	
	John Seabrook Holdings Limited	Director	No fee	Estate of late husband	
	AuPairlink Limited	Governance Advisor	Fee	Provider of early childhood education	

	NZ Council of Midwifes Tamaki Transformation Transitional Board Health Promotion Establishment Board	Council member Chair Chair	Fee Fee	services contracted to the MoE. Statutory Authority	
Robyn NORTHEY	Self employed Contractor Hope Foundation	Project management, service review, planning etc. Board member	Fee Nil	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	1 November 2011
Gwen TEPANIA-PALMER	Waitemata District Health Board Manaia PHO Ngati Hine Health Trust Te Taitokerau Whanau Ora	Board member Board member Chair Committee member	Fee Fee		18 May 2011
Ian WARD	C -4 Consulting Limited NZ Blood Service	Principal/ Director Board Member	 Fee		24 August 2011

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CONFIRMATION OF MINUTES

- WEDNESDAY 2 NOVEMBER 2011

Auckland District Health Board
Minutes

MEETING DETAILS	
Time and Date	2:00 pm, Wednesday, 2 November 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

1	**Karakia**
	The Chair declared the meeting open at 2:14pm. Gwen Tepania-Palmer led the meeting with the karakia.
2	**Attendance and Apologies**
	Board Members Dr Lester Levy (Chair) Susan Buckland Dr Lee Mathias Gwen Tepania-Palmer Judith Bassett Dr Chris Chambers Robyn Northey Ian Ward **Management in Attendance** Garry Smith - Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman - Chief Financial Officer Greg Balla – Director Performance and Innovation Taima Campbell – Executive Director of Nursing Janice Mueller – Executive Director of Allied Health, Scientific and Technical Vivienne Rawlings – General Manager Human Resources Ian Bell - Board Administrator **Apologies** Apologies had been received from Jo Agnew, Peter Aitken and Rob Cooper.
3	**Conflicts of Interest**
	There were no declarations of conflicts of interest for any item on the agenda. The Board Administrator had noted changes to the Interests Register for Lee Mathias and Robyn Northey.
4	**Confirmation of Minutes 5 October 2011**
	Moved Robyn Northey; seconded Lee Mathias *That the minutes of the Auckland District Health Board meeting held on 5 October 2011 be confirmed as a true and correct record.* Carried
5	**Action Points 5 October 2011**
	The action points had been addressed.

6.0	**Chairman's Report**
	As part of the Board's governance responsibility, which it takes very seriously, it is in the process of assessing its overall performance as well as that of individual Board members performance. The purpose is to ensure any areas of weaknesses can be identified and remedied. Work being undertaken by Garry Smith (Chief Executive, Auckland DHB) and Dale Bramley (Chief Executive, Waitemata DHB) on collaboration between the two Boards was progressing constructively. A meeting is to be held on 9 November of those Board members handling the collaboration portfolio (Lester Levy, Lee Mathias, Max Abbott, Chris Chambers, Wendy Lai and Gwen Tepania-Palmer). This group will act as a governance steering group to guide the overall collaboration process. Proposals would be considered by the Waitemata DHB Board in November and the Auckland DHB Board in December.
7.1	**Chief Executive's Report**
	Key events included the gas leak and its subsequent impact on ADHB and also the successful handling of the Rugby World Cup through AED. This was acknowledged by the Board. During the previous week the home dialysis unit at Greenlane was formally opened. Events surrounding the Challenge Trust (who were contracted for Mental Health Services) pose a risk to ADHB and steps are being taken to ensure that the Trust is able to maintain continuity of service. The Clinical Practice Committee released its Annual Report. The submission on the Auckland Council Plan had been made incorporating changes resulting from the Waitemata District Health Board meeting. The relationship between with the ADHB, the Regional Public Health Service and the Council is critical in order to promote health gain. More Maori health statistics were being brought to the Board with a new Maori Health Plan is being developed through the consolidation of the Auckland and Waitemata plans.
7.2	**Minister's Six Health Priorities**
	These had been discussed at previous meetings.
7.3	**Management Operating System (MOS)**
	Prior to the meeting there had been a presentation to the Board on the Management Operating System (MOS) which was a visual management system with the key outcome being the boards understanding of how the system was worked.
	Accountability Structure
	A revised explanation of the structure was provided based on the HSG structure. Accountability and how the relationships work were discussed in detail.
8.1	**Committee Recommendations**
	Community and Public Health Advisory Committee Recommendation Moved Lee Mathias; seconded Gwen Tepania-Palmer *That the Auckland District Health Board notes the background and progress made to date on developing a locality approach in Auckland DHB, the linkage with concurrent primary care and community engagement activity, and the actions to align and coordinate across Auckland and Waitemata DHB.* Carried
9.1	**DAP Projects Report**
	The report was noted.

10.1	**Finance Committee Recommendations**

Crown Health Funding Agency

Moved Lee Mathias; seconded Gwen Tepania-Palmer

That the Auckland District Health Board resolves that the signatories of persons who have been fully authorised to give notices and other communications to the Crown Health Funding Agency be updated by deleting Pat Snedden and Harry Burkhardt and replacing them with Lester Levy and Ian Ward and confirms the CEO and CFO as signators.

Carried

Oracle Upgrade

Moved Ian Ward; seconded Robyn Northey

That the Board:

1. *Approves a dispensation from tender.*

2. *Approves the business case for forwarding to the Regional Capital Committee and the Crown approval processes on the basis that:*
   - *a) The business case is for the purpose of migrating ADHB on to the shared services Oracle Release 12 system operated by healthAlliance (in accordance with the standardisation principle of shared services) from the current partially supported Oracle software*
   - *b) The business case comprises the components (inclusive of contingency budget) of:*
     - *i. Project Office $201k*
     - *ii. System Functional and Technical $1,247k*
     - *iii. Staff Backfill $251k*
     - *iv. Infrastructure and IS Technical $150k*
     - *v. IPM, Analytics and Barcode $131k*
     - *vi. Change Management and Training $102k*
     - *vii. Purchase of new Oracle Licences $539k*

     Totalling up to $2.675 million including $0.222 million contingency budget

3. *Notes the reprioritisation of ADHB capital expenditure budget of up to $1.875 million over the 2011/12 and 2012/13 financial years to finance this business case.*

4. *Notes the increased annual operating costs from 2012/13 of $0.8 million per annum estimated by healthAlliance in the business case, to be met from a reprioritisation of other planned ADHB operating expenditure.*

5. *Notes and supports that negotiation is undertaken with Oracle in order to minimise the increased license, and associated maintenance support costs, incurred by the sector.*

6. *Notes that, during detailed planning, healthAlliance will review the proposed go live date in order to ensure that the implementation and change management risks are minimised whilst not unduly jeopardising any national FMIS developments.*

7. *Requires that, concurrent with the Crown approval processes, healthAlliance finalises and provides the detailed project plan specifying project timeline, detailed resourcing and detailed costings to enable confirmation and approval by ADHB of the final budget within the above limit.*

8. *Requires that healthAlliance confirms that any operational costs currently funded by the DHBs will not be charged to the project and therefore double-funded.*

9. *Requires that healthAlliance confirms, supported by a stakeholder impact analysis, that no matters specified as being outside of project scope will require additional unbudgeted expenditure in order to achieve successful delivery of this project.*

	10. Notes that healthAlliance shall only charge for actual costs incurred and authorised within the limit of the final approved budget. *11. Requires that the healthAlliance Board considers and recommends for Shareholder approval whether their services are charged to the sector at cost recovery or at "commercial" charge out rates.* *12. Approves commencement of the implementation, subject to Crown approvals and the above requirements, at a time which enables the achievement of a successful go live within the final approved budget.* *13. Subject to the Capital Asset Management Planning Committee and Expenditure Committee approval.* *14. Subject to bi-monthly reports from the CFO on the project's progress, risk etc.* Carried **Primary Options for Acute Care** Moved Robyn Northey; seconded Lee Mathias *That the Auckland District Health Board agrees to host the Primary Options for Acute Care contract of a Metro Auckland value of $5,344,474 noting that ADHB's share will be $1,416,309.* Carried ADHB as host would be managing the contract and the figures stated were the annual figures in a two year contract. There was research and evaluation of the project planned in the coming year. It was noted that a Waitemata District Health Board member was doing research into the Six Hour target in ED at ADHB and the necessary probity and declarations of interest had been provided.
10.2	**Finance Report**
	A number of matters had been discussed at the Hospital Advisory Committee including patient volumes. At the consolidated level the year to date result is a $719k surplus which is $1.28 favourable to budget. Revenue was favourable with the PHO realignment, which was offset in Funder Payments, increased revenue from Ministry contracts and IDFs. Capex expenditure was increasing pace now that more proposals had moved through the approval process. Cash resources were reducing but this was planned until the $21m CHFA draw down planned for February. FTE were of some concern with potential flow through of unfavourable employee costs, however, there was a management review process in place. The Audit and Finance Committee had asked Regional Internal Audit to review the GAIHN contract noting that when contracts are let there must be a process to ensure appropriate governance was in place.
11	**General Business**
	Celebration Week and Healthcare Excellent Awards The Board were invited to the Health Excellence Awards and Celebration Week.

13	**Public Exclusion**

Moved Chris Chambers; seconded Susan Buckland

That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 15

The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
13.1 Confidential Board Minutes 5 October 2011 13.2 Laboratory Services Up date 13.3 ER Update 13.4 ACH Car Park Leases	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.

Carried

The items discussed in public exclusion were confidential minutes 5 October 2011, laboratory services update, employment relations update, ACH car park leases and Te Whetu Tawera.

Moved Robyn Northey; seconded Susan Buckland

That the meeting resume in public.

Carried

Next Meeting

The meeting closed at 4:17pm

The next scheduled meeting is:
2:00pm, Wednesday, 7 December 2011
A+ Trust Room, Clinical Education Centre
Level 5, Auckland City Hospital

Grafton

CONFIRMED

CHAIR: **DATE:**

5

ACTION POINTS

- WEDNESDAY 2 NOVEMBER 2011

Board
Action Points from the meeting on Wednesday 2 November 2011

Item	Detail	Designated	Action
5.1	Letter of appreciation from the Chair to CPC to be drafted	Margaret Wilsher Garry Smith	Drafted
	Accountability Structure: How HSGs work	Garry Smith	Item 12.3
	Audit NZ V8 recommendations to be distributed	Ian Bell	3 November
	Chair to brief Chair of Chairs ER Committee on SM0 negotiations	Vivienne Rawlings	Completed.

6

CHAIRMAN'S REPORT

6.1 Report - Verbal

6.2 Executive Committee of the Board

6.1 Report – Verbal

6.2 Executive Committee of the Board

ADHB Board

Author: **Ian Bell (8077)**

Subject: **Establishment of Executive Committee of the Board**

Recommendation

1. *That the Board approve the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/ New Year Board recess.*

2. *That membership of the Committee is to comprise the Board Chair, the Deputy Board Chair and the Chair of the Audit and Finance Committee, with …….. as an alternate.*

3. *That the Executive Committee be given delegated authority to make decisions on the Board's behalf relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from a Committee or the Chief Executive.*

4. *That all decisions made by the Executive Committee be reported back to the Board at its meeting on 15 February 2012 for ratification.*

5. *That the Executive Committee be dissolved as at 15 February 2012.*

Background

The purpose of the resolution is to seek the Board's approval to establish a Committee to conduct pressing Board business during the Christmas/New Year recess.

The final normal scheduled meeting of the Board for the year is on 7 December 2011. The next meeting is on 15 February 2012. This leaves a longer gap than normal between Board meetings for this time of year, a one off occurrence as the Board transitions from a monthly meeting cycle to a six weekly meeting cycle. There are likely to be some items of business requiring approval at Board level that need to be processed during this period. It is expected that most of these items will be able to be considered at either the Audit and Finance Committee on 25 January 2012 or the Community and Public Health Advisory Committee meetings in the period on 14 December 2011 and 1 February 2012, however those Committees can not make decisions, but only recommend to the Board.

Under the NZPH&D Act (Schedule 3 Clause 38) there is provision for the Board to establish one or more committees for a particular purpose or purposes.

It is proposed that the Executive Committee should have a relatively small membership so that it can be convened at short notice, should this be necessary.

The proposed membership is the Board Chair and Deputy Chair and the Chair of the Audit and Finance Committee, with one alternate.

It is expected that, by their nature, most of the items referred to this Committee will need to be taken in public excluded session. It is suggested that a meeting of the Committee be held after the Audit and Finance Committee meeting on 25 January 2012, timed for 12 noon, to approve anticipated recommendations from that meeting. At this stage we are not aware of any other items that will require the Committee to meet between 7 December 2011 and 15 February 2012, however it is possible that a critical issue or issues could arise in that two month period. The date and agenda items of any meeting(s) would, as soon as confirmed, be advised to all Board members. All decisions of the Executive Committee will be required to be ratified at the 15 February Board meeting.

7

CHIEF EXECUTIVE'S REPORT

7.1 Chief Executive's Summary

CHIEF EXECUTIVE'S REPORT

1	**EVENTS AND NEWS IN OCTOBER**
2	**EVENTS AND NEWS IN NOVEMBER**
3	**MANAGING THE WIDER HEALTH SYSTEM**
4	**BOARD PERFORMANCE PRIORITIES**
5	**REGIONAL SERVICE PLAN 1ST QUARTER REPORT**
6	**APPENDICES**

Introduction

This report covers the month of October. It includes a brief summary of events of note in October and November an update on management of the wider health system and a summary of progress against the Board's priorities to confirm these matters are being appropriately addressed.

1 Events and news in October

1.1 Events

The Home Dialysis Unit, at Greenlane Clinical Centre, was opened on 27 October by Associate Minister of Health, Jonathon Coleman. This now combines home haemodialysis training and a peritoneal dialysis wing in the same facility for the first time.

1.2 People

- Senior clinicians Cameron Grant, Sally Roberts, and Colin McArthur are part of the New Zealand based project team that has won an international contract to monitor and study influenza patterns to prevent the spread of the illness.
- The trial of ED doctors accompanying the Auckland Regional Helicopter Trust (ARHT) helicopter on emergency missions has started.
- ADHB's ACC manager, Jayanthi Mohanakrishnan, has been honoured with a Fellowship from the Australasian College of Health Service Management.
- Starship Consultants Teri Bidwell and Phil Morreau competed in the World Ironman Champs in the US.
- The late John Neutze and Toby Whitlock were both acknowledged with obituaries published on the ADHB intranet.

1.3 Media

- ADHB's ED Department in the news for producing record results during the Rugby World Cup.
- Four-year-old Eva Mitchell, who has spent most of her life living at Starship, was featured on TVNZ's 20/20. The programme experienced its highest ever ratings with this article.
- The Taranaki gas leak led to a modified Incident Management team being set up and extensive interest in ADHB's contingency plans.
- Intense media interest in former All Black Jonah Lomu continued. ADHB respected the family's wishes for no comment to media.
- A Herald on Sunday Official Information Act (OIA) request for reports on maintenance and future developments at Starship Children's Hospital was received.

1.4 Internal

- The ADHB smoking cessation team has introduced quit clinics at the level 5 Atrium at Auckland City Hospital. This is a direct approach to connect with

staff about the options available at ADHB to quit smoking; for example – Nicotine Replacement Therapy (NRT), the Quitline phone on level 5 next to reception at Auckland City Hospital.

2 Events and news in November

2.1 Events

- Vital Signs CEO Briefings started on 7 November and ran through to 18 November.
- Celebration Week starts on 21 November and includes the inaugural Healthcare Excellence Awards

2.2 Media

- Coroner's report into Zachary Gravatt death from meningococcal a year ago was released. Media communications were led by Chief Medical Officer, Dr Margaret Wilsher
- The Herald on Sunday Official Information Act (OIA) request for reports on maintenance and future developments of Starship Children's Hospital was fulfilled. Dr Richard Aickin made himself available for interview by the Herald on Sunday regarding this.

2.3 Internal

- The Clinical Skills Centre received a $40,000 pendant from Modempak, which will be used for anaesthesia training. CEO attended a small event on the day to acknowledge the gift on 8 November.
- Preparation for pre-election voting and voting on the day of elections for patients and ADHB staff in Auckland City Hospital is underway.
- The inaugural Healthcare Excellence awards were a great success, with 76 applications received. Judges reported the standard of the applications were impressive. A commemorative booklet has been published which celebrates the winners and finalists of the awards. An electronic version of the booklet is on the ADHB Intranet site. Hard copies have been sent to all board members.

3 Healthcare system report

3.1 System performance

The Rugby World Cup concluded without any major public health event, other than the measles which was on-going prior to the commencement of the rugby. Confirmed measles cases continue at about the rate of 3 or 4 per day, while the Incident Management team has been scaled down to provide input to the regional primary care response.

The primary care response is an enhanced immunisation campaign targeting those born after 1969 that are unsure of their immunity status to get vaccinated. It also involves some change to the timing of the immunisation schedule for children. As previously reported the potential costs were scoped at $1.5-2.5m for the region. Communication is the key to the uptake of this campaign and with only a limited response to the first communications through radio, print media and primary care a second has been developed. This will involve radio supported by posters and flyers for practices and will be launched within the next two weeks.

3.2 Financial performance

A full report is included in the Audit and Finance Committee papers, but in summary the net result for the month is a deficit of $1,015k compared to the budgeted surplus of $1,236k. This brings the year to date to a deficit of $296k compared to the budgeted surplus of $674k.

The major feature of the month variance was a reduction in the level of IDF referrals being received compared with budget. Although a portion of this IDF revenue reduction was reflected in lower direct treatment costs, this cost reduction was offset by higher outsourcing costs than budgeted.

3.3 Clinical quality and professional governance

Serious & Sentinel Events Reporting

The Health Quality & Safety Commission (HQ&SC) has postponed the release of the annual report on District Health Board Serious and Sentinel events until February 2012. The HQ & SC are still collating data received from DHB's on SAC[1] 1 & 2 events and have noted variation in reporting. ADHB has undertaken a recent audit which confirms an underreporting of events such as falls with harm though the current incident reporting system. A number of organisation-wide safety programmes are in progress to reduce patient harm and improve safety. Further detail is provided in the following sections.

Adverse Events

There are 36 formal investigations into SAC 1 or 2 events in ADHB at present. All events that are coded as SAC 1 are investigated using the Root Cause Analysis (RCA) method of investigation. These should be completed within 70 working days of the incident being notified, including submission to the Adverse Events Review Committee for approval of methodology and recommendations. A summary report from the RCA is forwarded to the HQ&SC which is the national repository.

SAC 2 incidents must have a detailed investigation. This could take the form of an RCA; however other appropriate and effective investigation methods may be used e.g. Serious Incident Review Process (SIRP) or case review. It is possible to aggregate similar events and review together. The investigation must be completed within 70 working days. A copy of the report is also sent to the Adverse Events Review Committee for approval of methodology and recommendations.

[1] Severity Assessment Code is numerical score given to an event, based on the consequence or outcome of the event and the likelihood that it will recur. SAC 1 & 2 are major adverse or serious and sentinel events.

Table 1: Adverse Events Metrics

Measure - 14th November 2011	Actual	Target	Trend
Number of Sac 1/ 2 incidents (scored)	**8**	**0**	↑
Number of Near miss reported	0	**5**	→
Current Number of formal investigations in progress	**36**	**15**	↑
Days to completion of formal investigation	**116**	**70**	→

Reducing the number of falls with harm is one of the goals of the 'First Do No Harm' regional programme and requires an accurate record of falls to form a baseline. It is recognised that voluntary reporting may not capture all events accurately so chart reviews were undertaken using discharge coding data and additional falls with fractures were identified. The 32 falls with harm for the 2010 / 2011 period is therefore higher than the previous year (9) due to the baseline audit and subsequent changes in the method of data collection and inclusion criteria. The increase in the number of adverse events in November (Table 1) is a result of these changes. The volume of investigations is also impacting on the days to completion which includes final review of actions by the Adverse Events Review Committee.

Patient Experience

The health care excellence criteria ask how the organisation listens to patients and gains information regarding their experience, and how this information informs improvement. As part of the Consumer and Community engagement framework it was recognised that the previous patient satisfaction survey was not meeting this need.

A new patient experience survey has been developed based on the PICKER Institute with the ability to benchmark ADHB results internationally. The new online survey was launched in mid-October and offers every discharged patient that provides an email address with the opportunity to participate. The first report (appendix 1) rates hospitalisation in ADHB as an overall "positive experience" from 76% of responders based on data collected over a 3 week period. Over time we will analyse respondent demographics and identify opportunities to ensure feedback is obtained from a representative sample of our patients. We will report back to the Board after more data has been collated and analysed in February 2012.

Hand Hygiene

ADHB was the successful tenderer to provide leadership and implementation of a national hand hygiene programme. The Hand Hygiene NZ programme is one of three projects sponsored by HQ&SC which aims to reduce healthcare associated infections in New Zealand DHB's. On acceptance of the leadership of this

programme, Dr Josh Freeman (Microbiologist) has been appointed as the clinical lead to the project.

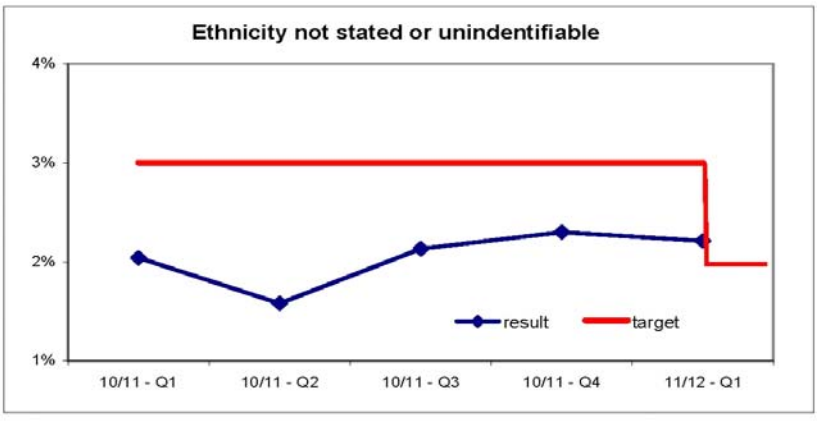
3.4 Support services

A summary of the current position for performance indicators for Information Management, Human Resources and Finance/Shared Services is shown below:

Service	Number of indicators	Exceptions
Information management	26	The exception for October relates to duplicate NHI numbers (featured indicator in the October Report) and Ethnicity Data (featured indicator in this month's report).
Human Resources	40	There were no exceptions in October and the featured indicator for the month is discussed below.
Finance and shared services	15	There were no exceptions in October and the featured indicator for the month is discussed below.

Featured Information Management indicator – Ethnicity Data Quality

ADHB's rate of new registrations that have been created with an unspecified ethnicity code (i.e. ethnicity not stated or ethnicity unidentifiable) has been tracking consistently between 1.5 – 2.5%. The MoH target has been less than or equal to 3% in previous years, and ADHB has achieved this historically. For FY2012 the MoH target has been changed, so that DHBs are now expected to create new NHI registrations with less than or equal to 2% of cases having an unspecified ethnicity. This has had an adverse impact on ADHB's performance against this measure.



ADHB's relative position on the DHB comparison table has remained constant over time.

The following table reflects DHB performance for FY2012 Q1.

DHB	New NHI Reg's	Total with Non-spec Code	%	MoH Rating
West Coast	224	0	0.00%	Outstanding
Tairawhiti	222	2	0.90%	Achieved
Northland	695	8	1.15%	Achieved
Waikato	1408	19	1.35%	Achieved
Counties Manukau	2718	37	1.36%	Achieved
Lakes	602	10	1.66%	Achieved
Whanganui	218	4	1.83%	Achieved
Canterbury	1952	39	2.00%	Achieved
Auckland	**3795**	**84**	**2.21%**	**Partial achievement**
Hawkes Bay	742	17	2.29%	Partial achievement
Hutt	719	18	2.50%	Partial achievement
Capital and Coast	1434	41	2.86%	Partial achievement
Southern	2100	76	3.62%	Partial achievement
Bay of Plenty	990	45	4.55%	Not achieved
Wairarapa	172	8	4.65%	Not achieved
Nelson Marlborough	786	39	4.96%	Not achieved
Taranaki	561	36	6.42%	Not achieved
South Canterbury	194	13	6.70%	Not achieved
Waitemata	2582	222	8.60%	Not achieved
Midcentral	697	224	32.14%	Not achieved

The MoH target of 2% is a realistic goal for ADHB to achieve and work is underway with various services to promote an understanding of the value of accurate ethnicity data and the importance of compliance with patient registration best practice to improve the quality of our data.

Featured Finance indicator G13. Revenue to Fixed Assets

This measure reflects the percentage of total revenue for the month to total fixed assets held in ADHB.

Since the final quarter of the previous financial year (FY11), there has been an increase in this indicator to a percentage above 18% compared with the prior year average of approximately 17%. The change in the percentage is driven more by the movements in assets than revenue where (a) the June 2011 accounts recorded a property devaluation of $21.7million and (b) following the March 2011 establishment of the regional shared services agency there was a reclassification of the $20million of assets to be transferred in to the property intended for sale account.

The following table illustrates movements in the indicator since July 2010.

Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11
16.8%	16.8%	17.1%	16.4%	17.3%	17.3%	16.9%	17.6%	18.0%	18.2%	18.4%	19.0%	18.3%	18.8%	19.5%	18.8%

Featured Human Resources indicator - F.22 Number of Serious Harm Work-injuries

Definition of Serious Harm Work-Injuries

According to the Health & Safety in Employment Act (1992) serious harm work-injuries are defined as any work-injury that causes permanent or severe loss of bodily function. This includes death or requirement to stay in hospital for treatment and recovery for a period of 48 hours or more commencing within 7 days of an injury's occurrence. All incidents of serious harm injuries occurring at ADHB must be reported to the Department of Labour immediately and in writing within 7 days. Also, all incidents are investigated by the OH&S Department. Serious harm clearly has a high impact on employee health and organisation productivity and requires immediate identification of causes and interventions implemented.

Serious Harm Work-Injury Occurrences at the ADHB

The Run Chart below (F.22) indicates a total of 47 occurrences from July 08 – October 11. Almost all serious harm incidents reported over this time period were fractures, and around 50% of these were from employee slips and falls caused by 'unsafe' hospital areas such as wet floors, uneven surfaces in entrances and car parks. Of the remaining incidents 25% were caused by employee handling of equipment, 15% due to employee involvement with sports activities with patients and 10% related to other factors including workplace violence.

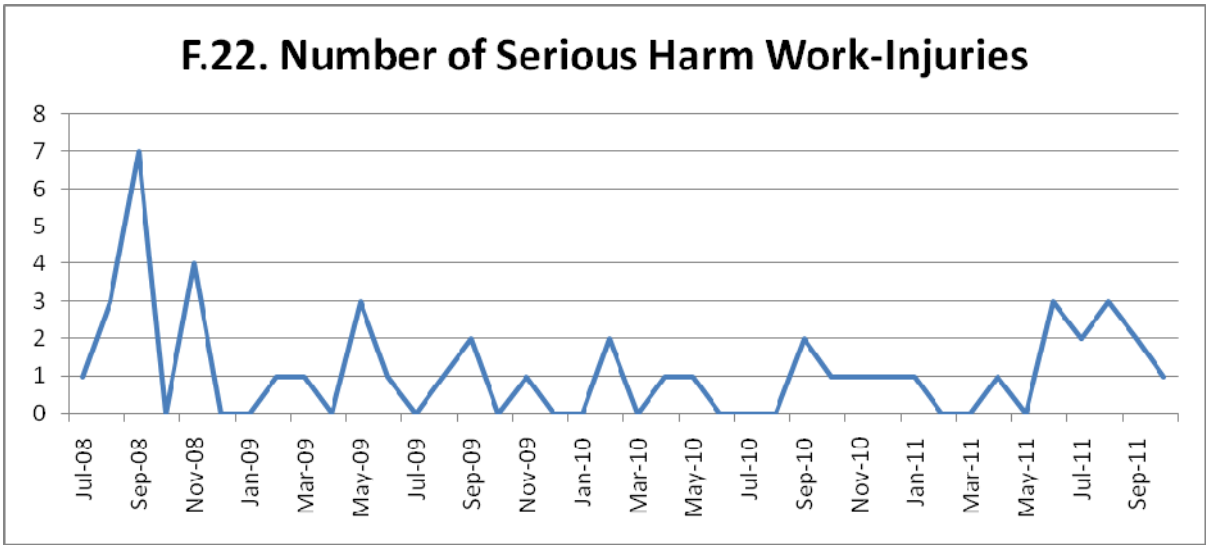
November Indicator

During the first 4 months of this fiscal year the number of serious harm occurrences was greater than usual, 8 compared to 3 in the same period last year. From these 8 injuries, 2 were due to slips and falls, and 4 related to equipment. Additionally, one injury was from an employee playing sport with patients and one was due to an employee striking a locker. This spike in the level of serious harm work-injuries has also translated to an increase in the lost time injury frequency rate for the year to date.

Remedies for Serious Harm Work-Injuries

Targeted initiatives including training for employees, employee awareness programmes, and repairs to car parks/entrances/grass verges etc have been undertaken by OH&S, Quality, and relevant managers to combat serious harm work-injuries with success. The number of serious harm work-injuries fell from 21 in 2008/09 financial year to 9 in 2010/11 financial year.

To address the recent increase in the level of serious harm work injuries an article has been written for the Occupational Health and Safety Directions (appendix 2) to ask managers to ensure their Slip/Trip/Fall checklists are completed and potential trip hazards are addressed. Additionally, the monthly team talk for Health and Safety Representatives this month will address slip and fall prevention.



3.5 Hospital services

October month performance did not reach health target levels for elective services (94%), YTD performance was over 99%. Outsourcing, although still above budget, reduced markedly in October; for all populations outsource cases in October were 157 (ADHB only 79 cases) compared to 291 (ADHB only 189) in September.

FTE for the year to date remain below budget (10 FTE) but an unfavourable variance of 33 FTE has arisen in October that is to be addressed by the respective Health Service Groups. More than half of this variance (18 FTE) relates to a large backdated payment in respect of SMO job sizing that creates an FTE entry. Additional resources are needed for Adult Orthopaedics OR capacity, Adult Neurosurgery OR capacity and increased session times at Greenlane in the New Year. These requirements will need to be accommodated by re-prioritising resources in other areas.

Direct treatment costs were close to budget with the favourable variance of $400k year to date. The Provider currently has a very favourable position on drugs costs representing lower than anticipated demand for haemophilia and cancer drugs; in both these cases there is a corresponding revenue impact as the drug utilisation is funded through IDF revenue. Lower volumes and the Concord “Blood is a Gift” programme have also contributed to the favourable direct treatment costs

Strong performance against the other Ministry of Health targets has continued. Of particular note is the reduction in the cardiac wait list at 31 October to the Ministry target level.

The net result for the provider at a deficit for the month of $3.3 million was unfavourable to budget by $3.6 million with the most significant variance relating to revenue $3.7 million below budget. A significant component of this shortfall relates to IDF referral numbers being abnormally lower than planned during the weeks surrounding the Rugby World Cup.

3.6 Primary care and community services

Community Pharmacy

The northern region is continuing to progress and support the development for the new national pharmacy contract for 1 May 2012 start date. This is a significant undertaking and it is positive that four GMs and a lead CEO have now been appointed to the project. Nevertheless the timelines are tight and the process will need to be managed carefully.

A workshop was held on the 29 September to present the work completed with the pharmacy sector on progressing the Long Term Conditions aspect of the national pharmacy contract and a further workshop including the pharmacy programme managers has been scheduled for 25 November.

With respect to the Auckland Region, the existing *Metro Auckland Variation* will be brought into line with the new national contract which allows the service specs for Gout (CMDHB), ECP (ADHB) and Medicines Utilisation Review (WDHB) to be further developed by each member of the regional work group. It is envisioned that each DHB may then be able to purchase volumes of each service according to need and specific pharmacies will have access to the contracts, but it will not be universal as it is currently.

There are concerns that unless the pharmaceutical waste issue is rectified at a national level the metro variation may still be needed to support this at a local level. A national survey was undertaken around DHBs' hospital and community pharmaceutical waste processes and currently interest in a national solution is being explored.

Any metro variation proposals will be considered by the Regional Funding Forum (RFF), a date for this has not yet been set.

Oral Health

Currently the key activity in the oral health portfolio is the implementation of the Child and Adolescent Oral Health Business Case. Work is progressing according to plan with the build of thirteen new clinics (one being a refurbishment) and purchase of four diagnostic mobiles (with a decision on an additional treatment mobile still pending).

The building of the five first phase clinics have been completed and all are now treating patients. The five second phase clinics will be completed with the final three (Blockhouse Bay, Royal Oak and Ponsonby) seeing patients before the end of December. Planning has begun for the three clinics in the final phase due for completion by mid 2012. There are, however a number of issues regarding one school in this phase which are unlikely to be resolved in a satisfactory manner.

Auckland Normal Intermediate have made the building of a clinic on their site conditional on a number of requirements including the construction of a new secure bike/scooter enclosure and various other upgrades unrelated to the clinic. These conditions are not acceptable to ADHB (or fair to all of the other schools who have been involved in dental clinic development) and thus the Project Steering Team is looking at alternative site options in the area. Greenlane Clinical Centre has been

suggested as a possible suitable site and the viability and design factors for this are being considered at the moment.

Child Health

B4 School Checks

It is pleasing to note that first quarter reporting showed a significant improvement of performance compared to the previous year. 22% of all eligible children had received a check and 21% of children from high deprivation areas had received a check against an expected year to date target of 25%.

Agreement has now been reached with Plunket to become an additional provider of checks and performance is expected to improve further once they begin undertaking checks by late October. The B4SC Service Alliance Leadership Team is confident that the annual targets of 80% will be met or will be very close to being met by financial year end.

Women's Health

Maternity Service Specifications

The Ministry of Health has published a suite of new draft maternity services service specifications. Both ADHB and Counties Manukau DHB had indicated concerns regarding a proposed change to the definition of post natal care that could have major capacity implications for DHBs whose systems depend upon transfer of women and babies to a primary maternity facility for post natal care. The Ministry of Health has acknowledged these concerns and agreed changes and on this basis ADHB and Counties Manukau DHB have agreed to endorse the service specifications. Both ADHB and CMDHB concerns have been largely allayed by the agreed amendments.

The Ministry has also agreed to a change suggested by ADHB to the definition of a post natal stay which will have the effect of allowing flexibility around the length of post natal care depending on a woman's need and choice.

Cervical Screening

ADHB has been the lead DHB on behalf of Waitemata and Counties Manukau DHBs for a contract with WONS for a mobile service providing cervical smears to priority women. This contract was refocused in 2009 on cervical smears for priority women and tendered. WONS won the tender but have struggled to achieve contracted volumes. As a result WONS proposed that they exit the contract and this has been accepted following a number of meetings with them.

It is of concern that the Auckland Region has the lowest rate of cervical smears in the country and the three DHBs are working closely with the National Screening Unit to identify effective strategies to improve the rates particularly for Maori, Pacific and Asian women as well as others who meet the criteria as priority women. One of the strategies being considered is the establishment of Cervical Screening Coordinators in primary care to work with practices on ways to reach women and act as 'champions'. There is also some evidence to show that offering free smears is an effective strategy to reach priority women.

Health of Older people

Residential care

The Seaside Sanctuary closure is underway, with 12 of the 20 residents having been relocated to new facilities off Waiheke without incident. Of the seven residents that remain, two have identified placement preferences and these are being progressed. For the remaining five, a small group home on Waiheke is being explored following clinical approval for each of the residents, and discussion with families and carers. ADHB is developing a tender document seeking small group home providers and Seaside Sanctuary has agreed to leave one wing of the facility running whilst this process is undertaken and appropriate alternatives are developed. This is an exciting opportunity for the population of Waiheke as a clinical panel has been convened to review new referrals for rest home care on the Island for suitability for small group homes in the future. Media and community attention remains high but weekly updates on progress from the ADHB seem to be reducing the one off reactive responses.

Dementia Day Care

This tender is now complete with negotiation underway with the preferred provider. This has been an extraordinarily positive outcome, with Selwyn Village committing to taking on all residents as well as staff from the Meadowbank service, including the transport service and the current driver. The continuity that this will provide is highly valued by the families of dementia clients. From November the service will operate from Selwyn Heights in Hillsborough, with an assurance that a property in the Eastern suburbs will be secured as a priority. All transport issues will be managed in the interim for Eastern Bays residents, however an analysis of the current client group has revealed that many travel from central Suburbs each day. The evaluation panel has therefore also agreed that the second placed proposal will be accepted to deliver an additional 15 places in Onehunga using new CFA funding for respite care from 1 July 2012.

Palliative care

Specific progress has been made in the last month in respect of integrating the services that are provided by Mercy Hospice Auckland and the ADHB District Nursing Service. Although this is a slow process, this is central to all other parts of the model succeeding. There has also been discussion in the past month about working regionally to build on the progress that ADHB has made with its Palliative Care redesign, as neither WDHB nor CMDHB have managed to get buy in from stakeholders as yet to even begin the conversation.

Refugee Health Collaborative

Practices continue to target their refugee populations. Current focus is on ensuring a manageable and sustainable approach to future funding to practices. An end of project evaluation is being developed for Feb/March 2012.

Primary care

GAIHN

As reported previously, GAIHN is seeking further funding from the DHBs and both ADHB and WDHB have required that these requests be considered by their respective Audit and Finance Committees. Consequently similar papers were prepared for consideration at the November meetings of both Committees. The Committees agreed to a reduced level of funding focussed on the achievement of clear deliverables and that this, together with any request for additional funding in subsequent years, was to be managed through appropriately designed stage gates. The development of clear governance and project reporting processes were also requested. The paper also noted the funding implications if Waitemata PHO were to withdraw its partnership from GAIHN and the Committees required that the funding request be reduced accordingly.

The GAIHN Alliance agreement has been signed by Auckland PHO, East Health and ProCare. The agreement is currently going through Auckland DHB's internal sign-off process. As Waitemata PHO has still not yet confirmed their partnership in GAIHN, the agreement has been signed without their inclusion. Waitemata PHO can be added into the GAIHN Alliance agreement at a later date if necessary. Once the agreement has been signed by all parties, Sector Services will be instructed to prepare the PHO Variation and maximisation of Care Plus can begin. The Ministry of Health will however only release the maximised Care Plus funds once the ALT has agreed on how this funding will be spent and that the DHB has contracted appropriately for this.

A transition plan to shift the management of the *Regional Annual Plan Projects* to GAIHN has been developed and is being implemented. However concern has been raised by the Regional Governance Group about the governance of these projects (and also the business cases) and greater transparency and structure in this respect is being requested. It is likely that the DHBs will continue to play a major role in the management of the *Regional Annual Plan Projects.*

National Hauora Coalition (NHC)

ALT Membership: The first workshop to re-establish the NHC ALT was held on 27 October and hosted by He Kamaka Oranga at Auckland DHB. It is intended that the first formal meeting of the newly established ALTs (Auckland and Midland) will occur in early November.

NHC and DHBs are developing the process for setting targets at both a local and national level for the PHO Performance Management Programme (PPP) as well as for the setting of baseline data and measurements for implementation plan targets.

The DHBs have been clear that while NHC may create baseline data amalgamated from the historical PHOs for a national target, it is nevertheless expected that there will be improvement for those PHOs who may already be above the proposed national target. Local targets will be set between DHBs and locality providers.

Alliance Health + (AH+)

AH+ have been addressing the need to improve performance of their organisation and began by reviewing governance. As a result they have resolved to disband the current Board and establish an Interim Board while they go through a process to establish a new, more skills based Board. The MoH has provided Pacific Provider Development funding to contract Health Partners to support this process. In addition Health Partners will also support a review of management and related systems, and a review of contracts with regard to delivering value for money. AH+ have fully briefed their DHB and other funders, who all are supportive of these actions.

AH+ have appointed a new Clinical Director, Dr. Siobhan Trevelyan. Siobhan will be responsible for strengthening the clinical leadership and network within AH+.

The AH+ Mt Wellington IFHC was officially launched on 20 October 2011 by the Prime Minister.

3.7 Māori Health

Work continues to be focussed on a broad range of activities relating to Māori health gain and the reduction of health inequalities across Auckland DHB's region. A prominent aspect of this month's update is the Māori Health Gain Advisory Committee (MHGAC)'s second meeting held on 19 October. You will note a number of activities reference actions and papers from this meeting, and, given the significance of work required in Māori health, will continue to be a prominent feature in many updates to come.

Specific activities continue to cover a wide variety of work from primary care through to secondary and tertiary care.

Particular focus has been placed on:

- Implementation of the Better, Sooner, More Convenient (BSMC) initiative
    - Greater Auckland Integrated Health Network (GAIHN)
    - Alliance Health + (AH+)
    - National Hauora Coalition (the Coalition)
- Whānau ora
- Iwi Relationships
- Regional projects to improve primary/secondary system efficiency.

Implementation of the BSMC initiative

GAIHN

The successful BSMC business cases have been charged with developing strategies to reduce health inequalities. Given the striking inequalities between Māori and non-Māori across various indicators, the Auckland DHB Māori health team have been working closely with GAIHN (as the largest provider of primary care services for

Māori in Auckland DHB's catchment area) to develop strategies to reduce inequalities between Māori and non-Māori. High-level dialogue continues to occur, whilst a number of service level projects are being developed and progressed. In particular, a project involving ProCare Auckland PHO to increase the enrolment of Māori in PHOs has commenced. The project will review the quality of ethnicity data recorded by ProCare Auckland PHO in order to ascertain the accuracy of data before any specific initiatives that enable enrol are developed and implemented.

AH+

Work is currently being undertaken to review whānau ora within Auckland and Waitemata DHB regions (see Whānau Ora below). The focus of this work will be to reconcile both BSMC and Whānau ora strategies and activities to avoid duplication and ensure that the current infrastructure evolves appropriately. This will have a direct impact on AH+ activity as they are both a Whānau Ora Collective and BSMC business case.

National Hauora Coalition

The Coalition has achieved two key milestones this month. Firstly, the organisation has increased its capacity considerably through the integration of one of its largest member PHOs Te Hononga o Tamaki me Hoturoa (Te Hononga) based in Auckland. Te Hononga and other member PHOs exited their PHO agreements with their respective DHBs earlier in the year in order for the NHC to apply and receive their own PHO agreement, a milestone achieved in July of this year. The second key milestone achieved recently was the completion of the Alliance Leadership Team (ALT) selection process. Nominations were received from Coalition stakeholders for membership on its Auckland and Midlands ALTs. The nominations were assessed by a selection panel based on criteria developed at an ALT workshop which included representatives from member providers, Auckland and Counties-Manukau DHB, and the Ministry of Health. The selection panel's recommendations are currently awaiting approval by the Ministry of Health.

Whānau Ora

The MHGAC at their recent meeting (dated 19 October 2011) approved a paper put forward by Waitemata DHB and Auckland DHB to undertake a stocktake of whānau ora activity in both areas. There are currently two clear whānau ora work streams emerging in our area, one Ministry of Health-led under BSMC and the other Te Puni Kōkiri-led under whānau ora, the latter the result of the much heralded Whānau Ora Taskforce Report. The stocktake will provide the MHGAC with information about the scope of work being undertaken that relates to whānau ora, and make it easier to assess ways in which the DHBs can provide support in these areas.

Work specific to the DHB includes the implementation of a Devolution/Whānau Ora Centre Project and an Integrated Contract Project led by He Kamaka Oranga Māori Health, each of which are touchstones of the whānau ora policy. A Māori provider forum has also been established to promote more provider involvement in AUCKLAND DHB activities, and the building of relationships among providers and between the DHB and providers.

Iwi Relationships

Māori staff from He Kamaka Oranga continue to support Te Runanga o Ngati Whatua – Te Kahu Pokere, and specifically, the completion of their sustainability plan. A brief has been circulated for review and advice from Dr Lester Levy, Chairman of Auckland DHB and Waitemata DHB. The option to obtain further expertise from Price Waterhouse Coopers in preparing a sustainability plan is being considered.

The impetus for the plan has been the ongoing concern around the financial sustainability of Te Kahu Pokere as a MoU partner with the Auckland DHB. Te Kahu Pokere's input into strategic activities is necessary to honour our MoU and Māori within our region who we are both accountable to. The Auckland DHB is committed to ensuring this relationship continues, and both partners are able to participate effectively.

Tikanga

The report on Tikanga and its application within AUCKLAND DHB commissioned by He Kamaka Oranga was presented at the MHGAC on October 19th gaining the support of the committee.

Following a request by the Māori Health Advisory Committee of Auckland District Health Board, He Kamaka Oranga was commissioned to undertake an annual review of Auckland DHB Māori health expenditure. He Kamaka Oranga were requested to develop a framework for the determination of AUCKLAND DHB Māori health expenditure that could then be used as a basis for determining Māori Health Spend targets across Auckland District Health Board. The MHGAC meeting of 19 October 2011 approved this initiative and further requested that the committee be provided with an annual spend on a per capita basis and population proportions.

Toi Oranga

The Toi Oranga project looks at the development of a whānau ora focused healthy lifestyle pilot programme in a Māori education setting. This project will undertake health promotion/prevention and primary care activities to achieve whānau ora. A draft project plan has been completed with GIS mapping that identifies the location of primary care providers, Marae, Māori medium education and school oral health centres. This will enable the most appropriate selection of education sites to participate in the Toi Oranga Whānau project.

Youth Health

A regional youth training initiative seeking to increase the capacity of primary care to effectively address key youth health issues has begun with a series of training sessions. These sessions were part of a joint Auckland DHB and Waitemata DHB approach that seeks to enhance the youth-friendliness of general practice and increase timely access to appropriate primary care services for young people. The first series of three training sessions were completed in October and these were attended by primary care staff from across the Metro Auckland region. A further five series of three sessions each will be held in Waitemata DHB and Auckland DHB over the next three months.

Mental Health

In July Auckland DHB released a Request for Proposal for an iwi-based Māori mental health community based service. This RFP was developed to respond to the recommendations from the 2009 Māori mental health reconfiguration project which sought to develop an iwi based solution for Auckland DHBs kaupapa Māori community mental health services. The process included collaboration with Te Kahu Pokere, which resulted in a new provider to Auckland DHB, Mahitahi Trust, being selected for the provision of services. Mahitahi will focus on providing more support hours, a day programme, and residential care for Māori mental health consumers in Auckland. Auckland DHB are working with Mahitahi to transition clients from a former provider to the new service and supporting the development of Mahitahi's implementation of the service. Mahitahi is expected to have the first component of the service operational by March 2012.

The Regional Māori Mental Health Strategy was endorsed by both Regional Funding Forum and at the MHGAC at their October meeting. This strategy is aligned to the Māori health plans and will assist in supporting Māori mental health content in future regional services plans.

Māori health plan development across the NGO sector is a key component when being audited and currently Auckland DHB is working to develop a standardised guideline, template and monitoring process to assist mental health providers to attain a level or service responsiveness to Māori that meets Māori needs. It is anticipated that this will be rolled out across all NGO providers funded by Auckland DHB.

3.8 Pacific Health

Pacific Best Practice Training (PBPT)

Since the Launch in Nov 2010 of ADHB's Pacific Best Practice Guidelines, education workshops have been delivered to over 500 ADHB staff. Most staff are working in areas identified as having high Pacific patient utilisation rates. The attendees have included both clinical and non clinical staff. The focus of the training aligns to key objectives to deliver patient centred excellence for Pacific consumers and the wider Pacific community. Training has focused on:

- All new staff coming into the organisation – at Welcome Day.
- Health Service Groups with high Pacific utilisation rates and need.
- Key occupational groups such as Dieticians, Nurses, Allied Health, ARPHS workers involved in Health promotion.

From September this year, PBPT has been on offer:

- Twice monthly via L&D kiosk for staff (Second and fourth Wednesday of every month, venues are either CEC or the Liggins theatre at GCC)
- On request to any service groups outside of the 2 sessions per month.

To date, the evaluation from training has been extremely positive as well as constructive.

We have received several requests from primary care providers and other DHBs for the programme to be delivered to their staff, however our priority has been ADHB staff and we are limited in our capacity to deliver the training elsewhere.

ADHB HVAZ Programme

Self management education (SME) for Pacific peoples with Chronic conditions in the community – HEHA funding

Two 6 week SME classes are being held per month with an average of 25 Pacific participants completing the courses. Two (Samoan-speaking) Pacific SME 6 week courses were completed in October, with HVAZ Latter Day Saints churches in Mt Wellington/Panmure and Royal Oak. A total of 30 participants graduated with 4 identified as potential Community Course Leaders. Both churches want to start exercise & nutrition classes – and have sought support from ADHB to identify and support the training of their own champions to deliver classes. Another 2 (English-speaking) Pacific SME courses at 2 other churches are currently underway at week 4 of their 6 week programme, ending in November, with a total of 23 participants.

ADHB and WDHB Pacific teams' collaborative projects

The 2 Pacific team Managers meet fortnightly to discuss the development of a Regional Pacific plan with identified key priorities are underway. A combined ADHB and WDHB Pacific Health Advisory Committee is in progress.

The Pacific Smoking Cessation service (with ARPHS) enrolments are tracking at 33% of the minimum annual target. There has been an increase in referrals to the service from the hospitals and primary care providers, with enrolment targets for ADHB clients being exceeded. Ongoing promotion and recruitment to the service is an added effort, with mixed results. Overall the service is tracking well towards meeting its annual minimum enrolment target. Promotion efforts have been persistent and concentrated mainly to increase client enrolments for WDHB. Strong relationships with key contacts/stakeholders have contributed to additional networks and linkages in churches and community services.

Pacific Youth Suicide Prevention and Postvention

Pacific youth are disproportionately represented among suicides in ADHB. This is a recent problem and not previously identified in published data. In the past Pacific rates of suicide were similar to NZ European deaths; data from the first 2 years of the ADHB CYMRG suggests that this is no longer the case. Pacific youth are definitely now at increased risk and no longer remain the same as 'other' and is more in line with Maori (or even higher) (for CMDHB and ADHB). A joint approach by the 3 regional Pacific managers of Auckland DHB's is planned to urgently consider DHB Postvention and prevention strategies. A core Pacific reference group will be set up to consider priority actions which will contribute to DHB strategies for Pacific communities. Currently there is no funding available to support this work.

3.9 Intersectoral relationships

The ability of the health sector to achieve health gain on its own is limited in many areas where the determinants of health are social in nature. The health sector therefore works with other sectors such as housing, income support, welfare and education in order to achieve its goals. Each month this part of the report focuses on topical intersectoral initiatives and projects.

It is often difficult to directly influence outcomes due to the absence of direct authority over the processes and the lack of aligned strategic goals. As a result the best outcomes are often achieved through consultation, informal partnerships and working relationships and exchange of information. Good examples are the ADHB Immunisation Governance Group which has members from a wide range of other sectors, primary care and community organisations, and the initiative related to homeless people where the targets are clear and the action plan has a wide base of support from the various agencies involved.

The special focus in this month's report is on the ADHB Localities work. This is a Planning and Funding Project that aims to create the 'conditions in which families/whanau can take greater control over their lives and maximize their health'.

Localities are defined using the Auckland Council Local Board areas. They include all people usually resident in that Board area. A defining characteristic of the locality approach is its emphasis on intersectoral collaboration. This has included seeking partnerships with government and non-governmental agencies which have an influence on health and its wider determinants.

A focus of the work has included the development of collaborative projects to undertake research with communities. This includes a partnership with Ka Mau Te Wero, a community non-government organisation and Auckland University of Technology (AUT) to undertake a community action research project in Tamaki. The research covers an exploration of all aspects of health and wellbeing.

We are also collaborating on a second AUT supported research project being led by the Parnell Trust. This project is in response to a growing recognition that the demographic profile of the CBD is changing, including a growing number of young families. The research project is seeking to explore 'community connectedness' within the CBD. Feeling connected within local communities and knowing neighbours are important factors in promoting and protecting health.

The Localities approach is also facilitating greater collaboration with agencies such as Ministry of Social Development (MSD) and the Department of Internal Affairs (DIA). Both these organisations are developing initiatives in the Mt Roskill area and ADHB is represented at a DIA convened group designed to support the project and the greater alignment of community development activity.

4 Board performance priorities

The Board has set 10 priority areas. These have been mapped to the Regional and DAP goals and the key result areas specified by the MoH as follows:

Regional goal	Auckland DHB Goal	Auckland DHB Key Result Areas	Board Priorities
Improved population health	Lift the health of people living in the ADHB area	Improved health status	Chronic disease management Health of older people
Improved patient experience	Performance improvement	Better quality care Increased patient safety Staff engagement	New models of care Emergency care Elective surgery Shorter waiting times for cancer treatment Clinical leadership Culture
Cost and productivity management	Live within our means	Economic sustainability	Regionalisation through collaboration Living within our means

Progress in each area is summarised in this report under three headings:

- Scope of the work programme
- Current status
- Expected outcome for the year

Proceeding to plan 

Issues being addressed 

Target unlikely to be met 

The information set out on the following pages summaries the projects that support the Board's priorities and identifies the current phase and status of each project. The table below summaries the status of those projects and provides a summary of progress by comparing he position with last month. A negative figure in the last column therefore indicates the number of projects that have moved beyond that phase.

The reduction in the number of projects reflects continued refinement of the project allocations and amalgamation of related projects wherever possible when work commences

Project Overview

Projects	This Month	Last Month	Change
Not Yet Started	0	0	0
Planning	63	64	-1
Implementation	10	9	1
Completed	0	0	0
Cancelled	0	0	0
Totals	**73**	**73**	**0**

Priority Status

Board Priority	Description
1 Emergency Care	95% of patients are admitted, discharged or transferred from adult and children's EDs within 6 hours
	95% of patients admitted, discharged or transferred from Adult and Child Emergency Departments within six hours in October. There are a number of going initiatives within both the Adult and Child departments to maintain and improve this achievement.

Projects	Phase	On Time	On Budget	Expected Outcome
1044 - Implement primary care initiatives to reduce acute hospital presentations that could have been prevented with earlier intervention	Measure			
1046 - Streamline and improve the process of referral to inpatient specialties and admission to the inpatient ward or discharge	Improve			
1047 - Reduce inpatient length of stay	Improve			
1045 - Streamline Emergency Department processes to reduce the time to be seen in the Emergency Department	Define			

2 Elective Surgery	Achieve the number of elective procedures specified in the DAP
	Quarterly 1 performance was 101% to target. October 2011 was 94% against the health target and the services are reviewing their production plan at a daily and weekly level to achieve the Q1 target. Services have scheduled some volumes into Q2 and Q3 for increased lists and outsourcing.

Projects	Phase	On Time	On Budget	Expected Outcome
978 - Increase surgical and inpatient bed capacity	Define			
981 - Improve outpatient efficiency and patient experience	Define			
983 - Implementation of Production Planning by service area	Define			

980 - Improve Pre Admission Process	Define			
982 - Reduce waiting time for patients for First Specialist Assessment and Elective Surgery	Define			

3 Shorter waits for cancer treatment	Radiation treatment within four weeks of first specialist assessment and medical oncology within agreed DAP timelines
	In October 100% of eligible patients were treated within the four week target timeline. As at 31 October Radiation Oncology had delivered to the target for 553 consecutive days. A delay waitlist report enables daily monitoring and immediate remedial action if required. Initiatives continue to be implemented to maintain service delivery. The Aria project – development of a electronic record system – is expected to complete in December.

Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
1043 - Establish a service delivery model aligned with the recommendations outlined in the Radiation Therapy Strategic Plan	Define			

4 Health of Older People	Integrate and streamline services, one point of entry to specialists, specialised inpatient areas for stroke, dementia and delirium, co-ordination of discharge planning, improve respite care and ensure effective outreach programmes (primary and community)
	Regional clinical network is being established with first meeting planned for 17 November. HSG leadership team beginning discussion with key clinicians on areas of focus for longer term strategy deployment. Work continues with ARC to support nursing workforce.

Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
1020 - Review specialist support to Aged Residential Care	Define			
1015 - Establishment of the Regional Clinical Network	Define			
1019 - Implement pathways for Older People with Cognitive Decline	Define			
1018 - Review and evaluate capacity for respite care	Define			
1021 - Scope workforce shortages	Define			

1017 - Review rates of access to Aged Residential Care by age across the region	Define			
1016 - Services closer to home that are more flexible and responsive	Define			
5 Clinical Leadership	Leadership from bedside to boardroom, clinicians involved in all strategic and operational decisions, leadership development for clinicians and development, management and monitoring of clinical networks			
	Recruitment for the remaining 3 level 2 roles is in progress. The clinical leaders group meetings are now business as usual with accountability for clinical governance and reporting to HAC.			
Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
1102 - Develop a talent identification and development programme for future clinical leaders	Define			
1100 - Support the development of, and provide leadership to, implement regional/national multidisciplinary clinical networks, inclusive of whole of sector participation	Control			
1099 - Develop and implement a comprehensive leadership programme for clinical leaders and senior managers	Define			
1101 - Develop and implement Auckland DHB Leadership Framework	Measure			
1098 - Continue to implement the clinical leadership model for level 2 and 3	Improve			
6 Culture	Professionalism, clinical excellence coupled with patient service and improved communication with patients			
	Overall we are progressing well with the development of the healthcare excellence framework. We have draft plans for community and patient and engaged workforce. We are planning to do our first evaluation in March next year.			
Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
1053 - Improve Risk Mitigation Management and Root Cause Analysis	Analyse			
1055 - Improve Feedback Process	Define			

1054 - Establish an integrated complaints framework	Define			
1051 - Continue to implement our consumer and community engagement framework	Control			
1052 - Bereavement management framework is developed and implemented	Define			
1050 - Introduce a staff engagement survey tool	Define			
1048 - Develop a culture of patient safety, open disclosure, timely and empathetic communication	Define			
1049 - Develop our clinical leaders and managers to be more effective at developing culture and taking action within our management operating system	Define			

7 New Models of Care	New models of care for fast stream elective surgery, readmission prevention, Whanau Ora, health promotion, children and young persons and older people
	Good progress is being made in a number of initiatives. Releasing Time to Care has a review underway to ensure project planning for deployment, resourcing and improved capture of direct care time /benefits. The Haematology clinical net work has been established, with clinical, management and funder membership from each of the 4 Northern region DHBs plus additional clinical representation from Midland DHB. Administrative support is provided by the Northern Region Cancer network. Significant progress made for improving outcomes for people with COPD, with the presentation to GAIHN clinical network team 19.10.11 on implementation of COPD clinical pathway including spirometry, pulmonary rehab and self management. Proposal accepted subject to approval by Alliance Leadership Team.

Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
1072 - New model of care to integrate kidney disease prevention, early intervention, and chronic kidney disease management services	Define			
1071 - Renal Services will work in partnership with primary care to design, devolve, and deliver Adult Haemodialysis (AH) for patients who are unable to home dialyse	Define			
1064 - Scope low secure rehabilitation service for high and complex needs	Define			
1069 - Establish a regional mechanism to strengthen the delivery capacity of palliative care providers	Define			

1062 - Increase awareness of mental health services	Define			
1057 - Increase the number of wards in Adults, Children's, Cancer, Cardiothoracic and Mental Health services using Releasing Time to Care	Define			
1068 - Continue regional bowel tumour stream development and service improvement in care pathways	Analyse			
1066 - Implement medical oncology service improvements	Define			
1063 - Increase responsiveness to those with a coexisting problem (CEP)	Define			
1070 - Participate in the establishment of a Haematology Clinical network	Measure			
1067 - Continue regional lung tumour stream development and service improvement in care pathways	Improve			
1061 - Develop new services	Define			
1058 - Implement the productive operating theatre programme/lean improvement programmes (TPOR)	Define			
1075 - Improve the outcomes for people with COPD	Analyse			
1073 - Agree the principles which will inform a new service design for rehabilitation services	Define			

8 Chronic disease management	Better assessment of cardiovascular risk, enhanced treatment for heart disease and diabetes, reduced waiting times for elective cardiac surgery and clinical pathways to be across the care continuum
	Cultural-specific courses are being developed to support self management of long term conditions including diabetes and CVD. The diabetic retinal screening community programme is delayed by roll out of the software, but should be in place early in the New Year.

Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
990 - Report on care planning for people screened who either have diabetes or a risk assessment >15%	Define			
992 - Implement a community retinal screening service	Control			

989 - Evaluate 2 community-based cardiac rehabilitation programmes	Define			
993 - Raise PHO awareness re Diabetes Get Checked programme for diabetic patients -- practices encouraged to keep Get Checked in high awareness	Define			
9 Regionalisation through Collaboration	Collaboration as an overriding principle undertaken with studious intent and with a special focus on Waitemata DHB			
	There have been a number of project activities at regional level. The NRHP has published the first quarterly results against the plan. All streams are revising indicators and diabetes and cardiac are working to have individual and practice level data available for comparisons. The project "do no harm' has local baseline measurement for falls with harm completed and process for baseline measurement for pressure injury have been agreed. CLAB programme implementation on track in all 3 ICUs. Global Trigger Tool case reviews commenced.			
Projects	**Phase**	**On Time**	**On Budget**	**Expected Outcome**
1129 - The stronger bilateral opportunity offered by a shared chair and Maori board membership will allow us to optimise service planning and delivery across our two organisations	Define			
1128 - Reduce back-office costs through standardisation and consolidation of systems and processes in the regional entity	Define			
1127 - The informed patient	Define			
1126 - Life and Years	Define			
1125 - First Do No Harm: Regional work to improve patient safety	Analyse			
10 Living within our Means	Financial deficits are not acceptable under any circumstances			
	The major feature of October was the reduction in the level of IDF referrals being received compared with budget. Although a portion of this IDF revenue reduction was reflected in lower direct treatment costs, this cost reduction was offset by higher outsourcing costs than budgeted. A full report is included in the Audit & Finance Committee papers. A portfolio of projects have been included in HSG plans and projects are underway to deliver the targeted improvements. Concord continues to consider new projects and inventory management is currently being reviewed. Further information about clinical supply overuse will inform specific projects.			

	Remanufacture of single use devices will be led by WDHB and ADHB proposes to join this project.

Projects	Phase	On Time	On Budget	Expected Outcome
1116 - Strengthen collaboration within and outside the organisation	Define	●	●	●
1118 - Non Clinical: Implement new Health Alliance organisation	Analyse	●	●	●
1109 - Managing Administration and Management staff numbers within the cap	Control	●	●	●
1114 - Utilisation of new and existing clinical supplies monitored for clinical effectiveness	Define	●	●	●
1115 - Leverage national and local procurement for clinical supplies	Define	●	●	●
1112 - Deliver productivity and quality gains by HSG	Improve	●	●	●
1120 - Waitemata and Auckland DHBs integrate services where there is service quality and cost opportunities	Define	●	●	●
1107 - People Cost	Define	●	●	●
1110 - Manage and review impact of MECA Settlements	Define	●	●	●
1108 - Disciplined management of FTE numbers, annual leave, sick leave and CME	Define	●	●	●
1119 - National contracts to transfer to NHB	Define	●	●	●
1104 - Elective volume and funding: Implementing a patient and operations planning process to ensure early visibility of variances to plan and corrective action	Improve	●	●	●
1106 - Disciplined volume and funding risk management for IDFs. Continue IDF relationship management process with key IDF customers	Analyse	●	▲	●
1103 - Disciplined volume and funding risk management for the Auckland DHB Population	Define	●	●	●
1105 - Acute volumes: Manage volume and cost risk through productivity improvement and BSMC initiatives	Improve	●	●	●
1122 - Ensure BSMC + 3 Business cases deliver improved processes and realise the planned benefit from defined projects	Define	●	●	●

1124 - Oral Health capital expenditure programme within budget	Define			
1121 - Manage contracts within budget , with particular focus on Community Pharmacy, Laboratories, Rest homes	Define			
1123 - NHB new payment system eliminates transaction error	Define			

5 Northern Regional Health Plan – 1st Quarter Report

Below summarises progress against the 10 deliverables. Progress has been good, with action occurring within all health targets. Some are more advanced than others. ADHB retinal screening rates are set to improve now that technology has been rolled out and contacts with community providers confirmed and ADHB palliative care team have secured Ministry of Health funding to continue the roll out of Advanced Care Plans. For other targets, progress is at the discussion stage, such as surgical treatment for lung cancer, harmful falls and pressure injuries all have plans to collect and review additional data. More details on progress for the 1st Quarter is available in Appendix 3.

1	Achieve and maintain the Minister's Health Targets		See Minister's Health Target reports	ADHB progress
2	Reduce the number of harmful falls in our hospitals by 20%	Baseline to be set in Q2	The methodology to measure baseline has been agreed in Q1. The results are expected to commence in Q2	The top five areas of concern for falls at ADHB (provider arm) are A+ Links, General Medicine, Rehab Plus, General Surgery and OPH Specialist Mental Health. 20% of falls are repeat falls and this is a target population. With the exception of falls with major harm, falls with minor injury are not aggregated or reported, nor are costs associated with falls identified. An audit of all RMPro data has been completed for 2009/2010 year, with 32 Falls with Harm identified. Q2 will focus on determining how to grade falls, checking the accuracy of falls reporting, developing a cost model, agreeing on interventions and how to measure success. The ADHB Steering Group includes members from the ARC sector to share learning's and take a "whole of system" view as much as possible.
3	Reduce the number of patients who have pressure injuries in hospital or aged residential care by 20%	Baseline to be set in Q2	The methodology to measure baseline has been agreed in Q1. The results are expected to commence in Q2	Currently ADHB provider arm pressure injuries are self reported by RMPro. The rate of hospital acquired pressure injury per 1000 bed-days is reported with the highest in the adult medical and OPH wards. Significant investment has already been made in educating the ARC sector and ADHB now has agreement to report pressure areas as part of the Clinical Network activity. A Provider Arm baseline audit will be completed during Q 3 The ADHB Steering Group also includes members from the ARC sector to share learning's and take a "whole of system" view as much as possible.
4	Ensure 50% of patients with lung cancer will have	37.5%	Note: 57% of primary lung cancer patients had	The discrepancy in results (MDT presentation vs receipt of referral) can be

	first surgical treatment within 14 days of multidisciplinary meeting		surgery as first treatment within 14 days from the time the referral was received by the cardiac surgical team.[2]	explained by a significant number of patients requiring additional investigation between the two processes as a result of the MDT discussion. The target may need to be refined given the co-morbidities patients with lung cancer have, and the need in some cases to delay surgery whilst other clinical problems are addressed. Further data is required to determine if certain populations experience more delays than others.
5	70% of patients admitted with acute coronary syndrome will go from 'door to catheter laboratory' within 72 hours		Result not available in Q1.	As ADHB is the regional provider of this service we know that our population is well served as this has been the standard of care for two years. The Cardiac Clinical Network has focused on improving access for WDHB and CMDHB populations (this is not feasible for NDHB).
6	Increase to 80% the number of high needs diabetes patients with microalbuminuria / proteinuria who are taking ACE/ARB		Result not available in Q1.	Both the Diabetes and Cardiac clinical networks have focused on processes to obtain practice level and patient level data to inform their workstreams. Once this is possible the networks will be able to target those individual GP practices where there is variance.
7	Undertake retinal screening on 4,500 additional people in metro Auckland area	●	See Appendix B. While the results for this quarter were less than the average required to meet the target, DHBs are expected to increase numbers when the new IS management system is implemented in Q2/3.	Retinal screening has required software implementation and roll out, and contracting with community providers. This has been completed and access will now increase for the ADHB population.
8	For each DHB train 2 more specialist nurses and 3 diabetes nurse specialists as prescribers	▲	Priority for network in Q2	ADHB has already trained 4 diabetes nurse specialists with prescribing rights.
9	Complete Whanau Ora Assessment for targeted population		Result not available in Q1.	Discussions are ongoing with NHC about engagement on Whanau Ora deliverables.
10	500 patients will have discussion regarding Advance Care Plans	●	71 patients have had ACP discussions. Actions on track to increase number.	ADHB has the only established palliative care clinic with access to ACP. The tools have been developed and trialled at ADHB and the team have secured MOH support for the continued roll out of ACP. Applications for training at level 2 and 3 ACP practitioners have closed with high degree of interest from our clinical staff.

[2] The difference in the results is due to the short time lag between the MDM decision and referring the patient to the wait list.

6 Appendices

Appendix 1 Patient Experience Newsletter

Report 01
6 November 2011

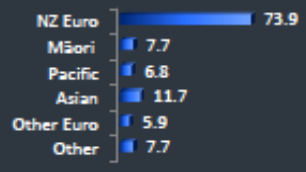
Report on **Patient Experience**
Auckland District Health Board

KEY FIGURES

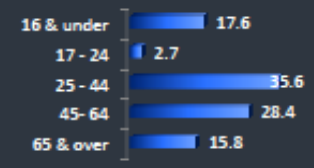
About the respondents

Gender % (n= 222)

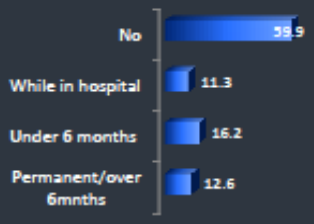
Ethnicity % (n= 222)



Age % (n=222)



Disability % (n=222)



TOP THREE

Patients believe these things make the most difference to the quality of their care and treatment:

1. Communication (clear answers patients can understand) 48.6%
2. Feeling confident about the quality of their care and treatment 45.9%
3. Getting good information 43.7%

In-Patient Experience Survey

Patients and their whānau and families have unique perspectives on their care. When they share these perspectives and insights they can help those delivering health care services to identify ways of improving performance.

ADHB's In-Patient Experience Survey was launched on 19th October 2011.

The survey is on-line. An email containing a survey link is sent to patients two weeks after they have been discharged from hospital. They are asked about their most recent experience in hospital. The survey is sent out weekly and the results will be collated, analysed and reported each month.

The goal of the Patient Experience Survey is to provide staff and management with feedback that is relevant, timely and actionable, and that can be used to improve the quality of the care delivered and ADHB's clinical outcomes.

First wave

The Patient Experience Survey was sent to 877 patients discharged between 1st September 2011 and 10th October 2011.

In total, 222 patients completed the first wave. Just over two-thirds (68.5%) of respondents (152) answered the survey on behalf of themselves and 68 (or 30.6%) answered on behalf of a baby or child 16 years or under. A further 2 respondents (0.9%) answered on behalf of someone who was unable to answer it themselves.

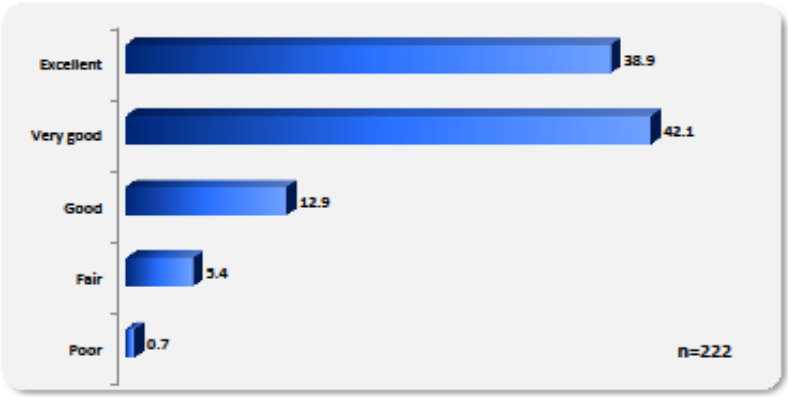
This report looks at the feedback from the first wave of the survey.

How patients rate their overall care and treatment

Most patients rate their overall care and treatment as either very good (42.1%) or excellent (38.9%).

Of the patients (186) who commented 40.6% were impressed by the compassion, empathy, support and understanding shown towards them, 31.6% on the quality and standard of their care and 10.5% on the way they kept informed.

Of the 116 patients who suggested general improvements, 14.7% felt that they were not treated respectfully, 13.7% gave examples describing the lack of coordination of their care, and 11.8% felt that communication needed to be improved, in particular listening to patient input and keeping patients better informed.

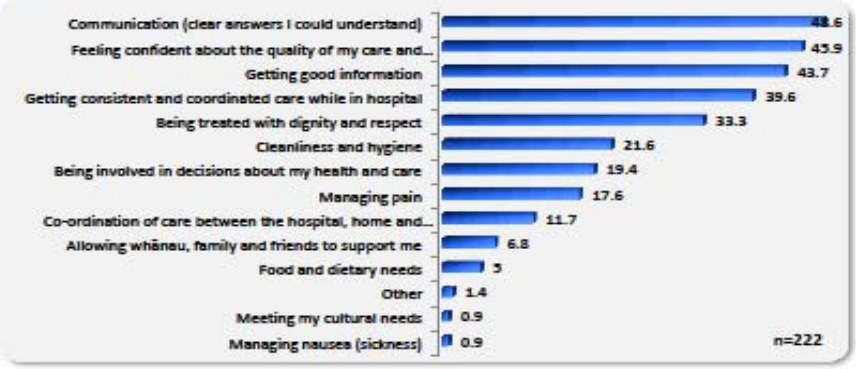


Factors which patients feel make the most difference to their care and treatment

In the survey patients are asked to select up to three things that they feel make the most difference to their care and treatment.

Communication, information needs and having confidence in the quality of their care and treatment are the top three things that patients identified as making the difference to their care and treatment whilst in hospital.

Getting consistent and co-ordinated care and being treated with dignity and respect also rated highly.

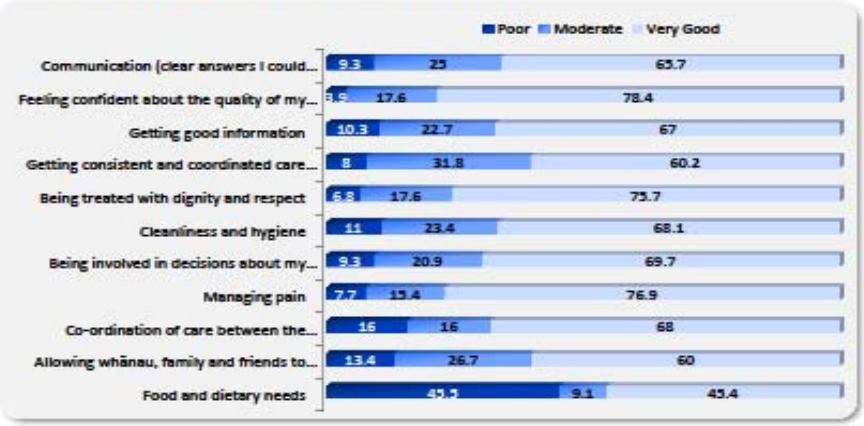


How patients rate their care and treatment

Having identified the factors they consider make the most difference to their care and treatment, patients are then asked to rate ADHB's performance on each of these dimensions, on an 11 point scale, where 0 is 'poor' and 10 is 'excellent'. The ratings have been grouped as Poor (1-4), Moderate (5-7) and Very Good (8-10)

Most patients rated ADHB's performance as very good (between 8 and 10). Over one-quarter gave their most recent experience a poor or moderate rating.

Although most did not consider food to be one of the most important factors, it rated poorly amongst those who did feel it makes a difference to their care.



NB: The factors have not been reported if fewer than 5 people rated them.

Patient voices

INFORMATION

Rated "Very good"

"Being able to talk directly to the surgeon before and after makes a world of difference."

"Both my wife and I met with the nurse, the anaesthetist and the surgeon separately prior to the operation in a relaxed, open discussion about what would happen with time for questions."

"Doctors told us what the plan was so each new piece of the puzzle was not a surprise"

Rated "Moderate"

"On discharge, I felt like we had to ask to get full advice on how the immediate recovery period should progress, when really this should be standard procedure to be told."

Rated "Poor"

"Each (shift) I would have to explain again what had happened...it got confusing wondering why I had to explain the same things and answer same questions to all the many people who treated me. No-one really explained from the outset how it all works, and what the process was for my injury in the coming week etc....the process was a bit difficult and confusing."

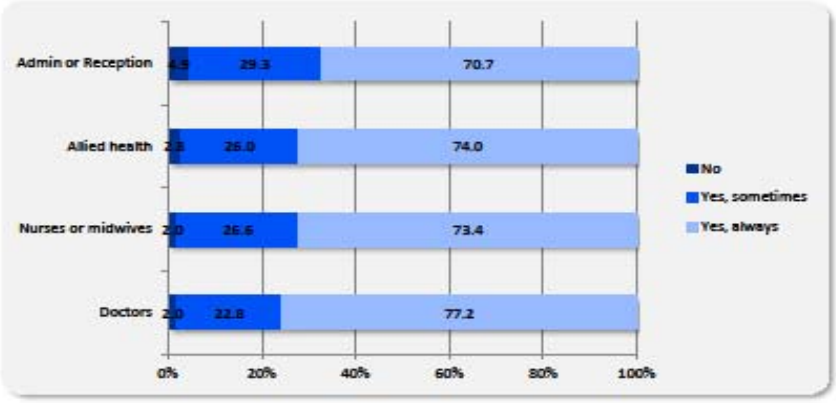
"(Within earshot of my young teen) I was told that sometimes kids (with her condition) don't go back to school for a year. This had a major impact on her state of mind. She was left thinking that she was going to be experiencing this same level of pain for a year. Please have these discussions privately, or at least qualify the information at an age appropriate level."

In Focus: Communication

Good, clear communication is important to patients.

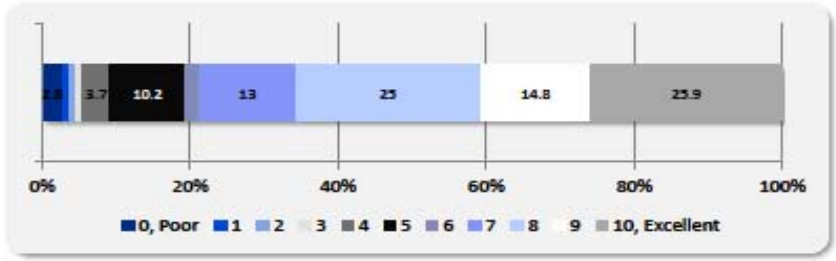
Half (48.6%) of the patients rated communication, getting clear answers that they could understand, as one of the things that makes the *most difference* to the quality of their care and treatment.

Most patients felt that they always received clear answers. Around one-quarter said that they either did not, or did not always get answers they could understand from doctors, nurses or midwives, allied health workers, or admin and reception staff.



How ADHB Rates on Communication (on an 11 point scale)

NB: The rating is by patients that think communication makes a difference to their care.



Of those that rated communication as one of the things that makes the most difference to their care, most (65.7%) rated it highly (8-10). These patients indicated that the communication was clear (20.8%) that they were given thorough explanations (20.8%), they were kept informed and up to date (18.9%) and that they were given accurate expectations about what to expect.

Those that gave communication a moderate rating (25%) tended to feel that they were not fully informed about what was happening, there appeared to be a lack of clarity about what was happening, they were told things at the last minute, they were left unattended without explanation, they had unanswered questions and test results were not communicated.

Similarly, those patients (9.3%) that rated communication poorly (0-4) felt that they had not been kept well informed, that they had not been asked important questions (such as whether they were pregnant), that they had been left with unanswered questions, no-one appeared to know what was happening, people did not introduce themselves or say what their role was, or felt as if important information was given at a time they when they were unable to retain it.

Patient voices

COMMUNICATION

Rated "Very good"

"The staff were very good a talking to my son on a level he could understand and he was given the opportunity to ask questions. Very good!"

The doctors spoke in 'layman' terms easy to understand. My baby had a very serious medical condition but they explained it to us using language we could understand. Actually all the staff were fabulous and kept us informed 24 7 of what was happening.

Rated "Moderate"

"When many people are involved in care and assessment, it would help if each person could at least indicate what the next steps in the process are. Going into ED is like going into a vortex you are unsure how you'll ever get out of - and this is not because of your condition, but because of the processes in the place and the processes not being well communicated."

"Was told about risks last minute before surgery when was due for anaesthetic, also had no time to think about that. some questions I asked few times werent really answered, midwife said dr will, dr would say yes we will get to that soon..."

Rated "Poor"

"I was being advised of medical procedures and risks if surgery and asked to sign documents when I was not in a coherent state!"

"Doctors seem to think that patients don't need to know a lot of the information/test results etc ... this is not true we need to know all the information about our health so that we can make our own decisions and be informed this is especially important given that we usually see different doctors for follow ups etc."

Administrative Information

Response Rate: Wave 1

A total of 877 patients discharged between 1 September 2011 and 10th October 2011 were sent an email containing a link to the survey. This survey closed on 3rd November 2011. In the first wave of the survey 25.3% completed the survey and 33.4% partially completed the survey.

Mail-outs are weekly. To date there have been two subsequent mail-outs. The next survey wave is due to close on 8/11/201 (the survey technically closes at 4am following the closing date).

Date sent	No. of Patents emailed	Status	Completed	Completes and Partial Completes	Response rate % (completes only)	Response rate % (includes incompletes)
19/10/2011	877	Closed 3/11/11	222	293	25.3%	33.4%
25/10/2011	131	Open until 8/11/11	-	-	tbc	tbc
1/11/2011	148	Open until 15/11/11	-	-	tbc	tbc

NB: Bounce backs were not recorded in the first wave of the survey due to security reasons. This decision has since been reviewed and bounce backs have been recorded in subsequent survey waves

Requests for ADHB to Contact Respondents

A total of 25 (11.3%) of patients who completed the survey requested ADHB contact them directly about their experiences. Of these 22 (9.9%) completed the web form asking for their contact details following the survey.

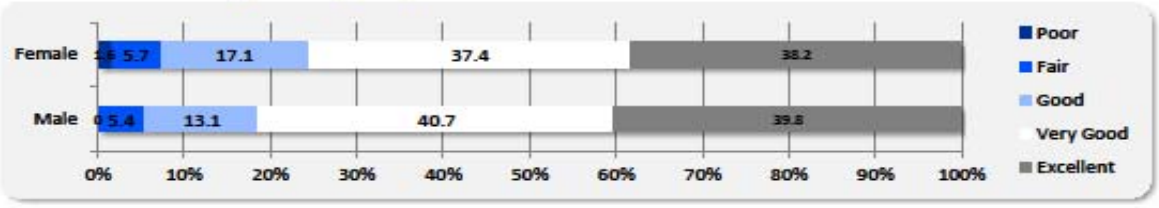
Complaints

Three (1.4%) requests for contact were formal complaints, three were compliments.

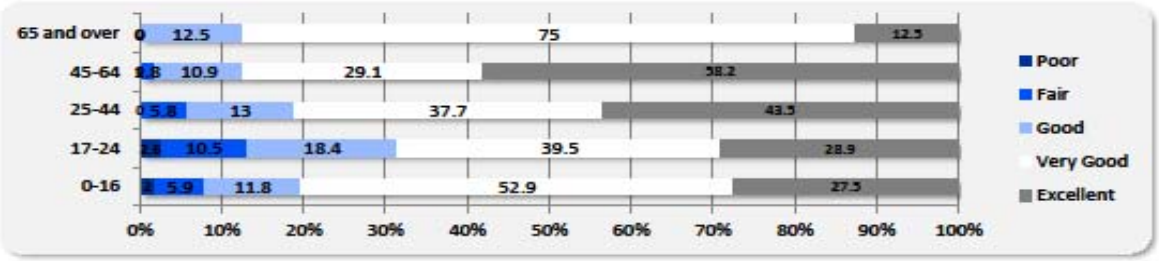
Contact Requests	Completed contact details	Compliments	Formal Complaints	Total
11.3%	9.9%	1.4%	1.4%	n=222

Addendum

Overall satisfaction by gender (n=221)



Overall satisfaction by age (n=221)



Appendix 2 : OH&S Intranet page

OH&S Directions

November 2011

WHATS NEW
- Three Serious Harm injuries from trips over equipment!!
- GM Quarterly Reports
- ACC Partnership Programme annual reminder for staff
- OH&S Training for Managers: Last one this year .. 30 November

THIS MONTHS SAFETY TOPIC
- Trips and Falls

SUPPORTING YOUR H&S REP
- H&S Rep CPD Forums in December!!! .. ensure your H&S Rep is registered!
- What your H&S Rep can do for you!!
- H&S Reps: Check the list… do you have a vacancy?

HELPFUL LINKS
- See list of quick links

OH&S INFORMATION
- Find OH&S information

WHAT'S NEW

Three Serious Harm injuries from trips over equipment!!

The Quarterly meetings for the Health and Safety committees has just occurred. (see the notice below) It is very concerning to see that so many Serious Harm injuries occurred this past quarter. Serious Harm injuries are ones where a staff member has suffered a significant injury .. usually a fractured bone or similar. Three of these over the past couple of months have been due to trips over equipment.
Increased risk of accidents are associated with trip falls are often associated with housekeeping .. Where and how is equipment stored, how is it moved , how is it placed for use, it is causing an obstruction ??

One of the injuries was a nurse tripping in the base of a mobile sphyg that was protruding into the adjoining bed space under a curtain, this resulted in a fractured arm. The ward now has brightly coloured hazard tape on the base of all their mobile sphygs so that they can be seen better .. a great solution.
Have a look at the equipment in your areas: store it safely (especially the cords), transport it carefully and ensure it does not cause obstructions when in use.

GM Quarterly Reports

All of the GM H&S Committee meeting have been held recently. The GM quarterly reports for July to September 2011 are now on the OH&S Intranet .. click here

The two main injury concerns are trip falls as covered above and patient handling.

Another area for concern is a drop in the number of BBFA reports from clinical areas.

Under reporting is evident in the Occurrence to Claim ratio on page 7 of the Summary report. Near miss reports should far exceed claims .. but in the case of Equipment, Patient handling and Manual handling the claims out number the minor injury reports. This shows a lack of awareness for the importance of hazard identification. Under reporting is a constant issue and staff need to be reminded to be vigilant and protect themselves and others by reporting potentially hazardous situation.

ACC Partnership Programme annual reminder for staff

If you have already actioned this request .. Thank you .. if not READ ON!!

ADHB is in the ACC Partnership Programme. This means that ADHB stands in the shoes of ACC in relation to the management of work related ACC claims. ADHB uses an external supplier (WorkAon) for claims administration and an internal OH&S department resource for case management.

All staff need to be reminded annually that ADHB is in the ACCPP and that WorkAon is our work related ACC claims administrator. Please put this poster on your H&S Notice board and have these notices available to all staff in your department. The notice has a cut out card that staff can keep with them and give to their health care provider if a work injury occurs. This information facilitates quicker claim registration. Both of these resources are also on the OH&S forms page.

H&S Training for managers:

H&S Training for managers has been included in a course called Managing Business Risk for a number of years. This is one of the mandatory courses in the Management Essential suite of courses. The OH&S component of this course will now be offered as stand alone 4 hour session. This is an essential course for all managers who are accountable for health and safety of a team.

This session includes:

- OH&S Systems overview
- Managers role and responsibility for OH&S
- Hazard Management
- Work Accident reporting and management
- Work and non work related ACC Rehab
- Illness absence referrals to OH&S
- Working with your H&S Rep
- Over view of many other OH&S processes

Courses for 2011 are on the L&D calendar click here to register for one on the sessions this year. The last one for 2011 is 30th November.

Lots more to read .. keep going >>>>>>

THIS MONTHS SAFETY TOPIC

Trips and Falls

Slips trips and Falls are no joke!! They regularly lead to painful injuries for our staff. Injured staff cannot fully participate in their regular duties and patient care could suffer!! You may think that these are “just accidents” .. and that nothing can be done to prevent them… BUT … it you think that way you **will** do nothing and they will continue to happen. Slip fall prevention is a complex challenge. Many factors contribute to the risk of an injury. A good place to start is making sure that the annual slips/Trip/Fall checklist is completed for your area. Make sure the review of practice in your area is robust and honest!! If reports are coming back with nothing to address … then go back and look again!! See the managers hazard information

sheet for a short overview of this topic. Every area should have the potential for trips and falls indentified as a significant hazard because there is not a single ADHB staff member who fully escapes the risk. Your H&S Manual should include a local hazard control plan: click here to see an example. We will be asking H&S Reps to deliver Team Talks on this topic. You can help by ensuring this is included at your next team meeting.

Everyone has a part to play in reducing injuries at ADHB.

SUPPORTING YOUR H&S REP

Next H&S REP CPD Forums in December…. Make sure your Rep is registered!

The next quarterly CPD Forums for H&S Reps are **Wednesday and Thursday 7th & 8th December.**

Two workshops will be offered; Chemical Safety (new) and Manual Handling (repeat from last quarter). Your H&S Rep can attend both workshops on one day, if they need to catch up on modules, or to attend only the new one.. this is up to you and your H&S Rep.

Chemical Safety Workshop: will cover the basics of chemical safety management including an introduction to HSNO legislation and what MSDS are all about.

Manual Handling Workshop: Manual Handling is ADHB 4th most frequent reason for Occurrence reporting and a frequent cause of workplace injuries. This workshop will look at the causes, hazard management and safety messages around Manual Handling.

H&S Reps can register for these courses on KIOSK (Training) … or call OH&S for assistance with registration.

Lots more to read .. keep going >>>>>>

What your H&S Rep can do for you!!

The role of the H&S Rep is an important one. The main function of the Reps is to be a voice for their colleagues on H&S issues. Key tasks of a H&S Rep are:

- Provide local H&S Induction for new staff in your area
- Do the 6 monthly workplace check lists (and other H&S audits)
- Deliver safety messages to your team (Team Talks)
- Assist their colleagues to find OH&S information and report hazards.

It is important for you to meet with your H&S Rep(s) regularly to discuss H&S in your area. Click here for sample agenda. You should also include H&S on the agenda of your team meetings or briefings and give Reps the opportunity to present the Team Talks that OH&S provide for them in H&S REPort each month.

H&S Rep database … is your Reps name on it?

A H&S Rep is an official position recognised in the Health and Safety in Employment Act. How ADHB works with H&S Reps is outlined in the Employee Participation Agreement that ADHB has with the joint unions. H&S Reps need to be elected or endorsed by their colleagues before they are deemed to be H&S Reps. OH&S has a database for all elected/endorsed H&S Reps. We communicate with them regularly and if they are not in the database they will not receive a lot of important information and guidance.

Could you please help us by checking the list of H&S Reps on the OH&S site and let us know if:

- your H&S Rep is not listed or
- there has been a change with the H&S Rep that we are not aware of.
- also if your area has a vacancy for H&S Rep call OH&S Help Desk (27800) and we will let you know how to address this.

HELPFUL LINKS ON INTRANET PAGE
OH&S INFORMATION

OH&S Intranet site (including OH&S FORMS)
OH&S Contact numbers
OH&S Advisor Help Desk (Ext: 27800)
OH&S Clinic (Ext: 4584)

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Appendix 3

Northern Region Health Plan

Implementation Progress Report

Quarter 1 - July to September 2011

Contents

1. Summary

The first quarter of 2011/12 has focused on mobilising the implementation plan set out in the Northern Region Health Plan. There was a need to finalise budgets and provide further information to Boards which has impacted progress in some areas. On the whole though good progress has been made around foundation activities in this quarter and the cancer and CVD workstreams are progressing initiatives with direct impact on patient outcomes.

As is to be expected when a new work programme is developed, some changes have been considered and endorsed by workstreams as they undertake more detailed planning. In particular: some changes to patient outcome measures have been agreed in diabetes and cardiac. This is due largely to issues associated with collecting data in a consistent and sustainable way across the four DHBs and primary care

Key achievements this quarter include:

- Cancer services have agreed prioritisation criteria for colonoscopy and all gastro units in the region are implementing these to achieve regional consistency
- The First Do No Harm workstream has agreed the methodology and measures which are aimed to show improvements to patient safety in our hospitals and rest homes and has put in place two key training events for mid October
- The Radiology Network has developed a comprehensive capital and asset plan which takes into account expected demand patterns and the capital impacts over the next 5 – 10 years
- Advanced Care Planning has developed a business case for workforce training as a foundation for future activity.

An overall summary of progress for each work stream is outlined below.

2. Progress for the top 10 commitments

The table below shows progress against the top 10 commitments

On track	Some concerns regarding progress to target	Not achieved or declining performance	target discontinued

	Commitment	Status	Notes
1	Achieve and maintain the Minister's Health Targets	See Appendix A	
2	Reduce the number of harmful falls in our hospitals by 20%	Baseline to be set in Q2	The methodology to measure baseline has been agreed n Q1. The results are expected to commence in Q2
3	Reduce the number of patients who have pressure injuries in hospital or aged residential care by 20%	Baseline to be set in Q2	The methodology to measure baseline has been agreed n Q1. The results are expected to commence in Q2
4	Ensure 50% of patients with lung cancer will have first surgical treatment within 14 days of multidisciplinary meeting	37.5%	Note: 57% of primary lung cancer patients had surgery as first treatment within 14 days from the time the referral was received by the cardiac surgical team.[1]
5	70% of patients admitted with acute coronary syndrome will go from 'door to catheter laboratory' within 72 hours		Result not available in Q1.
6	Increase to 80% the number of high needs diabetes patients with microalbuminuria / proteinuria who are taking ACE/ARB		Result not available in Q1.
7	Undertake retinal screening on 4,500 additional people in metro Auckland area		See Appendix B. While the results for this quarter were less than the average required to meet the target, DHBs are expected to increase numbers when the new IS management system is implemented in Q2/3.
8	For each DHB train 2 more specialist nurses and 3 diabetes nurse specialists as prescribers		Priority for network in Q2
9	Complete Whanau Ora Assessment for targeted population		Result not available in Q1.
10	500 patients will have discussion regarding Advance Care Plans		71 patients have had ACP discussions. Actions on track to increase number.

[1] The difference in the results is due to the short time lag between the MDM decision and referring the patient to the wait list.

3. Progress summary for the workstreams

Initiative on track to time, cost, quality and business benefit	Some concern regarding progress to plan	Not achieved or stopped due to reasons of change of plan or resource availability	initiative discontinued

Workstream	Foundation	Patient outcome results	Process results	Achievements	Challenges
The 3 priority areas					
First, do no harm	▲	▲	▲	• $1.3m budget approved • Methodology to measure baseline agreed • Key programme appointments made • Stocktake of current activity completed • IHI training courses organised for October	• Delayed recruitment of team Clinical Leader and Programme Director commencing mid April.
L&Y -Cancer	●	●	●	• Radiotherapy service model and contract completed • All Gastro Units are using regional prioritisation criteria for colonoscopy • Lung cancer pathway alignment to national standards	• SMO medical oncologist availability
L&Y - CVD	●	● Measures changed	●	• Clinical director recruited • KPI framework & prevention strategies agreed • A number of working groups have been established to progress specific initiatives e.g. STEMI, PCI, cardiac nurses and CVD risk assessment • Guideline development well underway	• Slow implementation of Acute Predict at ADHB
L&Y Diabetes	▲	● Measures changed	▲	• Project Manager recruited • Indicator set developed • NZ Guideline accepted with minor modifications	• Clinical Lead position advertised • Stock take pending • Changes required to patient outcome measures

Workstream	Foundation	Patient outcome results	Process results	Achievements	Challenges
L&Y Health of older people	●	None identified except FDNH	●	• Project manager recruited • Methodology and targets agreed for patient safety initiatives (falls reduction causing serious harm & decreased pressure injuries)	
Informed Patient Advance Care Planning	●	●	●	• Workforce training business case drafted • Project plan drafted • Communications material developed	• Some delays in development and sign off of project plan
Informed Patients Whanau Ora				•	No Quarter 1 report available
Services					
Laboratory	●		▲	▪ Development of long term strategy progressing ▪ Joint Laboratories Advisory Group established and progressively taking a wider role in reviewing clinical practise and monitoring of KPIs	▪ A wider range of laboratory stakeholders need to have the opportunity to comment on potential future direction for laboratories which means a longer timeframe is required to complete this work
Radiology	●		●	• Initial draft of radiology asset and capital plan completed • Engagement with national network	• Clinical leader role advertised • Asset and capital plan work needs to be integrated into regional capital planning
Vulnerable services			▲	• After hours plan for acute care agreed • Actions underway for 4 other services	• Two MoH mental health projects underway to review forensic and intellectual disability • No MoH action to resolve maternity workforce shortage, but issue relieved with lower birthrate • Regional action planned to resolve acute spinal and MaxFax workforce issues needs to be resolved
Service reviews (WDHB and			▲		No Quarter 1 update provided

Workstream	Foundation	Patient outcome results	Process results	Achievements	Challenges
ADHB)					
IS	●		●	▪ Regional PAS: - Current state complete and future state planning underway to determine compatibility with iSoft ▪ Regional Population Information – discussion draft completed ▪ Regional clinical workstation, CDR and resilience workstream scoping progressing	Mobilisation has taken some time but good progress is now being made Business case to support IS investments required and needs to be integrated with regional capital and assets work.
Workforce	▲		●	• Regional Clinical Leadership Group established and functioning • Regional Training Hub established within ARRMOS and relaunched as NoRTH • Regional dataset developed to support workforce planning	• Clarification of workforce initiative accountability and deliverables is needed • Reporting lines to be confirmed
Capital and assets	●		▲	• Initial consolidation work undertaken and agreed plan developed to complete and validate regional collation • Collation of national guidance	• Scope change driven by MoH methodology and national stock take processes • Delays in collation of summary detail of strategic projects • IS capital not fully reflected in DHB capital intentions
Service Devolution					
Long Term Support for Under 65 year olds with long term conditions (LTSCHC)	▲		●	• Devolution completed smoothly with no major patient or provider issues • Regional risk pool sharing approach agreed • Regional Review Panel established with focus on cases over $80k • Working group established to: o Ensure a consistent regional approach to determining client eligibility and appropriate placement o Undertake client profiling to inform future decision making and service development	• Awaiting correct financials from MoH, delaying reconciliation • Awaiting policy decisions on key issues such as national review processes

4. Development plans

The focus in the first quarter has been on mobilising the 2011/12 implementation plan with more limited work undertaken on the development areas identified in the 2011/12 plan. These areas are:

Child health	Confirmed that this remains a priority to progress for inclusion on 2012/13.plan
Workforce	Considerable work has been undertaken around the establishment of the Northern Region Training Hub. This now provides a good platform from which to leverage the region's considerable training and intellectual capability particularly in areas of priority for the region.
2012/13 health plan	Work on 2012/13 will start in Quarter 2 when guidance is provided from NHB on regional planning expectations for 2012/13. The region needs to deliver on current commitments before adding additional priorities in a resource constrained environment. It is therefore envisaged that the 2012/13 Plan will largely build on the current plan with work programmes reviewed and extended as appropriate. Additional initiatives will be added in a comparatively small number of areas as agreed with the Northern Region Health Plan Steering Group

5. Risk Management

The key NRHP risks are summarised below.

Risk ID	Description	Business Unit	Inherent Classific-ation Baseline risk	Residual Classific-ation Risk left after controls in place	Controls
1	**Information systems** *critical to support many of the proposed changes in models of care*	Health Alliance	High	Medium	The healthAlliance work programme has its own reporting lines and risk management controls.
	Actions: No action required. Controls under healthAlliance management. NRHP to stay in the information loop.				
2.	**Workforce** *Time is needed to grow the workforce to work in new fields but limited funding within current capacity*	Clinical Leadership Group to assess	High	High	Controls are in place in individual DHBs and workforce entities such as NoRTH.
	Actions: Steering Group and Clinical Leadership Group to agree: • KPIs and deliverables for the NRHP initiatives, and the processes to deliver and manage these initiatives • What information is needed for initiatives which are not directly managed by the NRHP e.g. NORTH and DHB specific initiatives				
3	**Recruitment of support for networks** *Delay in recruitment may delay progress*	NRHP Steering Group	High	Low	• Recruitment process has resulted in key positions being filled • Workarounds in place for other positions
	Actions: No action required.				
4.	**Interdependencies with BSMC business cases** *The cumulative change agenda is significant and will require careful management*	NRHP Steering Group, GAIHN NHC, Alliance Health Plus	Medium	Low	• Alliance Leadership Team in place • Cross-over membership between NRHP and BSMC • Networks comprise primary care clinicians
	Actions: ALT and NRHP Steering Group to regularly test the cumulative change impact				
5.	**DHB commitment** *DHB leadership must commit and participate in monitoring and decision making processes.*	DHBs Executive Management NRHP Steering Group	High	Low	• NRHP Steering Group in place comprising of senior executives • Budgets approved
	Actions: No action required				
6.	**National leadership of vulnerable services** *Maternity and Forensic and ID Mental Health are not on NHB agenda*	NHB	Medium	Medium	Controls in place for the MoH programme of work. Regional agreements in place to respond to peaks in births
	Actions: Continue to lobby NHB				

6. Financials

The 2011/12 budget was finalised in Quarter 1 and delegations within this were agreed. A phased budget has been developed for the 2011/12 financial year. The phasing of the First Do No Harm budget should be viewed as indicative only at this stage and will be reviewed in Quarter 2 as part of the more detailed planning work that will be undertaken for the campaign.

The budget for Quarter 1 was comparatively low at $135,000 reflecting the fact that the work would initially be undertaken by people in posts and already budgeted for and that no major training events were scheduled for this first quarter. Actual expenditure was slightly below the Quarter 1 budget.

	Quarter 1			Year to Date			Year End Forecast***		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Overall NRHP Costs									
First Do No Harm									
FTE Costs	-	-	-	-	-	-	730,000	730,000	-
Other Costs	-	-	-	-	-	-	555,000	555,000	-
Total FDNH	**-**	**-**	**-**	**-**	**-**	**-**	**1,285,000**	**1,285,000**	**-**
							-	-	-
Other NRHP Activity									
FTE Costs	124,710	125,000	290	124,710	125,000	290	599,710	600,000	290
Other Costs	9,455	10,000	545	9,455	10,000	545	249,455	250,000	545
Total Other NRHP	**134,165**	**135,000**	**835**	**134,165**	**135,000**	**835**	**849,165**	**850,000**	**835**
				-	-	-			
Total NRHP Costs	**134,165**	**135,000**	**835**	**134,165**	**135,000**	**835**	**2,134,165**	**2,135,000**	**835**

During the first quarter there were some changes agreed to budgets with the Steering Group that will impact both the first and subsequent quarters. These were as follows

- The $150k budget established for external assistance with regional spatial, capital and asset planning was reallocated to the core FTE budget as the focus of work is not on spatial planning (where external expertise would have been required) and the work is being undertaken 'in house"
- Additional funding of $86k was agreed for Advance Care Planning increasing the budget from $150k to $236k. This was necessary as HWNZ has not committed to any funding where the initial budget bid has been based on a 50/50 share of training costs. This additional budget request has been accommodated by reallocation of the core NRHP implementation budget.

In addition commitments were made to IHI training for FDNH and Advance Care Planning training which will occur in Quarters 2 and 3 respectively.

The DHB revenue contributions towards these costs are as outlined below.

	First Do No Harm	Other NRHP Costs	Total
Northland	-	16,368	16,368
Waitemata	-	41,725	41,725
Auckland	-	35,030	35,030
Counties Manukau	-	41,041	41,041
All DHBs	**-**	**134,165**	**134,165**

Appendix A: National Health Targets

Q1 National Health Targets

	Electives	ED Waits	Hospital smoke free	Diabetes HBA1C <8	Diabetes Annual Checks	CVD Risk Assessment	Combined CVD and Diabetes	Immunisation	Radiotherapy Treatment
Northland		86%	100%	71%	70%			81%	100%
Waitemata	99%	93%	96%	69%	58%	80%	69%	92%	100%
Auckland	99%	92%	80%	75%	60%	79%	71%	92%	100%
Counties Manukau	108%	96%	89%	56%	81%	80%	73%	89%	100
Regional average	**102%**	**92%**	**91%**	**68%**	**67%**	**80%**	**71%**	**89%**	**100%**
Target	*increase*	*95%*	*95%*	*increase*	*increase*	*90%*	*increase*	*95%*	*100%*
Previous result Q4 2010/11	107%	94%	86%				72%	89%	100%

Notes

- Some Northland DHB results will not be available until 7th November. These will be reflected in the Q2 report. This includes Electives, CVD and Diabetes measures.

Appendix B: Retinal Screening

2010/11 Baseline

Waitemata	12,812
Auckland	6,500
Counties Manukau	10,491
Total 2010/11	29,803
Target additional for 2011/12	4,500
Annual target 2011/12	34,303
Average required / quarter	***8,576***

Q1 Results 2011/12

Waitemata	3159
Auckland	1468
Counties Manukau	2490
Total Q1	**7117**
Variance to average	*- 1,459*

7.2 Health Targets

7.2 Health Target Updates

The performance against the Health targets overall is positive. Four of the six targets were met for the month the remaining two are progressing towards the target with action plans in place. (Notes: The three measures: Diabetes checks, Diabetes management and Cardiovascular risk assessment are combined to form one health target. The cardiac bypass target is additional to the national six health targets)

For Acute patient flow management (6hr ED target) both Adult and Childrens Healthcare service groups achieved the target of 95%.

Results for diabetes checks, management and risk assessment are now available for Q1, while we did not fully achieve, there are a number of initiatives that have been put in place to raise performance. These are detailed in the individual report sections.

Immunisation achieved the target of 91%. The target has increased to 95% by July 2012 and it is recognized this will be challenging and significant support is being provided to increase two year old vaccination rates.

	Status	Comment
Adult acute patient flow		95% achieved against 95% target.
Child acute patient flow		95% achieved against 95% target.
Improved access to elective surgery		94% achieved against 100% target 99% YTD
Shorter waits for radiation therapy		100% of eligible patients treated.
Increased immunisation		Q1 2011/12 achieved 91% against target of 91%
Better help for smokers to quit		82% achieved against 95% target
Diabetes checks		Q1 2011/12 results showed target not met in July, but did achieve in August and September
Diabetes management		Q1 2011/12 results 75% achieved against target of 79%
Cardiovascular risk assessment		Q1 2011/12 results 81% achieved against target of 90%
Cardiac bypass surgery		Patients waiting 92 against a target of 94

Key to symbols

Proceeding to plan 

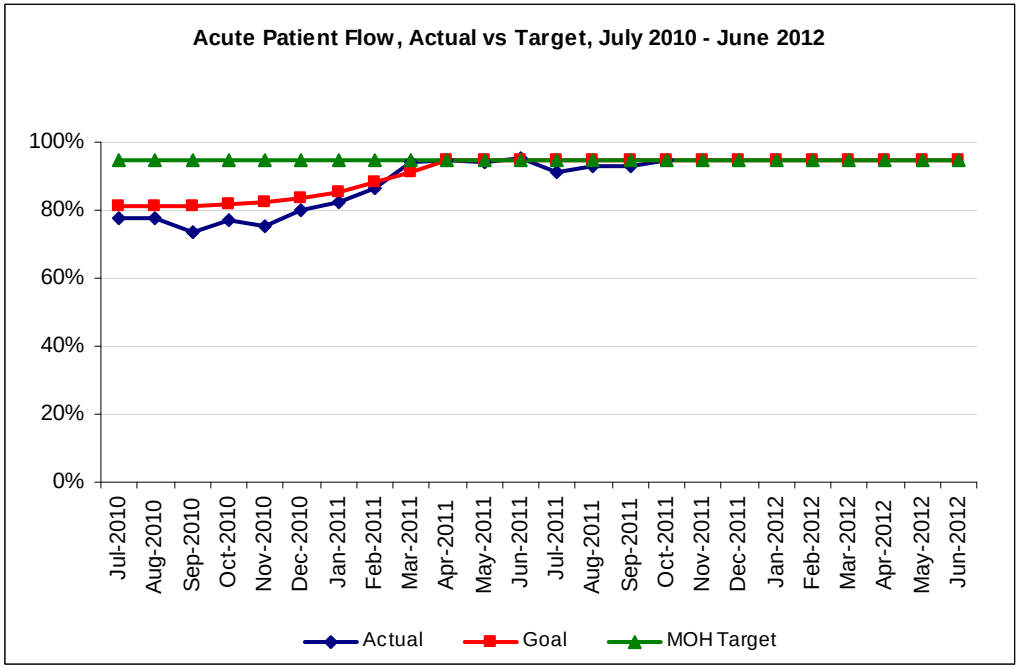
Issues being addressed 

Target unlikely to be met 

Project:

Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours

Date of Delivery: 30 June 2012



Project Risks / Comments:
95% of patients admitted, discharged or transferred from Emergency Department within six hours in October.

Actions continue to be taken across Adult and Children's service to respond to constraints impacting on flow and to sustain current level of performance.

Project: Adult Acute Patient Flow

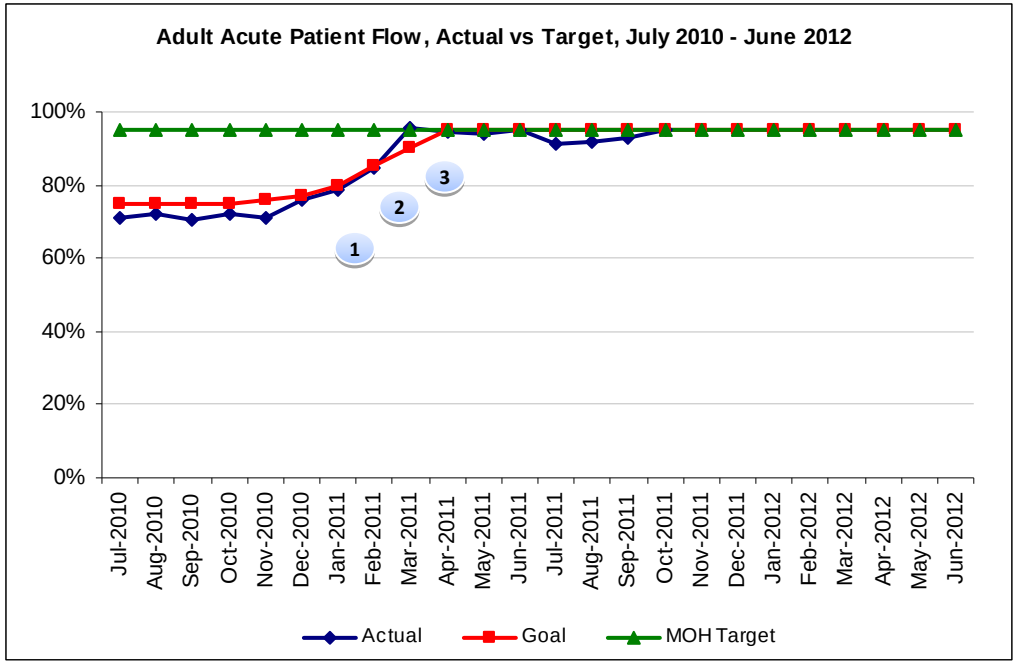
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2012

Clinical Leads: Nurse Director Margaret Dotchin , Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

Steering Group: Nurse Director Margaret Dotchin, General Manager Ngaire Buchanan, Dr Tim Parke, Dr Art Nahill, Dr Wayne Jones, Dr Andrew Old



Project Risks / Comments:

95% of patients admitted, discharged or transferred from Adult Emergency Department within six hours in October.

Three areas for further focus include: reducing delays to ED sign on, reducing delays to inpatient specialty sign on post referral from ED, reducing access block (no beds available).
Measures underway to address these concerns include:
Finalising Adult ED escalation plan and incorporate into hospital wide plan.
Workshop review of 3 hour strategies to identify further improvement opportunities
Implement Gen med redesign
Develop acute and elective bed capacity forecasting to integrate with elective surgery POP.
Review clinical documentation in ED to reduce duplication.

Improvements to date:

Streamlined AED processes and measurement and manage the challenge of growing demand

Reviewed Medical / Nursing requirements for AED and approved business case for resource increase to match increased workload.
Charge nurse patient flow coordinator introduced
Improved access to Radiology
Streamlined documentation required for safe transfer
Improved triage processes.

Managing bed block with additional resources

58 Additional beds opened 2009-2010
Winter Ward 31 General Medicine 10 additional beds August – October 2010

Managing bed block & reducing the time patients wait through improved processes and teamwork

Daily Rapid Rounds introduced in General Medicine (Feb 2010) and Orthopaedics (July 2010)
Nurse Facilitated Discharging in General Medicine (April 2010)
Improved Bed Management Communication via Estimated Discharge Dates, CMS upgrades, improved visual management, more efficient bed management meetings, earlier time of day discharging.
Daily breech review meetings to understand root causes and implement short term solutions.

Immediate actions to improve performance:

1. Increased engagement of Senior Leadership Team to support improvement activities and reduce road blocks to improvement.
   Increase communication and engagement of Clinical Directors, SMO's, RMO's
   Increase communication and engagement of Charge Nurses and RN's after hours to further reduce wait times for patient transfer from Emergency Department
   Engage with SMO's, RMO's and nurses one to one, by CD, Nurse Advisor or Level 2 clinical leader where resistance to required behaviour is demonstrated.
   Valuing patient time poster campaign
2. Establish ED short stay unit
   Implement APU flex beds
   Improve measurement of Ready to Go patients in ED
   Complete recruitment of remaining ED resource to improve weekend coverage
   Support General Medicine by diversion of patients to subspecialties
   Implement general surgery acute flow team initiatives to improve response time
   CMO to attend Orthopaedic SMO meeting to increase engagement.
   Relocate bed manager to ED after hours
   Implement ED discharge nurse on weekend
   Hands on support of ED flow Charge Nurse to reduce roadblocks to timely review and transfer of patients
   Commence physiotherapy facilitated discharge in Orthopaedics.
   Establish discharge co-ordination responsibility in Gen Med ward nursing team.
   Further increase timely overnight transfers from ED to inpatient wards once bed allocated.
3. Five day rapid improvement event planned for April to focus on improvement of process from decision to admit to patient transfer complete.
   Improve elective scheduling.

Project: Children's Acute Patient Flow

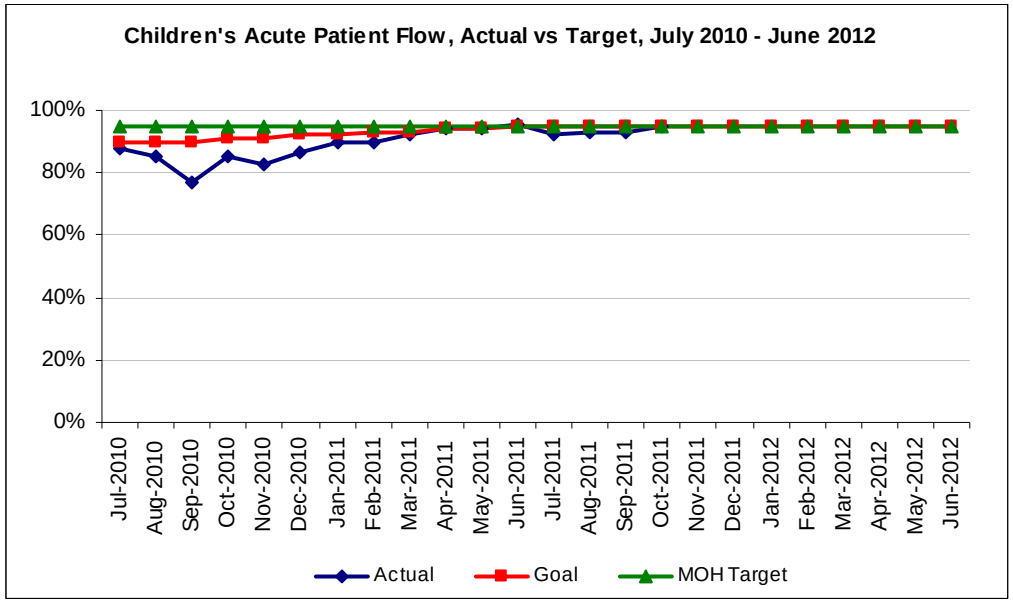
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: **30 July 2012**

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

Steering Group: Ngaire Buchanan, Richard Aickin, Michael Shepherd, Janet Campbell, Stuart Dalziel



Project Risks /Comments:

We are very pleased to report that October proved to be a very successful month for achievement of the 95% of Patients within six hours target. Our 95% result represented a 2% improvement over the prior month and a significant 9% above the equivalent month last year.

While Acute patient presentations and admissions numbers were almost the same as last year, our Elective throughput was very favourable and this meant that Starship still operated at a relatively high level of occupancy. Our ability to achieve this we believe, in part, was due to our continued focus on the Capacity Planning process. Looking at the numbers of cancelled Electives for the period July to September for the past three years we have seen that 2011 was comfortably the lowest. While not conclusive in itself, the result is encouraging and we will monitor over the coming months.

Our focus on the use and accuracy of Estimated Discharge Dates continues and October produced our best results to date. This is proving to be very useful not only for discharging patients in a timely manner and communicating with families, but also for the Capacity Planning process.

As Acute volumes subside in the coming months we will be renewing our focus on the two hour component of the 3-2-1 breakdown of the six hour process. We have continued to share data with the appropriate teams to continue to improve awareness and engagement in the process.

Improvements to date:

Improvement in the Estimate Discharge Date (EDD's) for current inpatients – steady improvement in accuracy.

Improvement in the forecasting occupancy

Immediate Actions to Lift Performance

We continue to progress the specific project we are operating on the 2 hour component. While advancement is slower than planned, we have identified five key areas for improvement and are moving these forward.

1. A new suite of reports including a breakdown of the 3-2-1 performance is now produced each Monday and is distributed to key stakeholders.
2. Ongoing focus to ensure timely discharging by improving the rounding process. General Pediatrics is paying particular attention to Nurse presence on rounds to enhance communication, particularly with parents.
3. In addition Pediatric Orthopedics has been operating a daily Rapid Round Meeting including the Multi Disciplinary Team to improve communication and agree actions for a co-ordinated discharge plan.
4. We have concluded a project on Bed Turnaround time in our Pediatric Surgical Ward and we will be replicating the project in other wards starting with Pediatric Orthopedics.
5. We continue to progress the specific project we are operating on the 2 hour component. While advancement is slower than planned, we have identified five key areas for improvement and are moving these forward as priorities allow.

Longer term projects

Starship Capacity Planning Project

Project: Improved access to elective surgery

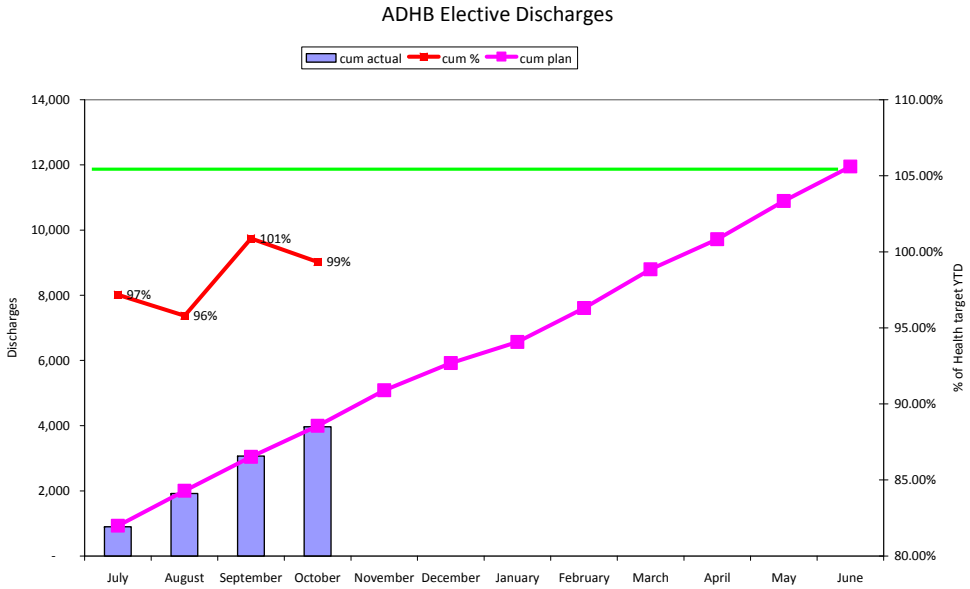
Primary Objective: Increase ADHB Elective Surgical Discharges from 11,149 to 11,950

Date of Delivery: 30 June 2012

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

Steering Group: Ngaire Buchanan, Dr Vanessa Beavis, Margaret Dotchin, Fionnagh Dougan, Ian Civil.



Planned activities:

1. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Continuing to review the production plan at a daily and weekly level.

Risks / Comments: (Amber)

1. Quarter 1 performance was 101% of target.
2. October was 94% of target.
3. Year to Date 31 October 2011 is 99% of target.
4. September is the only month we have met or exceeded monthly target.

Project: Shorter waits for Radiation Therapy

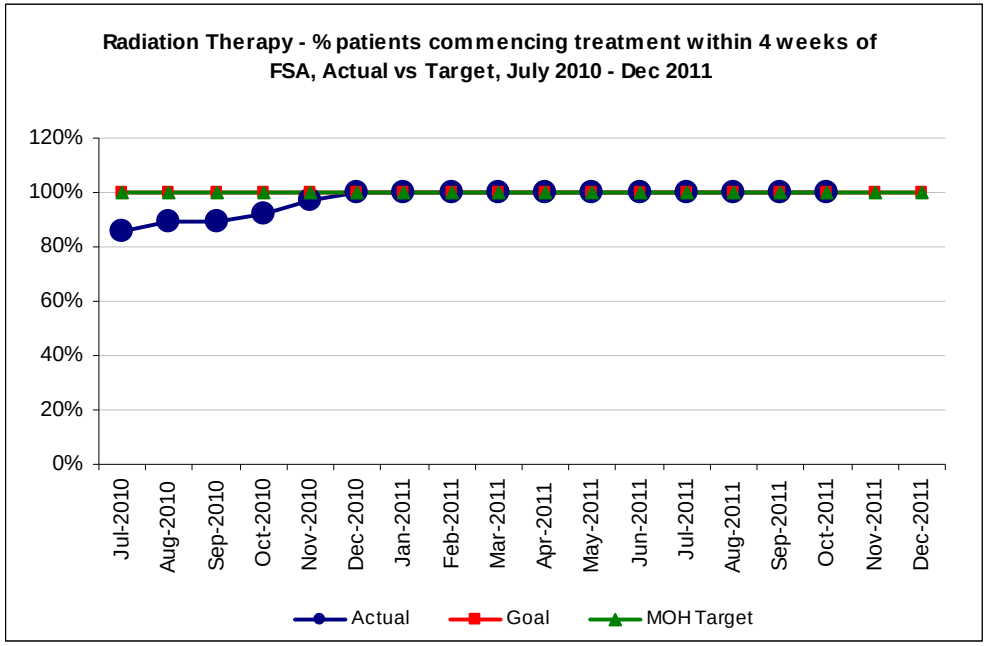
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

Steering Group: Fionnagh Dougan, Andrew Macann, Margaret White, Robyn Dunningham



The service is 100% compliant for October 2011

Key risks which may impact capacity to deliver to the target in the coming months:

Introduction of new technology also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment.

Radiation Oncology Wait times – October 2011

In October 100% of eligible patients were treated within the 4 week target timeline. As at 31 October Radiation Oncology has delivered to the target for 553 consecutive days.

Further improvements in progress to sustain delivery:

Replacement of MV6: The replacement of MV6 is almost complete and is due to reopen on 21 November 2011.

Introduction of HDR for Gynaecological patients: The HDR machine has been replaced and will be operational in mid November.

A public/private Model of care has been developed to enable our clinicians to treat public patients at ARO. Noting the variability in our referral flows, ARO have agreed to operate a 4 week rolling average of approx 3 patients per week from August 2011.

Introduction of new technology: The introduction of V-Mat treatment has the potential to reduce treatment times for specific tumour groups by up to 50% when fully implemented next year.

Aria project: A project is well underway to develop a full electronic record within the LINAC machine's operating system. Project end expected Dec 2011.

An "Operational team" measures KPI's to prioritise the waitlist and analyse performance on a weekly basis. This is ongoing.

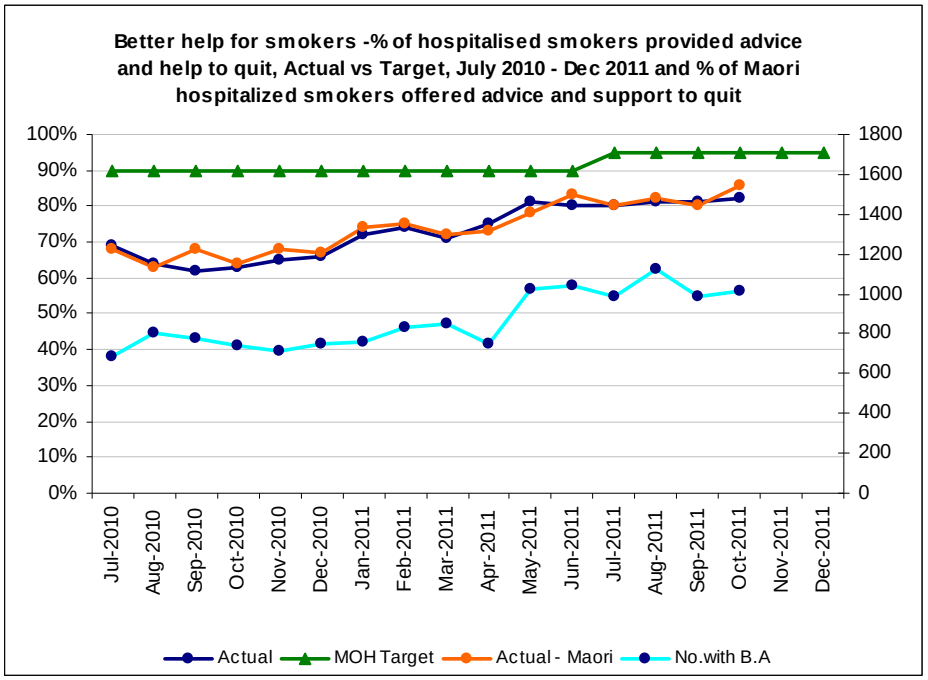
A daily Waitlist report enables daily monitoring and immediate remedial action if required.

Project: Better help for smokers to quit

Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child Programme Sponsor: Taima Campbell Programme Manager: Jan Marshall

Steering Group: Di Roud, Anna Schofield, Maggie O'Brien, Stephen Child, George Laking, Jim Kriechbaum, Paul Bohmer, Arun Kulkarni, Michelle Stevens, Kristine Nicol, Bernadette Rehman, Paul Birch, Anne-Marie Pickering, Victoria Child, Jan Marshall, Kara Hamilton, Steven Stewart



Comments

Result: Of the 8734 events coded in October 1231 (14%) were identified as smokers. 82% (1013) of all smokers were given brief advice to stop smoking. 86% of Maori patients were recorded with brief advice this month.

Systems to ensure brief advice is given and recorded at the Greenlane Surgical Unit have improved results and as reported in September our ability exclude the ex-smokers coded F17.1 from the smoking prevalence increased the brief advice result by 2%.

It is clear that the biggest gains to be made to lift the target over 90% and move to 95% will need to be made in the Adult Emergency Department and the Admission and Planning Unit. If AED and APU had reached the 95% target (recorded brief advice for an additional 100 patients) in October the overall ADHB result would have risen 8% to 90% . The Emergency Department is working to address the shortfall and he APU results continue to improve.

The remaining 5% is spread in relatively small numbers across other services. Weekly results including the number of patients missed by ward are distributed to indicate which areas need to improve their results.

Achievements in October:

- Greenlane Surgical Centre recording of ABC on day of surgery implemented and being monitored weekly

Immediate Actions to improve performance by 13%:

A. Focus on short stay/high volume areas to achieve 5-8%:

- Continued auditing and 1:1 coaching in AED and APU
- To reduce the "not asked/ documented" option in the Electronic Discharge Summary in AED from 27% to 10%

B. Improve engagement of clinical workforce to achieve 3-4%:

- Data on target now distributed weekly to senior leadership
- Best Practise Guidelines to be distributed to wards and updated weekly
- To work with Registrars to determine barriers and support mechanisms to assist junior doctors complete the ABC in clinical documents and EDS

C. Data collection systems and processes to achieve 1 % :

- Smoking and Brief advice column to be added to Ward electronic whiteboards to monitor the ABC completion
- Investigation of generation of a Brief Advice Brochure with the EDS for AED
- Research – ADHB joining 6 other DHBs is participating in a ABC Outcomes survey funded by the MOH to measure the outcomes of Brief Advice given in hospitals

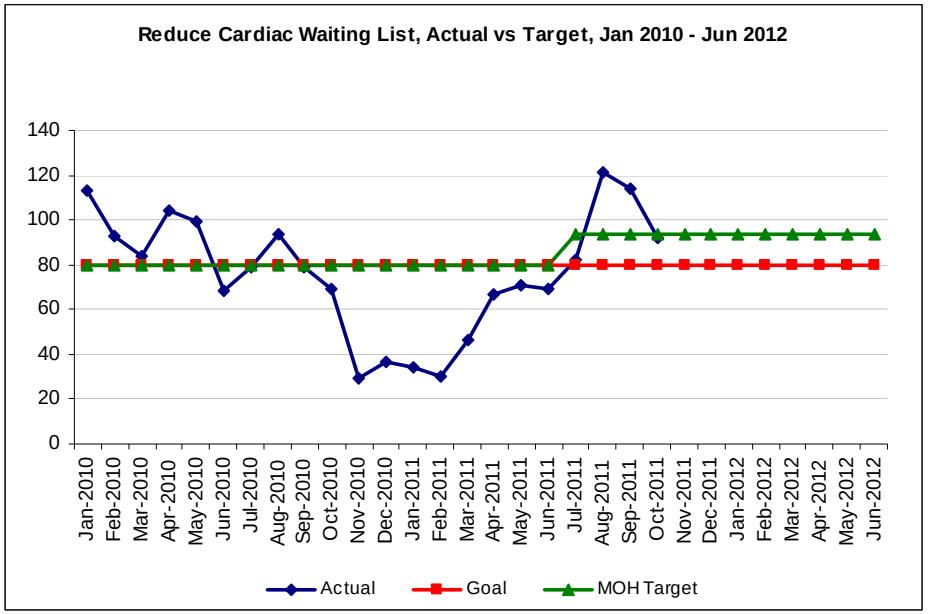
D. Communications – planned activities

- An NRT working Group as been established to develop an NRT promotion campaign to all clinical staff
- Quit Banner to be set up at Level four entrance

Project: Cardiac Bypass Surgery

Primary Objectives: To enable timely access to cardiac bypass surgery the waiting list should be no greater than 94.
To support the national cardiac bypass intervention target, 940 bypasses should be completed in 2011/2012

Date of Delivery: 30 June 2012
Clinical Lead: Peter Ruygrok
Project Sponsors: Fionnagh Dougan
Steering Group: Paget Milsom, Andrew McKee, Peter Ruygrok, Elizabeth Shaw, Pam Freeman



Monthly Performance
76 Bypass procedures were completed by the service during October. Of these completed procedures 64 are eligible to be counted against the MoH target for the Northern region population . There was a high demand for other bypass procedures in the month of October with four aortic dissections and a heart transplant completed in this month. In addition to these volumes 19 eligible bypass procedures were outsourced to Mercy Hospital. The outsourcing strategy has continued as part of the recovery plan to reduce the waiting list. At month end we were just under this limit which is ahead of our forecasted decrease.
Prior to this the average had been 21 referrals per week (FYTD). Coming into November we have a large number of inpatients who we are waiting to 'be ready' for surgery and are yet to be listed. If historical trends ring true November is also likely to be a month of high referrals and therefore we need to continue to outsource to mitigate an increase in the waiting list. Weekend contracts are also scheduled for completion throughout the month.
At the end of October the service was facing issues with long stay patients in CVICU causing theatre cancellations. To offset this a large quantity of thoracic procedures have been scheduled for the start of the month. The logic underpinning this approach is to increase our theatre utilisation as well as our potential bypass capacity later in the month. The enhanced recovery data has been captured throughout October and analysis of this will be completed shortly. Rapid rounds have started in ward 42 in October and this work ties in well with the delays to discharge projects in ward 42 and CVICU. The benefit of this work is to be captured in November.

Completed Improvement Activities:

- Developed and implemented electronic scheduling system
- Initiated pre-admit process
- Developed detailed operational reporting
- Set up development production process
- Approved business case for CVICU bed capacity
- Built capacity planning model for CVICU and Ward 42
- Developed patient load planning tool
- Initiated daily bed management meeting
- Enhanced recovery pathway in ICU
- Scheduling workshop for productive theatres
- Releasing time to care foundation modules
- CVICU\HDU merger

Further improvements in progress:

- . 3 in a row bypass (productive list)
  Optimise the theatre schedule by planning a "productive list"
- ECMO – Resource planning process
  To improve resource planning and day to day processes to reduce the impact of high ECMO demand on bypass cases
- The Productive Operating Room (NHS Programme)
  To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- Delay to discharge – ward 42
  To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Delay to discharge CVICU
  To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Elective patient focused team project
  To maintain elective throughput in the service during periods of constrained production
- ICU Nursing FTE business case approved
- Weekend contract case certainty
- Rapid Rounds ward 42

Project: Diabetes

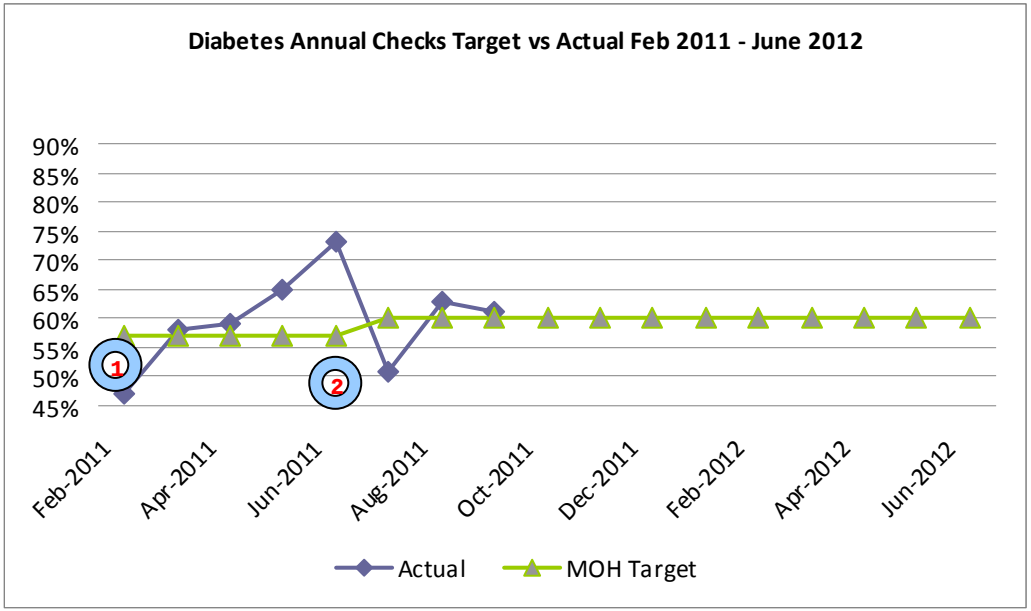
Primary Objectives: Increase the percentage of people with diabetes accessing and attending their free annual diabetes get check

Date of Delivery: 55% June 2011

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Past activities

- Increase awareness project with PHOs driving information share
- Practise based data (results) feedback
- Improved understanding of IT linkages in Practice systems
- Paper from the Auckland Diabetes Advisory Team to CPHAC requesting funding to implement improvements in diabetes care and management that will impact on National Health Targets.
- Routine reports to clinical advisory leadership meetings
- CPHAC initiatives for long term conditions quality improvement coordinators and population audit tool beginning to be implemented.
- Regional shared care pathway work
- Regional shared target setting and service outcomes

Recent and Current activities:

1. LTC Coordinators working with primary care to better identify and manage their population .
2. Support utilisation of population audit tools for all ADHB practices

Project Risks / Comments:

The MOH issued revised prevalence for 2011/12, increasing the prevalence of ADHB's population with diabetes by 2,000 compared to 2010/11. Despite a sharp drop in July, we have met the 60% target for August and September. While performance for Pacific remains above target, performance for both Maori and Pacific has been below target. Since the MOH announcement that this target will be dropped, it has been more difficult to keep PHO's and practices focused on achieving this target.

The Long Term Condition Quality Improvement Coordinators have now visited all practices they can gain entry to (less than 10 didn't allow access), and completed a data match to ensure practices have an accurate diabetes register and can proactively manage and monitor their population with diabetes through tools such as Dr Info. They continue to provide targeted support to practices requiring further training and support in the use of tools, and are working with PHO's to link in with their activities. They are also focused on reviewing the educational pathway for practices nurses in diabetes/CVD management, and have recently started quality improvement initiatives with some practices, focusing on patients with high HbA1c's. They continue to link in with all stakeholders including the Auckland Diabetes Centre, PHO's, NGO's and AUT.

Project: Diabetes

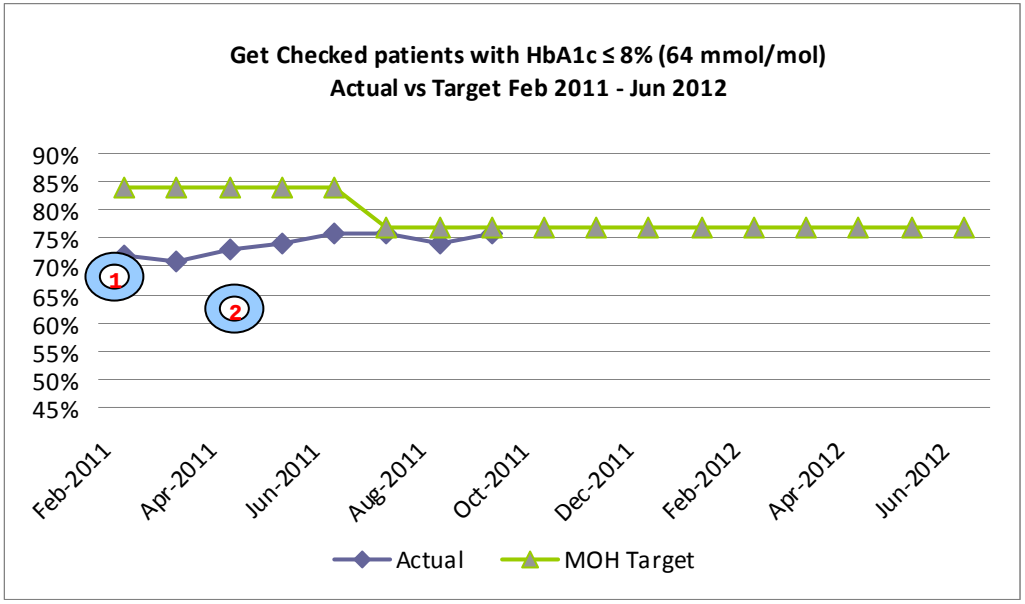
Primary Objectives: Increase the percentage of people with diabetes having satisfactory or better diabetes management

Date of Delivery: 79% of people with diabetes will have a HbA1c ≤8%

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Group, Auckland Diabetes Advisory Team



Project Risks / Comments:

Over the last few months performance has been 1% below target, at 76% (for months of June, July and September, with August at 74%) . Broken down by ethnicity, performance for Maori has been consistent with the target of 72% being exceeded in July and August, and 1% below in September. For Pacific, we continue to fall below target at 62%, although September increased to 64%. For Other, targets have been met each month. There are a number of activities to support this component of the target, including the long term condition quality improvement coordinator initiative, who are working with practices and secondary services to improve this performance. The Diabetes Self Management Education service provider has run 21 courses between February and September, with a focus on our high needs populations. Participation however remains low and the Provider is undertaking further work to increase attendance numbers and referrals (including self referral). The generic self management course that is being rolled out for our Pacific populations through HVAZ , ran two courses in the last financial year, with a further 2 this year. Additionally courses are being run through the PHO's which are delivering this under HVAZ, and two courses are near completion at the Tongan Health Society, with courses also have been completed at Procare. Ongoing training for the new facilitators of this programme continues.

Past activities:

- Direct Secondary Service phone support for GPs
- Increased SE Asian Nurse Specialist access
- Improved understanding of IT linkages in Practice systems (linking PPP)
- Redesign the supported self management to meet needs of population – to include any person diagnosed with Type 2 diabetes and improved culturally appropriateness of courses.
- Developing shared care pathway for Diabetes
- Regional shared care pathway work including clinical workshop
- Implementation of Long Term Condition Quality Improvement Coordinator project
- Population audit tools made available for each practice.

Recent and Current activities:

1 New Diabetes Self Management Education contract commences and Pacific Self Management Facilitator employed 0.5 FTE initiate roll out of Stanford programme for Pacific populations in ADHB**.**

2 LTC Coordinators working with primary care to better identify and manage their population.

Project: Cardiovascular Risk Assessment

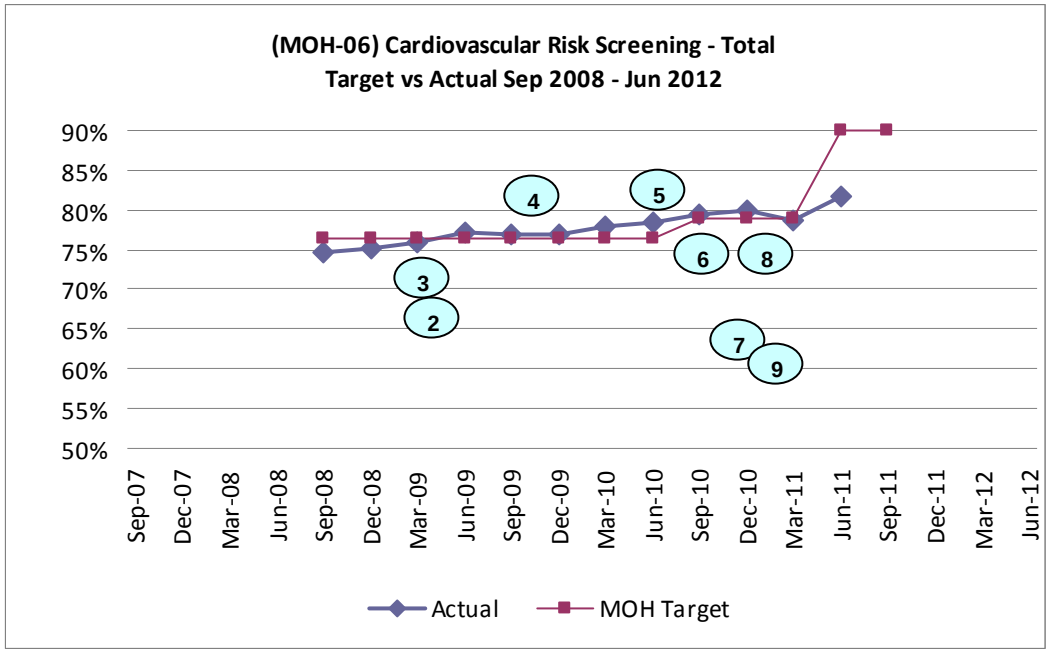
Primary Objectives: Increase the percentage of our eligible population who have had their CVD risk, assessed in the last five years

Date of Delivery: Overall goal is to have 80% of eligible population CVD risk assessed every five years.

Clinical Lead: Gayl Humphrey

Project Sponsor: Dr Denis Jury

Steering Group: Primary Care Clinical Advisory Team



Recent and Current activities:

1) Support the uptake of an electronic CVD tool

2) Training and information system support for electronic tool

3) IT help line for GPs for risk assessment tool

4) Increase the cumulative incentive payments for achieving both good assessment and good management together

5) Review and reshape incentives to link with PPP targets

6) Enhance links to Green Rx and maximise primary care uptake

7) Continue to work in various workplaces to enhance CVD risk assessment for men

8) Link in with research looking at ways to optimise Pacific males participation in health self management

9) Work regionally to have similar focus on incentive goals

Project Risks / Comments:

Q1 data (April – June 2011) for CVD data shows a 3% increase from last quarter to 81.6%. Increases were seen across all ethnicities, with Maori up 2% and Pacific and Other up 3%.

This target is measured via a proxy using CVD lab data. There is a national target of 90% in 2011/2012, which no DHB has been able to achieve this quarter (statement from MOH website). The CVD-lab data will be used next quarter, but thereafter the new CVD Risk Assessment results from PHO Performance Programme will be used, with a scaled target (60% by June 2012, 75% by June 2013 and 90% by June 2014).

ADHB continues to support primary care in CVD screening and management through funding the license of the Predict tool and an incentive based contract. We are meeting with WDHB as to how we might revise and align these contracts. The Long Term Condition Quality Improvement Coordinators (noted in the diabetes comments above) are also supporting CVD screening and management in primary care.

Project: Increased Immunisation

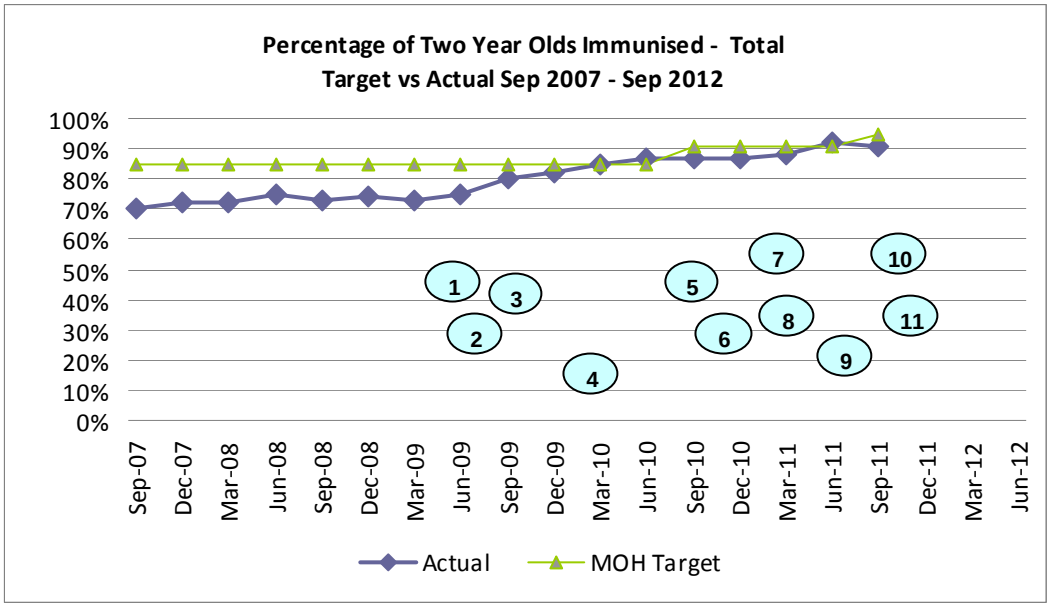
Primary goal: That 85% of two-year olds will be fully immunised by July 2010, 91% by July 2011 and 95% by July 2012

Date of Delivery: 1 July 2010, 1 July 2011 and 1 July 2012

Clinical Lead: Richard Aickin

Project Sponsor: Richard Aickin

Steering Group: Richard Aickin, Carol Stott, Aroha Haggie, Hilda Faasalele, Ruth Bijl, Alison Leversha, IMAC, Auckland PHO, Public Health, Plunket, Commissioner for Children Office, Ministry of Health



Activities

1. Practice level reporting available
2. Primary care Immunisation Co-ordinators funded - ongoing
3. ADHB Immunisation Strategy approved
4. Funding application made to Starship Foundation to fund social marketing programme. Not approved.
5. Data cleansing project in primary care approved and funded
6. Scoping project for multi-agency engagement in promoting immunisation to high needs families
7. Data cleansing and practice nurse education project by NIR team and Immunisation Coordinators in all practices. Results from audit included over 6000 immunisation events being manually entered on NIR.
8. Letters sent to all parents who are noted on the NIR as having declined immunisation for their child to check that this is correct. Follow up activity planned for November 2011 to include phone calls by practices if decline not certain to confirm.
9. Health promotion activities including posters and DVDs displayed in all Community Link sites across Auckland. Health education delivered in 8 PD sites supported by Corrections. Extremely positive feedback on both Immunisation and SUDI presentations from attendees and supervisors.
10. Automated referral to the outreach services when a child is overdue for any scheduled immunisation.
11. Letter to all practices regarding importance of timeliness of primary series along with their practice's 6 months coverage rate.

Project Risks / Comments:

As at 30 Sept 2011, ADHB's immunisation coverage (2 year olds full immunised all ethnicities) was 91%. ADHB is committed to achieving the lowest possible incidence of vaccine preventable disease and to reducing inequalities by achieving the highest possible immunisation coverage across the whole population. The target of 95% will, however, be extremely challenging. Significant work continues to support achievement of this target including inter-sectoral activity which has most recently included health promotion activities in Community Link sites (MSD) with posters, DVDs playing and a nurse available to educate parents attending for newborn hearing screening appointments. Additionally, inter-sectoral activity through Corrections has resulted in delivery of education to people on periodic detention. Immunisation presentations were accompanied by the Maori health specific SUDI presentation. We have been disappointed to see a slip back from a high light in August when equity was achieved in terms of coverage for Maori children. Coverage for Maori children has now dropped back and as of 7/11/11 is 10 percentage points below NZ Euro. There is no apparent reason for this. Both Asian and Pacific rates have however remained high. A fortnightly operations meeting which include primary care, midwifery, paediatrician, NIR and outreach services continues to trouble shoot and drive solutions.

8

LIFT THE HEALTH OF PEOPLE IN AUCKLAND CITY

8.1 Committee Recommendations

8.1 Committee Recommendations

Community and Public Health Advisory Committee Recommendations

Recommendation

That the Auckland District Health Board:

1. Approves the approach to annual planning for 2012/13, including the longer term direction and timetable.
2. Notes the suggestion for a joint set of annual plan priorities for Auckland and Waitemata DHBs through joint activity.
3. Notes the draft national planning guidance which has been sent out to members electronically.

Background

This is a recommendation from the CPHAC following a presentation on the 2012- 2013 planning approach.

Maori Health Advisory Committee Recommendations

Disability Support Advisory Committee Recommendation

Recommendation

That the Auckland District Health Board notes that the DSAC supports the recruitment of a person to assist with the implementation of the NZ Disability Strategy, and that consideration be given to the alignment with the current Waitemata DHB position, by way of a partnership approach.

Background

This is a recommendation from the DSAC. An Accessibility Review recommended the appointment of a Disability Liaison Officer. Waitemata has such an appointment and the Committee sees alignment of the two positions in a collaborative partnership approach as being advantageous for both organisation.

8.2 Auckland Plan Submission

Draft Auckland Plan Submission

Prepared by: *Andy Roche (Policy Analyst Auckland Regional Public Health Service)on behalf of: Denis Jury (Chief Planning and Funding Officer Auckland DHB), Janine Pratt (Group Planning Manager Waitemata DHB), Doone Winnard (Public Health Physician Counties Manukau DHB), Frank Booth (Service Manager Auckland Regional Public Health Service) and the other members of the Auckland Unleashed Working Group.*

Glossary

ARPHS - Auckland Regional Public Health Service

Council – Auckland Council

CPHAC - Community and Public Health Advisory Committees

DHB - District Health Board

NDSA - Northern Region DHB Support Agency.

The Plan – the Inaugural Auckland Plan.

DECEMBER 2011

Purpose

X	Information		Update	X	Approval

Recommendation

That the Board:

1. **Receive the information.**

2. **Endorse the submission to the Draft Auckland Plan process lodged by the Auckland Regional Public Health Service.**

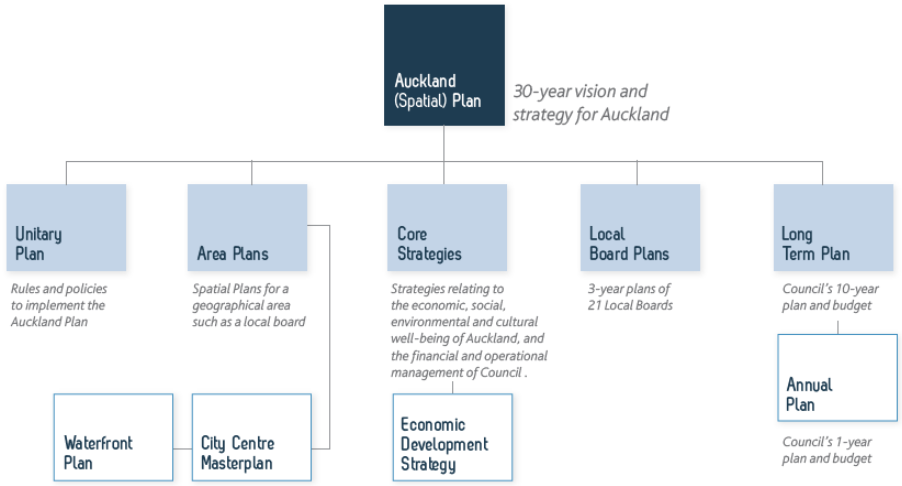
Summary

On 31st October 2011 ARPHS lodged a submission to the Auckland Council Draft Auckland Plan process. This submission is attached as Appendix 1.

This submission was prepared by health professionals and staff from across the three DHBs, NDSA and ARPHS and lodged as an ARPHS submission. The submission was developed through an iterative process which considered ideas and material put forward by staff and individual board members. The work programme occurred under the sponsorship of Geraint Martin CEO of CMDHB and Denis Jury, Chief Planning and Funding Officer, ADHB who are leading health's response to the Auckland Plan process and also considering how Council and health might work better together in the future.

Council views the Auckland Plan as its overarching strategic document (as set out below). Much of the content of the draft plan contains initiatives and actions that address the social determinants of health and will support improved health outcomes and reduce health inequalities. There are a number of areas where the plan is capable of being strengthened.

Figure 1 Auckland Council: Planning and Strategic Hierarchy[1]



The ARPHS submission contains a range of comments and recommendations designed to improve the impact of the Plan on health outcomes in three main areas, namely:

- Drawing Council's attention to the health gain possible through bringing alcohol and tobacco (and Council's roles in relation alcohol and tobacco), explicitly into the Plan.
- Recommending amendments of other areas of the draft plan to improve the scope of the plan and the effectiveness of the proposed actions
- Seeking ongoing work with Council on those areas relevant to health, as traversed by the Plan.

Earlier drafts of the final submission were considered by the:

- ADHB / WDHB Joint CPHAC committee electronically during the week commencing 17th October.
- CMDHB Board electronically during the week commencing 17th October
- WDHB Board at its meeting on 26th October.
- ADHB / WDHB Joint CPHAC and CMDHB CPHAC also considered issues related to the Draft Auckland Plan at meetings in the period August to October.
- Regional Governance Group at its meeting on 28th October.

During the submission's development it was intended that it would be endorsed by the DHB Boards before lodgement. Due to the short consultation period, the time needed to assess the Draft Auckland Plan and prepare the submission, and the timing of Board and CPHAC meetings, it was not possible to provide a completed submission for endorsement by the

[1] Auckland Council. The Auckland Plan. Available at: http://www.aucklandcouncil.govt.nz/EN/AboutCouncil/PlansPoliciesPublications/theaucklandplan/Pages/theaucklandplan.aspx?utm_source=homepage%2Bpromo%2Btile&utm_medium=website&utm_campaign=Auckland%2BPlan

Boards before its lodgement. This paper provides each Board with the opportunity to formally consider the submission.

The submission lodged by ARPHS is one of over 1800 submissions received by Council on the Draft Auckland Plan. Over 2500 submissions were received by Council on the Draft Auckland Plan and the three other more detailed plans[2] on aspects of the Draft Auckland Plan it was simultaneously consulting on.

The Auckland Plan is scheduled to be adopted by Council in February 2012. Before that time Council will be holding oral hearings for those submitters who have asked to address Council (or attend one of Council's planned workshops). ARPHS has asked, on behalf of the health sector, for the opportunity to be heard by Council at an oral hearing. The oral hearing is scheduled for Tuesday 29th November 20011 for 30 minutes between 4 and 5 pm. ARPHS are working with the DHBs to ensure that those involved in this oral hearing are at an appropriate level in the health sector, well supported by technical staff, so as to maximise this opportunity.

The preparation of the Plan also provides an opportunity to consider how the DHBs and Council can work better with each other both at the governance and management levels to advance their overlapping and complementary objectives around health and social wellbeing. The current Working Group, under the sponsorship of Geraint and Denis, has been tasked with developing a separate 'think piece' for the Regional Governance Group which will outline the options, benefits, resource implications and risks of differing models for future relationships.

[2] Draft Economic Development Strategy, Draft City Centre Masterplan, Draft Waterfront Plan.

Auckland Regional Public Health Service
Rātonga Hauora ā Iwi o Tamaki Makaurau

Working with the people of Auckland, Counties Manukau and Waitemata

Auckland Regional Public Health Service
Cornwall Complex, Floor 2, Building 15
Greenlane Clinical Centre, Auckland
Private Bag 92 605, Symonds Street,
Auckland 1035, New Zealand
Telephone:09 623 4600
Facsimile:09 623 4633
Website:www.arphs.govt.nz

31/10/2011

Auckland Council
The Auckland Plan
Private Bag 92300
Auckland 1142

Submission to the Draft Auckland Plan

1. Thank you for the opportunity for the Auckland Regional Public Health Service (ARPHS) to provide feedback to the Draft Auckland Plan.

2. We understand Council's desire to adopt the inaugural Auckland Plan in time to allow the Auckland Plan to inform Council's long term planning process, which must be completed by July 2012. Notwithstanding Council's decision to extend the consultation period by one week, there has been insufficient time to both prepare our comments on the Draft Auckland Plan and to formally have those comments considered and endorsed by each District Health Board (Auckland, Counties Manukau and Waitemata DHB).

3. This feedback has been prepared on a 'best efforts' basis by ARPHS and is in the process of being formally endorsed by the Board of each DHB at their board meetings. As such this feedback represents the views of the Auckland Regional Public Health Service and cannot formally be seen to reflect the views of the three District Health Boards it serves, until the DHB Boards have had the opportunity to endorse the submission.

4. We would like to be heard at an oral hearing and at that hearing will raise any additional issues that the DHB boards believe are relevant.

5. We understand that all feedback will be available under the Local Government Official Information and Meetings Act 1987, except if grounds set out under the Act apply.

6. The primary contact points for this submission are:

Andy Roche
Policy Analyst
Health Improvement and Business Support

Auckland Regional Public Health Service
Private Bag 92 605
Symonds Street
Auckland 1150
09-6234600 ext 27105
aroche@adhb.govt.nz

Dr Lavinia Perumal
Public Health Medicine Registrar
Medical Team

09-6234600 ext 27116
lavinia.perumal@adhb.govt.nz

7. This feedback has been prepared by ARPHS[1] with input from staff of the three DHBs and ARPHS. Where comments have been made from our joint perspectives, the term 'we' has been used. In other areas, comments may be more relevant to an individual DHB or ARPHS; in these cases the text reflects that interest. Please do not hesitate to contact ARPHS if you would like further elaboration on any issue or would prefer a direct briefing from the relevant health sector staff.

8. The inaugural Auckland Plan will be a comprehensive and effective long term strategy for Auckland's growth and development and is a key planning document for the region. As such, Council's consultation on the Draft Auckland Plan is, perhaps, the single most important opportunity to engage with stakeholders and the wider regional community.

9. We commend Council on the contents of the Draft Plan, which if implemented in full, will materially improve health outcomes and social wellbeing for all Aucklanders.

10. We would also like to acknowledge the many areas where Council has responded to the issues raised in our feedback to the 'Auckland Unleashed – The Auckland Plan Discussion Document' (the Discussion Document) and incorporated them into the Draft Plan. These areas include the impacts of physical and social environments on health, along with planning of health service facilities / infrastructure.

11. The health sector is a key stakeholder in the region. The District Health Boards and Council have many common and complementary objectives in supporting Auckland's population and its future wellbeing. We look forward to an environment where we can work more closely with each other to ensure that we both make the optimum contribution to the future of the region. We view the Auckland Plan process as the start of this process of ongoing engagement between Council and the DHBs. Such ongoing engagement will help both Council and the DHBs achieve their objectives.

12. The majority of the disparities in health status between differing individuals and communities in the Auckland region arise:

> "…from the societal conditions in which people are born, grow, live, work and age, referred to as the social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and the environment, and effective systems of preventing and treating ill health."[2]

[1] Please refer to www.adhb.govt.nz for additional information for more information on ARPHS.
[2] WHO (2011) *Rio Political Declaration on Social Determinants of Health.* Rio de Janeiro, Brazil, 21 October 2011, accessible through http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf

13. We acknowledge Council's statement that the high level principles through which it will work to achieve the Draft Auckland Plan's outcomes namely: work together, value te Ao Maori, be sustainable, act fairly, make the best use of very dollar spent and check progress and adapt to improve, reflect the "eco city approach and the creation of healthy neighbourhoods as expressed" in figure 1 below.[3]

14. Health disparities will not be addressed successfully without attention being paid to reducing social inequalities as these have substantial influence on health. Many population health issues are interwoven right across the Draft Plan. The inter-linked nature of many of the issues traversed in the document means that it is impossible to address any single issue in isolation.

Figure 1 Eco City and Determinants of Health and Wellbeing

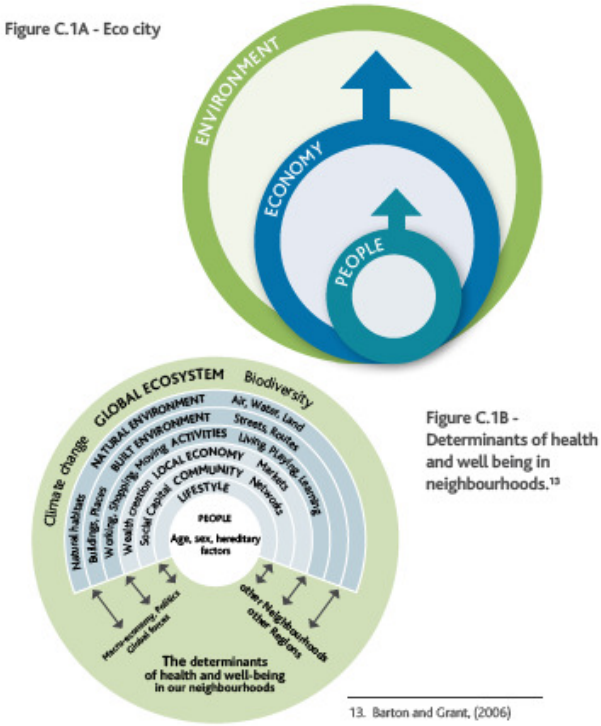


Figure C.1B - Determinants of health and well being in neighbourhoods.[13]

13. Barton and Grant, (2006)

15. Council makes many decisions that influence the health and wellbeing of the residents of the region. For some issues, the link is direct and immediate (e.g. decisions around water quality influence enteric disease levels). For other issues the link is less direct and immediate (e.g. decisions on urban street patterns influence obesity levels) and other factors may influence the same outcome.

16. The decisions that Council makes through the Auckland Plan process and its subsequent implementation have the potential to deliver substantial health gain for all Aucklanders, now and for future generations, and in particular those Aucklanders who are most disadvantaged. Decisions that support improved health outcomes will also help Council meet its wider social, economic, environmental and cultural objectives.

17. ARPHS is of the view that major gains to health and wellbeing can be made by addressing the following issues:

[3] Draft Auckland Plan page 26 and Health Sector Feedback to Auckland Unleashed page 11.

- Placing children and youth in the centre of all policies.
- Decreasing the life expectancy and health outcome gaps between Māori and Pacifica, and other New Zealanders.
- Reducing disparities in socioeconomic conditions as these strongly influence health outcomes.
- Acknowledging alcohol and tobacco as two major contributors to avoidable premature deaths, ill health and injury. Alcohol is also one of the main causative factors in some crime, safety and family violence.
- Controlling the rapid growth of obesity, and conditions where unhealthy nutrition and lack of physical activity contribute such as diabetes, cardiovascular disease (CVD) and cancer.

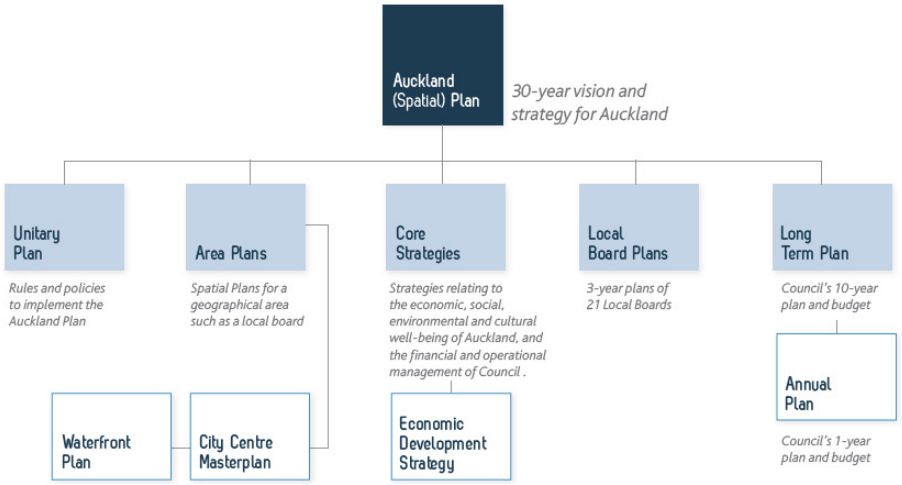
18. In all decision making, Council should consider the consequences for Aucklander's health and wellbeing by putting in place the appropriate tools and structures to support its consideration of health outcomes.

19. Many of Council's strategic directions set out in the Draft Plan will directly support the areas where the health sector thinks that substantial gains can be made. These areas include:

- Create a strong, inclusive and equitable society that ensures opportunity for all Aucklanders.
- Strengthen children and families and support stable homes.
- Enable Māori aspirations.
- Develop an economy that delivers prosperity for all Aucklanders.
- Appropriately house all Aucklanders.
- Create better connections and accessibility within Auckland.
- Plan, deliver and maintain quality infrastructure to make Auckland liveable and resilient.

20. We note Council's views around the hierarchy of its planning and policy documents encapsulated in the diagram[4] set out on it's website below:

Figure 2 Auckland Council Planning, Policy and Strategy Framework



[4] Auckland Council. The Auckland Plan. Available at: http://www.aucklandcouncil.govt.nz/EN/AboutCouncil/PlansPoliciesPublications/theaucklandplan/Pages/theaucklandplan.aspx?utm_source=homepage%2Bpromo%2Btile&utm_medium=website&utm_campaign=Auckland%2BPlan

21. We support Council's holistic approach and its view on the pre-eminent place of the inaugural Auckland Plan in contributing to Auckland's social, economic, environmental and cultural wellbeing. Notwithstanding the value we see in the Draft Plan, we consider there are areas that can be improved or that are missing from the Draft Plan. If Council is to deliver on its proposed Auckland Vision these issues should be included as they impact significantly on the wellbeing of present and future Aucklanders.

Recommendations

22. We recommend that the following key changes be made to the Draft Auckland Plan:

- Include specific reference to the spatial distribution of children and young people and the proportion of Aucklanders living with disability in the section on population growth and demographic change.
- Include the needs of people with disabilities as the subject of a separate directive in the Auckland's Peoples chapter of the inaugural Auckland Plan.
- Ensure the inaugural Auckland Plan explicitly and transparently confronts the tradeoffs between differing elements of the "vision" and "transformational shifts"[5] in its decision making.
- Ensure that in making those tradeoffs that Council prioritises issues of inequalities and fairness.
- Contribute to enabling Māori aspirations by formally integrating Māori conceptual models (e.g. Whānau Ora) and frameworks throughout the Auckland Plan and not just in isolation in Chapter Two.
- Extend the initiatives proposed in the Southern initiative area to other areas with high levels of socio-economic deprivation in subsequent phases of the inaugural Auckland Plan.
- Bring alcohol control and tobacco into the inaugural Auckland Plan as specific areas where high health gain is possible.
- Ensure equitable access for urban dwellers to open green spaces in order to protect overall health and wellbeing, especially in the context of increased urbanisation in the next three decades.
- Acknowledge and address the potential social consequences that can flow from poor urban design if it leads to the creation of areas of concentrated socio-economic deprivation.
- Institute a rolling programme of reviews of public transport services in differing areas across the region, with priority being given to areas suffering high levels of socio-economic deprivation to "provide better, more convenient access to educational institutions, employment and social services".[6]
- Provide further details of proposed actions in the implementation actions listed in Chapter 12. The current table provides insufficient detail as to how the actions proposed will support the priorities and directives contained in the relevant chapters.
- Ensure that in its exploration and implementation of new funding models that Council does not create the perverse outcome of increasing health and social inequalities from its decisions.

[5] Draft Auckland Plan page 24.
[6] Draft Auckland Plan Southern Initiative Directive 2.

- Undertake a social impact assessment for each new major project and its associated funding mechanism to ensure that Council is fully informed before reaching a decision to go ahead.
- Strengthen the monitoring and evaluation framework in collaboration with key strategic partners, including health.

23. We have provided further detail of our recommendations and views in Appendix 1.

24. A healthy population is a key requirement for the achievement of society's goals and the vision for Auckland. Council's contribution to health outcomes will be one of the foundations that support its delivery of the inaugural Auckland Plan and one that will leave a lasting legacy for the first new Auckland Council.

25. We look forward to a closer working relationship with Council over the life of the inaugural Auckland Plan as we work towards our shared and complementary health and social well-being objectives.

Yours sincerely

Frank Booth
Service Manager
Auckland Regional Public Health Service

Dr Richard Hoskins
Acting Clinical Director
Auckland Regional Public Health Service

Appendix 1: Further Information to support the submission to the Draft Auckland Plan

CONTENTS

THE AUCKLAND PLAN AND HEALTH

1. The inaugural Auckland Plan will be one of the key documents that influences population health outcomes in the Auckland Region for the remainder of this century. The majority of the disparities in health status between differing individuals and communities in the Auckland region arise from determinants outside the influence of the health sector, most of which are described in the Draft Auckland Plan ('Draft Plan') and which the Draft Plan seeks to respond to.

2. We acknowledge the many areas within the Draft Plan where Council has responded to our previous comments to the Auckland Unleashed Discussion Document and incorporated issues and actions within the Draft Plan that will materially improve health outcomes.

3. We support the Vision for Auckland and are pleased to see that while "a fair, safe and healthy Auckland" is only one component of the Vision Table, there are a number of components that will positively impact on the health of Aucklanders and support a reduction in health and other inequalities.

4. All of the "transformational shifts" described in the strategic direction will help improve health outcomes over time. The strategic direction will also help the DHBs deliver on the Northern Region Health Plan objective to raise population health by "lifting the health outcomes of the 1.6 million people living in the Northern Region[7] and reducing health inequalities.[8]

5. We are aware of the requirements imposed on us to consider the Auckland Plan in decision making. We think that the Auckland Plan will be of value to the health sector in considering future population health improvement initiatives, health services and facility planning and will be one of the factors that will enable the Northern Region Health Plan to be successful.

6. We consider, however, that the Draft Plan is capable of improvement and in the detail provided in the following sections we provide comment on those areas where we believe that positive changes to the Draft Plan are desirable and will lead to improved health outcomes.

7. In parallel with its consultation on the Draft Plan, Council is also consulting on its Draft City Centre Masterplan, Draft Waterfront Plan and Draft Economic Development Strategy. We have chosen not to respond separately to these additional consultation processes, we have however incorporated some comments on these documents within our comments on the Draft Plan.

8. In our comments to the Discussion Document we suggested that Council include an overview table setting out the inter-linkages between differing elements of the Draft Plan. We wish to reiterate this suggestion as we believe that unless a reader has the ability to read and reflect on the entire Auckland Plan he or she will only understand part of the inaugural Auckland Plan if they read what may appear to be the chapter relevant to their interests.

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[7] N.B: The Northern Region includes the area covered by Northland District Health Board.
[8] ADHB, CMDHB, NDHB & WDHB (2011) *Northern Region Health Plan* accessible through http://nshint02.healthcare.huarahi.health.govt.nz/nrhp/LinkClick.aspx?fileticket=cWDW59jcYQc%3d&tabid=67&mid=410

SPECIFIC COMMENTS ON THE DRAFT AUCKLAND PLAN

1. HEALTH AND ECONOMIC BENEFITS OF ADDRESSING POTENTIALLY MODIFIABLE DISEASE RISK FACTORS

Relevant sections in the draft Auckland Plan

- *Chapter 1 – Auckland's People*
- *Chapter 3 – Auckland's Arts, Culture and Heritage*
- *Chapter 8 – Urban Auckland – Priority 1 and 3*
- *Chapter 12 – Implementation Framework*
- *Unitary Plan development*

Recommendations

Bring alcohol control and tobacco issues into the inaugural Auckland Plan. These are the two main omitted areas where high health gain is possible.

Ensure that the issue of alcohol use and its associated harm be addressed before the City Centre Masterplan is finalised.

Ensure that a regional smokefree policy is prepared and considered by Council.

Include smoking prevalence in Council's monitoring framework.

Adopt an additional high level target relating to increasing the number of Aucklanders who meet health guidelines for daily exercise.

Expand the Directive 3.9 (promote Auckland's sporting and recreation culture and encourage and nurture sporting talent and excellence) to also focus on raising levels of participation.

Include 'green' open space in the list of key aspects of design in the proposed Auckland Design Compedium.

Use the Unitary plan to restrict the location of gambling, alcohol and fast food outlets.

Supporting Information

9. A recent study on the health and economic benefits of addressing potentially modifiable disease risk factors[9] reviewed the evidence for six issues; intimate partner violence (IPV), high risk alcohol consumption, inadequate fruit and vegetable consumption, physical inactivity, tobacco smoking and high body mass index.

[9] Cadilhac D, Magnus A, Cumming T, Sheppard L, Pearce D and Carter R (2009) *The health and economic benefits of reducing disease risk factors,* Victorian Health Promotion Foundation, accessible at http://www.deakin.edu.au/dro/eserv/DU:30020085/magnus-reducingdiseaserisk-2009.pdf

10. This study suggests that that alcohol and tobacco use impose the greatest cost on the economy. From the perspective of health alone alcohol and tobacco impose substantial costs on both the health sector and on families and individuals. If strong economic growth is indeed the driver which will deliver improvements to the quality of life we believe that alcohol and tobacco issues need far more prominence in the inaugural Auckland Plan than they are given in the Draft Plan.

The importance of alcohol control in improving health and safety

11. It is disappointing that alcohol use and the harm it causes has limited mention in the Draft Auckland Plan. It is mentioned only once in the Draft City Centre Masterplan in the Point under Factor 4: Inclusiveness and a child-friendly city as set out below:

> "A framework is needed to address competing considerations in the City centre. These include, providing high quality affordable housing for families, balancing alcohol and adult entertainment with the City as a safe place for children, competing uses for open space, noise and urban neighbourhoods, and the provision of appropriate social services and infrastructure for residents."[10]

12. Alcohol is a significant, direct and indirect, contributor of community wellbeing it should be acknowledged and considered within all local planning and decision-making processes, including the Auckland Plan.

13. Local government has a pivotal role to play in alcohol harm reduction. Given the planning, regulatory, enforcement, community development, and employment roles of Auckland Council it is in an ideal position to demonstrate leadership and facilitate a co-ordinated response to reducing alcohol harm.[11]

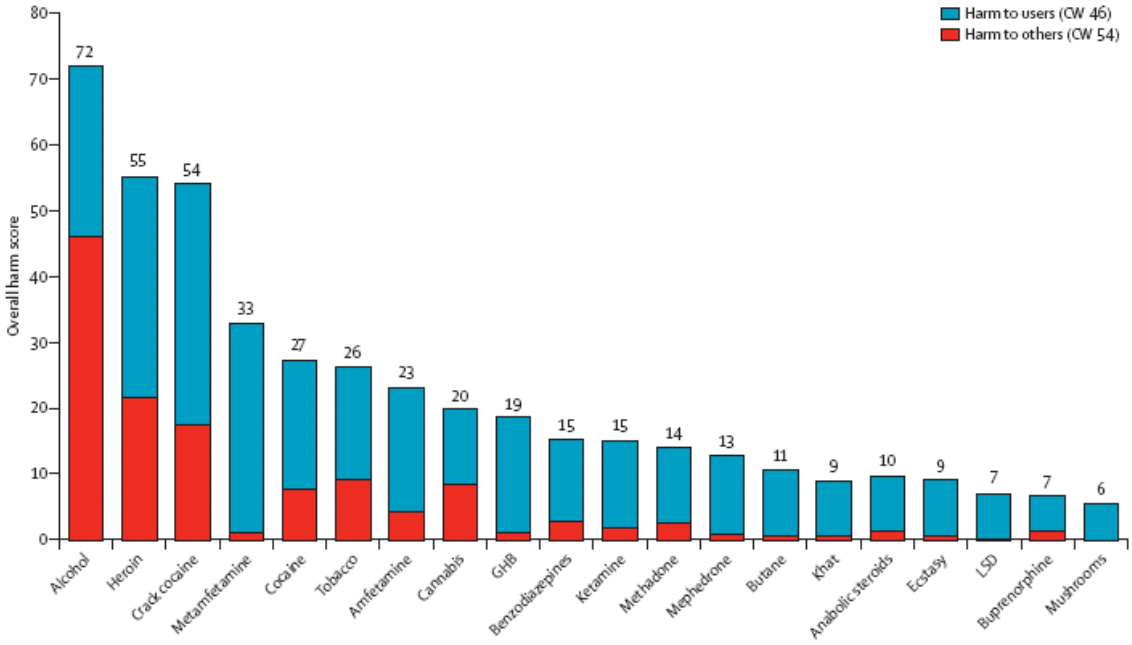
14. Alcohol is the most widely used recreational drug; it is not an ordinary commodity. A recent study assessed the harm caused by the misuse of a range of drugs and found that alcohol was the drug with the highest level of harm to users and others (see Figure 3).[12]

[10] Draft City Centre Masterplan – Factor 4 Inclusiveness and a child friendly city. Accessible through http://www.aucklandcouncil.govt.nz/EN/AboutCouncil/PlansPoliciesPublications/theaucklandplan/citycentremasterplan/Pages/home.aspx

[11] Dibley, G. (2007). Local government reducing harm from alcohol consumption. *Prevention Research Quarterly*, Issues Paper No. 2.

[12] Nutt, D., King, L., & Phillips, L. (2010). Drug harms in the UK: a Multicriteria Decision Analysis. *Lancet, 378*, 1558-65.

Figure 3: Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others.



NB: The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ-hydroxybutyric acid. LSD=lysergic acid diethylamide.

15. Strategies at the local government level to address the determinants of alcohol abuse in communities are likely to bring about a reduction in harm for both the users of alcohol and those impacted by the heavy drinking of others.

16. Council has many roles in controlling and mitigating the harm from alcohol consumption as outlined below:

    i. Policy and strategy development
        - Develop a comprehensive alcohol strategy addressing Council's role in licensing, community-based programmes, Council events, host responsibility at Council venues, etc.
        - Develop and implement liquor bylaws with community consultation.
        - Develop overarching policies which cover responsible advertising and sponsorship practices, particularly relating to alcohol.
        - Ensure that alcohol issues are addressed within the development of the Unitary Plan – making the consent for all taverns a discretionary activity and ensuring that density and conflicting uses are included as an assessment criteria (relevant to Chapter 10 of the Auckland Plan).
        - Consider the impact of all policies on their ability to reduce inequalities (e.g. use Health Impact Assessment to inform project and policy development).

    ii. Council events:
        - Organise and promote Council-run community events which are alcohol-free.

iii. As an employer:
- Ensure host responsibility practices are in place for events for Council staff.
- Train relevant Council staff in host responsibility.

iv. Monitoring and evaluation:
- We recommend the use of additional measures:
  - Social capital (as this measure is related to a number of health outcomes, including alcohol and smoking).
  - Alcohol-related harm indicators such as road crashes involving alcohol etc.
  - Number of licensed premises compliance checks undertaken and % compliant.

17. The Medical Officer of Health (at ARPHS) is keen to work with Council in relation to the alcohol law reform bill and the development and implementation of local alcohol policies.

The importance of tobacco control in improving health and protecting our children

18. Tobacco is a leading cause of preventable death in New Zealand. It especially affects Māori and reducing Māori smoking prevalence and supporting whānau ora approaches should be priorities of Council (as per Chapter 2).

- In 2009 the current smoking rate for Māori was 44%, still significantly higher than for other New Zealanders (18%) for both males and females.
- Māori in all age groups had higher smoking rates than other New Zealanders.
- Māori non-smokers were more likely than other New Zealanders to be exposed to second-hand smoke in their homes and cars.
- Māori were more likely to be asked by their health care worker about their smoking status, and to have been referred to quitting programmes or given quitting products by a health care worker in the past 12 months, compared with other New Zealanders.
- In 2009, 62.3 percent of Māori current or casual smokers had attempted to quit smoking in the past five years.[13]

19. A key strategy to put children first and improve their health and wellbeing is to reduce smoking prevalence and minimise tobacco-related harm. We were delighted to see the September 2011 Social and Community Development Forum resolution[14]:

> "That the Forum notes that officers are preparing a report to a future meeting of the Social and Community Development Forum on the request raised by the Cancer Society to restrict cigarette / tobacco smoking in the following places:

[13] Ministry of Health (2011) *Māori Smoking and Tobacco Use 2011,* Wellington, Ministry of Health
[14] Minute SCD/2011/67

- Open spaces, parks, sportsfields and playgrounds controlled by the Auckland Council
- Malls and pedestrian areas."

20. We were, however extremely disappointed when following up with Council staff to see what assistance ARPHS could provide to discover that officers weren't preparing the report referred to in the resolution.

21. Our understanding is that all Council officers are currently undertaking is some evaluation of the success of past Manukau, Waitakere and ARC initiatives to prohibit smoking in parks.

22. We urge Council to require its staff to prepare and complete the report as envisioned by the Social and Community Development Forum.

23. We are disappointed that Council's commitment to having smoke free public spaces is lacking in the Draft Plan and believe that a smoke-free policy that covers the entire Auckland Council region should be implemented to ban outdoor smoking in order to protect children from second hand smoke (SHS) exposure, reduce the modelling of smoking to children, de-normalise smoking to young people, and ultimately to prevent uptake of smoking among young people.

24. We recommend that outdoor smoking be banned:

- At public areas where children predominate, such as parks, playgrounds, sports grounds, stadiums, parts of beaches, swimming pool complexes and library precincts.
- In all Council held events, or events receiving Council support.
- In all council controlled land including land 'owned' by council controlled organisations (CCO). Auckland Zoo and Mt Smart Stadium have gone totally smoke-free. These outdoor smoking bans have received support from the majority of the public.

25. The implementation of this smoke-free (auahi kore) policy aligns with the vision of making NZ a smoke-free nation by 2025. We recommend that outdoor smoking bans be in effect by 2015.

26. We recommend that Auckland Council should be 'smoke-free' (auahi kore) and the 'smoke-free' brand should be included in all council uniforms, stationery, merchandise, etc. All council tenders and contracts should also include 'smoke-free' (auahi kore) clauses and schedules.

27. Council should consider requiring the Auckland CBD to be smoke-free. A recent New Zealand study has found that the place of the highest second hand smoking hazard is the outdoor smoking areas of hospitality venues, followed by areas inside bars that were adjacent to outdoor smoking areas.[15] ARPHS Compliance Officers have also consistently received complaints from the public in terms of air flow between outdoor smoking areas and inside hospitality venues.

[15] Wilson, N., Edwards, R., and Parry, R. (2011). A persisting secondhand smoke hazard in urban public places: results from fine particular ($PM_{2.5}$) air sampling. *The New Zealand Medical Journal*, 124(1330), p34-47.

28. We recommend making the Auckland CBD smoke-free (including street trading areas). This will help make Auckland a cleaner and 'liveable' city to all Aucklanders and tourists and help support its vibrancy and attractiveness as a destination for both Aucklanders and tourists.

29. Council should also consider requiring street trading areas and town centres to be smoke-free. For example, Otara and Botany Town Centres have gone totally smoke-free and received high levels of public support.

30. To address the high smoking prevalence amongst Māori, we recommend that Auckland Council implements a Whānau Ora approach to addressing Māori health inequalities within the Auckland Region. This approach shifts attention from individuals to collectives and include a focus on inter-sectoral collaboration and capability building, one example of such a programme is Te Whānau o Waipereira's Whānau Ora, Whānau Tahi model.

31. Research shows that people who have never smoked usually have the lowest rates of sick leave than both current and previous smokers.[16] Compared to non-smokers, current smokers are approximately three times more likely to take sick leave. It is also found that in general non-smokers are more productive at work than employees who smoke.[17],[18] Smokers take about three extra 10-minute breaks for smoking each day during working hours.[19] This means that a smoker works on average three weeks less than a non-smoker in the course of a year. In 2005, the loss of productivity as a result of longer breaks taken by smokers and their increased absenteeism cost New Zealand around $1.7 billion.[20] Smoking reduction is one way in which greater productivity can be achieved and is one that does not require substantial capital investment to implement.

32. We would like to encourage Council to link with smoking cessation providers in order to assist council staff to stop smoking. This is considered an effective way that Council is able to work in partnership with health agencies across the region to improve staff health and wellbeing. Smoke-free policies and initiatives are one of the keys to creating a prosperous economy.

33. We recommend Council consider including the following smokefree indicators to aid monitor and evaluate their activities in this area:

    - Census data to determine whether or not smoking prevalence in Auckland Council has dropped.
    - Quality of Life Survey by adding questions in relation to smoking into it.

[16] Halpern, M. T., Shikiar, R., Rentz, A. M., et al. (2001). Impact of smoking status on workplace absenteeism and productivity. Tobacco Control. 10: 233-238.
[17] Ibid
[18] Health Canada. (2008). Smoking Cessation in the Workplace: A Guide to Helping Your Employees Quit Smoking. Canada: Ministry of Health.
[19] Ibid
[20] O'Dea, D. & Thomson, G. (2007). *Report on Tobacco Taxation in New Zealand*. NZ: ASH and the Smoke-free Coalition. Retrieved from http://www.sfc.org.nz/pdfs/TobTaxVolOneNovember.pdf. 6 October, 2011.

The importance of physical activity in improving health

34. We support Priority 4 Support Auckland's outdoors culture, recreation and sport and are particularly in agreement with Points 335 and 336.

35. Improving participation of Aucklanders in physical activity has positive overall benefits to health and wellbeing. Having access to public open spaces and public sports facilities (especially swimming pools) should be prioritised and maintained by Council. We believe that swimming pool provision will help support learning how to swim in a safe environment (directly supporting water safety and injury prevention) and also because they provide the opportunity for low impact / strain physical activity. Similarly we need to ensure open spaces are maintained for both organised and general use, i.e. grass mown, rubbish collected etc, not only to encourage participation in exercise, but to ensure these assets are maintained for the future.

36. Numerous studies point to the direct benefits of green spaces to both physical activity and mental health [21] and wellbeing. Green spaces have been associated with a decrease in health complaints, blood pressure and cholesterol, improved mental health and reduced stress levels perceived better general health and the ability to face problems. There is strong evidence that the provision of green space effectively improves mental health and less strong/inconclusive evidence that it improves levels of physical activity.[22,23] This is especially important in urban areas where access to green open spaces may be more limited.

37. Council should ensure equitable access for urban dwellers to open green spaces in order to protect overall health and wellbeing, especially in the context of increased urbanisation in the next three decades.

38. We would like to encourage Council to include a target of having open green spaces within 30 minutes walk of every family home to ensure improved access to quality and open green spaces available across the social gradient. For areas where a greater proportion of residents are transport disadvantaged it is more important that quality open green space and recreation areas are within close proximity and an easy walk for tamariki and rangatahi. Council recreation provision also needs to be relevant to the pastimes that particular communities prefer and are relevant to them, be they rowing or waka ama racing, skateboarding or lawn bowls. We believe that Council's transformational shift approach of having a focus on those most in need applies equally to open space and recreation as it does to raising living standards. This issue is reflected in the current Auckland Regional Physical Activity Strategy's focus on:

    - "Strategy 2.1 Develop initiatives that focus regional resources on demographic groups that will benefit significantly from increased physical activity.

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[21] Public Health Advisory Committee (2008) Re-thinking urban environments and health, Wellington. Available at http://www.phac.health.govt.nz/moh.nsf/indexcm/phac-rethinking-urban-environments-and-health?Open

[22] The Marmot Review: implications for Spatial Planning. Page 6. Available at: http://www.nice.org.uk/guidance/index.jsp?action=download&o=53895

[23] ARPHS (2011) *Health Sector Feedback to Auckland Unleashed,* ibid, Table directly under paragraph 29.

- Actions … physical activity initiatives that increase participation in at risk groups such as Māori, Pacific people, people with disabilities, ethnic minorities and others."[24]

39. We are not convinced that the target of ensuring all Council sports fields are fit for purpose throughout the year is the most appropriate high level target as it does not encompass the full benefit of open spaces and sports fields to the community. While the usability of sports fields is important to encourage existing participants in sports activities, and we are aware is a significant issue for winter sports, we are of the view that an additional high level target should be adopted, framed in terms of:

- Increase the number of Aucklanders who are physically active and who meet health guidelines for daily exercise.[25]

40. We suggest that Directive 3.9. (Promote Auckland's sporting and recreational culture etc) "and encourage and nurture sporting talent and excellence" is expanded to include "to increase overall participation in physical activity".. As noted in our submission to the Discussion Document elite sport's value to health is in the possible inspiration it provides for other members of the community to participate. We consider that the directive as currently worded could lead to an over emphasis on the pursuit of talent and excellence rather than higher levels of overall participation.

41. Getting Aucklanders to 'push play' any time of the year will contribute towards improving wellbeing and promoting health via physical activity and engagement with other members of the community. However besides having sports field areas, Council should look at other ways in which the community can use other facilities to engage in physical activity/games. For example large halls can be used as areas where community members can partake in indoor physical activity and games such as dance, exercise groups, bowls and table tennis.

42. Council's control of the urban environment gives it the ability to lift physical exercise levels as individuals go about their daily life, by ensuring that urban areas have a large number of trip destinations within close proximity, prioritisation of pedestrians and cyclists in the transport network, the general 'walkability' of suburbs by avoiding closed cul de sacs and promoting grid patterns with high connectivity and permeability.

43. We are disappointed that the issue of open space is not included in Box 8.3 (Key aspects of design) that outlines the key aspects of design. Where space is mentioned its context appears to be that of urban space. We believe that green space is a necessary component of such space and needs a specific mention.

[24] Auckland regional physical activity and sport strategy (ARPASS) accessible through http://www.arc.govt.nz/albany/fms/main/Documents/Plans/Regional%20strategies/ARPASS%20-%20Part%203.pdf

[25] Ministry of Health New Zealand Physical Activity Guidelines accessible through http://www.moh.govt.nz/moh.nsf/indexmh/activity-guidelines

The importance of access to fresh fruit and vegetables in improving health

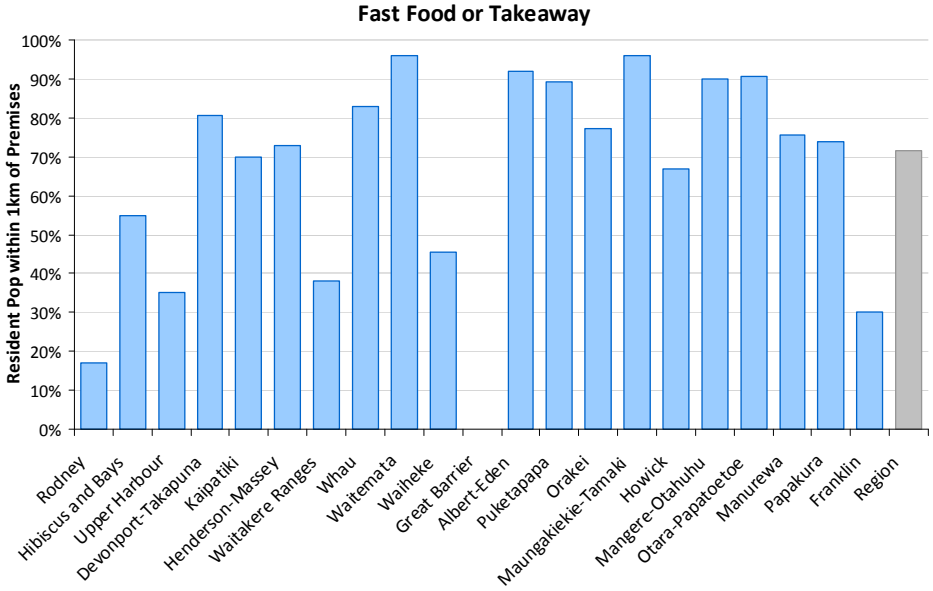
44. Low income and area deprivation are both barriers to purchasing fresh or unfamiliar foods,[26] whilst lower income households are the harder hit by price fluctuations.

45. Living in neighbourhoods without public transport or the ability to walk to grocery stores means reliance on cars for food purchasers. The escalating cost of food and petrol also impact more on people with low income to eat nutritious food. Access to a car and food are related because the cheaper, healthier food outlets are often in regional shopping centres. The lack of a car can reduce food access by 50%.[27]

46. There is a strong association between neighbourhood deprivation and geographic access to fast food outlets in New Zealand. However, outlets potentially selling healthy food (e.g. supermarkets) are patterned by deprivation in a similar way. These findings highlight the importance of considering all aspects of the food environment (healthy and unhealthy) when developing environmental strategies to address the obesity epidemic.[28]

47. The graphs below outline the differing access to fast food compared to supermarkets in differing local board areas across our region.[29]

Figure 4: Fast Food or Takeaway - Resident Population within 1 km of Premises



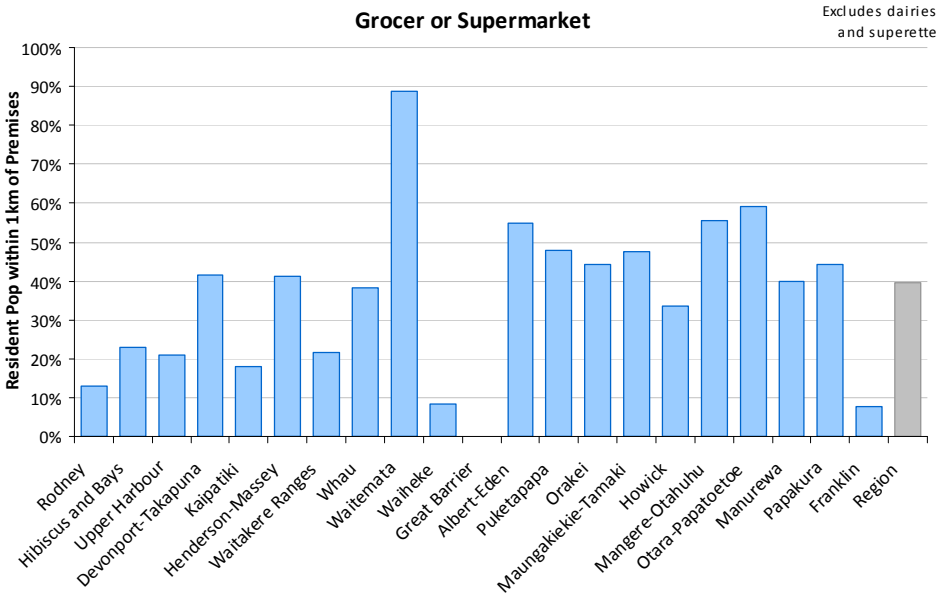
[26] Burns C & A. Inglis, The relationship between the availability of healthy and fast food and neighbourhood level socio-economic deprivation: A case study from Melbourne, Australia. Obesity Review, 2006. 7

[27] Obesity in Australia under review: Vic Health Response June 2008. Available at: http://www.aph.gov.au/House/committee/haa/obesity/subs/sub059.pdf=

[28] Pearce J, Blakely T, Witten K, Bartie P. Neighbourhood deprivation and access to fast-food retailing: a national study. Am J Prev Med. 2007 May;32(5):375-82.

[29] ARPHS (2010) *Auckland (Local Board and Ward) Council Data,* accessible through http://www.arphs.govt.nz/downloads/Auckland%20Council%20Demog%20and%20Access.doc

Figure 5 Grocer or Supermarket - Resident Population within 1 km of Premises.



48. The proliferation of fast food outlets contributes to an obesogenic environment. Studies have indicated a link between consumption of food and drink from fast food outlets (FFOs) and greater likelihood of obesity.[30] The mix of shops in deprived areas tends to be weighted towards FFOs, making it harder to access healthy food, particularly fresh produce. Partly as a consequence of this, and the potential for food deserts to be created, low income groups are more likely to consume fat spreads, non-diet drinks, meat dishes, pizzas, processed meats, whole milk and table sugar than higher income groups.[31]

49. Council should actively seek to increase access to healthy food in areas of deprivation. This can be done by looking at ways to increase the:

- Number of fresh food markets.
- Number of grocery stores/ food markets/supermarkets within walking distance of every household.

50. We would like Council to restrict new fast food outlets (FFOs) close to schools, parks and low socioeconomic areas. Council could do this through the Unitary Plan by[32]:

- Setting a minimum distances between schools and FFO.
- Limiting on density of FFOs in any neighbourhood or Restrict FFOs proximity to one another.
- Apply restrictions to location/hours of operation of FFOs.

51. We also consider that opportunities for people living in an increasingly high density urban environment to produce their own vegetables and fruits are also

[30] Obesity in Australia under review: VicHealth Response. June 2008. Available : http://www.aph.gov.au/House/committee/haa/obesity/subs/sub059.pdf
[31] Food Standards Agency. Low income and diet survey. 2007. London, Food Safety Authority
[32] Example of such a planning framework: London Borough of Barking & Dagenham (2010) Saturation Point. Addressing health impacts of hot food takeaways. Supplementary Planning Document, Local Development Framework. London: London Borough of Barking & Dagenham

important. Over time, more and more people (and particularly older people) will be living in high-rise apartments with no opportunity to do any gardening. Auckland actively needs to plan for this issue, as many other more liveable cities in the world have.

The negative impact of gambling on health and wellbeing

52. Gambling has been identified as negatively affecting health and wellbeing, employment, study, personal finances, criminal offending and is an identified co-morbidity.[33,34] We would like Council to restrict new gambling facilities in low socioeconomic areas.

53. As part of its urban development proposals we believe that Council needs to look further at what role the inaugural Auckland Plan can play in restricting access to gambling, alcohol and fast food outlets. As Council notes in point 253 of the Draft Plan poor health is influenced by "the proliferation of liquor outlets and gambling venues". In our earlier comments to the Discussion Document we suggested a number of approaches that Council could use to influence the location and density of such outlets and we believe that these issues are worthy of further consideration.[35]

[33] Auckland Regional Public Health Service. (2004). Gambling in New Zealand. Chapter in 2 in Report: Tongan Gambling Research report. Available at: http://www.arphs.govt.nz/publications_reports/pacific_health/Chapter_Two.pdf

[34] Centre for Social and Health Outcomes Research and Evaluation & Te Ropu Whariki. (2006). Socio-economic impacts of gambling. Auckland. Available at: http://www.shore.ac.nz/projects/Gambling%20socioeconomic%20FINAL%20REPORT%202.2.06.pdf

[35] ARPHS (2011) *Health Sector Feedback to Auckland Unleashed,* ibid. Paragraphs 94 and 107.

2. CHILDREN AND YOUNG PEOPLE AS A PRIORITY

Relevant sections in the draft Auckland Plan

- *Section C – Auckland's Strategic Direction – Dramatically accelerate the prospects of Auckland's Children and Young People*
- *Chapter 1 – Auckland's People – Put Children and Young People First*

Recommendations

Incorporate a greater focus on injury prevention; e.g. fire and burns prevention, water safety and road safety as part of Council's safety objectives.

Review and incorporate where valuable, pre-existing child, social and health assessment techniques in its proposed child impact assessment for all Council activities.

Extend the initiatives in the Southern Initiative area to other areas with high levels of child poverty in subsequent phases of the inaugural Auckland Plan.

Place greater emphasis on access to learning and education in high deprivation areas in order to enable the cycle of poverty and deprivation to be broken.

Consider the location of early childhood education centres (ECEC) and kōhanga with respect to air pollution and traffic issues as part of the Unitary Plan's development.

Include further details as to how Council intends to engage children and young people over the life of the inaugural Auckland Plan.

Ensure that design assessments specifically consider the needs of children.

Supporting Information

54. We applaud Council's focus on children and young people. All children matter because:[36]

- Children have a developmental requirement to explore their environments, without the necessary understanding of consequences. This makes them vulnerable to harm.
- Improving the wellbeing of all children is crucial to reducing inequities.
- Children are our future.

55. Getting things right in early childhood is important as this is the stage when there is:[37]

- Rapid brain development.
- Genetic-environment interactions.
- Effective, cost effective interventions.

[36] Public Health Advisory Committee. The Best Start in Life: Achieving effective action on child health and wellbeing. 2010. Wellington: Ministry of Health. Available: http://www.phac.health.govt.nz/moh.nsf/pagescm/7700/$File/the-best-start-in-life-2010.pdf

[37] Public Health Advisory Committee. The Best Start in Life: Achieving effective action on child health and wellbeing. Ibid.

56. We have a responsibility to protect the rights of the child and ensure these rights are fulfilled and respected. Article 6 of the 'Convention of the Rights of the Child' states that a child has a right to live and that government's should ensure that children survive and develop healthily.[38]

The importance of housing in keeping our children and young people healthy

57. As outlined in the Draft Plan, Auckland has a third of New Zealand's children and the proportion of children in Auckland is projected to grow significantly more than the national average rate in the next three decades.

58. The Auckland Region had 50% of all cases of Acute Rheumatic Fever (ARF) cases in New Zealand from 1996-2006 with CMDHB having the greatest number.[39] ARF mainly affects children and young people resulting in lifelong rheumatic heart disease and is a condition where almost all cases are preventable.[40]

59. Māori and Pacific Island children are especially affected by ARF. This incidence of ARF is largely contributed to by housing overcrowding[41] and poor quality housing. The same observation can be made for other infectious diseases such as meningococcal disease[42] and skin infections.

60. It is vital that Council emphasise and facilitates the delivery of better housing conditions to improve the health of our children. Housing is a key enabler and support for efforts by the education, health and social welfare sectors and will provide one of the key foundations for Auckland's long term prosperity and success.

The importance of safety in protecting our children and young people

61. In the Draft Plan safety is presented mainly in the context of freedom from crime. While crime is an important component of safety, it is not the only one. We believe that freedom from injury is an equal component of safety and should be given greater emphasis in the inaugural Auckland Plan.

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[38] UNICEF. Fact sheet: A summary of the rights under the Convention on the Rights of the Child. Available at: http://www.unicef.org/crc/files/Rights_overview.pdf

[39] Jaine R, Baker M and Venugopal K. Epidemiology of acute rheumatic fever in New Zealand 1996–2005. Journal of Paediatrics and Child Health. 44 (2008) 564–571. Available: http://www.healthyhousing.org.nz/wp-content/uploads/2010/01/Jaine-Epi-ARF-in-NZ-J-Paed-Child-Health-2008.pdf

[40] Lennon D. Acute Rheumatic Fever. In: Feigin R and Cherry J (Eds), Textbook of Pediatric Infectious Diseases, 5th ed. Philadelphia: WB Saunders; 2004:413–26.

[41] Lennon D, Martin D, Wong E, Taylor LR. Longitudinal study of poststreptococcal disease in Auckland: rheumatic fever, glomerulonephritis, epidemiology and M typing 1981-86. NZ Med J 1988; 101: 396-8.

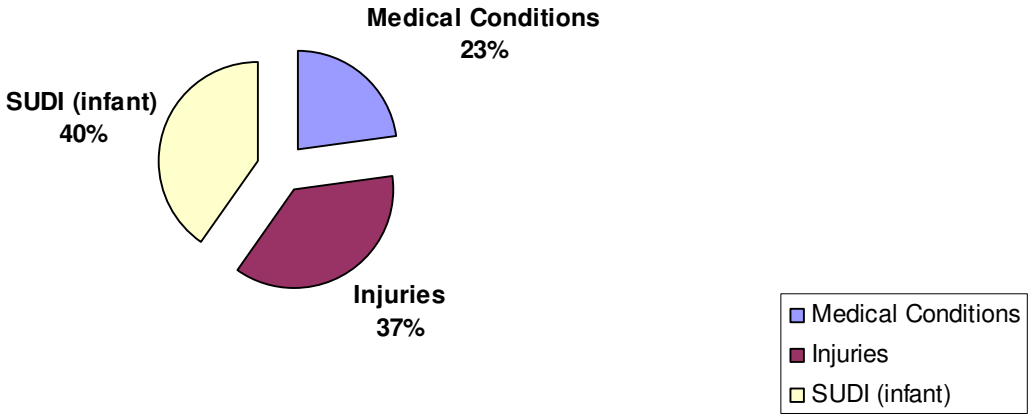
[42] Baker M, McNicholas A, Garrett N et al. Household crowding a major risk factor for epidemic meningococcal disease in Auckland children. Pediatr Infect Dis J 2000; 19: 983-90.

62. Local Government's wide ranging role (regulation, service delivery, place shaping and choice architect) provides Auckland Council with substantial opportunities for preventing injury and trauma. Notwithstanding this extensive role, local government's effort and contribution in injury prevention and safety promotion is frequently underestimated and undercounted.

63. There is a social gradient[43] for child injury fatalities, and disparity between different socioeconomic areas is evident.[44]

64. Figure 6 shows that injuries (mainly from vehicle occupant related deaths followed by pedestrian injuries and drowning) contributed to 37% of deaths in children from conditions associated with a social gradient.

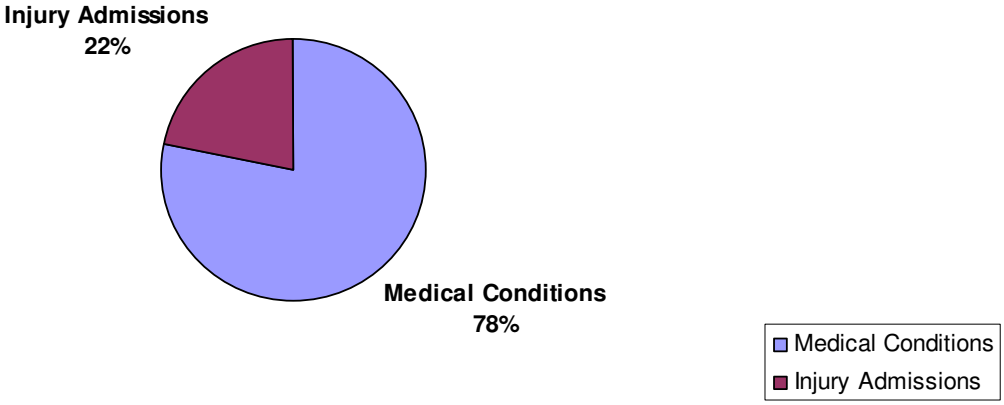
Figure 6: Mortality from conditions with a social gradient in children aged 0-14 years (excluding neonates) by cause, New Zealand 2004-2008.[45]



Note: SUDI: Sudden Unexplained Death in Infancy.

65. Figure 7 shows that injuries contributed to 22% of hospital admissions in children from conditions associated with a social gradient.

Figure 7: Hospital admissions for conditions with a social gradient in children aged 0-14 years (excluding neonates) by cause, New Zealand, 2006-2010[46]



[43] A social gradient here implies that the injury or disease increases with increasing socioeconomic deprivation
[44] Craig, E. The Children's Social Health Monitor Update 2011. Wellington. Pages 45 and 46.
[45] The Children's Social Health Monitor Update 2011 Ibid. Page 46 - Table 4.
[46] The Children's Social Health Monitor Update 2011 Ibid. Page 45 Table 3

66. There is some mention in the Draft Plan of road safety and we acknowledge the proposed injury target contained within the transport chapter. There are, however, no priorities or directives that specifically relate to road safety. We are of the view, that considering the downstream cost of poor road safety a strategic commitment to road safety needs more emphasis.

67. To emphasize the value of health and safety in children by preventing injuries from occurring, we would recommend Council include a high level acknowledgement of traffic safety, fire and burns prevention, drowning and water safety in the inaugural Auckland Plan.

68. When planning transportation and infrastructure for Aucklanders (in Chapters 10 and 11), in order to maintain and promote health and safety for all Aucklanders (especially children) we recommend that Council makes traffic safety an explicit focus.

69. There are many ways in which Council can take a pro-active role in childhood injury prevention. Some examples are listed below:

- Preventing road traffic trauma:
  - Road crash fatalities and serious injury have steadily reduced nationally and within local areas. Area wide traffic calming and reduction of speed around schools, coupled with community partnerships for enforcement and public education have been shown to be effective and best practice Public Health Guidelines have been developed.[47]
  - Commitment to road traffic safety is a significant part of the Auckland Council's CCO (Auckland Transport) and its commitment should be reflected within the Spatial Plan. Road traffic safety and the reduction of trauma are extremely relevant to both Chapter 1 and Chapter 11 of this Draft Plan.

- Drowning prevention and promotion of water safety activities:
  - To prevent infant and child drownings, Council should consistently implement the regulatory enforcement of the Pool Fencing Law.
  - Council should also promote safety in areas where aquatic activity is actively promoted (e.g. Council owned swimming centres) and continue to provide swimming centres that foster swimming skills and water safety. Council also has a role in supporting initiatives which provide free instruction for children to learn how to swim in areas of higher socio-economic deprivation.

- Burns Prevention – Preventing fire and hot water burns:
  - Burn injuries have a socio-economic gradient that requires strategic consideration for the most effective response[48]
  - Education campaigns to inform communities about first aid measures and prevention have been shown to be effective and mortality in developed countries is decreasing.[49]

[47] NICE: National Institute for for Health and Clinical Excellence (2010). *NICE Public Health Guidelines 31 Preventing unintentional injuries among children and young people aged under 15: Road design and modification* NICE Public Health Guidence,. National Institute for Health and Clinical Excellence. London. Accessible through http://guidance.nice.org.uk/PHG

[48] Mistry R, Pasisi S, et al. (2009). "Socio-economic deprivation and burns." Science Direct.

- Auckland Council has an important role in preventing burn injury. Burns prevention covers such activities as the reduction of fires through effective building controls, partnerships with agencies such as the Fire Service for smoke alarm installation, and supporting public education programmes about the dangers of hot substances scalds.

Other impacts on children and young people's health and wellbeing

70. We agree and support the Southern Initiative priority; however we would like Council to ensure that initiatives to improve children and young people's well being are not merely localised to the Southern Initiative but are implemented in all areas in Auckland where there are issues of high levels of socio-economic deprivation and associated underachievement, e.g. pockets of West Auckland.

71. We would like Council to ensure it takes into account the fact that the burden of poverty inequitably affects Māori and Pacific youth and children compared to other population groups.

72. It is important that young Māori and Pacific youth have a voice and more importantly are heard in contributing to Council's processes. We suggest that the inaugural Auckland Plan contains further detail in this regard e.g. actively working with the Auckland Youth Council to ensure that the voice of youth is heard and respected in Council decision-making. The concept of Ngā Manukura: Māori leadership[50] may be of value in both encouraging rangatahi and other youth in becoming more involved with Council[51] as will evaluation of past and current models of youth participation e.g. Te Roopu Puawai from the former Waitakere City Council and the Youth Advisory Panel currently supported by Waitemata District Health Board.

73. We support Council's intention to develop and then ensure a child impact assessment be undertaken for any significant projects / policies as part of delivering on this Priority. We note that Council is currently using health impact assessment (HIA) as a technique to look at its policy options around prostitution and adult entertainment.

74. Early childhood consent processes would be improved by the incorporation of principles that incentivise or prioritise placement of centres where air quality, land use and access is most conducive to achieving better health outcomes for children.

75. While it may appear more convenient for some working parents to have ECECs located in industrialised zones close to their employment. Locating ECECs in environmentally degraded areas will impact negatively on child health and development and should be avoided.

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[49] Skinner, A., T. L. Brown, et al. (2004). "Reduced Hospitalisation of burns patients following a multi-media campaign that increased adequacy of first aid treatment." Burns 30: 82-85.
[50] Ngā Manukura: Māori Leadership accessible through http://www.waitakere.govt.nz/abtcnl/pp/ltccp/pdf/nga-manukura.pdf
[51] Te Roopu Puawai provides one model for Rangatahi engagement and leadership used by the former Waitakere City Council

76. We support young people being well prepared to work or further their education on leaving school. Perhaps the most important aspect of this readiness, that is also likely to be overlooked unless planned for, is that young people are 'life ready'. Many young people struggle to cope at work although they have received good training for the technical aspects of their work, because they do not have the life skills necessary to survive in the workplace. This renders any work difficult.

77. Self-care will ensure that people remain healthy and productive members of the workplace and society and should include knowledge on physical activity, nutrition, drugs, tobacco, alcohol, gambling, sexual health and access to health care services.

78. While these issues may be largely outside Council's control we believe that they are issues that should be considered by educational and other providers working with youth and rangatahi.

79. We think that it is in the public interest if children are supported to have a good start in life regardless of their parents' situation, or their engagement in up-skilling themselves.

3. AUCKLAND'S MAORI

Relevant sections in the draft Auckland Plan

- *Section C – Auckland's Strategic Direction*
- *Chapter 1 – Auckland's People*
- *Chapter 2 – Auckland's Maori*

Recommendations

Consider the role that marae can play within Tāmaki Makaurau in terms of wider wellbeing and Whānau Ora.

Support the achievement of wellbeing for papakāinga housing, including accessibility of health services.

Utilise Whānau Ora health impact assessment as one method of engaging Māori communities, including rangatahi in Council's policy and project development.

Supporting Information

80. We support the overall strategic direction described in this chapter- of enabling Māori aspirations through recognition of the Treaty of Waitangi and customary rights. We think that better outcomes for Māori will be achieved when they are actively involved in issues within a framework that supports their involvement.

81. In New Zealand there is clear evidence of the differential distribution of social, environmental, economic and cultural determinants of health for Māori and other New Zealanders. The right to health cannot be realised if structural inequities in the presence of these determinants exist.

82. A further way of addressing these inequalities is that of Whānau Ora, which is an inclusive approach to providing services and opportunities to families across New Zealand. Whānau Ora takes a whānau centred approach rather than focusing separately on households and their problems. This approach requires multiple government agencies to work together with families. The approach involves providing support to strengthen whānau capacities to undertake functions that are necessary for healthy living and contribute to the wellbeing of whānau members and the whānau collective. We hope that Council will support the Whānau Ora approach whenever possible in its programmes and collaboration with central government.

83. A way of Council achieving the goal of "enabling Māori aspirations" is formally integrating Māori conceptual models and frameworks throughout the Auckland Plan and not just in isolation in Chapter 2. Excellent examples of this in health and wellbeing are the concepts of 'Te Pae Māhutonga'[52] and 'Te Whare Tapa Whā'.[53]

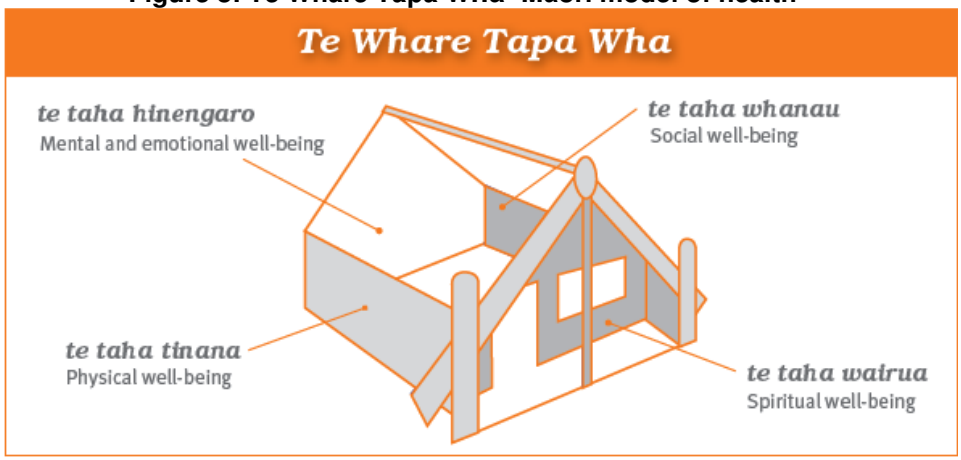
84. Te Whare Tapa Whā is a way to understand how Māori view health and wellbeing (and also their different world view from other ethnicities). It shows

[52] Ministry of Health. Māori Health Models. Available at: http://www.maorihealth.govt.nz/moh.nsf/pagesma/445
[53] Te Pae Māhutonga: A Model for Māori Health Promotion, ibid 13.

hauora (health) as four walls to a whare (house). All four walls need to be in place for someone to have good health. The four walls each represent :

1. Spiritual well-being (Te Taha Wairua).
2. Emotional and mental well-being (Te Taha Hinengaro).
3. Physical well-being (Te Taha Tinana), and
4. Family well-being (Te Taha Whānau).

Figure 8: Te Whare Tapa Whā- Māori model of health [54]



85. The health perspective using the Te Pae Māhutonga[55] model headings (set out below in Figure 9) also provides a useful lens through which to approach the issue of enabling Māori aspirations.

Figure 9: The main themes of Te Pae Māhutonga (a Māori model of Health Promotion)

86. The Te Pae Mahutonga framework was successfully utilised by the former Waitakere City Council in developing its Long Term Council Community Plan

[54] Healthcare NZ. Te Whare Tapa Whā': A learning resource. Available from: http://www.healthcarenz.co.nz/IM_Custom/ContentStore/Assets/103/7/106827404b64b6396d54e94769f2d134.pdf

[55] Ministry of Health. Māori Health Modles: Te Pae Māhutonga. Available: http://www.maorihealth.govt.nz/moh.nsf/pagesma/446

for its Māori outcomes process and the subsequent development of indicators that used the framework.

87. These concepts need to be understood and adopted across the spectrum (not just in health) in engaging with Māori and meaningfully work alongside them in delivering change and positive development.

88. Key issues should be seen through the lens of our indigenous people if they are to successfully deliver sustainable and meaningful outcomes. Mainstream frameworks and concepts have limited ability to minimise inequities between Māori and other New Zealanders, and in fact can widen the gap.

89. Experience has shown us that these concepts are useful in achieving gains in all sectors and areas for the total population and not just for Māori or in the health sector. Using these concepts also ensures greater equity is achieved by placing Māori in the centre and not at the margins of decision making.

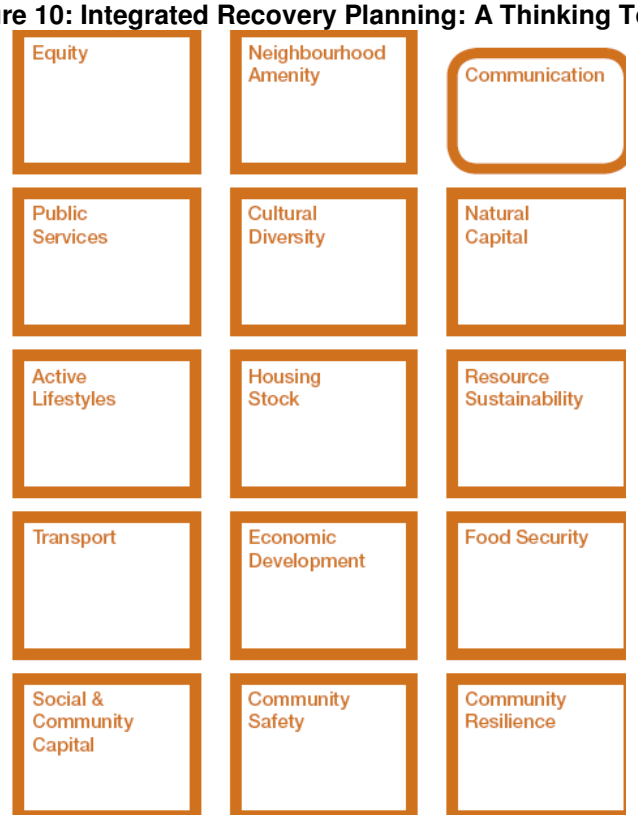
90. The recently released Canterbury Integrated Recovery Planning Guide is a good example of using a Māori conceptual framework as a way of thinking about recovery work for all Cantabrian's after the Canterbury earthquakes.[56] We suggest that it has merit as a method for Council to think about wider planning and urban development issues. The model uses the following principles:

- Well designed, safe and accessible places and spaces support good health, wellbeing and a sense of belonging.
- Housing that is affordable, secure, dry and warm is critical for ensuring good health outcomes, particularly for the very young and elderly.
- People who enjoy and identify with their local neighbourhoods are more likely to engage in community activities and establish social connections.
- The quality of our air, water, soil and biodiversity underpin the health and economic prosperity of our society.
- Incorporating sustainability considerations will help achieve economic, social and environmental goals simultaneously, in both the short and long term.
- Promoting safe, direct, convenient, comfortable and attractive cycling and walking networks, so people can choose active transport options, encourages active lives.
- Prosperous businesses, quality employment and job security can make it easier to pursue a healthy lifestyle.
- Establishing and maintaining effective communication links with the community is essential.
- Engaging communities and encouraging participation in recovery planning and actions will build stronger more resilient communities.

91. The Canterbury Integrated Recovery Planning Guide's worksheets (Figure 10) allow these principles to be used to consider the differing issues (set out below) that collectively will support successful urban and community development.

[56] Christchurch City Council, Greater Christchurch Urban Development Strategy and Canterbury District Health Board (2011) *Integrated Recovery Planning Guide,* accessible through http://www.cph.co.nz/files/RecoveryPlanningGuide.pdf

Figure 10: Integrated Recovery Planning: A Thinking Tool.



92. Another useful tool based on Māori concepts that can be used across the spectrum is the Whānau Ora Health Impact Assessment (WOHIA). It is a tool used to predict the potential health effects of a policy on Māori and their whānau. It pays particular attention to Māori involvement in the policy development process and articulates the role of the wider health determinants in influencing health and well-being outcomes.[57]

93. A good example of how the WOHIA has been used by Local Government is the Wiri Spatial Structure Plan HIA completed in 2010. It was used to gauge the impact of Spatial Structure Plan (for the Wiri area) on people's health and wellness and engage key stakeholders. This process centralised Māori concerns, setting out to make a positive difference for Māori, promoting equity, supporting Māori determination and employing a bottom up approach. The central findings of this HIA cover the desire for the Wiri Spatial Structure Plan to support open space, cultural diversity, leisure / recreation, healthy affordable housing, safety, and access to amenities and services.[58]

Priority 1 Establishing papakāinga in the Auckland Region

94. We support auahi kore (smokefree) papakāinga as part of achieving the overall strategy. Papakāinga housing also needs to have good access to health services.

[57] Ministry of Health. Whānau Ora Health Impact Assessment. 2007. Available at: http://www.moh.govt.nz/moh.nsf/indexmh/whanau-ora-hia-2007
[58] Ministry of Health. Wiri Spatial Structure Plan HIA. 2010. Available at: http://www.moh.govt.nz/moh.nsf/indexmh/hiasupportunit-completed#wiri

Priority 2 Enable tangata whenua to participate in the co-management of natural resources

95. We support the principles of the Treaty of Waitangi for Council to maintain and actively deliver on Priority 2. We also support co-governance where mandated by Treaty settlements.

Priority 3 Explore partnerships with mana whenua to protect, identity, and manage wāhi tapu sites in the Auckland region

96. We support this priority and the protection of wāhi tapu.

Priority 4 Enable Māori aspirations for thriving and self sustaining marae

97. We support auahi kore (smokefree) marae as part of achieving the overall strategy.

98. We would also like to note that marae provide a good opportunity for development as community hubs (with the support of the marae community and whānau) and possible site for health services.

Priority 5 Support sustainable development of Māori outcomes, leadership, community and partnerships

99. We believe that strengthening the involvement of iwi and Māori communities in emergency management preparedness will pay dividends should the region suffer a disaster, whether or not it is city wide like that of Christchurch or is more localised.

100. We also note Council's intention to facilitate the network of community hubs. We believe that Council should consider marae as possible locations for such hubs. We encourage Council to engage with mana whenua and taurahere marae in discussions around their potential use as community hubs. Marae will also have value in terms of civil defence as many marae have far better facilities to cater for welfare needs than do other community institutions such as schools, although would need further support in catering for welfare needs and / or civil defence emergencies.

4. THE IMPACT OF THE ENVIRONMENT ON HEALTH OUTCOMES

Relevant sections in the draft Auckland Plan

- *Section B - Auckland Now – B1 The role of Auckland in NZ and the world*
- *Section C – Auckland's Strategic Direction – A well connected and accessible Auckland*
- *Chapter 5 – Auckland's Environment*
- *Chapter 8 – Urban Auckland*
- *Chapter 10 – Auckland's Infrastructure*

Recommendations

Ensure that Council understands the health issues potentially associated with water consumption reduction before implementing any action to reduce per capita water consumption. Therefore reconsider its proposed environmental design principle for water conservation to ensure that this principle adequately addresses the potential health risks from water conservation.

Reconsider the suite of actions proposed to achieve the Draft Plan's air quality target and include more effective short term actions.

Give more detailed consideration to areas where there are vulnerable populations or 'captured' populations who should be protected from ongoing exposures to poor air quality.

Please include specific reference to the biosecurity threat that Auckland's 'gateway' status to New Zealand creates.

Aim to reduce the levels of discharges and contaminants wherever possible, not just manage them.

Add an additional environmental design principle to ensure that noise is appropriately addressed in urban design.

Give further consideration to the potential conflicts between a substantially increased City Centre resident population and the City Centre's role as an entertainment centre.

Ensure that the health implications from proposed changes to on-site wastewater and water supply systems are considered.

Decrease the time period before which revised wet weather overflow targets are to be achieved.

Water related recommendation
Ensure that all water supplied by Watercare Services is fluoridated.

Supporting Information

Water conservation

101. We note and largely support the targets set out on the Table on page 80, but wish to make the following additional comments.

102. While reducing gross per capita water consumption makes sense from the environmental and economic perspectives, reducing water consumption has the potential to increase risks to public health if achieving that target means that families and individuals use less water than is necessary for health and hygiene purposes.[59]

103. There is no discussion in the Draft Plan as to how the proposed figure has been arrived at or what consideration of health issues there has been in setting this target. It is also unclear as to whether the target is to be achieved by reducing the current levels of leakage from the water supply network or by a reduction in household water use (or a combination of the two).

104. We would welcome further discussion with Council on the proposed per capital water consumption target so that we can provide advice to Council on the health issues potentially associated with water consumption reduction.

Air pollution

105. We fully support the proposed air pollution targets. Achieving the target will make a substantial contribution to reducing the estimated 436 premature deaths due to air pollution in each year and the 368,000 restricted activity days lost region wide due to illness or poor health (vehicle pollution not all pollution).[60,61]

106. We do not think that the actions listed in the implementation actions section of the Draft Plan (set out below) have any realistic hope of achieving the target by 2016.

- Reduce emissions from transport through policies to encourage compact urban form and alternative means of transport to private car use.
- Reduce industry emissions through requiring best practice through the resource consent process.
- Reduce home heating emissions through improved home energy efficiency.

Our reason for this view is that the actions suggested will impact over the medium to long term and we do not foresee them having much impact on air pollution levels within next 5 years.

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[59] Thornley S, Barnfather D, Simmons G, Roberts S, Anderson P and Stewart A (2009) *When the tap is turned down – restricted water flow increases bacterial contamination after handwashing,* V122, No 1300 accessible through http://journal.nzma.org.nz/journal/122-1300/3741/content.pdf

[60] ARC http://www.arc.govt.nz/environment/air-quality/aucklands-air-quality/aucklands-air-quality_home.cfm and HAPiNZ Study http://www.hapinz.org.nz/

[61] Kuschel G & Macmillan A (2009) *2010 RLTS WP20 Environmental Sustainability and Public Health Policies,* ARC accessible through http://www.arc.govt.nz/albany/fms/main/Documents/Transport/RLTS/RLTS%202010WP20%20Environmental%20 sustainability%20and%20public%20health%20policies.pdf **N.B.** this estimate is for vehicle related pollution, not all pollution.

107. Poor air quality is responsible for a significant reduction in life expectancy and with increased morbidity. In addition to addressing the root causes of poor air quality (fires, industry, vehicle emissions), consideration should be given to areas where there are vulnerable populations or "captured" populations that should be protected from ongoing exposures to poor air quality, primarily by ensuring appropriate placement of institutions, such as early childcare centres and schools in the case of children. Placement of housing and workplaces also needs due consideration as adults spend the vast majority of their time at home or at their workplaces.

Waste management

108. We support the aspirational target of achieving zero waste to landfill by 2040. We look forward to seeing further details of how Council proposes to work towards this target in its Waste Minimisation Plan.

109. We recommend that the DHBs are viewed as key stakeholders in policy development in relation to waste management as health services are significant contributors to current landfill volumes and changes will require coordination with health services delivery and related supplier management, e.g. Waitemata DHB is the first DHB in NZ to have a Sustainability Officer whose purpose is to improve the DHB's sustainability, reduce the DHB's carbon footprint and move the DHB to being more environmentally friendly.

Climate Change

110. The environmental changes and associated health consequences of climate change include, but are not limited, to the following:[62]

- Increasing average summer temperatures and numbers of hot days, with associated increases in heat mortality, food and water-borne diseases, aggression and crime, sleep-deprivation and alcohol consumption, and habitat expansion of mosquitoes capable of transmitting important diseases such as dengue fever and Ross River virus.
- Increasing incidence of drought, heavy rain, flooding and rises in sea level with associated increases in contaminated land and waterways will be associated with increases in water-borne disease, reduced availability and affordability of food, increased incidence of communicable disease etc.
- Worsening urban air pollution concentrations may increase during heatwaves with significant consequences for cardiovascular and respiratory mortality and morbidity.

111. We are disappointed to see that in Box 6.1 Council has not included the potential negative health impacts that climate change can create for Aucklanders as described in our submission on the 'Discussion Document'.[63] Over the lifespan of the inaugural Auckland Plan there is an increasing risk that these health impacts will arise.

112. Council notes that Auckland is likely to become increasingly attractive for persons seeking to emigrate from nations and territories rendered

[62] Lyne M. The impact of climate change on population health in the Auckland region. Mal Consultancy Services, June 2009.
[63] ARPHS 2011. Health Sector feedback on the Discussion Document, ibid. Paragraphs 177 – 179.

uninhabitable by climate change effects. While this increased migration will have wide societal impacts due to pressure on infrastructure, there is also potential for health impacts on Auckland communities. Several recent outbreaks of infectious disease in Auckland have been triggered by disease importation events involving persons returning from climate change affected Pacific island nations. These events may become more frequent as climate-influenced migration increases and will need to be appropriately prepared for and managed.

113. Auckland is New Zealand's major gateway to and from the rest of the world - 32% of commodity exports and 61% of imports passed through either Ports of Auckland or Auckland International Airport. However there is no acknowledgement of the biosecurity risk to humans, native flora and fauna and the rural economy that Ports of Auckland and Auckland International Airport present.

114. The vigilance of the Ministry of Agriculture and Forestry (MAF) and the Auckland Regional Public Health Service (ARPHS) means that mosquito incursions are rare. However, they do still occur, and exotic species have become established in New Zealand over the past 200 years. Eradication is highly costly (for example, the recent eradication of the Southern Saltmarsh mosquito).[64] With increased global traffic, it is important to maintain this activity accordingly as the introduction of such mosquitoes could have dire consequences on the health of Aucklanders.

115. The Draft Plan's promotion of concepts such as 'green roofs' and the use of swales will provide increased potential habitats for exotic organisms. We believe that it is important that the inaugural Auckland Plan recognises this risk and ensures that the appropriate checks and balances are included to manage it.

116. We look forward to supporting Council as it works with key partners to assess the effects and impacts of climate change. Understanding the impacts in greater depth will help both with facility design and the consequences for health service demand resulting from projected climate change.

Noise

117. With a more compact urban form we believe that noise will become a greater health and nuisance issue. We believe that Council should add an additional principle to the proposed list in box 8.5 as follows:

- Noise – consider high levels of noise insulation (both external and internally sourced).

118. We note Council's proposals for the city centre. ARPHS raised the issue of the potential conflicts between a quadrupled resident population (with higher proportions of children, families and the elderly) and the city centre's function as an entertainment centre in its submission to the City Centre Masterplan Discussion Document.[65] This submission comments on the conflicting needs

[64] See information on this eradication at:http://www.biosecurity.govt.nz/pests/southern-saltmarsh-mosquito

[65] ARPHS (2011) *Feedback on the Auckland City Centre Masterplan Discussion Document,* accessible through

of differing users of the city centre and the potential health consequences that can flow from them, e.g. unsafe alcohol use, noise, pollution etc.

119. We do not believe that Council has adequately addressed these issues and recommend it give further consideration to the issues raised.

Water supply, wastewater and stormwater (the 'three waters')

120. We support directives 10.1-10.4 but would also like Council to explicitly incorporate in its directives that it will 'actively seek pragmatic and reasonable solutions to prevent wastewater pollution of beaches and fishing closures'.

121. We note Council's comments around wastewater challenges and wet weather. We believe that the wastewater wet weather overflow target in chapter 13 is 2 pa per site by 2040 sets an inappropriate time scale over which to achieve this goal. Performance is directly related to investment and a zero target should be aimed for. We are particularly concerned that large developments currently going through the planning process e.g. Hobsonville Point[66] are using the international standard of 10 overflows in a 5 year period.

122. Council should aim to ensure that all consents granted from now on address this issue by imposing conditions that support a zero target. Pollution of beaches, reserves and residential properties already exists. We do not believe that Council needs to wait for its development of an updated water strategy to start to work towards this goal.

123. We note with concern Council's comments that

> "in some locations, on-site solutions to our stormwater, wastewater, and water supply can reduce demand on our reticulated networks".

124. We believe that on site wastewater and water supply systems present a greater health risk than does connection to the reticulated system. We do not support their use unless the risks to health from their use are less than the risk to health from using reticulated services. Where such on site services are approved then, from the health perspective, any approval needs to both consider the original designed performance of the system and secondly, and perhaps more importantly, how the performance of the system can be assured over a life of the building in which it is used. Before any such approval is given consideration also needs to be given to any potential hazards that the system creates for the property occupiers and the wider community.

125. We look forward to the ARPHS Medical Officer of Health having the opportunity to be part of development of the proposed updated water strategy for Auckland.

126. We note that the Draft Auckland Plan is silent on the subject of water fluoridation. From the public health perspective water fluoridation is a cost-

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http://www.arphs.govt.nz/submissions/downloads/2011/20110617_CityCentreMasterplanDiscussionDocument.pdf

[66] The wet weather overflow issue formed part of a presentation given by Watercare Services at the Upper Harbour Local Board meeting of 26th April 2011 and subsequent correspondence between Watercare Services and the Upper Harbour Local Board.

effective population based dental public health intervention. We believe that Council should require Watercare Services to fluoridate all the water it supplies to Aucklanders.

127. Water fluoridation is the process of 'topping up' the natural fluoride content of public water supplies to an optimal level (0.7 to 1milligram per litre) that gives extra protection against tooth decay. It can benefit all people with natural teeth regardless of age, income or education level. It doesn't require any behavioural changes from its recipients. Drinking fluoridated water is a simple and cost-effective way to help prevent and reduce tooth decay in the whole population. Treating decay is around 30 times more expensive than preventing it with water fluoridation.

5. THE IMPACT OF HOUSING ON HEALTH OUTCOMES

Relevant sections in the draft Auckland Plan

- *Chapter 9 – Auckland's Housing*
- *Unitary Plan development*

Recommendations

Ensure that its proposed housing policies don't lead to geographically based concentrations of socio-economic deprivation.

Develop a target to monitor progress in implementing Council's housing objectives.

Re-consider the proposed overcrowding target and reduce it to no more than 5% overcrowded houses by 2040.

Continue current programmes that provide some home insulation funding and expand the programme across the entire region in the future.

Give attention to potential mechanisms to improve the quality of rental housing.

Include access to health services as one of the issues considered when planning housing developments.

Supporting Information

128. We congratulate Council on the quality of the housing chapter of the Draft Plan. We believe that Council has provided a comprehensive overview of housing issues and captured all the collateral impacts that inadequate housing contributes to. We thank Council for incorporating the issues raised in our response to the Discussion Document in the Draft Plan.

129. The key housing issues that impact positively on health and wellbeing are all covered in text of the Draft Plan – affordability, availability, quality standards, location and security of tenure.

130. We support all of the targets proposed in this chapter. Reducing the proportion of Aucklanders who pay more than 30% of their income for housing from the current national average of 27% to 20% will deliver disproportionate benefits to Aucklanders as they have a higher percentage of the population paying more than the national average than elsewhere in the country.

131. Quality housing is especially important for the health and well being of children. There is strong evidence that improving housing conditions and reducing overcrowding can significantly reduce housing related respiratory hospitalisations in children in socio-economically deprived areas of Auckland.[67,68]

[67] Jackson G, Thornley S, Woolston J, Papa D, Bernacchi A, Moore T. Reduced acute hospitalisation with the healthy housing programme. J Epidemiol Community Health 2011;65:588-593. N.B. this research also considered the impact of associated health interventions that a household's participation in the programme allowed.

132. We believe that concentrating efforts on those groups most in need will have the greatest impact on improving the health of children in Auckland. Resulting spin offs are reduced costs incurred by the health and welfare sectors and also money saved by families through less GP visits, prescription costs, days off work and school.[69]

133. In addressing the needs of the groups most in need, care should be taken to avoid creating areas where socio-economic deprivation is concentrated. One of the aims of the current Tamaki Transformation Programme (in which Council is an active participant) is to reduce the concentration of deprivation in the Tamaki area in the belief that this will produce better social outcomes for both current and future residents.

134. Housing policy in the past has often failed to take into consideration quality, location and access issues - access to health services is often a factor not considered in the design of new communities. We believe that this is a further issue that needs to be considered across the Urban Auckland, Auckland's Housing and Auckland's Transport chapters of the inaugural Auckland Plan.

Priority 2 Increase housing choice to meet preference and need

135. We support the Council's target to reduce household crowding. However, we suggest council change the proposed proportion of people living in households requiring at least one extra bedroom from 15.7% in 2006 to 5% in 2040 (rather than 10% by 2040). While this target will be more challenging to achieve than that currently in the Draft Plan it reflects the importance of the issue and a more challenging target is likely to concentrate efforts over the life of the inaugural Auckland Plan.

Priority 3 Improve the quality of existing and new housing

136. We are pleased with Council's decision to encourage and incentivise retrofitting insulation to existing housing stock and to require new housing development to incorporate best practice urban design and sustainable housing principles.

137. In New Zealand it has been demonstrated that retrofitting insulation can bring substantial improvements in health with a 51% reduction in days off school and a 38% reduction in adults having time off work.[70,71] We understand that an economic impact analysis of the Warm Up NZ project will be published in the next month or two.

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[68] Chapman PH. Effect of insulating existing houses on health inequality: cluster randomised study in the community. *BMJ*, doi:10.1136/bmj.39070.573032.80

[69] Chapman PH. Effects of improved home heating on asthma in community dwelling children: randomised controlled trial. *BMJ* 2008; 337:a1411 doi: 10.1136/bmj.a1411

[70] Housing, Insulation and Health Study accessible through http://www.healthyhousing.org.nz/research/current-research/the-housing-crowding-and-health-study/

[71] Chapman R, Howden-Chapman P, O'Dea D, Viggers H & Kennedy M, *Retrofitting houses with insulation: a cost-benefit analysis of a randomised community trial.* Accessible through http://www.maarama.co.nz/Insulation_Benefits_feb07.doc

138. As part of meeting Directive 9.2 (Ensure a mix of dwelling types etc), we believe that Council should develop a target to ensure it is on track to meet this directive (either in the housing or urban Auckland chapters). As part of this, we suggest that Council needs to identify what the housing needs are of its population. Presently, developments or an increase in housing supply are driven by developers and their assessments of what development will be commercially viable, rather than there being significant planning of specific housing needs and typologies to meet projected population growth and changing demographics.

139. In Point 575 we consider it would be more accurate to amend the last sentence to include the term 'cold' in the list of housing conditions associated with asthma and respiratory illnesses.[72]

140. We support Council's intention to encourage and incentivise retrofitting of existing housing stock. Manukau and Papakura councils provided some funding for home insulation; unfortunately these programmes are due to finish in 2012. Auckland City also supported home insulation in the past. We hope that that Council will be able to continue to provide some home insulation funding in these areas and expand the programme across the entire region in the future.

141. We note Council's own 'retrofit your home' programme was also established earlier this year. Once the 'retrofit your home' programme has been running for longer we would like Council to review this programme to measure its effectiveness and 'reach'.

142. As part of point 577, we would like Council to address improvement of energy efficient housing across the social gradient. We would like to see reducing fuel poverty for households as part of the strategy that Council adopts in achieving Directive 9.2. (Ensure a mix of dwelling types etc).

143. We also believe that further consideration should be given to how retrofitting can be supported for renters / landlords and for low income households. This may be an area where an inter-agency approach should be considered.

144. These actions would go some way to decreasing fuel poverty in deprived households (although increases in income are also necessary). It will also decrease energy related emissions which will help tackle climate change and has positive health impacts.[73]

145. We would like Council to actively monitor housing quality and develop some indicators and targets around this. The Building Research Association of New Zealand (BRANZ) has commented on the lack of home maintenance on NZ homes which consequently impacts on housing quality. Presently there is no baseline data on quality of homes in Auckland. We suggest this be done by Council and that Council also regularly monitors it (perhaps every 5 to 10 years).

146. In point 583 Council comments "that the quality of the rental housing stock varies substantially". We believe that the issue of rental housing quality is

[72] Childhood Asthma. S Afr Fam Pract 2011;53(4):333-335
[73] The Marmot Review: Implications for Spatial Planning accessible through http://www.apho.org.uk/resource/item.aspx?RID=106106

worthy of further attention in the inaugural Auckland Plan. Council could consider developing the equivalent of a warrant of fitness for existing homes, particularly for rental homes, as a means to ensuring good standard of housing for lower income families (as lower income families are more likely to be renters).

Priority 4 Improve housing affordability

147. We support Directives 9.4 - 9.8. Home ownership has been linked with improving health outcomes and we support this priority of Council's – to ensure there are adequate houses to meet demand. With respect to Directive 9.5 (Support Māori to achieve etc) Council should also support initiatives which support Māori involvement, solutions and world views.

148. Consideration needs to be given to encouraging the mix of communities in both new housing developments as well as intensification of existing neighbourhoods. There is substantial evidence that areas with more mixed social composition tend to be more popular, more satisfying to live in, lower crime rates, and have better services than poorer areas. Their residents have better quality of life and outcomes. Mixed communities also promote a more egalitarian or socially cohesive society; encourage racial or religious integration and create more workable or sustainable communities.[74]

149. A range of planning mechanisms can be used to preserve or offset the loss of affordable housing in redevelopment settings, reduce barriers to the development of low-cost housing, and facilitate the increased supply of new affordable housing. These mechanisms include affordable housing targets in new developments, density bonuses and inclusionary zoning.[75]

150. We suggest that Council look at its own proposed implementation actions for housing and other avenues open to it e.g. the use of inclusionary zoning through planning regulations to promote the inclusion of realistic affordable housing options any housing development plan that it consents. We suggest that is should be the aim to include 20 - 25% of affordable housing that incorporates good quality standards in new developments.

151. With regards to Points 588 and 590, and the trade offs made by families under the heading 'appropriateness', we would like to emphasise that this is especially the case for Pacific families, some of whom are living in severely overcrowded homes.

152. We support Directive 9.4 (Actively use Council's statutory and discretionary roles etc) and the Affordable Housing Strategy. However, we would like to encourage Council to ensure that the strategy includes clear indicators, timeframes and outcomes. With regards to Directive 9.5 (Explore all options to improve housing affordability etc), we support development of third sector housing partnerships that also provide wrap around health and social services particularly for low socioeconomic communities.

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[74] Tunstall L. Communities and Local Government Mixed Communities Evidence Review, London, 2010. London School of Economics

[75] Australian Housing and Urban Research Institute (AHURI). International practice in planning for affordable housing. 2006. Available at: http://www.ahuri.edu.au/publications/p60322/

6. THE IMPACT OF TRANSPORT ON HEALTH OUTCOMES

Relevant sections in the draft Auckland Plan

- *Section C – Auckland's Strategic Direction – Move to outstanding public transport within one network*
- *Chapter 11 – Auckland's Transport*

Recommendations

Include in the plan the specific actions Council proposes to take to prioritise walking and cycling networks and pedestrians in town centres.

Give further consideration to how social, economic, environmental and cultural well-being, access and affordability are optimised by all Council's transport investments.

Institute a programme of reviews of public transport services in differing areas across the region, with priority being given to areas experiencing high levels of socio-economic deprivation to "provide better, more convenient access to educational institutions, employment and social services".

Amend the proposed principles in Box 11.1 (principles for transport planning and delivery) by including consideration of the needs of the transport disadvantaged and those who have the least access as an additional principle through which the network will be managed.

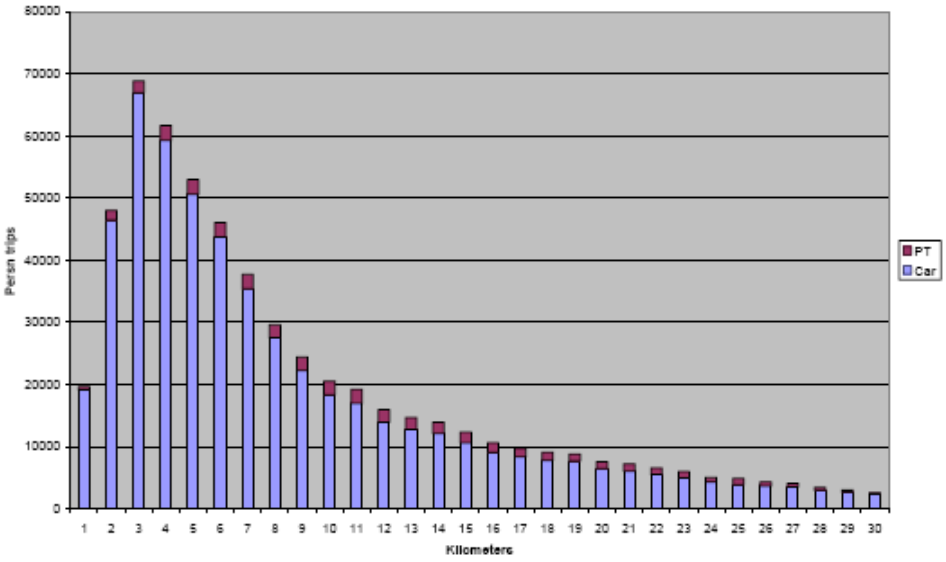
For rural areas give consideration to demand responsive and community transport models as part of Council's investigation of rural area public transport.

Specifically address and resolve the provision of alternative "realistic and equitable travel options" before any toll or road pricing regime is introduced.

Supporting Information

153. We agree with the high levels targets in this chapter, however we believe that there are other issues that are worthy of consideration as high level transport targets. We believe that given the distribution of trip distance lengths in the peak period the proposed targets are achievable, provided Council's investment decisions prioritise the targets outlined in the Draft Plan.

Figure 11: Trip Lengths by Mode (2008) Morning Peak Period 07.00 - 0.900 (ARC Auckland Transport Model 2008)[76]



Priority 1 Manage Auckland's transport as a single system

154. Coordinating and synchronising the public transport in Auckland to one network will improve public health gains by encouraging the use of public and active transport (decreasing pollution, improving exercise levels and stress, decreasing diseases caused by sedentary lifestyles). This will likely also improve Aucklanders access to health services- access to community and primary health care services, outpatient clinics, and hospitals.

155. In the current Regional Land Transport Strategy transport disadvantage is defined as "people whom the regional council has reasonable grounds to believe are the least able to get to basic community activities and services (for example, work, education, health care, and food shopping)".[77] We believe that this definition encompasses those who are transport disadvantaged because they can not drive (children and elderly), those suffering physical disability and those who are transport disadvantaged because of poverty.

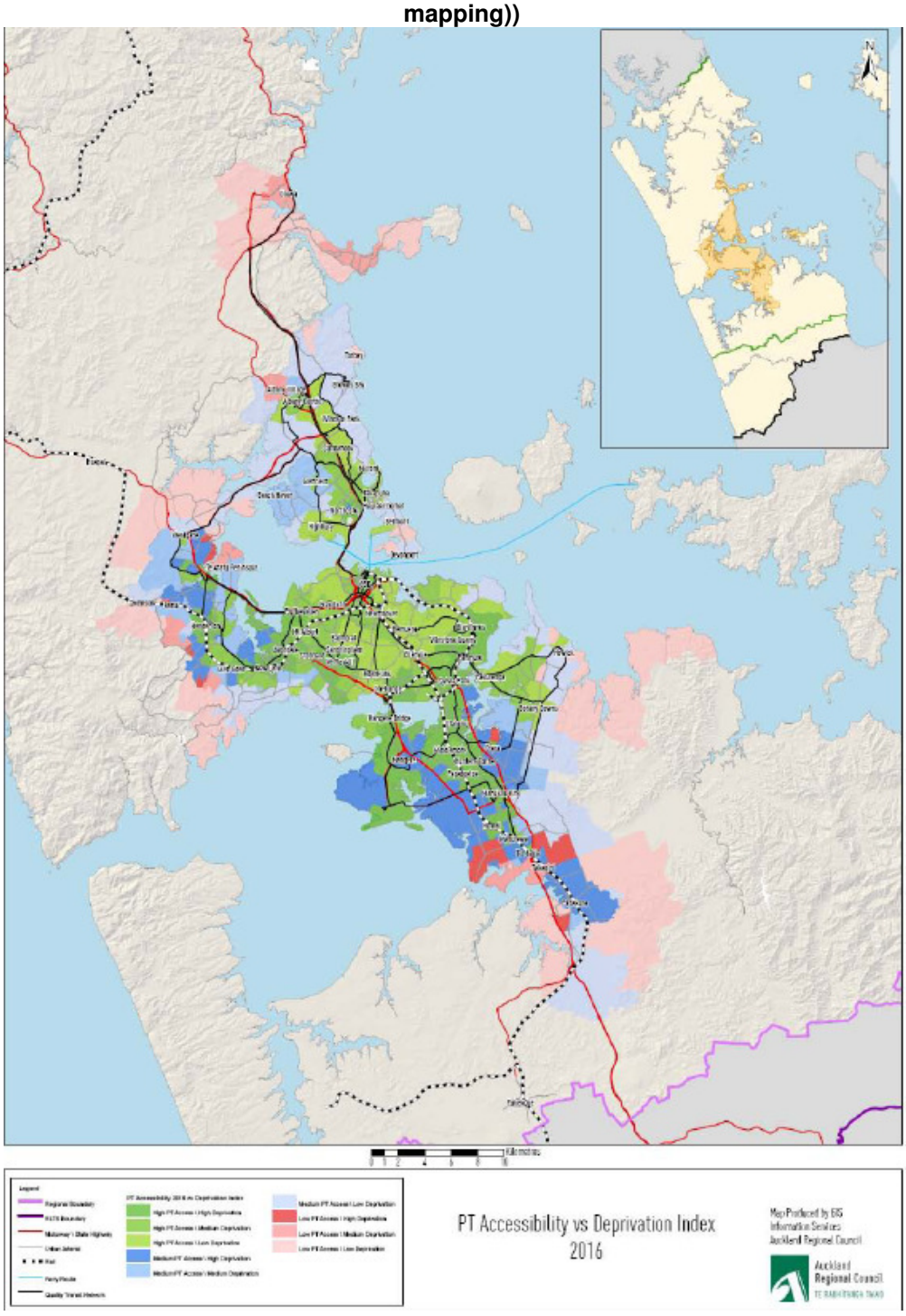
156. Neither the principles outlined in Box 11.1 nor the remainder of Chapter 11 contains any explicit consideration of the transport disadvantaged. Consideration of the needs of the transport disadvantaged is a requirement of both the Land Transport Management and Public Transport Management Acts and we recommend that transport disadvantage be added to the principles contained in Box 11.1

[76] ARC (2008) *Trends and Issues (Transport Challenges) WP 2010/08* accessible through http://www.arc.govt.nz/albany/fms/main/Documents/Transport/RLTS/RLTS2010WP08%20Trends%20and%20Issues%20(Transport%20Challenges).pdf

[77] ARC (2010) *Auckland Regional Land Transport Strategy 2010-2040,* accessible through http://www.arc.govt.nz/albany/fms/main/Documents/Transport/RLTS/RLTS%202009/Regional%20Land%20Transport%20Strategy%20(RLTS)%202010-2040.pdf

157. The reality of the current public transport network is that it does not meet the needs of the transport disadvantaged (see following map).[78]

Figure 12: Proposed PT Accessibility versus Deprivation Index (2016) (Source: Statistics New Zealand (deprivation data) and ARC (accessibility data and mapping))



[78] ARC (2008) *Trends and Issues (Transport Challenges) WP 2010/08* ibid.

158. We acknowledge and applaud Council's intention for the Southern Initiative area to:

> "Immediately review public transport services in the area to provide, within one year, better, more convenient access to educational institutions, employment and social services."

159. We recommend that Council continue to undertake reviews of public transport services in differing areas across the region, with priority being given to areas suffering high levels of socio-economic deprivation to 'provide better, more convenient access to educational institutions, employment and social services'. In any such review affordability of services together with issues such as fare zones need to be one of the factors that are considered in relation to services provided to the transport disadvantaged.

160. In Council's current management of the public transport system there is relatively little management of it as a single network. The reality is that in spite of the terminology of the; rapid transport network, the quality transport network and the local connector network that Auckland does not have a public transport network. Instead Auckland has a collection of separate routes that while they may geographically overlap and connect they do not overlap as a functioning effective system. The current Auckland Regional Public Transport Plan[79], description of services contains the following standards for connections:

Figure 12: Minimum Service Level Guidelines[80]

Service Attribute	Timing or Mode	Rapid Transit Network (RTN)	Quality Transit Network (QTN)	Local Connector Network (LCN)
Service strategy	Peak	Express + Limited Stop + All Stop	Express + Limited Stop + All Stop	All Stop
	Off-peak	All Stop	All Stop	All Stop
Connections		Non-timed connections	Services should be scheduled to arrive within 10 minutes of drop-off	Services should be scheduled so drop-off is within 10 minutes of RTN and/or QTN departure
Frequency	Peak (7.00am to 9.30am and 3.30pm to 6.00pm)	5 – 10 min	10 min (15 min new services/ferry)	20 – 30 min
	Interpeak (9.30am to 3.30pm)	20 – 30 min	20 min (30 min for new services/ferry)	30 – 60 min
	Evening (after 6.00pm)	30 min	30 min (60 min for new services/ferry)	60 min
	Saturday	30 min	30 min (60 min for new services/ferry)	60 min
	Sunday	30 min	30 min (60 min for new services/ferry)	60 min

[79] ARTA (2010) *Auckland Regional Public Transport Plan 2010,* accessible through http://www.aucklandtransport.govt.nz/about-us/publications/PlansProgrammes/Documents/AT-ARTA-Report-RegionalPublicTransportPlan.pdf

[80] ARTA (2010) *Auckland Regional Public Transport Plan 2010,* ibid.

161. The reality of most longer potential trips that do not start or terminate in the CBD (given the region's current CBD centric public transport model) is that passengers are likely to need to transfer from one service to another to reach their destination. Public transport is unlikely to become an attractive mode for many potential passengers until it starts to rival the convenience of the private vehicle. We recommend that Council specifically include timed connections as part of its service specification as we suggested in our earlier response to the Discussion Document.[81]

162. The detail of the Draft City Centre Masterplan refers to bus patronage to the city centre increasing from the current 23,536 in the morning peak nearly doubling with an additional 17,299 passengers.[82] The Draft City Centre Masterplan also notes that bus congestion in the city centre will become a problem in the near future.[83] It also refers to, but without giving any detail, the need to streamline bus routes to optimise network efficiency and accessibility.[84] From the health perspective we can foresee issues around air pollution from this increase, notwithstanding that the bus fleet is likely to have a better emissions profile in the future.

163. We hope that the optimisation and streamlining of bus routes to the city centre will include consideration of whether those routes servicing medium and longer distance journeys could be replaced by routes that go from their point of origin to the nearest stop on the rapid transport network. The proposed reduction in journey times for suburbs, such as New Lynn, to the city centre to 11 minutes[85] will substantially alter the dynamics of public transport in the areas served by rail and may make such an approach practicable.

164. We note and support Council's intention to continue to invest in public transport and walking and cycling networks and that Council is intending to prioritise the needs of pedestrians in town centres. We support this aim and believe that it will help deliver long term health benefits for the region.[86] It is unclear from the Draft Plan as to how Council intends to achieve this goal.

165. We note the content of Directive 11.2. We hope that this presentation is not intended to be hierarchical. If this is the case, we will wish to make further comment.

Priority 2 Integrate transport planning and investment with land use development

166. We support the integration of transport planning with land use development. We believe that this will produce better social, economic, environmental and health outcomes than does the current planning framework.

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[81] ARPHS (2011) *Health Sector Feedback to Auckland Unleashed,* ibid, paragraphs 257 & 258 and Appendix 5.
[82] Draft City Centre Masterplan – Factor 2 Access to and through the City Centre.
[83] Draft City Centre Masterplan Paragraph 538.
[84] Draft City Centre Masterplan Page 47.
[85] Draft Auckland Plan Box 8.0
[86] The value of investment in active travel fact sheet published by the UK Active Travel Organisation provides a good short overview of the benefits, accessible through: http://www.sustrans.org.uk/assets/files/AT/Publications/PDFs/The%20value%20of%20investment%20in%20active%20travel%20FINAL.pdf

167. With respect to the proposed additional Waitemata harbour crossing we are disappointed that there is no mention of active transport options being incorporated in the crossing. While active transport may not be a practical option for a new tunnel, we are of the view that once the second crossing is commissioned that an active transport option should be incorporated in the current harbour bridge (assuming that the current Hopper Development proposal hasn't come to fruition).

Priority 3 Prioritise and optimise investment across transport modes.

168. Cycling is pre-eminently suitable for shorter journeys up to 8 km and we believe that it has real potential as an alternative for the majority of shorter distance peak hour trips (see Figure 12 above). We believe that expenditure on cycling should be prioritised around centres to support the switch to this particular mode. While a regional cycling network may result from improvements around centres it should not be one of the key aims of transport investment.

169. We note the intention to continually investigate possibilities for some form of public transport in rural areas. We hope that as well as conventional public transport that Council's investigations will also include consideration of demand responsive transport and community transport models.

Priority 4 Implement new transport funding mechanisms

170. In any contemplation of road pricing (including congestion charges / network charging models) care will need to be taken to ensure that the model chosen:

- Takes account of the diverse needs of all users, including the transport disadvantaged, people with disabilities, users of commercial transport, public transport, pedestrians, cyclists and emergency services.

- Considers the equity implications of transport decisions and the distribution of costs and benefits, paying particular attention to the impacts on and improving access for the transport disadvantaged and people with disabilities.[87]

171. The current Auckland Regional Land Transport Strategy states:

> "Road Pricing
>
> While congestion pricing has the potential to make a significant contribution to achieving the NZTS targets and demand management objectives, it is not feasible without realistic and equitable travel options, particularly public transport services. Charging for road use could be considered when realistic, equitable transport options are available".[88]

[87] Policies 12.2.1 & 12.2.2 Auckland RLTS ibid.
[88] ARC (2010) *Auckland Regional Land Transport Strategy 2010-2040.* ibid. , accessible through

172. We look forward to further detail around Council's current proposals that shows how "realistic and equitable travel options" for the majority of users of the transport network are to be provided, before any such charge is introduced.

http://www.arc.govt.nz/albany/fms/main/Documents/Transport/RLTS/RLTS%202009/Regional%20Land%20Transport%20Strategy%20(RLTS)%202010-2040.pdf

7. SOCIAL AND COMMUNITY INFRASTRUCTURE AND HEALTH'S ROLE IN PLANNING FOR POPULATION GROWTH

Relevant sections in the draft Auckland Plan

- *Chapter 8 – Urban Auckland*
- *Chapter 10 – Auckland's Infrastructure*
- *Chapter 12 – Implementation Framework*

Recommendations

That Council involve DHBs early in the area spatial planning processes for future developments.

Include the DHBs and primary and community health care organisations in Table 10.1 (Agencies involved in delivering infrastructure in Auckland).

Include the Mason Clinic and Manukau Health Park in the list of critical social infrastructure.

Ensure that Council facilitates the re-development of critical social infrastructure on key sites.

That the Council note the additional capital intentions information provided.

Supporting information

Health's role in planning growth areas

173. We note Council's intention to classify centres into; regeneration centres, emergent centres and market attractive centres (Directive 8.2). We also note Council's intention to "undertake area spatial planning to facilitate future development, opportunities through master planning and structure planning exercises..." Health services are an integral component of all but the very smallest communities; we hope that Council will involve the health sector early on in these processes.

174. The health sector will need to be pro active and look at the health needs of the regeneration centres, emergent centres and market attractive centres – as these are all areas which will likely have significant population growth in the next few decades and its populations will need to have adequate access to primary care and hospital services.

175. We note Council's expectation that regeneration centres will require "... a mix of public sector actions..."

176. We are happy to explore further with Council the role that we can play in this area, subject to the proviso, of course, that it is health need and the provision of the appropriate model of care that are the prime drivers of where health sector facilities should be located.

Critical Infrastructure

177. We note and support Council's inclusion of hospitals and the broader health provider network in its definition of critical infrastructure.

178. The main national health strategy is aimed at delivery of health services closer to communities to provide; better, sooner, more convenient care. This is critical for transformation of health service delivery into a sustainable model and consideration of health facilities access beyond the large campuses is key to the success of this strategy, i.e. planning beyond the main Auckland City, Middlemore, North Shore and Waitakere hospitals.

179. Enabling better access to health facilities will require a collaborative view of urban planning in relation to safe roading and public transport options and is a key enabler for high needs communities to access health care. For example, the Manukau Health Park is associated with a large number of vulnerable patient visits and public transport options require crossing a busy four lane road to reach the facility. The DHBs have proactively engaged with the former Councils' urban planning teams and engagement is critical at a strategic planning level to ensure appropriate accessibility if we are to advance 'community wellness' and the overall aims of the inaugural Auckland Plan.

180. We also wish to raise the issue of development levies with Council. We believe that major investments such as hospitals should be exempt from development levies. Hospitals do not drive volume and demand for other community infrastructure. Health invests in such facilities because of growth in the population, in the same way in which Council may need to invest in a new library due to population growth. We understand that this issue has been raised by Waikato DHB with its local authorities and this view has been accepted.[89] Historically Waitakere City Council were open to this view.

181. While we believe that hospitals and other health facilities should be exempt from development levies we do accept the appropriateness of financial contributions to address localised site specific issues that health facilities development can create.

The scope and nature of infrastructure planning for the Auckland Plan

182. We note and support the proposed guidelines for infrastructure planning of; be adaptable, enable connectivity, plan for longevity and ensure stewardship.

183. We note and share Council's views around the need for resilient critical infrastructure. Potentially there are substantial health consequences from failure of any component of that infrastructure.

184. Point 617 refers to the Public Health Act. New Zealand does not have a Public Health Act; the relevant legislation is the Health Act 1956 and the New Zealand Public Health and Disability Act 2000.

[89] Hamilton City Council (2010) *Development and Financial Contributions Policy,* accessible through http://hamilton.co.nz/file/fileid/29648 .Hospitals are specifically referred to as an example of developments which can be subject to a special assessment procedure allowing for reduced levels of development contributions.

185. We note the inclusion of a number of health facilities within Council's definition of existing critical infrastructure. We believe from the health perspective that the Mason Clinic[90] in Point Chevalier which provides forensic psychiatric care and Manukau Health Park (formerly the Manukau Super Clinic) are equally critical. Appendix A sets out in more detail the relevance and role of the Manukau Health Park in CMDHB's planning for the future and its wider relevance for Auckland Council and the community.

186. Most of the three Auckland DHBs major facilities are currently aggregated on to a number of key sites. Redevelopment of these sites to expeditiously meet the increasing demand of Auckland's growing population will require facilitation and cooperation between Council and the DHBs. We hope that the inaugural Auckland Plan will contain provisions that help support this aim. Such provisions will help shape the framework for the subsequent work on the Unitary Plan.

Capital Intentions

187. We note the information presented about DHB capital intentions in Table 12.1. District Health Boards' Capital Budgets.

188. We wish to provide the following additional information. Waitemata DHB is currently implementing approved major redevelopment projects costing $131.48M (i.e. Elective Surgery Centre - $39.436M; Car Park - $24.544M; Lakeview Extension - $53.7M; and Oral Health project - $13.8M). Approval is being sought for the redevelopment of Taharoto Mental Health facility on the North Shore hospital campus (estimated to cost $33M).[91] Attached as Appendix B is a longer term overview of the DHBs current capital intentions. Please note, however, that this is an indicative picture only.

[90] http://www.waitematadhb.govt.nz/PatientsVisitors/TheMasonClinic.aspx
[91] WDHB- internal email communication

8. OTHER AREAS OF INTEREST TO THE HEALTH SECTOR

The Southern Initiative

Relevant sections in the draft Auckland Plan

- *Chapter 1 – Auckland's People – The Southern Initiative*
- *Chapter 12 – Implementation Framework*

Recommendations

Extend the initiatives proposed in the Southern initiative area to other areas with high levels of socio-economic deprivation in subsequent phases of the inaugural Auckland Plan.

Supporting Information

189. The Southern Initiative is one of the two big Initiatives for Auckland and is of great interest to the health sector, especially for Counties Manukau District Health Board.

190. We support Council's vision and goals outlined in the Southern Initiative. We are encouraged to read that Council plans to work alongside central government and third party sectors in housing, education, police and social development.

191. At present there is reference in Chapter 12 that the implementation plan for this initiative is yet to be scoped. It would be useful if more detail on how this scoping activity will be undertaken is provided in the inaugural Auckland Plan.

192. Auckland Council's commitment to the Southern Initiative provides opportunity for more effective focus on injury prevention in this area as well (See our earlier points around injury prevention).

193. We note the comments made with respect to CMDHB in point 277 and we would like to highlight the strategic importance of the Manukau Health Park (MHP), not only to the DHB but also the Council and the local communities (see Appendix A).

194. The body of work completed with former Manukau Urban Planning Team (now disbanded) at the centre of the southern area relating to Manukau Health Park (MHP) as an enabler of urban planning as well as a centre of wellness was useful from the health perspective and also we believe valuable to Council. This work involved the commissioning and completion of HIA / WOHIA on aspects of Manukau Centre and Wiri as an approach through which the issues could be more easily and effectively considered. We look forward to future opportunities to engage with Council on similar issues.

195. We would also like to correct the data that Council has used on Page 51 regarding life expectancies of the different ethnicities living in the Counties Manukau area. The figures given were taken from the CMDHB website which we have subsequently realised need correcting. Correct figures should be:

- Māori life expectancy (2008-2010 average) at birth in Counties Manukau is 72 years, 11 years lower than for Non Māori Non Pacific (83 years).
- Pacific people's life expectancy (2008-2010 average) at birth in Counties Manukau is 77 years, 6 years lower than for Non Māori Non Pacific (83 years).

196. The figures for the same population groups in the ADHB area are:

- Māori life expectancy (2010) at birth in Auckland is 75 years, 8 years lower than for Non Māori, Non Pacific (83 years).
- Pacific people's life expectancy (2010) at birth in Auckland is 77 years, 6 years lower than for Non Māori, Non Pacific (83 years).

197. The figures for the same population groups in the WDHB area are:

- Māori life expectancy (2008-2010 average) at birth in Waitemata is 76.6 years, 7.5 years lower than for Non Māori, Non Pacific (84.1 years).
- Pacific people's life expectancy (2008-2010 average) at birth in Waitemata is 76.9 years, 7.2 years lower than for Non Māori, Non Pacific (84.1 years).

198. The difference between the CMDHB, ADHB and WDHB populations mirrors the differences in the social and economic profile maps set out on pages 42 and 43 of the Draft Auckland Plan and provides evidence to support the existence of a social gradient in health in the Auckland region. Please, note, however that presenting figures at the DHB level masks more localised differences for particular areas both above and below these aggregate figures.

199. We would like Council to ensure that initiatives to improve children and young people's well being are not merely localised to the Southern Initiative but are implemented in all areas in Auckland where there are issues of high levels of socio-economic deprivation and associated underachievement, e.g. pockets of West Auckland.

Healthy City Approach

200. We believe that the Healthy City inter-sectoral approach acknowledges the importance of all sectors in creating a healthy city. The Draft Plan incorporates many issues relevant to the Healthy City approach including; housing, employment, recreation, environmental infrastructure, transport, etc. The statutory requirements imposed on Council for the development of the Auckland Plan also contain elements of the Healthy City approach. Evaluations of Healthy Cities have shown many positive outcomes such as increased partnerships and improved targeting of poverty and exclusion.[92]

201. We look forward to further work in this area by Council and hope that the experience gained with pre-existing initiatives such as Te Ora o Manukau (Manukau the Healthy City initiative) will provide a useful input into Council's

[92] Green, G. and A. Tsouros (Eds.). (2008). City leadership for health: Summary evaluation of Phase IV of the WHO European Healthy Cities Network. Copenhagen, Denmark: World Health Organization.

current work programme in this area. We look forward to further engagement with Council on the Healthy City concept.[93]

202. We also acknowledge the September 2011 Social and Community Development Forum resolution[94]:

> "That officers report on options for extending 'Manukau, the Health City Project' across the Auckland Council region.
> That a workshop be convened including elected members on effective actions, priorities and collaboration with health agencies on health issues."

Strengthen Communities

Recommendations

Actively engage with migrant communities and employers to help migrants integrate into their new home.

203. The health sector supports the Council's priority of strengthening communities. Communities with increased social cohesion have better health outcomes.

204. One of the frameworks that guides health sector activity is the Ottawa Charter for Health Promotion.[95] Council's aim to see a future where there is less disadvantage and active community participation in shaping its future could be drawn directly from the Ottawa Charter. Having Council policies that support and enable these objectives are reached are crucial. Council will need to have a pro active role in shaping these policies and the strength and determination to stand by them. Programmes and actions to 'strengthen communities' will ultimately be successful and sustained if it is owned and championed by the communities themselves.

205. We endorse the Council's overview of migrant issues and opportunities.

206. Reports show that despite migrants having equal or higher levels of education, they have a higher unemployment rate than the New Zealand European / Others group.[96, 97, 98]

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[93] Social and Community Development Forum minute SCD/2011/78
[94] Minute number SCD/2011/78
[95] World Health Organisation (1986) *Ottawa Charter for Health Promotion* accessible through http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf
[96] Perumal L. Health Needs Assessment of Middle Eastern, Latin American and African people in the Auckland Region. Auckland District Health Board, 2011. Available: http://www.adhb.govt.nz/healthneeds/Document/MELAAHealthNeedsAssessment.pdf
[97] Zhou L. Health Needs Assessment for Asian People in Waitemata. Waitemata District Health Board, 2009. Available:http://www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=Xh-hgWDylSc%3d&tabid=86&mid=409
[98] Gala G. Health Needs Assessment for Asian People in Counties Manukau. Counties Manukau District Health Board, 2008. Available:http://www.cmdhb.org.nz/About_CMDHB/Planning/Health-Status/Asian-Health/AsianHealthNeedsAssessment.pdf

207. Refugees and migrants have often voiced difficulties in finding employment in new host countries.[99] This negatively impacts on their health outcomes and ability to provide for themselves or their children.

208. It is unclear in this Draft Plan how Council will approach Directive 1.8 (Promote inclusion, reduce discrimination etc) for migrants and ethnic minorities with regards to employment. Point 264 - 267 describe the barriers faced by some with regards to employment, however there are no suggested ways/approaches that Council will take to address these issues.

209. We encourage the Council to actively engage with migrant communities and employers to look at novel ways to integrate migrants to jobs that make full use of their qualifications and experience.

Disability Issues

Recommendation

Make reference to the needs of people with disabilities as one of the groups' whose needs will be specifically addressed and include disability as the subject of a separate directive in the Auckland's Peoples chapter of the inaugural Auckland Plan.

210. There is little visibility in Auckland's vision of disability issues. As noted previously the proportion of Aucklanders living with disability is projected to increase over the life of the inaugural Auckland Plan. While wording such as "There is no discrimination nor any barriers to participation..."[100] implies that their needs will be accommodated, we believe that this group is often overlooked. The inaugural Auckland Plan should contain a specific section outlining how their inclusion will be addressed, e.g. through equal access to public transport as well as fair access to other infrastructure and utilities.

Workforce

211. We are supportive of the Priority and Directives 4.9-4.13. The health sector relies heavily on skilled employees and the three DHBs work closely alongside tertiary organisations in order to ensure adequate high skilled health care workers are produced. However, like most other industries, a large number of locally trained graduates leave New Zealand for overseas labour markets upon completion of their training. Delivering on Directives 4.9-4.13 will benefit the overall health care sector as will as ensure Aucklanders have adequate access to well resourced health services.

212. The health sector undertakes a range of activities designed to increase the proportion of its workforce that are Aucklanders, such as Auckland District Health Board's support of initiatives such as Rangatahi and Tāmaki Transformation Cadets.

[99] Pio E. Longing and belonging: Asian, Middle Eastern, Latin American and African peoples in New Zealand. Auckland: Dunmore Publishing; 2010.
[100] Draft Auckland Plan paragraph 110.

Innovation

213. We note Council's intention to build strong linkages between Auckland research and development institutions, business and organisations. We believe that it would be sensible to include education and health as key stakeholders in this work. From the health perspective, organisations such as the Liggins Institute and the recently established Ko Awatea Institute for Health Improvement and Awhina Health Campus (both participants in the recently announced National Health Innovation Hub[101]) are centres that will contribute to the development of Auckland as an innovation centre and a successful regional economy.

Implementation

214. We share Council's view that better collaboration and participation between a range of agencies including Health and Council will be necessary to achieve delivery of the inaugural Auckland Plan. We view the requirements imposed on health by the National Infrastructure Plan to consider the Auckland Plan as one of the requirements of good business case development and decision making as setting a low threshold for such collaboration. We hope that Council and health will be able to collaborate far more effectively in the future. It will take time, however, to re-configure internal and cross agency processes to facilitate and support improved collaboration, but we look forward to further dialogue with Council.

215. In terms of the key stakeholders listed in Table 12.5 we believe that it would be preferable to list the DHBs separately from central government. The DHBs are crown entities rather than departments of state and as such have more autonomy and ability to respond to the inaugural Auckland Plan than do other parts of central government. Similarly the inclusion of DHBs and primary or community health care providers should be included as key stakeholders in the proposed actions under directives 10.7 to 10.9.

216. In our feedback to the Discussion Document[102] we warned of the risk of unforeseen consequences from Council's funding decisions. For each project or activity Council is urged to rigorously assess its funding options against the parameters set out in the legislation. We also recommend that Council undertakes a social impact assessment for each new major project and its associated funding mechanism to ensure that it is fully informed before reaching a decision to go ahead.

Monitoring and Evaluation

Recommendation

Commit to future work with the DHBs and ARPHS to further develop and refine the proposed health- related measures in the monitoring and evaluation framework.

217. Several of the targets listed in Chapter 1 are of relevance to the health sector. We would like to continue actively engaging with Council on how these

[101] Beehive Release 22 September 2011. Innovation hub to help grow health tech sector. Available at: http://www.beehive.govt.nz/release/innovation-hub-help-grow-health-tech-sector

[102] ARPHS (2011) *Health Sector Feedback to Auckland Unleashed,* ibid, paragraphs 215 and 275 - 277

targets are reported sustainably and interpreted appropriately. It is unclear in the Draft Plan:

- The rationale for the proposed targets.
- How Council will be reporting on these targets.
- Who will have responsibility for collecting, reporting and actioning the target information.

218. The targets relevant to the health sector specifically are:

- By 2020, reducing housing related hospitalisations by 35%.
- Before School check- by 2017, all pre-school children demonstrate strong family/ whānau attachments.
- By 2040, 80% of population has a CVD assessment by a primary care provider.
- Perception of safety in Quality of Life Survey to increase to 70% by 2040.
- All Aucklanders can access health facilities within 30 minutes by 2040 (Chapter 10).

219. For example, we are unclear as to the rationale behind the proposed target 'all Aucklanders can access health facilities within 30 min by 2040 in Chapter 13. From the health perspective different health facilities provide primary (e.g. a GP's surgery), secondary (e.g. Waitakere hospital) or tertiary care (e.g. the Middlemore Hospital burns unit). Each class of facility provides a differing suite of treatments with differing levels of complexity and equipment. It is not clear:

- Which class of facilities Council is referring to.
- Why Council thinks 30 minutes is an appropriate target.
- What mode of transport Council believes the time target refers to, active, public or private transport.
- Whether the 30 minute target is intended to apply 24/7 or just during normal business hours.

220. We welcome further dialogue on this issue with Council so that we are better able to understand Council's intentions and make suggestions for an appropriate target and how it might be measured. We previously made comments in response to a request by Council's regional indicators and monitoring unit in August and are disappointed that Council has not incorporated those suggestions in the Draft Plan.

221. We consider the development of the monitoring and evaluation framework as one of the key enablers of the inaugural Auckland Plan succeeding. Due to their importance we wish to give more in depth consideration to what the indicators and their associated targets should be in relation to health and wellbeing.

222. At the moment, as Council will be aware, the Auckland region is facing a significant measles outbreak.[103] Unfortunately the staff that are involved in responding to this situation are those that are also best suited to comment on the proposed monitoring and evaluation framework. With Council's

[103] Auckland Regional Public health Service. Measles Update. Media Release. Available: http://www.arphs.govt.nz/Media_Releases/2011/4%20October%20Measles%20Update.pdf

agreement we will make additional comment on monitoring and evaluation once we have further opportunity to consider the issue and undertake to provide further comment before Council commences its deliberations on the Auckland Plan.

223. In the interim we have a number of issues that we think Council should consider as set out below.

- Reviewing other New Zealand or international monitoring frameworks associated with spatial plans or wider sets of indicators such as the framework proposed for the United Kingdom.[104]

- The former Waitakere City Council developed some measures based around Te pae Māhutonga[105] that may have value in assisting Council to further develop its monitoring and evaluation network.

CONCLUSION

224. Thank you for the opportunity to comment on the Draft Plan. We believe that much of the Draft Plan will help lift health outcomes and reduce health inequalities and we commend Council for its work to date.

225. We support the vision outlined for Auckland presented in the Auckland's Strategic Direction section of the Draft Plan. We believe that the recommendations we have set out in this document will improve the likelihood of the plan's successful implementation.

226. We look forward to a closer working relationship with Council over the life of the inaugural Auckland Plan as we work towards our shared and complementary health and social well-being objectives.

[104] Department of Health. (2011). Healthy lives, healthy people: Transparency in outcomes. Proposals for a public health outcomes framework. A consultation document. Retrieved 15 August, 2011, from http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122962.
[105] Waitakere City Council now accessible through http://www.communityoutcomes.govt.nz/web/coutcomes.nsf/unid/TCAO-7HQVTU?openDocument

APPENDIX A – MANUKAU HEALTH PARK

Background

The 52 Ha Manukau site was renamed the **Manukau Health Park (MHP)** in 2009 and fully supported by the Board. There were a number of reasons for this focus.

The 'site' has historically been referred to by the currently established functions and/or its location. Examples are: The Manukau Super Clinic, The Manukau Surgery Centre, The Browns Road site, The Browns Road Super Clinic et al.

The long term objective is that the **MHP** will house numerous health related, but wellness orientated services as well as the current clinics and hospital services which may well retain their names but within a health park complex – The **Manukau Health Park.** The emphasis within which will be **wellness.**

Strategic Importance

The development of this site is of significant strategic importance to **CMDHB, Auckland City** and the **Communities**

CMDHB

The Master Plan of CMDHB has embedded links and dependencies between Middlemore redevelopment (from its 1940s establishment), expansion of Manukau Super Clinic, the Manukau Surgical Centre and eventual rationalisation of a number of its inefficient and aged satellite sites.

By far the greatest dependency however is driven by the need to modernise and expand Middlemore Acute Hospital (MMH) to cater for the known growth from increased volumes. By taking non acute capacity out of MMH to an expanded MHP would result in much needed increased surgical and clinical capacity at Manukau, relocation of Mental Health, ARHOP and District Nurse base and also allowing the decanting of MMH to facilitate its much needed rebuild and expansion.

The interruption of capital and non approval of MMH business cases presented in 2009 has created a significant diversion of this process resulting in numerous contingency plans and reorganisations in order to continue services for the ensuing period of capital shortfalls and somehow manage the volume increases which are not halted.

APPENDIX B – DHB CRITICAL INFRASTRUCTURE CAPITAL INTENTIONS

Social infrastructure (critical region supporting)

Project	Expenditure 2011-2022	Expenditure 2023-2030	Expenditure 2031-2040	Funding Status	Funding Agencies	Contribution to Region
Major redevelopment projects at North Shore Hospital. Lakeview Extension; Elective Surgery Centre; Car Park; and Oral Health facilities	$131.5m			Approved	Waitemata DHB and Ministry of Health	Needed to meet the predicted demand for inpatient and outpatient health care delivery into the future in the Waitemata district
Redevelopment of Mason Clinic and Taharoto Mental Health facility at North Shore Hospital	$52m			Indicative	Waitemata DHB and Ministry of Health	Needed to meet the predicted demand for inpatient health care delivery into the future in the Waitemata district
Major redevelopment projects at North Shore Hospital. (maternity, medicine, surgery, labs, stroke renal in-centre, outpatients, tower and additional beds)	$228m	$144.3m		Indicative	Waitemata DHB and Ministry of Health	Needed to meet the predicted demand for inpatient and outpatient health care delivery into the future in the Waitemata district
NSH expansion - Specialist services for older Adults		$162.1m		Indicative	Waitemata DHB and Ministry of Health	Needed to meet the predicted demand for older adult health care delivery into the future in the Waitemata district
Waitakere Hospital development: Maternity, SCBU, Paeds, CSS	$70.2m			Indicative	Waitemata DHB and Ministry of Health	Needed to meet the predicted demand for inpatient health care delivery into the future in the Waitemata district
Waitakere Hospital expansion	$73.4m	$47.60		Indicative	Waitemata DHB and Ministry of Health	Needed to meet the predicted demand for inpatient and outpatient health care delivery into the future in the Waitemata district
Greenlane Clinical Centre – 120 bed rehab unit	$55m			Indicative	Auckand DHB and Ministry of Health	Needed to meet the predicted demand for inpatient health care delivery into the future in the Auckland district
Greenlane Clinical Centre – 320 bed Hospital and carpark	$170m			Indicative	Auckland DHB / Ministry of Health	Needed to meet the predicted demand for inpatient health care delivery into the future in the Auckland district

Major redevelopment of Middlemore Hospital. Replacement of core clinical facilities building including a new acute theatre suite.	$209m			Approved	Counties Manukau DHB and Ministry of Health	Needed to meet the predicted demand for inpatient and outpatient health care delivery into the future in the Counties Manukau district
Major redevelopment of Middlemore Hospital to replace diagnostic services and extend acute theatre capacity	$108m			Indicative	Counties Manukau DHB and Ministry of Health	Needed to meet the predicted demand for inpatient health care delivery into the future in the Counties Manukau district
Continued development of Middlemore Hospital to relocate Womens Health services	$80m			Indicative	Counties Manukau DHB and Ministry of Health	Needed to meet the modern care requirements for birthing women and babies needing hospital level care in the Counties Manukau district.
Redevelopment of the Middlemore Hospital site.		$50m		Indicative	Counties Manukau DHB and Ministry of Health	Needed to meet the predicted demand for inpatient health care delivery into the future in the Counties Manukau district
Redevelopment of the Manukau Health Park	$122.5m			Indicative	Counties Manukau DHB and Ministry of Health	Needed to extend a 'wellness' approach for care of ambulatory patients with chronic conditions and rehabilitation needs in the Counties Manukau district
Redevelopment of the Manukau Health Park to relocate and extend a Mental Health Campus	$49.40			Indicative	Counties Manukau DHB and Ministry of Health	Needed to meet the predicted demand for mental health support requirements for the future for the Counties Manukau district and broader region.
Continued development of the Manukau Health Park	$71m			Indicative	Counties Manukau DHB and Ministry of Health	Needed to meet predicted demand for ambulatory patients, birthing women and surgical services in the Counties Manukau district
Continued development of the Manukau Health Park	$93m	$44m		Indicative	Counties Manukau DHB and Ministry of Health	Needed to meet predicted demand for ambulatory patients, mental health and rehabilitation services in the Counties Manukau district

9

PERFORMANCE IMPROVEMENT

9.1 DAP Projects Report

9.1 District Annual Plan Progress Report

The information set out on the attached pages covers progress with improvement activities ADHB has committed to in the 2011/12 District Annual plan.

All of the projects for 2011/12 have been started. Completed projects now total 7.

On time project status is at 90%, 13 projects have been identified as 'issues being address' in order to achieve proceed to plan. These all have management plans in place however some will not deliver to the original plan.

	This month	Last month	Movement
Planning	103	110	-7
Implementation	31	26	5
Completed	7	6	1
	141	142	1
Cancelled/removed	0	14	0
Total	141	142	

Status	This month	Last month	Change
On time	90%	94%	-4%
On budget	97%	98%	-1%
Expected outcome	98%	98%	0%

Key to symbols

Proceeding to plan 

Issues being addressed 

Target unlikely to be met 

Group Pack Report

Group/Committee: Board

Goal Level Summary

DAP Projects - total projects: 141

Goal	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits		
			Plan			Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red
			Define	Measure	Analyse	Improve	Control														
1 Lift the Health of the people in Auckland City	55	55	41	0	2	6	4	0	46	7	0	53	0	0	52	1	0	2	2	0	0
2 Performance improvement	60	60	30	5	4	15	2	0	50	6	0	54	2	0	55	1	0	4	4	0	0
3 Live within our means	26	26	19	0	2	4	0	0	25	0	0	23	2	0	24	1	0	1	1	0	0
Total #	**141**	**141**	**90**	**5**	**8**	**25**	**6**	**0**	**121**	**13**	**0**	**130**	**4**	**0**	**131**	**3**	**0**	**7**	**7**	**0**	**0**
Total %	**100%**	**100%**	**67%**	**4%**	**6%**	**19%**	**4%**	**0%**	**90%**	**10%**	**0%**	**97%**	**3%**	**0%**	**98%**	**2%**	**0%**	**5%**	**%5**	**0%**	**0%**

10

LIVE WITHIN OUR MEANS

10.1 Finance Committee Recommendations

ADHB Board

Author: **Ian Bell (8077)**

Subject: **Northern Region Telecommunications Contracts**

Recommendation

It is recommended that the ADHB as part of the Northern Region DHB Boards approve:

1. *Dispensation from tender for fixed line, cellular, voice and data services contracts currently held by Gen-i and Vodafone respectively;*
2. *A 30 month extension to these existing contracts with Gen-i and Vodafone from 1 January 2012 to 30 June 2014 with a combined estimated value of $22m over the term;*
3. *Contract execution by the healthAlliance CEO; and*
4. *Contract schedule variation over the contract term by the healthAlliance GM Information Services, provided that such variations are within approved budgets of the DHB.*

Background

This will be discussed by the Finance Committee at their meeting on 2 December 2011**.**

ADHB Board

Author: **Ian Bell 8077)**

Subject: **Lease 615 New North Road, Morningside**

Recommendation

That the Board approves a renewal lease agreement for the property currently occupied by St Lukes Community Mental Health Centre at 615 New North Road, Morningside be entered into between British Jewellers N.Z. Limited and the Auckland District Health Board (ADHB(for a period of six (6), years with two (2), Rights of Renewal of three (3), years each.

Background

This will be discussed by the Finance Committee at their meeting on 2 December 2011**.**

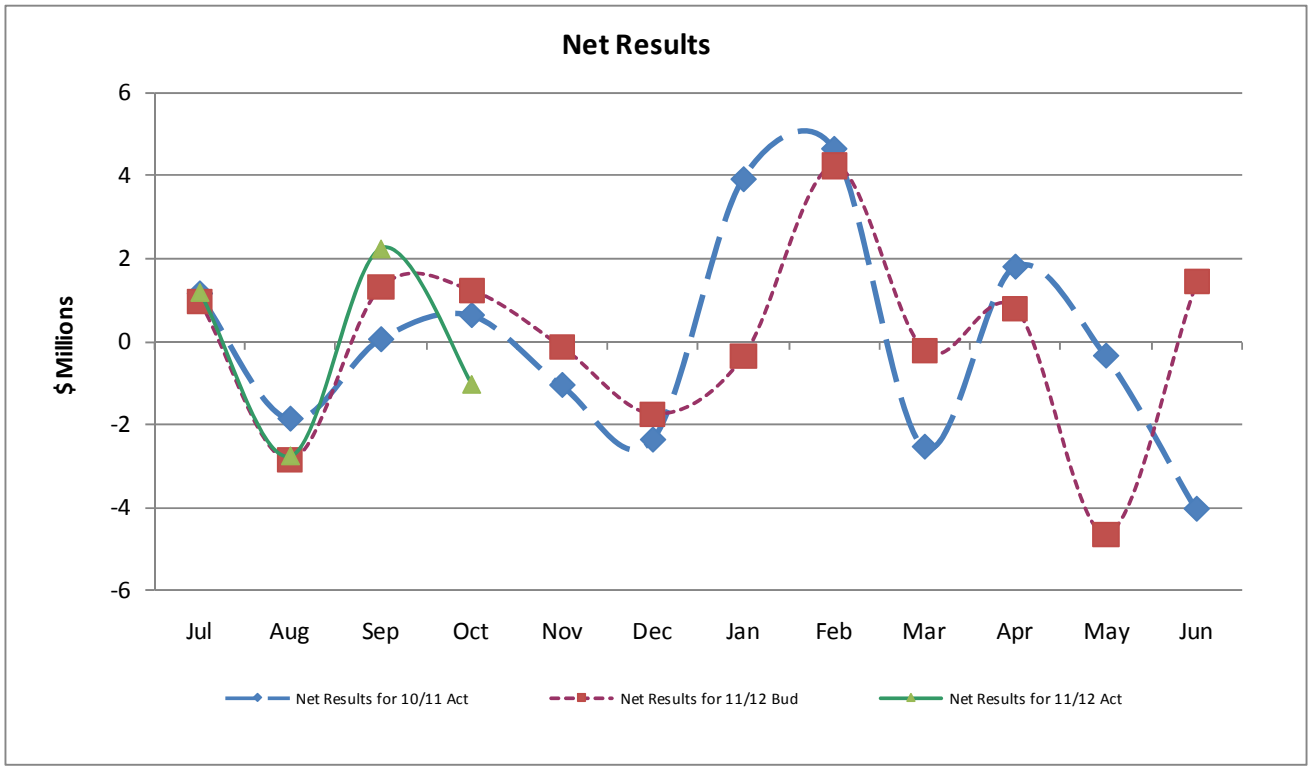
10.2 Finance Report

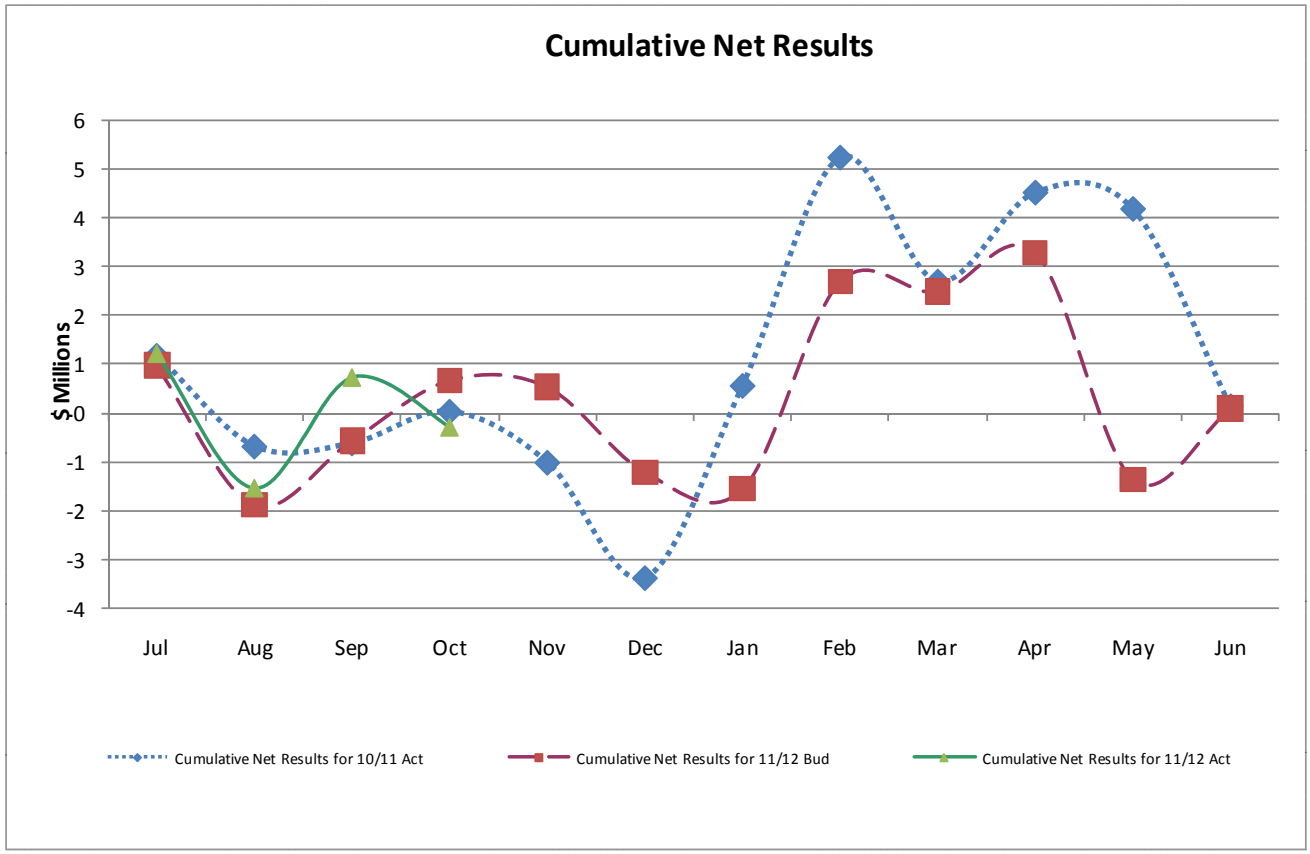
Auckland District Health Board

Board
Financial Report

October 2011

Performance Graphs by Month & YTD





Statement of Financial Performance
Month & YTD - Oct 2011

$000s	Month Actual	Month Budget	Month Variance	YTD Actual	YTD Budget	YTD Variance
Income						
PBF - AKL Population	82,204	82,264	60 U	328,816	329,057	241 U
Inter District Inflows	54,805	55,265	460 U	225,523	221,061	4,462 F
IDF Washup Provisions	0	0	0	F 0	0	0 F
Funder to Provider Revenue	0	0	0	F 0	0	0 F
	137,009	137,529	521 U	554,339	550,118	4,221 F
MOH Sub-contracts	9,238	8,128	1,110 F	35,486	33,030	2,456 F
Other Patient Care	2,841	3,724	884 U	14,068	14,974	905 U
Services & Products	4,333	3,912	421 F	16,015	16,008	7 F
CTA	1,732	1,560	172 F	6,980	6,739	241 F
Trust & Donation Income	370	319	51 F	697	1,276	579 U
Financial Income	596	593	3 F	3,576	3,236	341 F
Other Income	369	555	186 U	1,718	2,263	544 U
	156,487	156,320	168 F	632,880	627,642	5,238 F
Expenditure						
Employee Costs						
Medical	18,702	18,638	64 U	75,980	76,872	892 F
Nursing	20,623	20,311	313 U	81,293	80,496	796 U
Technical	10,106	10,126	20 F	40,465	41,750	1,285 F
Hotel Services	860	800	60 U	3,387	3,272	115 U
Administration	6,222	6,358	136 F	25,270	26,372	1,102 F
Other	3,103	3,257	153 F	13,881	13,317	564 U
Total Employee Costs	59,616	59,488	128 U	240,276	242,080	1,804 F
Outsourced Services	7,283	6,098	1,185 U	28,458	24,805	3,653 U
Direct Treatment Costs	16,595	17,482	887 F	69,523	70,771	1,247 F
Indirect Treatment Costs	3,507	3,552	45 F	14,514	14,187	327 U
Funder Payments	47,695	46,032	1,663 U	189,859	185,665	4,193 U
Inter District Outflows	9,018	8,497	521 U	36,281	33,987	2,294 U
Prop, Equip, & Maintenance	3,936	3,715	221 U	15,443	14,850	593 U
Administration Costs	2,077	2,012	64 U	8,139	8,135	3 U
Total Operating Expenditure	149,727	146,876	2,850 U	602,492	594,480	8,012 U
Operating Contribution	6,761	9,444	2,683 U	30,388	33,162	2,774 U
Depreciation	3,506	3,689	182 F	13,678	14,657	978 F
Finance Costs	1,507	1,623	116 F	6,021	6,255	234 F
Capital Charge	2,763	2,896	133 F	10,984	11,576	592 F
Total Non Operating Costs	7,776	8,208	432 F	30,684	32,488	1,804 F
Net Surplus / (Deficit)	(1,015)	1,236	2,251 U	(296)	675	971 U

Statement of Financial Position

as at 31 October 2011

$'000	Actual Oct-11	Budget Oct-11	Variance from Bud	Actual Sep-11	Var from Prev Mth	Actual Jun-11
Public Equity	574,180	574,160	21F	573,103	1,077F	573,103
Reserves						
Revaluation Reserve	331,808	353,538	21,730U	331,808	0F	331,989
Accumulated Deficit from Prior Year's	(468,224)	(468,308)	84F	(468,224)	0F	(468,367)
Current Year's Surplus/(Deficit)	(295)	674	969U	720	1,015U	143
	(136,711)	(114,096)	22,615U	(135,696)	1,015U	(136,235)
Total Equity	**437,469**	**460,064**	**22,595U**	**437,407**	**62F**	**436,869**
Non Current Assets						
Fixed Assets	834,171	884,147	49,976U	829,433	4,738F	829,642
Derivative Financial Instruments	5,580	4,207	1,372F	5,580	0F	5,669
Investments	4,400	10,548	6,148U	4,400	0F	4,400
Total Non Current Assets	**844,151**	**898,902**	**54,752U**	**839,412**	**4,738F**	**839,711**
Current Assets						
Cash & Short Term Deposits	84,124	83,050	1,074F	65,115	19,009F	83,325
Trust Deposits	19,659	10,534	9,125F	19,127	532F	19,160
Trade & Other Receivables	53,538	53,273	265F	70,041	16,503U	59,230
Inventory	11,961	12,454	493U	12,004	43U	12,021
Property Intended for Resale	20,041	-	20,041F	20,585	545U	20,041
Total Current Assets	**189,323**	**159,310**	**30,013F**	**186,872**	**2,451F**	**193,778**
Current Liabilities						
Interest Bearing Loans & Borrowings	(26,305)	(3,006)	23,299U	(29,175)	2,869F	(23,249)
Trade & Other Payables	(146,587)	(155,019)	8,433F	(136,715)	9,872U	(149,713)
Employee Benefits	(135,695)	(127,413)	8,282U	(135,040)	655U	(136,320)
Funds Held in Trust	(1,102)	(1,115)	13F	(1,099)	2U	(1,093)
Loan - Associated Entities	(4,714)	15,786	20,500U	(5,307)	593F	(1,386)
Total Current Liabilities	**(314,402)**	**(270,767)**	**43,635U**	**(307,336)**	**7,066U**	**(311,762)**
Working Capital	**(125,080)**	**(111,457)**	**13,622U**	**(120,464)**	**4,615U**	**(117,984)**
Non Current Liabilities						
Interest Bearing Loans & Borrowings	(259,644)	(304,136)	44,491F	(259,636)	9U	(263,110)
Employee Benefits	(21,958)	(23,246)	1,288F	(21,905)	52U	(21,748)
Total Non Current Liabilities	**(281,602)**	**(327,381)**	**45,779F**	**(281,541)**	**61U**	**(284,858)**
Net Assets	**437,469**	**460,064**	**22,595U**	**437,407**	**62F**	**436,869**

Statement of Cashflows for the Year ended 30 June 2012

	Oct-11			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Revenue Received	172,736	159,865	12,871	640,669	633,250	7,419
Payments	(146,639)	(155,322)	8,683	(628,717)	(597,702)	(31,015)
Net Operating Cashflows	**26,097**	**4,543**	**21,554**	**11,952**	**35,548**	**(23,596)**
Investing						
Income	296	593	(297)	2,061	2,444	(383)
Capital						
Sale of Assets	0	8	(8)	0	31	(31)
Purchase Fixed Assets	(7,639)	(5,972)	(1,667)	(17,544)	(23,888)	6,344
Net Investing Cashflows	**(7,343)**	**(5,371)**	**(1,972)**	**(15,483)**	**(21,413)**	**5,930**
Financing						
Equity Injections	1,078	0	1,078	1,078	583	495
New Loans	0	0	0	0	21,000	(21,000)
Loans Repaid	0	0	0	0	0	0
Equity Repayment	0	0	0	0	0	0
Loans Repaid	0	0	0	0	0	0
Net Financing Cashflows	**1,078**	**0**	**1,078**	**1,078**	**21,583**	**(20,505)**
Total Net Cashflows	**19,832**	**(828)**	**20,660**	**(2,453)**	**35,718**	**(38,171)**
Opening Cash	38,736	97,567	(58,831)	61,021	61,021	0
Closing Cash	58,568	96,739	(38,171)	58,568	96,739	(38,171)

Financial Commentary for October 2011

Financial Performance

- The net result for the month is a $2,251k unfavourable variance with a deficit of $1,015k compared to the budgeted surplus of $1,236k. This brings the year to date to a $971k unfavourable variance with a deficit of $296k compared to the budgeted surplus of $674k.

- The result for the month is driven by higher revenue and higher operational costs.

- The month's revenue was higher than budget by $0.2m. This was the result of:
  a) Unfavourable Inter DHB revenue $(0.5)m primarily driven by higher IDF revenue for PHO realignments $2.3m (refer Funder Payments below) and lower 2011-12 IDF wash up provisions $(3.4)m.
  b) Favourable MoH sub-contracts revenue $1.1m due mainly to higher SCI funding $0.2m, higher Additional Elective revenue $0.3m, higher Other Side contract revenue $0.3m and high CTA revenue $0.2m.
  c) Lower volumes of ACC and non residents $(0.9)m
  d) Higher external rentals $0.2m as a result of a Car park profit share receipt and higher research income $0.2m

- The month's expenditure was higher than budgeted by $2.4m. This was the result of:
  a) Unfavourable variance in Employee Costs of $(0.1)m, primarily due to higher Medical & Nursing FTE.
  b) Unfavourable variance in Outsourced services $(1.2)m following outsourcing in Orthopaedics, General Surgery, Cardiac, Paediatric ORL to achieve ADHB population elective discharge targets.
  c) Favourable variance in Direct & Indirect Treatment Costs of $0.9m mainly in Drug costs arising from favourable variances in PCT and Haemophilia Blood Products usage $1.0m. Lower IDF revenues are being driven by this to some extent.
  d) Unfavourable Funder Payments (including IDF Outflows) of $(2.2)m due mainly to increased PHO expenditure through the realignment of PHO's (1.5)m. This also in part drives the favourable variance in Inter District Flows noted above.
  e) Favourable variances in Depreciation, Interest and Capital Charges of $0.4m driven by lower levels of capital expenditure and the devaluation of properties at last balance date.

Year to Date

- The result for the year to date is driven by higher revenue and higher operational costs.

- The year to date revenue was higher than budget by $5.2m. This was the result of:
  a) Favourable Inter DHB revenue $ 4.5m due to PHO real ignments $7.8m (refer Funder Payments below) $2.3m f or the finalisation of 2 010-11 IDF wash ups, $(3.7)m for 2011-12 IDF wash up provisions and $(1.9)m in other IDF revenu e variations .
  b) Favourable MoH sub-contracts revenue $2.7m due mainly to higher SCI funding $0.9m, RCLM receipts $0.3m, Disability Support $0.2m, Additional Elective revenue $0.3m, Other Side contracts $0.7m and higher CTA revenue $0.2m.
  c) Unfavourable variance in donation revenue related to Starship Foundation donations $0.6m
  d) Interest rate derivative gains $0.3m

- The year to date expenditure was higher than budgeted by $6.2m. This was the result of:
  a) Favourable variance in Employee Costs of $1.8m following a lower and more favourable mix of FTEs than budgeted.
  b) Unfavourable variance in Outsourced services $(3.7)m following outsourcing in Orthopaedics, General Surgery, Cardiac, Paediatric ORL to achieve ADHB population elective discharge targets.
  c) Favourable Direct & Indirect Treatment costs $0.9m largely driven by favourable variances in PCT and Haemophilia Blood Products usage totalling $2.4m. Lower IDF revenues are being driven by this to some extent
  d) There are unfavourable Funder Payments (including IDF Outflows) of $(6.5)m due mainly to increased PHO expenditure through the realignment of PHOs $(5.8)m. This also, in part, drives the favourable variance in Inter District Flows noted above.
  e) Favourable variances in Depreciation, Interest and Capital Charges of $1.8m driven by lower le vels of capital expenditure and the devaluation of properties at last balance date.

Financial Position

- The balance of fixed a ssets is $5 0.0m below budget principally due to the downward revaluation of land & buildings $21.7m as at 30 June 2011, the reclassification of $20.0m worth of assets, to be transferred to Health Alliance, into P roperty Intended for Resale and the lower capital expenditure $6.3m.

- At month end there is an unused working cap ital facility o f $65.0m and an undr awn CHFA Loan facility of $21.0m.

11

GENERAL BUSINESS

12

PUBLIC EXCLUSION

12.1 Resolution

AUCKLAND DISTRICT HEALTH BOARD

RESOLUTION TO EXCLUDE THE PUBLIC FROM A MEETING OF THE BOARD

Clauses 32 and 33, Schedule 3, New Zealand Public Health and Disability Act 2000 ("Act")

That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 12

The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution**:**
12.1 Confidential Board Minutes 2 November 2011 12.2 ER Update 12.3 Health Services Groups 12.4 Bi-Lateral Collaboration Initiative: ADHB/WDHB	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.

ADHB Board
Agenda

MEETING DETAILS	
Time and Date	2:00pm, Wednesday 7 December 2011
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton
Members	Dr Lester Levy (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.
Apologies	Peter Aitken (leave of absence), Susan Buckland
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Naida Glavish, Janice Mueller, Vivienne Rawlings, Ian Bell.

	Item	Page No
1 2m to 2:02pm	**Karakia**	**001**
2 3m to 2:05pm	**Attendance and Apologies**	**005**
3 2m to 2:07pm	**Conflicts of Interest**	**007**
4 5m to 2:12pm	**Confirmation of Minutes 2 November 2011**	**015**
5 3m to 2:15pm	**Action Points 2 November 2011**	**023**
6 5m 5m to 2:25pm	**Chairman's Report** 6.1 Report - Verbal 6.2 Executive Committee of the Board	**027** **029** **031**
7 15m 5m to 2:45pm	**Chief Executive's Report** 7.1 Chief Executive's Report 7.2 Health Targets	**035** **037** **089**
8 5m 5m to 2:55pm	**Lift the Health of People in Auckland City** 8.1 Committee Recommendations 8.2 Auckland Plan Submission	**103** **105** **109**

ADHB Board
Agenda

	Item	Page No
9 5m to 3:00pm	**Performance Improvement** 9.1 DAP Projects Report	**175**
10 5m 5m to 3:10pm	**Live Within Our Means** 10.1 Finance Committee Recommendations 10.2 Finance Report	**179** **181** **185**
11	**General Business**	**195**
12 40m to 3:50pm	**PUBLIC EXCLUSION** 12.1 Resolution	**197**
NEXT MEETING		
	Time and Date: 2:00pm, Wednesday, 15 February 2012 **Venue:** A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton	

Hei Oranga Tika Mo Te Iti Me Te Rahi
Healthy Communities, Quality Healthcare