Open Board Meeting

Wednesday, 30 March 2016

09:45am

Note:

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

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

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

Published 23 March 2016

Agenda
Meeting of the Board
30 March 2016

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

Time: 9:45am

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

Apologies Members:

Apologies Staff: Margaret Wilsher

Karakia

Agenda

Please note that agenda times are estimates only

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

2. **RESOLUTION TO EXCLUDE THE PUBLIC**

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

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

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

12:45pm **4.** **CONFIRMATION OF OPEN MINUTES 17 FEBRUARY 2016**

12:55pm	**5.**	**ACTION POINTS 17 FEBRUARY 2016**
	5.1	Management Operating System
1:00pm	**6.**	**CHAIRMAN'S REPORT - VERBAL**
1:05pm	**7.**	**CHIEF EXECUTIVE'S REPORT** (
	8.	**COMMITTEE REPORTS - Nil**
1:10pm	**9.**	**PERFORMANCE REPORTS**
	9.1	Financial Performance Report
	9.2	Funder Report
1:25pm	**10.**	**COMMITTEE REPORTS**
		Hospital Advisory Committee
	10.1	Patient Experience Survey Net Promotor Score
1:30pm	**11.**	**DECISION REPORTS**
	11.1	Auckland District Health Board 2016 Triennial Election
1:35pm	**12**	**DISCUSSION PAPER**
	12.1	Tamaki Programme Update
1:40pm	**13**	**GENERAL BUSINESS**
	13.1	Design Lab Presentation – Justin Kennedy-Good and Stephen Reay

Next Meeting:	Wednesday, 11 May 2016 at 12:45pm A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

Hei Oranga Tika Mo Te Iti Me Te Rahi

Healthy Communities, Quality Healthcare

Attendance at Board Meetings

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

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Confirmation of Confidential Minutes 17 February 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Register of Interest and Conflicts of Interest	As per that stated in open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Action Points 17 February 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 NEHR Programme – Cost of current systems	**Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.2 Health Gain Strategy including DAP link to the Strategy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

	Negotiations To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety – Contractors Online Induction Presentation	**Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.2 Health & Safety Report February 2016	**Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5. NIP Update – healthAlliance Infrastructure Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Cyber Security Risk	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1	**Commercial Activities** To enable the Board to carry out,	That the public conduct of the whole or

Home Based Support Service Agreement Variations for in-between travel funding.	without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Emergency Dental Services for Auckland DHB	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.3 Revised Auckland DHB Capital Policies	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.4 Open Agenda for Audit and Finance Committee	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.5 Procurement Policy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	
6.6 Independent Security Risk Assessment External Reviews Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Protect Health or Safety** The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 NZ Health Partnerships	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Auckland DHB Adult Palliative Care Strategy 2015-2018	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Government Chief Privacy Officer Self-Assessment for Auckland DHB 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) Would disclose a trade secret; or Would be likely to unreasonably	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]	
7.4 Change in National Breast Feeding Target	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.5 Submission of Annual Plan and Statement of Intent for Auckland DHB	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Human Resources Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 Finance Update 2016/2017 Budget	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	Prevent Improper Gain The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	
9.2 Reducing Acute Flow to Auckland City Hospital's Emergency Dept	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10 General Business	NIL	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Possible reasons for passing resolution: Select relevant options, paste into the middle column for each item, and then delete this table by selecting '⊹' in the top left corner and pushing 'backspace'	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)] **Obligation of Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is subject to an obligation of confidence [Official Information Act 1982 s9(2)(ba)] **Privacy of Persons** To protect the privacy of natural persons, including that of deceased natural persons [Official Information Act s9(2)(a)] **Protect Health or Safety**

	The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public [Official Information Act 1982 s9(2)(c)] **Legal Professional Privilege** The disclosure of information would not be in the public interest because of the greater need to maintain legal professional privilege. [Official Information Act 1982 s9(2)(h)] **Prevent Improper Gain** The disclosure of information would not be in the public interest because of the greater need to prevent the disclosure or use of official information for improper gain or advantage [Official Information Act 1982 s9(2)(k)] **Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: ii) Would disclose a trade secret; or iii) Would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 s9(2)(b)]

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman - Auckland Transport Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership - University of Auckland Business School Head of the New Zealand Leadership Institute – University of Auckland Lead Reviewer – State Services Commission, Performance Improvement Framework Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	09.02.2016
Jo AGNEW	Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Professional Teaching Fellow – School of Nursing, Auckland University Appointed Trustee – Starship Foundation Casual Staff Nurse – Auckland District Health Board	15.07.2015
Peter AITKEN	Pharmacy Locum - Pharmacist Shareholder/ Director, Consultant - Pharmacy Care Systems Ltd Shareholder/ Director - Pharmacy New Lynn Medical Centre Shareholder/Director – New Lynn 7 Day Pharmacy Shareholder/Director – Belmont Pharmacy 2007 Ltd Shareholder/Director – TAMNZ Limited Shareholder/Director – Bee Beautiful Limited	07.10.2015
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter is a partner – Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	14.07.2015
Judith BASSETT	Fisher and Paykel Healthcare Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Group Daughter is a shareholder of Westpac Banking Group	13.07.2015
Chris CHAMBERS	Employee - ADHB Wife is an employee - Starship Trauma Service Clinical Senior Lecturer in Anaesthesia - Auckland Clinical School Member – Association of Salaried Medical Specialists Associate - Epsom Anaesthetic Group Shareholder - Ormiston Surgical	26.01.2014

Lee MATHIAS	Chair - Counties Manukau Health Deputy Chair - Auckland District Health Board Chair - Health Promotion Agency Chair - Unitec Director - Health Innovation Hub Director - Health Alliance Limited Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Director – New Zealand Health Partnerships	18.11.2015
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Auckland District Council of Social Service	17.02.2016
Morris PITA	Member – Waitemata District Health Board Shareholder – Turuki Pharmacy, South Auckland Shareholder – Whanau Pharmacy Limited Director and Shareholder of Healthcare Applications Ltd Owner and operator with wife - Shea Pita & Associates Ltd Wife is member of Northland District Health Board Wife provides advice to Maori health organisations	17.02.2016
Gwen TEPANIA-PALMER	Board Member - Waitemata District Health Board Board Member - Manaia PHO Chair - Ngati Hine Health Trust Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Member - Health Quality and Safety Commission	02.04.2013
Ian WARD	Board Member - NZ Blood Service Director and Shareholder – C4 Consulting Ltd CEO – Auckland Energy Consumer Trust Shareholder – Vector Group Shareholder / Director - Eltham Investments Limited Shareholder / Director - Cavell Corporation Limited Shareholder / Director - Ward Consulting Services Limited Trustee - LP Leasing Limited Trustee - Chris C Lynch Limited Son – Oceania Healthcare	07.10.2015

Minutes
Meeting of the Board
17 February 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 17 February 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:45pm.

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

1. ATTENDANCE AND APOLOGIES

That the apology of Dr Lee Mathias (Deputy Chair) be received.

[Secretarial Note: The meeting moved into confidential session with the open section of the meeting resuming at 1pm.]

2. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 5 – 10)*

Resolution: Moved Robyn Northey / Seconded Chris Chambers

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
2. Confirmation of Confidential Minutes 9	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official	That the public conduct of the whole or the relevant part of the meeting would be likely to result

December 2015	Information Act 1982 s9(2)(i)]	in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2.1 Confirmation of Circulated Resolution – Approval for Auckland DHB to Acquire further C Class Shares in healthAlliance NZ	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2.2 Confirmation of Circulated Resolution – Approval for Auckland DHB to Commission the Development of a Clinical Services Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] .	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Register of Interest and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

5.1 Health and Safety Performance Report December 2015	**Protect Health or Safety** The disclosure of information would not be in the public interest because the greater next to protect the health or safety of the public [Official Information Act 1982 S.9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 NEHR Programme Update	**Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is made available: (i) Would disclose a trade secret; or (ii) Would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 S.9(2)(b)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 National Infrastructure Platform (NIP) Update	**Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which is made available: (i) Would disclose a trade secret; or (ii) Would be likely to unreasonably prejudice the commercial position of any person who supplied, or who is the subject of, such information [Official Information Act 1982 S.9(2)(b)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Auckland DHB Fort Richard Laboratories Contract Extension	**Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.2 Motor Vehicle Business Case	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Linen and Laundry Contract	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.4 Starship Children's Hospital Level 5 Refurbishment	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.5 Delegation of Authority – Contract Approval and Signing	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D

		Act 2000]
7.6 Capital Funding Request Producing Business Intelligence Reports from the health Care Committee (HCC)	**Confirmation of Action Points** As per resolution(s) from the open section of the minutes of the meeting, in terms of the NZPH&D Act 2000.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.7 2015 Standard & Poor's Credit Rating	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.8 Non Clinical Services Sustainable Transport Project Update and Recommendations	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 Clinical Services Planning of Auckland DHB 2016	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Ophthalmology Service at Auckland DHB	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under

		any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.3 Auckland DHB – Waitemata DHB Facilities and Development Collaboration: Decision and Implementation Update	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.4 Review of 2016/2017 Annual Plan and Statement of Intent for Auckland DHB	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.5 Endoscopy Building Contract	**Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.6 Service Delivery and Funding Challenges for 2016/2017	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

9.1 Human Resources Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Health Gain Strategy – including DAP Link to the Strategy	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** To enable the Board to carry on, without prejudice or disadvantage, negotiations (including commercial and industrial negotiations) [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Auckland DHB Board Charter	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 Board Resolutions Status – Quarterly Report	As per the resolutions from the open section of the Minutes of the relevant meetings as they relate to particular items in terms of NZPH&D Act 2000.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

3. CONFLICTS OF INTEREST

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

The following changes to the Interests Register were noted:

Robyn Northey advised that she had closed her private practice and was also no longer a Board Member of the Hope Foundation.

Doug Armstrong advised that while he was a shareholder in Orion Healthcare he had no beneficial interest as it was held through a Trust. Chris Chambers wanted it noted that he was responsible for developing the functionality requirements for the NEHR assessment for Anaesthesia and Operating Rooms.

Morris Pita advised that he was a Director and Shareholder of Healthcare Application s Ltd, which was engaged in designing healthcare application to improve health outcomes in an Emergency Department setting.

4. CONFIRMATION OF MINUTES 9 December 2015 (*Pages 14-28)*

Resolution: Moved Gwen Tepania-Palmer / Seconded Jo Agnew

That the minutes of the Board meeting held on 9 December 2015 be confirmed as a true and accurate record.

Carried

5. ACTION POINTS *(Page 29)*

Rules of Sourcing

Rosalie Percival, Chief Financial Officer advised that following internal consultation and review by the Senior Leadership Team the draft Procurement Policy had been revised and would be presented to the next Audit and Finance Committee meeting for feedback.

Health and safety Bus Tour

The indicative arrangements for this are in hand with a programme currently with Lester Levy and Morris Pita who will liaise with Sue Waters with regard to their feedback.

6. HEALTH AND SAFETY - NIL

[Secretarial Note: Item 8 was considered next]

7. CHAIRMAN'S REPORT

The Chair, Lester Levy, advised that he, Ailsa Claire, Rosalie Percival and Margaret Wilsher had recently appeared before the Health Select Committee on behalf of Auckland DHB. The Auckland DHB had been required to provide answers to 108 questions in advance of their appearance.

He also advised that in response to media and other statements that Ailsa Claire had

received a 10% salary increase, he took the opportunity to raise the matter with the Committee. Prior to doing so he asked Audit New Zealand to audit the CEO's salary year (2014/15) on year (2013/14) and provide a certification of the actual increase, which was actually 1.11%. He felt that this step was required to transparently demonstrate the Boards prudence when managing a senior manager's salary.

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

- Doug Armstrong raising a question in regard to staff salaries in excess of $500K as reported in the Annual Plan and asking whether these high salary earners were full time FTE. He was advised that these were senior medical staff and their salaries are based on a job sizing exercise, rather than simply an FTE basis.

8. CHIEF EXECUTIVE'S REPORT (*Pages 30-36)*

Matters highlighted or updated by the Chief Executive included:

- The introduction of a new Internal Communication Tool - the Team Briefing. This is to help managers to better understand 'the big picture' and help them communicate with their teams. It contains a round-up of key news and actions, including Board decisions for managers to share and discuss with their teams. This document will be emailed to all people managers on the Friday after the full board meeting. There will be another Team Briefing produced and distributed midway between the Board cycles.
- The Associate Minister of Health the Hon. Peseta Sam Lotu-Iiga visited Auckland City Hospital for the first time in his role as Minister on 21 January. The Minister engaged in a series of discussions with staff, Chief Executive, Ailsa Claire and Board Chair, Dr Lester Levy before visiting Remuera Ward to meet staff and patients and observe initiatives in the care of older people.
- A reminder of a values session that Tim Keogh was to hold with the Board.
- Drawing attention to the Board members and staff that had been recognised in the New Year's Honours List. {See page 32 of the agenda}
- The acute flow figure during January was sitting at 96%. However, this improved figure is masking issues that still exist within the adult emergency department and which are signalling a new norm in activity emerging for the unit.
  In the 2015 winter fewer children presented to Starship's children's emergency department with gastroenteritis and this can be seen as a direct outcome since the rotavirus vaccine was added to the childhood immunisation schedule in July 2014.
- Financial performance for the month of December was favourable to budget by $52k, against a planned deficit of $279k for the month. The Board's financial performance for the year-to-date was favourable to budget by $187k, against a planned surplus of $4,371k for the year to date.
- Auckland DHB held its annual Strategy and Planning Day at Alexandra Park on 19

January. The strategy section was focussed around our high level goals of Healthy Communities, World-class Healthcare and Achieved Together. A number of working groups have been formed to work directly with the PHO's.

The Chief Executive invited the Director Provider Services, Joanne Gibbs to provide a brief update on discharge volumes.

- An anticipated recovery on discharge volumes for the second quarter had been delivered on. The start to 2016 had not however, been as good as expected with elective discharge volumes during January not being at planned levels.
  There had been an issue relating to a technical failure in air handling equipment on the Greenlane Clinical Centre site that equated to a loss in operating time and had affected 38 patients. There had also been significant leave taken through January which had affected all surgical directorates. All directorates were now on weekly tracking to assist in a recovery.

That the report of the Chief Executive for January 2016 be received.

Carried

[Secretarial Note: Item 7 was considered next]

10 PERFORMANCE REPORTS

10.1 Financial Performance Report (*Pages 37-42*)

Rosalie Percival, Chief Financial Officer advised that the January 2016 figures had recently become available and that the Board, for both periods, was tracking to budget. January showed a very small favourable variance. December had been a high and heavy activity month for the Provider Arm.

That the Financial Report for December 2015 be received.

Carried

10.2 Funder Report (*Pages 43-56)*

Debbie Holdsworth, Director Funding highlighted:

- The areas of concern in terms of targets are the elective surgical target which has already been mentioned and will be further discussed at the HAC meeting.
- The cancer target will also be a stretch but there is confidence in the approach that Auckland DHB is taking and the ongoing improvement quarter to quarter.
- A concern is held around the devolvement of the "in-between travel". While there is an agreement that no party will be financially disadvantaged, there could be a negative financial impact which is difficult to forecast.

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

- In relation to bariatric surgery do we have a specific target that we are aiming for in Maori Health Gain? If so, how are we tracking? Ailsa Claire replied that Aroha Haggie, Māori Health Gain Manager is undertaking investigative work in relation to Maori utilisation in order to be able to report back on this issue.
- Jo Gibbs, Director Provider Services advised that the bariatric surgery service, in general, required investigation on a regional basis. Margaret Wilsher, Chief Medical Officer commented that the decision to undergo such surgery was a big step for patients. It was found that patients themselves did not follow up, or if they did undergo the surgery, they did not sustain the required regime and it failed.
- Chris Chambers commented that he thought that the tertiary services review was undertaken as a result of uncertainty around requirements for the long term viability of the Starship hospital. Ailsa Claire clarified that it was commenced in order to address the development of specifications and pricing of all services across the hospital of which Starship services were a component.
- Lester Levy commented that the Asian population demographic changes had occurred very rapidly and had revealed complex issues that needed to be understood and responded to in order that services to this community were relevant and access was clarified. Judith Bassett commented that a stratification of this cohort was required as the group was too diverse to be treated as one. Simon Bowen, Director of Health Outcomes Auckland and Waitemata DHB's agreed that it was a heterogeneous group with different backgrounds and needs. A more nuanced stratification was needed and benchmarking internationally was being undertaken to gain better intelligence in order to be more responsive to this group's needs.
- Ian Ward asked what had led to the deteriorating waiting list position for bone marrow transplants as he thought a further four beds had been made available to cope with demand. He was advised that this had arisen as a result of an unusual and significant increase in acute Leukaemia demand impacting BMT capacity within the service and those beds had been utilised to deal with that spike. A recovery plan to resolve the current waiting list problem is underway.

That the Funder report for January 2016 be received.

Carried

11 DECISION REPORTS – NIL

12 INFORMATION REPORTS - NIL

13 GENERAL BUSINESS - NIL

The meeting closed at 1.55pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 17 February 2016

Chair: _____ Date: _____

Lester Levy

Action Points from 30 March 2016 Open Board Meeting

5

As at Wednesday, 30 March 2016

Meeting and Item	Detail of Action	Designated to	Action by
9.3 18 February 2015	**Rules of Sourcing** That the Chief Finance officer and Legal counsel undertake to ensure that the matter of development of a policy and supporting practises being put in place for rules of sourcing is placed on the agenda of the other Regional District Health Boards.	Rosalie Percival/Bruce Northey	When regional policy is developed.
4 1 April 2015	The response has not addressed the issues raised. Bruce Northey, Legal Counsel is following this up and will update the Board with progress.		
22 April 2015	MBIE sent a letter to all District Health Board Chief Executives regarding issues raised about the Rules of Sourcing. Auckland DHB Legal Counsel is working with hA and the other District Health Board Lawyers in the region to develop a common procurement policy that incorporates this feedback. This policy will then be forwarded to Boards for approval.		
Item 5 17 Feb 2016	Rosalie Percival, Chief Financial Officer advised that following internal consultation and review by the Senior Leadership Team the draft Procurement Policy had been revised and would be presented to the next Audit and Finance Committee meeting for feedback.		Transferred to Audit and Finance Committee.
9 Dec 2015 Item 8.1	**Health and Safety Bus Tour** That health and safety focus sessions along with required tours be set for Board members over the next 12 months.	Sue Waters	Programme agreed. First visit occurred 29 March 2016. More to follow.

Management Operating System (MOS) - Update

Recommendation

That the Board notes the progress and status of the Auckland DHB Management Operating System (MOS)

Prepared by: Tim Winstone (Programme Director, Performance Improvement)
Endorsed by: Joanne Gibbs (Director, Provider Services)
Andrew Old (Chief of Strategy, Participation and Improvement)

Strategic Alignment

Strategic Themes:				√	√		√
	Community, whānau and patient centred model of care	Investment on both treatment and keeping people healthy	Service integration and/or consolidation	Intelligence and insight	Evidence informed decision making and practice	Outward focus and flexible, service orientation	Operational and financial sustainability

Glossary

MOS	Management Operating System

1. Introduction

At its February meeting the Board requested an update on deployment of the Management Operating System at Auckland DHB. This paper provides some context to the development of the system, the current state of deployment, and plans for future development.

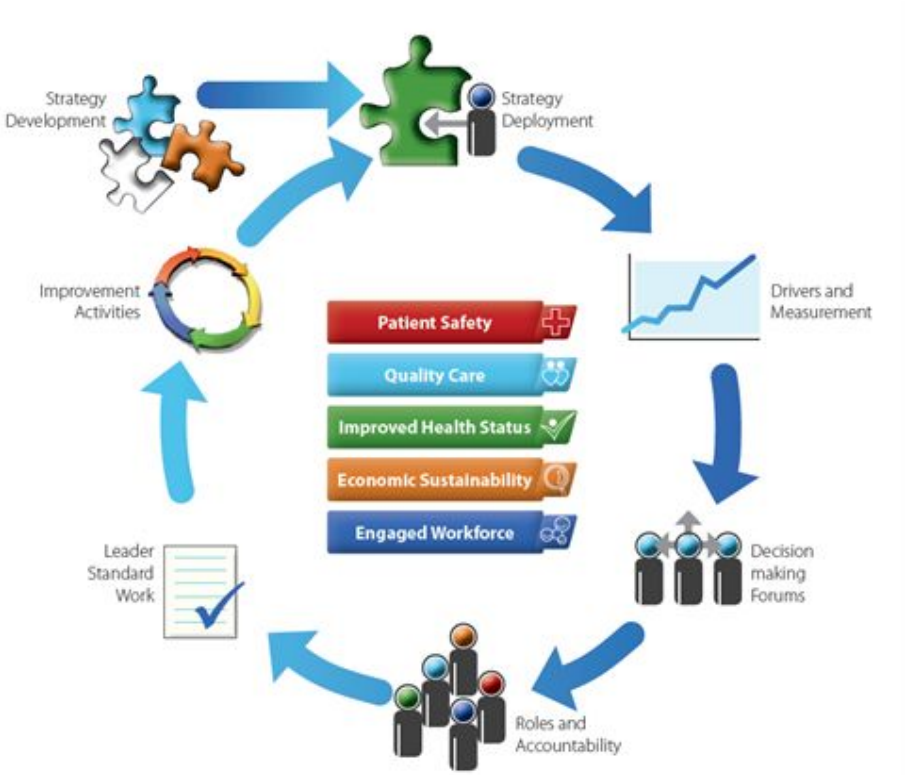
2. Background

Over the past two years Auckland DHB has focused on developing its management operating system to enable organisational alignment, action orientation, accountability and ownership. This approach has been developed by learning from other leading organisations which utilise Lean Management Systems, both in healthcare and other industries.

Auckland DHB's management operating system (MOS) employs key principles (Action orientation, Team ownership, Alignment, Visibility) however allows teams and services flexibility to develop it to work for them. It brings together several components (fig 1) of management to support teams in maintaining focus and making decisions. The system is centred on the organisation's key result areas, to ensure a balanced approach to management direction and decision making. An aligned measurement system is being developed to provide the right information to the right teams in a

consistent way.

Figure 1: Elements of the Management Operating System*

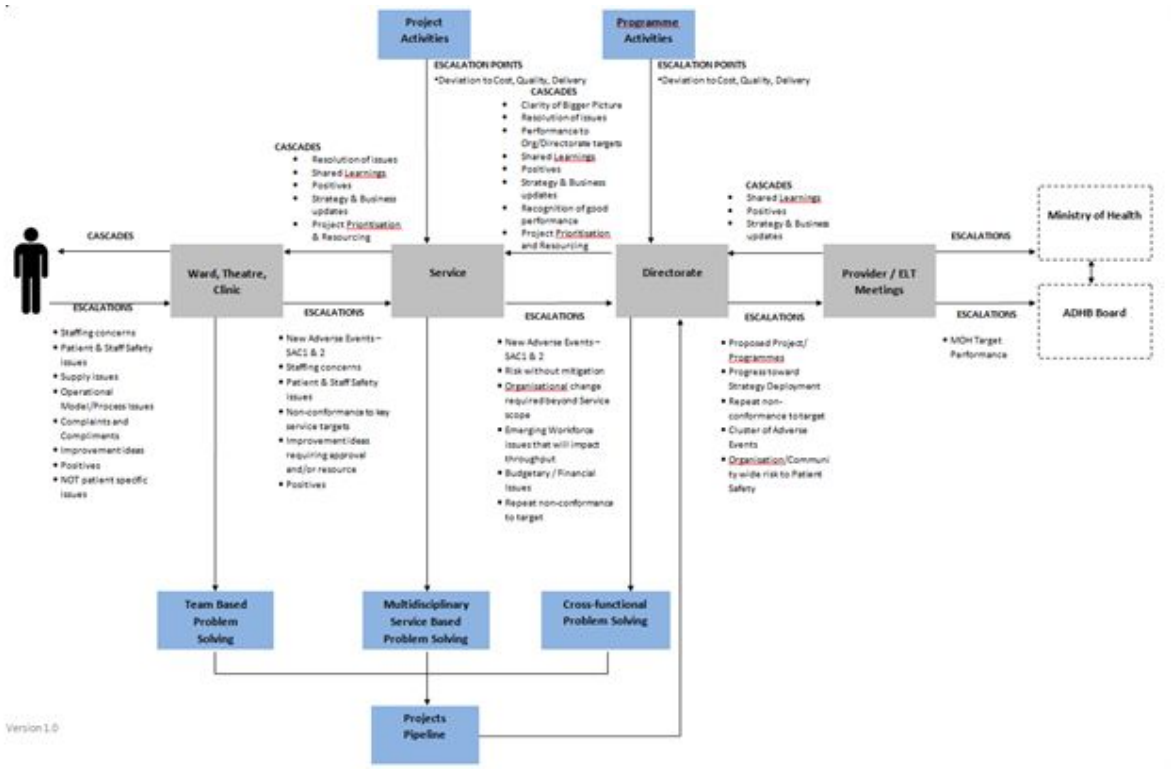


* The Key Result Areas are under review to ensure alignment with the Board Strategic Mandatories

The MOS is aligned and underpinned by development of organisational leadership and integration with improvement methods. A key focus is to define our pathways for escalation and cascade of information, decisions and strategy as outlined in figure 2.

Our Management Operating System is one of very few Lean Management Systems that have been systematically deployed within a healthcare provider. Most other known examples are within US organisations. As a result there has been a lot of interest in this method by other healthcare organisations in the South Pacific. We have been sharing our insights both in New Zealand and offshore to assist others in improving their health systems through showcasing the work at conferences (e.g. the APAC Forum) and through hosting visits.

Figure 2: Escalation and Cascade Pathway



3. Current State

There has been a very successful uptake of the MOS over the past two years. This has been primarily due to the organic nature of development which has enabled services and teams to own and develop the approach whilst being guided by other examples. A key to this has been the establishment of "Go-See" areas within the organisation that teams can visit and share ideas.

For many areas of Auckland DHB the MOS is now a core part of 'how we work'.

While most Directorates, Services and Teams have commenced the development of their MOS they are all at varying stages of maturity. This is influenced by many factors including the experience of leaders, changes in organisational structure, when they were first engaged and competing priorities.

Figure three outlines a summary of deployment across different areas of Auckland DHB Provider Services. This represents those areas that have commenced development of their MOS out of all potential areas in the organisation. The projection for future uptake is based on current plans and the aim is to have the majority of services with a level of Management Operating System in place by December 2016.

Figure 3

ADHB Management Operating System Development

High Level Status Update - March 2016

Workstream	Goal	Status *	Current State **	Projected Uptake *** Mar-16	Jun-16	Sep-16	Dec-16
Provider Services Management Operating System	*Effective Management Operating System for Provider Services Lead Team*		1 / 1	1	1	1	1
Directorate Management Operating System	*Directorate Management Operating Systems defined and in place*		11 / 11 Directorates	11	11	11	11
Service Management Operating System (*Priority Services)	*Priority Services* have Management Operating Systems defined and in place*		46 / 68 Services	46	51	58	66
Daily Management System (Ward /Team)	*All wards and theatres have their daily management systems operational*		81 / 93 Teams	81	86	90	91

** Overall Status of Deployment against Plan (Green = On Track, Yellow = Slightly Behind, Red = Significantly Behind)*

*** Numerator = the number of areas currently with MOS in progress; Denominator = the total potential areas*

**** Planned timeframe for uptake of MOS across areas*

As highlighted above, progress has been most challenging area for deployment at service level where there have recently been a number of changes to organisational structure within teams.

Future development will also focus on supporting those areas with their Management Operating System well embedded, to further refine and develop it.

4. Future Activity

The Management Operating System is currently a largely manual system. Through the DHW Lab we are engaging with designers to explore options for automating aspects of it and creating a digital version that will further enhance flexibility and useability.

5. Further information

Two videos have been produced for internal and external use to describe the Management Operating System. The links to these videos can be found on the Auckland DHB internet site:

http://www.adhb.govt.nz/HealthProfessionals/Videos.htm

Chief Executive's Report

Recommendation

That the report be received.

7

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 28 January to 11 March, 2016. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Patient and Community

Communications manages a generic communication email box. This is one of only two email addresses on the Auckland DHB website and acts as an unofficial online contact centre. Many of the requests are outside of the scope of the communication team's duties. The team responds to all emails and connects people to the correct departments. From 28 November to 11 March 150 were received that required action and of these, 90 of those were not communication-related

2.2 External and internal communications

2.2.1 External

Auckland DHB made public statements about:

- Bula Vinaka to staff and patients with family and friends in Fiji
- Starship Child Health and Auckland DHB submission to Building (Pools) Amendment Bill 2015
- Auckland and Waitemata DHBs announce new parenting and pregnancy advice provider
- Nominations open for Nursing and Midwifery awards 2016
- Auckland DHB earns 100% ranking in review of Good Employer obligations

We received 54 requests for information, interviews or for access from media organisations in the period from 28 January to 11 March. Media enquiries included interest in:

- Request to interview Dr Mike Shepherd regarding Starship and DHB submission on Building(Pools) Amendment Bill 2015
- Seeking to know if DHB patient has Zika virus
- Numerous requests about measles outbreak

Apart from those noted, 62 per cent of the enquiries over the period were enquiries about the status of patients hospitalised following crimes or accidents or who were of interest because of their public profile. We reviewed and provided responses to 9 Official Information Act requests over this period

2.2.2 Internal

- Three CE blog posts were published. These covered Car Parking; Health Select Committee and wellbeing.
- Hospital occupancy was updated daily on the Intranet.
- 22 news updates were published on the DHB intranet.
- six eNova (weekly electronic newsletters) were published.
- Feb/Mar edition of Nova was published.

In the Know - Team Briefing
In February we introduced a new Internal Communication Tool – In the know. In the Know is to help managers to better understand 'the big picture' and help them communicate with their teams. It contains a round-up of key news and actions. The format is a half hour briefing followed by an emailed summary for managers to share and discuss with their teams. The first sessions took place on 19 February and around 180 managers attended.

2.2.3 Events and Campaigns

Patient Experience Week
Patient Experience Week took place 7 – 11 March. The theme of the week was Communication.
The week opened with the Manaakitia Reflective Round at the Clinical Education Centre, entitled "Patients who have inspired me." During the week a collection of photo-story boards showed peoples unique stories, with a focus on how communication impacted their experience of care will be on display in our buildings. Staff, patients and visitors were encouraged to share their experiences.
On Wednesday 9 March Professor Ron Paterson, a New Zealand Parliamentary Ombudsman and former New Zealand Health and Disability Commissioner delivered a keynote presentation: The Heart of Health Care: Effective Communication with Patients and Families. To encourage frontline staff to participate, a series of short clinician-patient communication role-play sessions were held on the wards. The mini-plays will be based on real scenarios provided by our staff and demonstrate simple communication tools.

Sustainability Forum
A successful Sustainability Forum was held in February with Inspiring Guest Speaker Bob Harvey, former Waitakere Mayor. The next Forum is on 25 March with guest speaker Capt. David Morgan Air NZ.

Freeing up parking for patients and visitors
The project to free up more parking spaces for patients and visitors initiated a marketing campaign based on the message "In one day one carpark means…" highlighting patient and visitors stories about how being able to park easily made their experience better and lowered their anxiety.
The campaign included offers to staff to try off-site parking serviced by a shuttle service to Auckland City Hospital and Greenlane Clinical Centre, a two week free trial of the AT HOP card, and discounts for staff wanting to try cycling.

Danish Parliamentary Delegation visit
The Chief Executive, the Chief Medical Officer and the Director of Strategy, Performance and Improvement hosted a visit by a Danish parliamentary delegation comprised of the equivalent of the

Danish health select committee on 11 March. The parliamentarians focus was on care of the elderly, palliative care and advance care planning in New Zealand. The presentation included a detailed overview of Auckland DHB's Comprehensive Clinical Assessment for Aged Care, interRAI, programme. The Danish parliamentarians noted that the Danish health system faced the same issues as New Zealand. They complimented the DHB staff and management on a thoughtful and informative visit.

Service for people of Fiji following cyclone
Ecumenical chaplain Mele Tavelia led a service at the Auckland City Hospital chapel in February support of people affected by Cyclone Winston in Fiji. A staff member recounted how his family had survived the cyclone. A special collection for Fiji raised $405 that has been donated to the aid efforts in the aftermath of the cyclone.

Visit by Governor-General
The Governor-General, Lieutenant General The Right Honourable Sir Jerry Mateparae visited the Design for Health and Wellbeing Laboratory at Auckland City Hospital on 23 March. Sir Jerry learnt of the collaboration between Auckland DHB and AUT and met with designers behind innovative projects to improve the patients' experience through design.

Communicating our Values
Staff have been asked to complete a short survey to find out how we are doing against our values. The survey responses will be used as a benchmark to measure our values journey over the coming years. Survey results will be shared back with staff in March

Posters: Values decals are now in place in meeting rooms around our buildings. These contain real patient quotes that relate to our values:

2.3.4 Social Media

Facebook likes: 3,320

Twitter followers: 2,190

LinkedIn followers: 4,541

Instagram followers (*New account*): 35

Most popular posts:

- Patient Experience storyboard photos and #patientexperience
- Patient applause
- Top five things to know about Zika virus (from MoH)
- Good sorts video with Gareth Jenkins, Resuscitation Coordinator
- Dr Mike Shepherd – Starship submission on pool amendment bill
- Dr Peter Storey innovative adrenalin delivery system
- Early warning signs of a heart attack
- New Steamplicity menu
- New job postings
- World Kidney Day

2.2.4 Our People

Local Heroes
Twenty six people were nominated as Local Heroes during January and February. Our February and March Local Heroes are Nadya Atanasova, Health Care Assistant on ward 42, and Janice Duxfield, Nurse Unit Manager, Endoscopy. Nadya was nominated by a colleague who said, "Nadya consistently goes above and beyond to help the ward 42 team. She is always willing to help and no matter how busy and stressful the ward may be, she always does it with a smile on her face. The nurses are always raving about how much of a positive impact she has on the ward as well as on patients. She is always kind, caring and friendly towards patients and always available to help. The ward would not function the same without her."

Janice was also nominated by a staff member, who said "Janice has managed a very difficult time in Endoscopy over the last couple of months. She has been planning along with colleagues to decant a service across two sites whilst we refurbish the area. Whenever I meet with her she is always calm and happy and I see her supporting her nursing and medical colleagues during this really difficult time." "Janice has just got on and led the team through this so we get to the goal – an expanded endoscopy suite. She led the relocation and set up of the temporary endoscopy suite on the day required and had everything sorted in the afternoon – an amazing achievement."

Cape Reinga to Bluff challenge
Paul Browne, Production Planning Manager, left on 21 February on a 3-4 week self-supported (i.e. carrying everything he needs) brevet (a sort of long-distance bicycle tour/race with checkpoint controls) from Cape Reinga to Bluff. It is a tough course, 3000km long, with many sections on gravel trails and single-track (and including an 80km stretch on sand along 90 Mile Beach) with over 20,000m of hill-climbing (more than two Everest's worth!). On the way he is asking people to donate to the Starship Foundation. As of 11 March, he had raised $2620.

Auckland DHB rated top in Crown Entities and Good Employer Annual Report
Auckland DHB has scored top marks for the second year in a row in an independent review of its compliance against its Good Employer reporting obligations. In an annual review by the Human Rights Commission, Auckland DHB's overall compliance is rated at 100% for its reporting of its good employer obligations. Each year the Commission reviews the reporting of good employer obligations in annual reports and also monitors progress toward equality employment opportunities and the

provision of good employer guidance. The measures include a review of seven good employer elements, including Leadership, Accountability and Culture; Flexibility and Work design, and a Safe and Healthy Environment. Auckland DHB was rated at 100 per cent for overall compliance, Good Employer Elements and Workplace Profile. Auckland DHB's review summary is attached.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary

	Status	Comment
Acute patient flow (ED 6 hr)		Feb 95%, Target 95%
Improved access to elective surgery		96% to plan for the year
Shorter waits for radiation therapy & chemotherapy		Feb 100%, Target 100%, Year to Date 100%
Better help for smokers to quit		Feb 93%, Target 95%
Cardiac bypass surgery		Feb 83 patients, Target < 104
More heart & diabetes checks		Dec Qtr 92%, Target 90%
Increased immunisation 8 months		Dec Qtr 94%, Target 95%

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

Commentary

More Heart and Diabetes Checks

PHOs continue to perform well and consistently are at or above the target.

Better Help for Smokers to Quit

This target is proving challenging to achieve. This is due to the change in the target. The revised Target for 2015/16 reads "*90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months*". The impact of this change has seen an average decline of approximately 19% across the PHOs. The funder is working closely with each PHO to both monitor progress and support the PHOs in putting in place suitable interventions to support achievement of the target

3.2 Financial Performance

The financial performance for the month of February 2016 was favorable to budget by $16K, against a planned surplus of $2.73M. The DHB financial performance for the year-to-date was favourable to budget by $224K, against a planned surplus of $6.347M. We are on track to fully achieve the 2015/16 planned surplus of $2.3M.

For the eight months to February 2016, $15.3M savings have been achieved against a budget of $16.9M, resulting in an unfavourable variance of $1.6M. The unfavourable result is primarily driven

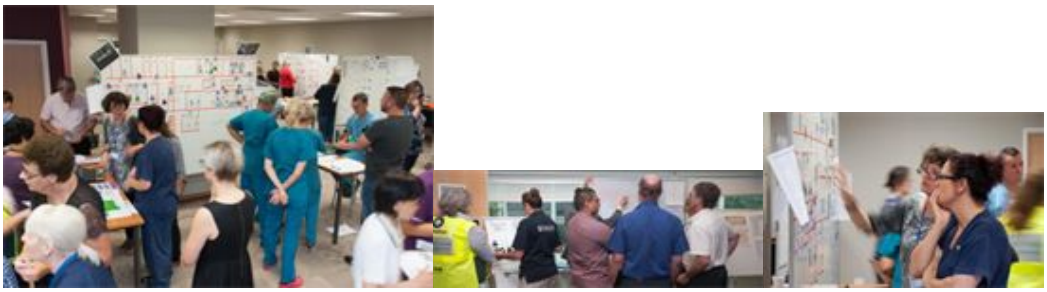
by the increased acute demand volumes that have remained consistently high since December 2015. As a result, cost containment savings ($1.1M) and revenue growth savings ($774K) were not achieved, although these were partially offset by a favourable result of $315K from model of service delivery initiatives.

4.0 Clinical Leadership Commentary

Exercise Outage

A training exercise to test the level of preparedness for a major incident at Auckland City Hospital was held on 18 March in the Clinical Education Centre. The scenario was power failure to the northwest corner of the main hospital (A32) due to failure in one of the substations. The scenario focussed on mitigating the risk to inpatient services and patient flow in multiple directorates, with a number of surgical and medical wards affected, as well as radiology and the adult and children's emergency departments. The exercise brought together more than 70 staff, including clinical directors, SMOs, specialist anaesthetists, charge nurses, duty managers, bed managers and orderlies with support from the IMTS (Incident Management Team Service) security and facilities. The exercise was supported by ETS senior instructors from other DHBs and St John Ambulance.

Exercise Outage has enabled the level of preparedness within the organisation to be measured without clinical risk. Findings from the exercise will provide valuable information to guide process reviews thus enabling the establishment of corrective measures to address identified deficiencies.



Staff engaged in Exercise Outage in the Clinical Education Centre.

Clinician leaders from Metro South, Queensland visit

Auckland DHB hosted a visit by clinician leaders from Metro South hospitals, Queensland. This was a peer group opportunity to share our approaches to quality and safety. Key learnings for Auckland DHB related to the development of a comprehensive safety scorecard and a tool for SMO performance development both of which are embedded in the Metro South network. We will continue to work with peers across Australasia as we seek to improve quality and safety at Auckland DHB. The Metro South executive director wrote to thank Auckland DHB for hosting the visit and praised Auckland DHB for systematically driving professional innovations and improvement at an exemplary level.

Positive feedback from Shorter Stays in Emergency Dept national champion

Dr Angela Pitchford has provided positive feedback following her visit to learn about the systems and processes Auckland DHB has put in place to achieve the Shorter Stays in Emergency Department health target. Dr PItchford noted that Auckland DHB emergency departments are among the busiest in the country, but have managed to achieve the health target in three of the last four quarters.

She was impressed by the work of the Quality Improvement Team and the Management Operating Systems (MOS boards) used to communicate priorities to staff and explain how their work contributes to the wider organisation's goals. Dr Pitchford suggests that more work be done to identify common themes in demographics or conditions for patients presenting and that the range of primary care pathway options be developed to target specific groups of patients.

Patient safety workshops
The first of several planned Auckland DHB workshops on patient safety will take place in April. The workshops will inform how we refine the patient safety strategy and map out the implementation plan. We are leveraging off the support of the HQSC and Professor Cliff Hughes, Chief executive Australian Quality Commission and including regional partners so we can align our approaches with the metro hospitals. The message is that of 'safe, reliable care every hour of the day' but we know that success lies in changing the culture hence there is an important alignment with our values project.

Applications open for Auckland Academic Health Alliance research grants
Following on from the success of the inaugural Auckland Academic Health Alliance research grants, we are calling for the next round of applications. This research funding opportunity is supported by both the University of Auckland and the A+ Trust and is aimed at building research collaborations between DHB clinicians and university scientists. Supporting such collaborations is the newly opened Auckland Regional Tissue Bank – Te Ira Kawai. For the first time researchers who wish to study human tissue will be able, with suitably approved research protocols, to access a collection of donated tissue. Whilst initial access is likely to be restricted to cancer research, with time the collection will grow enabling study of a wide variety of diseases including those with autoimmune, inflammatory or infectious aetiology. The Faculty of Medical and Health Sciences hosts the facility and there is a multi-DHB/University governance structure overseeing the establishment and activity of the bank.

Distinguished Clinical Teacher's Award
Dr Anne O'Callaghan, palliative care physician, has received a Distinguished Clinical Teacher's Award from the School of Medicine, University of Auckland. This is well deserved as Anne is an expert teacher in the field of communicating difficult news and she has just submitted her PhD on the topic for examination. Anne is also a trainer for our ACP programme. Other clinicians receiving the award include: Dr Simon Rowley, Mr Tony Hardy, Dr Cheryl Johnson, Dr John Fleming, Dr Diane Emery, Dr Gavin Pilkington, and Dr John Kennelly.

Care Capacity Demand Management work streams
The first Care Capacity Demand Management (CCDM) work streams are underway at Auckland DHB. Chief Executive Ailsa Claire is the formal sponsor for CCDM. A permanent CCDM Council made up of the partners has been established to provide leadership and oversight for CCDM at Auckland DHB. At the meeting on 25 February the CCDM Council approved two work streams: Variance Response Management and Staffing Methodology in the Reablement Services.
CCDM Council members and DHB Director of Patient Management Service Joyce Forsyth has set up a Variance Response Management project team. Their first task is to develop indicators of variance that are trusted across the organisation. Jane Lees, Nurse Director for Adult Community and Long-term Conditions is overseeing the staffing methodology work stream. In May the Safe Staffing Healthy Workplace Unit will conduct a Discovery survey and hold interviews with staff in the Reablement Service. The CCDM Council participated in a partnership workshop in March. Care Capacity Demand Management is a system to improve the process of matching demand with capacity in our hospitals. Auckland DHB, the New Zealand Nurses Organisation, the PSA and the Safe Staffing Healthy Workplaces Unit (SSWH) are CCDM partners

Nurse Practitioner Development

Auckland DHB currently employs 16 Nurse Practitioners across a number of specialty areas. A further five Auckland DHB nurses have secured five of the 10 available spaces in the University of Auckland Nurse Practitioner training pilot. This pilot is funded by Health Workforce New Zealand. This training programme seeks to increase coordination between potential NPs, their employers, tertiary education providers, and New Zealand Nursing Council. The aim is to align and promote NP preparation, registration and employment into a seamless pathway. Auckland DHB Nurse Practitioner Trainees are working with the areas of Cancer, Emergency Care (Adult and Paediatrics), Ophthalmology and Mental Health.

Nurse Endoscopy training

Two Auckland DHB senior nurses have commenced their Nurse Endoscopy training at University of Auckland this month. The Nurse Endoscopy training pathway is at a postgraduate level, consisting of two specialised papers and a practicum. Nurse Endoscopy trainees are required to have a minimum of five years full-time equivalent (FTE) clinical experience as a Registered Nurse. As part of this clinical experience, trainees have a minimum of three years specialist experience working in gastroenterology or a related specialty. The focus of the training is on reaching a safe level of clinical competency. Therefore, the duration and completion of the practicum will be at the discretion of the respective clinical supervisor. The required practical standards will be equivalent to those approved by the New Zealand Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy. Trainees are required to have a minimum of two dedicated 'nurses performing endoscopy' training lists per week.

Professional leadership progress

Professional leaders to Allied Health Scientific and Technical groups have been appointed to progress the clinician leadership strategy. The professional leaders for Radiation Therapy and Medical Physics have been appointed in the Cancer and Blood Directorate. The professional Leader Speech and Language Therapy has been appointed via the development of a joint role with acute allied health. The benefits have been an increase in resource dedicated to SLT across all adult services and clear arrangements for cross cover during absence. There are plans to create and appoint to a Professional Leader for Renal Physiology in the near future.

Supportive Care Initiative

The MoH Supportive Care initiative is well underway; the Regional Lead Psychologist has been active in establishing the service, recruitment to the other roles and ensuring communications both locally and regionally. The Auckland DHB Cancer Support Team is up and running staffed by psychologists and social workers. Auckland DHB is involved in the development of the key performance indicators with the National lead.

National Allied Health Conference

The Auckland Region is hosting the National Allied Health Conference on May 10/11 at the Langham Hotel. Auckland DHB holds the chair for the scientific committee.

Re-certification

Recertification is upon all AHS&T groups and processes are in place to ensure that this occurs across all directorates for the professional groups and with the certifying bodies and to ensure that self-regulated professional groups retain membership of the professional body.

Embedding TrendCare

Work with the embedding of TrendCare across all professional groups in Allied Health continues and is starting to provide useful workforce information for managers and teams.

National Directors of Allied Health have supplied workforce information to HWNZ regarding priority areas for professional groups for development in the future.

Crown Entities and the Good Employer

Annual Report Review 2007 to 2015

The Human Rights Commission reviews and analyses the reporting of good employer obligations by Crown entities in their annual reports. It also monitors their progress towards equal employment opportunities (EEO) and provides good employer guidance. The Commission's annual good employer review gives Crown entities an indicator report showing their reporting progress. The Commission's "Crown Entities and the Good Employer" web application allows Crown entities to track their progress across years and compare themselves to others of the same size, type and the sector as a whole.

Human Rights Commission

Auckland District Health Board

2015

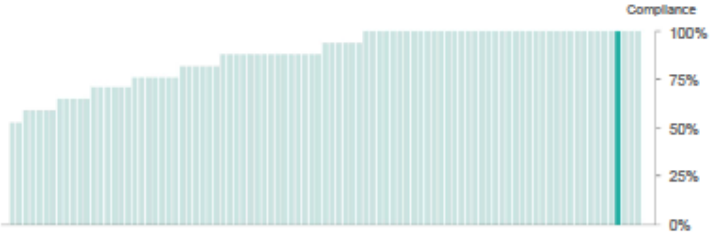
Type District Health Board
Size Large (> 1000 staff)

Overall compliance

100% 0%

Rank

1 of 93 entities 0

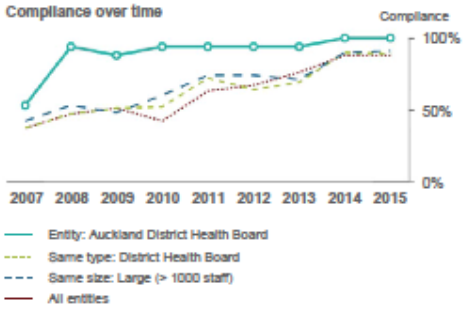


Average compliance of

Same type	Same size	All entities
89%	91%	88%

Auckland DHB continues to report well and has again fully met its obligation to report its 'good employer' and EEO programme in its annual report. Those Crown Entities that report the best provide a table with each of the 'Seven Good Employer Elements' listed and initiatives identified against them. They also include a full workplace profile to demonstrate that all EEO groups have been considered.

Compliance over time



Good employer reference

Average compliance of

Same type	Same size	All entities
100%	100%	99%

The Crown Entities Act requires an organisation to be a good employer, to have an equal employment opportunities policy and associated programme and to report these in the annual report.

EEO reference

Average compliance of

Same type	Same size	All entities
90%	89%	92%

Referencing EEO in reporting demonstrates good employer practice. EEO means eliminating barriers to ensure that all employees have equal access to the employment of their choice and have the chance to perform and progress to their maximum potential. Successful EEO outcomes result in fair representation of all groups throughout an organisation or sector.

1/2

Financial Performance Report

Recommendation

That the Board receives this Financial Report for February 2016

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for February 2016 was a surplus of $2.7M which was favourable to budget by $16K. For the Year to Date (YTD), a surplus of $6.6M was realised, favourable to budget by $223K. Favourable Funder arm and Governance results (both for the month and YTD) fully offset unfavourable variance in the Provider arm.

YTD revenue is favourable to budget by $8.4M. Underlying this revenue variance are significant movements including: $2.5M additional MoH PBFF sourced funding due to additional Capital Charge funding for assets revalued at 30 June 2015 and to additional Community Palliative Care funding ($1.2M for 2015/16); $1.8M additional MoH contracts Devolved funded initiatives under NGO services (mainly contracts finalised after budgets were set, with corresponding additional expenditure); $5.9M additional other income (includes research income and a one off settlement of a commercial contract); offset by unfavourable financial income ($1.3M) and donation income ($1.2M). YTD expenditure is unfavourable to budget by $8.2M. Significant variances include unfavourable outsourced personnel of $4.8M; clinical supplies of $2.4M and capital charge of $1M; offset by favourable Funder payments to NGOs of $1.1M and personnel costs of $1.2M.

The full year financial plan is a $2.4M surplus and we are on target to achieve that based on YTD performance and that forecast for the rest of the year.

Auckland District Health Board
Summary Results: Month of February 2016

$000s	Month (Feb-16)			YTD (8 months ending 29 Feb-16)			Full Year (2015/16)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	93,132	92,819	313 F	745,053	742,549	2,505 F	1,117,580	1,113,823	3,757F
MoH Contracts - Devolved	7,421	7,060	361 F	58,231	56,479	1,752 F	86,905	84,719	2,186F
	100,553	99,879	675 F	803,285	799,028	4,257 F	1,204,485	1,198,542	5,943F
MoH Contracts - Non-Devolved	5,155	4,737	418 F	38,534	38,108	426 F	61,622	57,598	4,024F
IDF Inflows	53,902	54,105	203 U	433,281	432,839	443 F	666,507	664,406	2,101F
Other Government (Non-MoH, Non-OtherDHBs)	2,829	2,878	48 U	22,875	22,824	51 F	31,921	34,212	2,291U
Patient and Consumer sourced	1,647	1,544	103 F	12,069	12,354	286 U	0	0	0
Inter-DHB & Internal Revenue	1,774	1,219	555 F	10,236	10,053	183 F	18,256	18,532	276U
Other Income	4,460	3,661	798 F	36,017	30,101	5,915 F	49,567	43,216	6,351F
Donation Income	178	588	411 U	3,369	4,612	1,243 U	6,011	7,830	1,819U
Financial Income	359	660	301 U	3,834	5,174	1,340 U	5,915	8,608	2,693U
Total Income	**170,856**	**169,271**	**1,585 F**	**1,363,500**	**1,355,094**	**8,406 F**	**2,044,284**	**2,032,944**	**11,340F**
Expenditure									
Personnel	70,802	69,736	1,066 U	566,412	567,608	1,196 F	856,116	857,732	1,616F
Outsourced Personnel	2,156	1,507	648 U	16,900	12,054	4,845 U	22,691	18,082	4,609U
Outsourced Clinical Services	1,895	1,859	36 U	15,481	14,975	506 U	22,898	22,515	383U
Outsourced Other Services (incl. hA/funder Costs)	4,589	4,591	2 F	36,769	36,726	42 U	55,140	55,089	51U
Clinical Supplies	18,819	19,123	303 F	160,865	158,482	2,382 U	241,453	239,097	2,356U
Funder Payments - NGOs	44,430	44,987	557 F	358,731	359,896	1,165 F	539,504	539,844	340F
Funder Payments - IDF Outflows	9,234	9,267	33 F	74,424	74,140	284 U	111,643	111,228	415U
Infrastructure & Non-Clinical Supplies	11,584	11,073	511 U	89,603	88,801	802 U	136,752	132,983	3,769U
Finance Costs	1,162	959	203 U	9,537	8,902	635 U	13,728	13,093	635U
Capital Charge	3,438	3,438	0 F	28,209	27,164	1,046 U	41,960	40,914	1,046U
Total Expenditure	**168,109**	**166,540**	**1,569 U**	**1,356,930**	**1,348,747**	**8,183 U**	**2,041,885**	**2,030,577**	11,308U
Net Surplus / (Deficit)	**2,747**	**2,731**	**16 F**	**6,571**	**6,347**	**223 F**	**2,399**	**2,367**	**32 F**

2. Result by Arm

Result by Division	Month (Feb-16)			YTD (8 months ending 29 Feb-16)			Full Year (2015/16)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	1,100	194	906 F	4,997	1,553	3,444 F	9,635	2,330	7,305F
Provider	1,587	2,537	950 U	141	4,794	4,653 U	(8,326)	37	8,363U
Governance	60	0	60 F	1,433	0	1,433 F	1,090	0	1,090F
Net Surplus / (Deficit)	**2,747**	**2,731**	**16 F**	**6,571**	**6,347**	**223 F**	**2,399**	**2,367**	**32 F**

The YTD $3.4M favourable Funder arm and $1.4M favourable Governance results fully offset the $4.7M unfavourable result realised in the Provider arm.

- The Funder YTD favourable result of $3.4M reflects lower expenditure for demand type services and favourable 2014/15 adjustments. Favourable 2014/15 adjustments include Community Laboratory wash-ups, Pharmac GST claims and higher Pharmac rebates. These were offset by adverse net IDF flows from PHO quarterly wash-ups and additional revenue allocations to the Provider Arm. Higher YTD revenue from funded initiatives is accompanied by equivalent expenditure and have a nil impact on the results.
- The YTD Provider Arm result is $4.6M unfavourable. This is driven by net unfavourable expenditure – primarily Outsourced Personnel, Infrastructure and Non Clinical Supplies costs.
- The YTD Governance Arm $1.4M result is driven by favourable outsourced costs (joint funder costs related) and infrastructure costs (professional costs, IT systems and other operating expenses), which fully offset a reduction in internal allocations. We expect actual spend to catch up in the second half of the year, but with the overall result remaining on budget by year end.

Overall, the consolidated year end forecast is still on target to achieve the plan, with the favourable Funder Arm and Governance Arm result expected to fully offset unfavourable forecasts for the Provider Arm.

3. Financial Commentary for February 2016

Month Result

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

Revenue was greater than budget by $1.6M, mainly driven by:

- Inter DHB Revenue $0.6M favourable reflecting revised provision for 2015/16 year end IDF wash-up.
- Unbudgeted revenue for Maternal Mental Health Acute Continuum $0.6M favourable.
- Research Income $0.3M favourable, offset by equivalent expenditure
- Donations $0.4M unfavourable – revenue fluctuates from month to month, depending on timing of key projects
- ACC income $0.4M unfavourable (Provider), reflecting lower volumes during the month, primarily in elective surgery as the focus remains on meeting elective discharge targets, offset by $0.2M for ACC (Funder) for a contribution from a patient's stay in a rest home attributable to an injury.

Expenditure was greater than budget by $1.6M. Significant variances are described below:

- Personnel/Outsourced Personnel costs $1.7M (2.4%) unfavourable. FTE were 74 above budget (19 of these were temporary summer holiday MRT students, meaning underlying FTE were 55 above budget). The FTE above budget equates to $0.6M of the unfavourable variance with the balance of the variance due to cost per FTE targets not met.
  The unfavourable FTE variance relates primarily to Nursing which is 54 above budget, reflecting a temporary peak for the February new graduate intake as they transition into their roles as a

Registered Nurse, along with volume pressure in areas such as Admission & Planning Unit, Critical Care and flex beds - there were 13 days in February with beds flexed above the resourced bed numbers. We also opened and resourced an additional 3 Bone Marrow Transplant beds to reduce wait times.

Ongoing mitigation strategies include:

  - Focus on reviewing our systems, processes and models of care in regards to vulnerable patients who require a patient attender. An oversight group has been established to provide governance for identified work streams that improves the safety and quality of care to adult vulnerable patients. Workstreams include Enhanced Support Rooms (ESR), Management of AWOL, Post-operative/Post-arrest Delirium and Behaviours of Concern.
  - Utilising Trendcare data to identify opportunities to move staff where possible and reduce bureau usage.
  - Work continues on recruiting to target skill mixes – this is improving month to month
  - Use of flex beds only as needed, flexing down as soon as possible.

- Clinical Supplies $0.3M (1.6%) favourable, in line with overall volumes very close to contract for the month.
- Infrastructure and Non Clinical Supplies $0.5M (4.6%) unfavourable, with the key variances being timing of facilities maintenance costs $0.2M unfavourable, and one off affiliation and software licensing costs for intranet redevelopment $0.2M unfavourable.
- Funder NGO payments are $0.6M (1.2%) favourable, due to lower utilisation rates in private hospitals within age related residential care.

Year to Date Result

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

Revenue was higher than the budget by $8.4M. Significant movements underlying this included:

Favourable revenue variances:

- MOH Sourced PBFF revenue is $2.5M favourable YTD due to additional Capital Charge funding (with offsetting expenditure) for assets revalued at 30 June 2015 ($2.5M full year impact) and additional Community Palliative Care funding ($1.2M for 2015/16). Community Palliative Care revenue is a funded initiative and is accompanied by equivalent expenditure requirement.
- MOH devolved contract revenue is $1.8M favourable YTD. This is mostly additional revenue for funded initiatives under NGO services. Favourable funded initiatives revenue is a result of contracts finalised by the Ministry after budgets have been set but have equivalent additional expenditures. The majority of the additional revenue for funded initiatives is for Zero Fees for under 13s programme. This favourable result includes the negative impact of National Services revenue now mostly received from other DHBs through IDF inflows ($2.8M for 2015/16). The Auckland DHB's own population component has additionally now been confirmed by the Ministry as requiring to be self-funded in 2015/16.
- Haemophilia funding $1.5M favourable for abnormally high blood product usage, offset by additional expenditure.
- Research Income $3.2M favourable, offset by equivalent expenditure.
- Pharmacy Retail sales $0.5M favourable, offset by additional cost of sales expenditure.
- One off revenue for settlement of commercial contracts $0.9M favourable.
- Inter DHB Revenue - IDF wash-up for 2014/15 $1.5M favourable – one off revenue.

Unfavourable revenue variances:

- Inter DHB Revenue - $0.8M unfavourable, reflecting the end of the LabPlus MidCentral DHB contract – the reduction in income is partially offset by favourable Clinical Supplies costs in LabPlus.

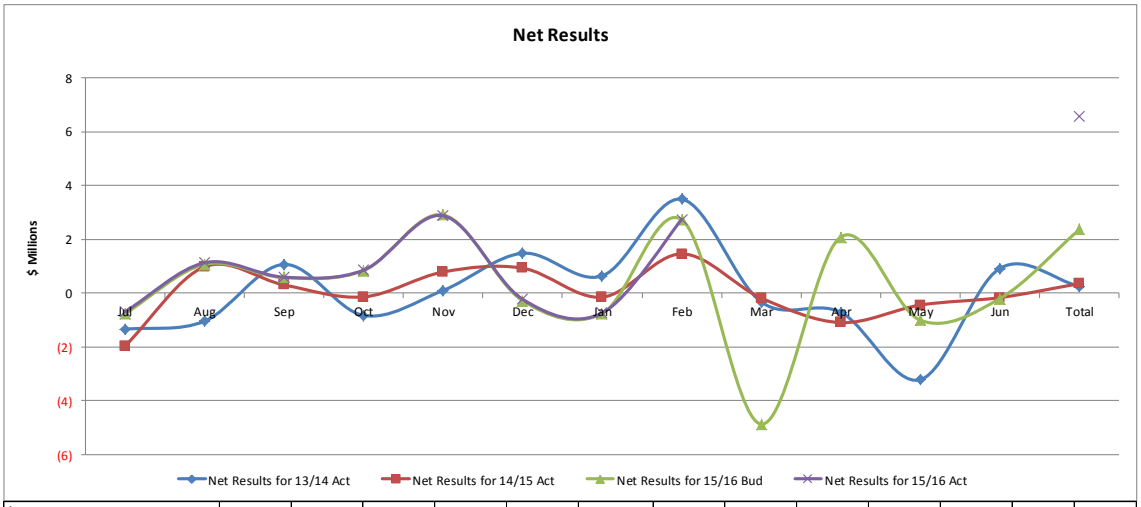
- Financial income $1.34M unfavourable due to lower market interest rates and lower cash balances than forecast ($825K relates to adverse DHB interest income and $515K relates to Trust interest income).
- MOH Public Health $0.6M unfavourable – in line with costs lower than budget for the YTD.
- ACC Income $1.0M unfavourable – primarily in elective surgery, reflecting the focus on achieving elective discharge targets.
- Donation Income $1.2M unfavourable – revenue fluctuates depending on timing of projects, and with no major projects in the current year, this variance will continue for the year.

Expenditure was higher than budget YTD by $8.2M, with significant underlying variances as follows:

- Combined Personnel and Outsourced Personnel Costs are unfavourable to budget by $3.6M (0.6%) and combined FTEs are 35 (0.4%) below budget. Underlying this net variance is:
  a. Personnel Costs are $1.2M (0.2%) favourable due to FTE 187 below budget – the FTE variance is spread widely with vacancies across all categories other than Nursing which is 15 above budget YTD.
  b. This favourable variance in Personnel Costs is substantially offset by $4.8M (40%) unfavourable Outsourced Personnel costs (151 FTE above budget), primarily for contract Support and Administration staff covering vacancies.
- Clinical Supplies $2.4M (1.5%) unfavourable –the key unfavourable variances are in Cancer & Blood Services - abnormally high haemophilia blood product costs ($1.4M unfavourable) which are fully funded and pharmaceutical costs in Oncology/Haematology ($1.5M unfavourable) due to additional costs for treatment previously funded under a research trial and high cost drugs in Haematology.
- Infrastructure and Non Clinical Supplies $0.8M (0.9%) unfavourable, comprising the following key variances – higher costs of goods sold for retail pharmacy $0.5M (offset by additional revenue), project costs $0.6M unfavourable (including intranet redevelopment $0.3M) and abnormally high cost of bad/doubtful debts $0.8M (these costs are variable from month to month).
- Interest & Financing charges $0.6M (7.1%) unfavourable due to valuation of trust investments (a result of fair value movements). The Trust investments are managed as a portfolio with advice from Trust Treasury advisors and the return on the total portfolio is considered over a number of years and has been overall positive for the DHB over time.
- Capital charge is $1M unfavourable offset by additional revenue.
- Funder Payments – NGOs the YTD favourable variance of $1.1M (0.3%) is driven primarily by favourable variances from demand type services as well as favourable prior year adjustments for Community Labs wash-up, Pharmac GST claims and Pharmac drug rebates. These were partly offset by adverse variances from additional expenditure for funded initiatives which are accompanied by equivalent additional revenue.

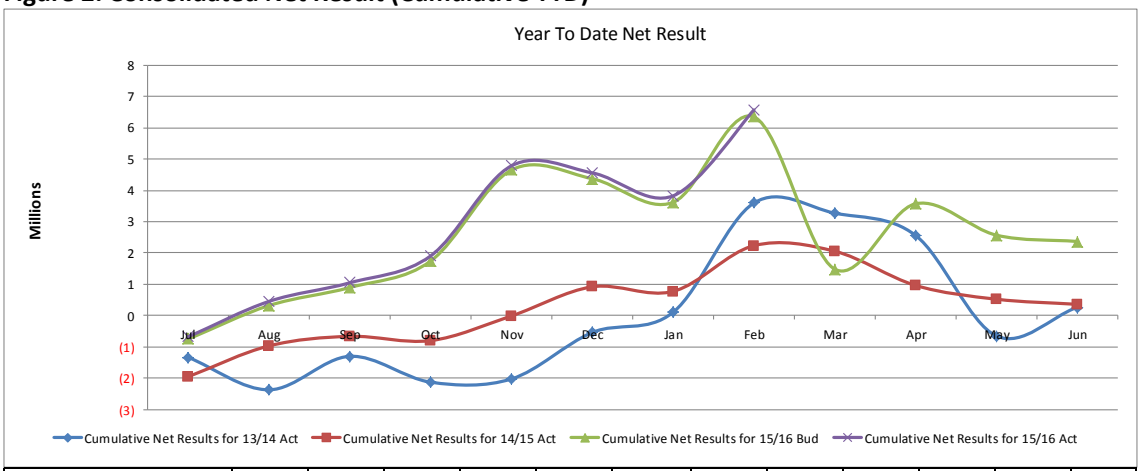
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Total
Net Result for 13/14 Act	(1.341)	(1.037)	1.072	(0.828)	0.105	1.486	0.645	3.494	(0.325)	(0.711)	(3.215)	0.918	0.262
Net Result for 14/15 Act	(1.957)	0.984	0.306	(0.137)	0.790	0.931	(0.147)	1.462	(0.179)	(1.093)	(0.441)	(0.164)	0.355
Net Result for 15/16 Bud	(0.755)	1.072	0.577	0.846	2.911	(0.279)	(0.754)	2.731	(4.867)	2.090	(1.003)	(0.202)	2.365
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747					6.571

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Cumulative Net Result for 13/14 Act	(1.341)	(2.378)	(1.306)	(2.134)	(2.029)	(0.544)	0.101	3.595	3.270	2.559	(0.656)	0.262
Cumulative Net Result for 14/15 Act	(1.957)	(0.973)	(0.668)	(0.804)	(0.014)	0.916	0.770	2.232	2.053	0.960	0.519	0.355
Cumulative Net Result for 15/16 Bud	(0.755)	0.317	0.894	1.740	4.650	4.371	3.617	6.347	1.480	3.570	2.567	2.365
Cumulative Net Result for 15/16 Act	(0.683)	0.450	1.045	1.904	4.785	4.557	3.824	6.571				
Variance to Budget for 2015/16	0.072	0.133	0.151	0.164	0.134	0.186	0.207	0.223				

5. Efficiencies / Savings

For the eight months to February 2016, $15.3M savings were reported against a target of $16.9M, resulting in an unfavourable variance of $1.6M. The unfavourable result is primarily driven by the increased acute demand volumes that have remained consistently high since December 2015. The main unfavourable impact on savings has been cost containment $1.1M and revenue growth $774K which has been partially offset by a favourable result of $315K from model of service delivery initiatives.

The revenue growth strategy adverse position is mainly due to ACC revenue below target in Children's $536K. The favourable model of service delivery changes is favourable largely driven by overseas resident revenue in Cardiovascular Services $241K and Perioperative service's improved theatre efficiencies $377K, offsetting targets not achieve. Cost containment initiatives are unfavourable against budget by $1.1M. This is mainly attributed to the impact of service demand

pressures in Adult Medical, Surgical Services, Cancer & Blood and also healthAlliance procurement related savings below target.

Note: Any year-end shortfall against specific initiatives is expected to be fully offset by the forecast favorable Funder position, enabling the DHB to achieve the planned surplus.

6. Financial Position

Statement of Financial Position as at 29 February 2016

$'000	29-Feb-16			31-Jan-16	Variance	30-Jun-15	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0F
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	438,457	406,629	31,828F	438,457	0F	438,457	0F
Cashflow-hedge Reserve	(3,925)	(3,877)	48U	(3,971)	46F	(4,293)	368F
Accumulated Deficits from Prior Year's	(464,047)	(458,252)	5,795U	(464,047)	0F	(464,402)	355F
Current Surplus/(Deficit)	6,572	-	6,572F	3,825	2,747F	356	6,216F
	(22,942)	(55,500)	32,558F	(25,736)	2,794F	(29,882)	6,940F
Total Equity	**553,856**	**521,298**	**32,558F**	**551,062**	**2,794F**	**546,916**	**6,940F**
Non Current Assets							
Fixed Assets							
Land	249,006	217,178	31,828F	249,006	0F	249,006	0F
Buildings	577,719	551,506	26,213F	579,367	1,648U	585,033	7,314U
Plant & Equipment	84,508	97,458	12,950U	78,238	6,270F	78,462	6,046F
Work in Progress	55,075	71,624	16,549U	60,070	4,995U	39,821	15,254F
	966,308	937,766	28,542F	966,681	373U	952,322	13,986F
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	49,585	44,930	4,655F	49,585	0F	42,170	7,415F
- HBL	12,420	12,420	0U	12,420	0U	12,420	0U
- ADHB Term Deposits > 12 months	5,000	-	5,000F	10,000	5,000U	-	5,000F
- Other Investments	462	-	462F	462	0U	462	0U
	67,467	57,350	10,117F	72,467	5,000U	55,052	12,415F
Intangible Assets	612	4,180	3,568U	652	40U	910	298U
Trust Funds	13,219	14,548	1,329U	13,238	19U	17,299	4,080U
	81,298	76,078	5,220F	86,357	5,059U	73,261	8,037F
Total Non Current Assets	**1,047,606**	**1,013,844**	**33,762F**	**1,053,038**	**5,432U**	**1,025,583**	**22,023F**
Current Assets							
Cash & Short Term Deposits	46,301	82,278	35,978U	22,594	23,707F	87,210	40,909U
Trust Deposits > 3months	12,600	7,700	4,900F	12,600	0F	8,500	4,100F
ADHB Term Deposits > 3 months	15,000	-	15,000F	10,000	5,000F	-	15,000F
Debtors	32,152	18,599	13,554F	37,387	5,235U	28,509	3,643F
Accrued Income	38,831	20,600	18,231F	34,683	4,148F	19,206	19,625F
Prepayments	2,929	1,166	1,763F	1,019	1,910F	1,035	1,894F
Inventory	13,807	12,723	1,084F	13,768	39F	13,154	653F
Total Current Assets	**161,619**	**143,066**	**18,553F**	**132,051**	**29,568F**	**157,614**	**4,005F**
Current Liabilities							
Borrowing	-	(3,611)	3,611F	-	0F	(52,454)	52,454F
Trade & Other Creditors, Provisions	(152,095)	(117,503)	34,592U	(138,081)	14,014U	(121,299)	30,796U
Employee Benefits	(167,459)	(176,254)	8,795F	(160,133)	7,326U	(176,735)	9,276F
Funds Held in Trust	(1,230)	(1,169)	61U	(1,228)	2U	(1,208)	22U
Total Current Liabilities	**(320,784)**	**(298,537)**	**22,247U**	**(299,442)**	**21,342U**	**(351,696)**	**30,912F**
Working Capital	**(159,165)**	**(155,471)**	**3,694U**	**(167,391)**	**8,226F**	**(194,082)**	**34,917F**
Non Current Liabilities							
Borrowings	(304,500)	(304,500)	0F	(304,500)	0F	(254,500)	50,000U
Employee Entitlements	(30,085)	(32,575)	2,490F	(30,085)	0U	(30,085)	0U
Total Non Current Liabilities	**(334,585)**	**(337,075)**	**2,490F**	**(334,585)**	**0U**	**(284,585)**	**50,000U**
Net Assets	**553,856**	**521,298**	**32,558F**	**551,062**	**2,794F**	**546,916**	**6,940F**

Comments

- The full revaluation of land completed at 30 June 2015 resulted in an increase in revaluation reserve of $31.8M, increasing the year end Equity position.
- Buildings, plant and equipment variances are largely due to different opening balances set in the budget. Capital spend is also $25M below forecast budget spend.
- Actual cash at month end is lower than budget cash and cash equivalents mainly due to favourable investments in term deposits. $5M matures within a year and $15M matures beyond a year. There was also a cashflow impact of $4.6M for investment in healthAlliance relating to regional IT projects previously approved.
- Accrued income variance is mainly due to the timing of invoices to MoH.
- Trade & Other Payables reflect timing differences for creditors' payments and income in advance.

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

$000's	Month (Feb-16)			YTD (8 months ending 29 Feb-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	166,708	169,270	2,562U	1,340,870	1,354,992	14,122U
Payments						
Personnel	(63,476)	(67,640)	4,164F	(575,688)	(556,478)	19,211U
Suppliers	(34,021)	(34,544)	523F	(275,510)	(281,712)	6,202F
Capital Charge	0	(3,366)	3,366F	(21,334)	(26,880)	5,546F
Funder payments	(53,664)	(53,356)	308U	(433,155)	(426,850)	6,304U
GST	10,899	0	10,899F	(3,330)	0	3,330U
	(140,261)	**(158,906)**	18,645F	**(1,309,018)**	**(1,291,920)**	17,098U
Net Operating Cash flows	**26,447**	**10,365**	**16,083F**	**31,853**	**63,072**	**31,219U**
Investing						
Interest Income	359	668	309U	3,834	6,018	2,183U
Sale of Assets	1	0	1F	7	0	7F
Purchase Fixed Assets	(3,421)	(10,030)	6,609F	(42,214)	(67,539)	25,325F
Investments and restricted trust fund	321	0	321F	(27,133)	0	27,133U
Net Investing Cash flows	**(2,741)**	**(9,362)**	**6,622F**	**(65,506)**	**(61,521)**	**3,985U**
Financing						
Other Equity Movement	1	0	1F	2	0	2F
Equity Injections	0	0	0F	0	0	0F
New Loans	0	0	0F	0	0	0F
Loans Repaid	0	0	0F	0	0	0F
Equity Repayment	0	0	0F	0	0	0F
Interest paid	0	(1,000)	1,000F	(7,259)	(9,290)	2,031F
Net Financing Cashflows	**1**	**(1,000)**	**1,001F**	**(7,256)**	**(9,290)**	**2,033F**
Total Net Cash flows	**23,707**	**2**	**23,705F**	**(40,909)**	**(7,739)**	**33,170U**
Opening Cash	22,594	82,277	59,683U	87,210	90,018	2,808U
Total Net Cash flows	23,707	2	23,705F	(40,909)	(7,739)	33,170U
Closing Cash	**46,301**	**82,279**	**35,978U**	**46,301**	**82,280**	**35,978U**

ADHB Cash	43,464	77,174	33,710U
A+ Trust Cash	1,072	0	1,072F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	1,765	5,105	3,340U
	46,301	**82,279**	**35,978U**
ADHB - Short Term > 3 months	15,000	0	15,000F
A+ Trust Deposits - Short Term > 3 months	12,600	**7,700**	**4,900F**
ADHB Deposits - Long Term	5,000	**0**	5,000F
A+ Trust Deposits - Long Term	13,219	**14,548**	1,329U
Total Cash & Deposits	**92,120**	**104,527**	**12,407U**

Funder Update

Recommendation

That the report be received.

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

Glossary

ACH	-	Auckland City Hospital
AOD	-	Alcohol and Other Drug
ARRC	-	Aged Related Residential Care
CADS	-	Community Alcohol and Drugs Services
CEO	-	Chief Executive Officer
DHB	-	District Health Board
DNA	-	Did Not Attend
GP	-	General Practitioner
HCSS	-	Home and Community Support Services
MoH	-	Ministry of Health
MoU	-	Memorandum of Understanding
NGO	-	Non-Government Organisation
NZMA	-	New Zealand Management Association
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
SACAT	-	Substance Addiction (Compulsory Assessment and Treatment) Bill
TRC	-	Tamaki Regeneration Company

Summary

This report updates the Auckland District Health Board (DHB) on planning and funding activities and areas of priority, since its last meeting on 17 February 2016.

1. Planning

1.1 Annual Plan

Work is progressing on the Annual Plan (refer associated Agenda item). The date for submission to the National Health Board is 31 March 2016.

2. Hospitals

2.1 Cancer target

The ADHB Quarter 2 FCT 62 day indicator result for the period July – December 2015 is 70.1%, which is an improvement on the nationally reported previous quarter's result of 66%. For the 32 day indicator the result is 85.4%, which is also an improvement. Efforts are being directed to further improve these indicator results for each tumour stream, with attention to data processes, pathways, and the deployment of additional tumour stream coordinators.

2.2 Auckland DHB 2015/16 Surgical Health Target

At the end of February ADHB has achieved 95% compliance with the Surgical Health Target, compared to 98.3% at the end of Quarter 2. There are a range of issues impacting the delivery of the health target including increased acute demand and constraints relating to specialist staff capacity. A range of strategies have been put in place to address the shortfall of volumes including additional Saturday lists and use of vacant lists. The recovery plans are being implemented and are expected to ensure the target is achieved by Quarter 4.

2.3 2015/16 IDF arrangements

The wash up position is being monitored regularly and the funder is working with Corporate finance to ensure any anticipated financial risk is managed. Some progress has been made with the Ministry of Health regarding the loss of revenue to ADHB associated with the change in funding of Eating Disorder Liaison services for the ADHB population. Discussions are continuing with Midland DHB Funders to resolve outstanding issues relating to the shortfall of funding for Eating Disorder Services and the funding arrangements for Child and Family Unit services with a meeting scheduled to occur 14 March.

2.4 2016/17 IDF arrangements

Final advice from the Ministry of Health regarding IDF and national service funding arrangements has now been received. Provisional costs of the new Eating Disorder service arrangements are expected to be known in the next month and the IDF funding arrangements for this service will need to be reviewed to determine if the funding is sufficient for the new model. The external review of ADHB Ophthalmology provider data is due for completion. Following a review of clinical pathways, a joint plan will be established between Waitemata and Auckland DHBs to resolve the outstanding service delivery and funding issues associated with the Waitemata population. Work is being progressed regionally and jointly with Counties Manukau to confirm the development of plans for local service delivery of Urology and Oncology services.

2.5 2016/17 ADHB funder/ADHB provider arrangements

The ADHB provider volumes and non-volume arrangements for the ADHB population have been finalised in the 2016/17 price volume schedule that forms part of the DHB production plan confirmed in draft 1 of the annual plan submitted to the Ministry of Health in early March.

2.6 Tertiary services review

The service specific analysis for all Starship clinical services is complete and the project team is proceeding with the financial analysis. A stakeholder engagement plan is being developed and the Director of Funding will confirm expectations of national DHB funders of this process.

Action	Status February	Timeframe
Framework for service review established and tested	Complete	
All Starship service descriptions signed off by Steering Group	On track	18-Dec-15
Preliminary update to other funders	On track	22-Dec-15
Starship Tertiary service review complete and local service specifications documented	Nearly complete	31-Jan-16
Implement stakeholder engagement plan regarding service specifications and financial analysis findings	Not yet started	31-March-16
Implementation of Starship Tertiary service review recommendations following stakeholder feedback	Not yet started	March - June 2016
Scope and commence Adult Tertiary service review	Not yet started	March 2016

2.7 Policy Priority areas

Colonoscopy Indicators

All waiting time indicators for colonoscopy were met within internal capacity in February. However Colonoscopy routine indicator (65% within 42 days) deteriorated to 61% in January mainly due to clinician leave but improved in February to 66%. Surveillance indicator (65% within 84 days) deteriorated slightly to 77 % in February however remains compliant. CT Colonography target of 65% within 42 days was met. The MOH has advised additional funding is available to ADHB if indicators are consistently achieved in each of the months in quarters three and four. The provider is on track to maintain the current good achievement while transitioning the service to new capacity by June 2016.

Radiology Indicators

The Auckland DHB provider has not met the outpatient CT indicator for January, achieving 87% against the target of 95%, which is a reduction in performance since December. This is as a result of reduced outpatient bookings over the Christmas/New Year holiday period due to staff leave and less working days available for outpatient bookings. There has also been a reduction in performance for both the outpatient MRI indicator - 41% achievement against the target of 85%; and the outpatient ultrasound indicator - 58% compliance against a target of 95%. The provider continues to work to an established improvement plan and improvement in all indicators is expected by April 2016.

Waiting Time Targets

As at the end of January Auckland DHB was moderately non-compliant (yellow) with ESPI2 (outpatient FSA) waiting time target (20 patients) and did not achieve (red) the ESPI5 (booked for surgery) waiting times target (approximately 80 patients). Key pressures continued in Paediatric Surgery and paediatric surgical sub specialties, however there was some improvement in February. This will be the first month considered as a breach by the MOH as a dispensation was provided in December.

Bone Marrow Waiting Times

At the time of this report (week ending 4 March) there were three patients waiting for Bone Marrow transplant longer than the clinically recommended time of six weeks. This waiting list has fluctuated as a result of variable demand of patients presenting with acute Leukaemia. The Director of Cancer services is leading the plan to address internal capacity issues contributing to the ongoing issues with waiting list breaches.

2.8 National services

Additional funding has been approved to enable increased capacity to be developed to support the national services and minimise disruption to other core clinical services. The Child Health team continue to make good progress with recruitment of additional staff to the National Paediatric Cardiac and Congenital Heart service and improvement is already occurring with reduced operating out of hours. At this stage cancellation rates have not materially changed however improvement is expected to have occurred by the end of the third quarter.

2.9 Regional Service Review Programme

ADHB funder and provider continue to actively participate in the oversight and management of regionally prioritised service reviews. Discussions have been initiated with the Director Provider services CMDHB to progress the plans for local delivery of Urology services.

3. Primary Care

3.1 Community Pharmacy

Metro Auckland District Health Boards (Auckland, Waitemata and Counties Manukau), and the Ministry of Health's Pharmacy Programme Team, hosted a local stakeholder forum on 'Integrated Pharmacists' Services in the Community' on 11th February 2016. This was one of the local pharmacy forums held across New Zealand during February 2016. The forum enabled engagement with a broad range of stakeholders and captured their views about the future landscape of pharmacists' services in the community over the next five to ten years.

The forum consisted of brief scene-setting presentations and collaborative brainstorming sessions to enable the development of future pharmacist services. Auckland DHB chief executive Ailsa Claire opened the forum by acknowledging the various innovations and services that are delivered regionally by community pharmacists and emphasised that the health sector needs to think more broadly about integration and how it can provide patient-centric services.

Approximately 60 stakeholders attended, including consumers, pharmacists, general practitioners, Primary Health Organisations (PHO), Non-Government Organisations (NGO), Age Related Residential Care (ARRC) representatives and other primary care providers such as the Community Alcohol and Drugs Services (CADS). The feedback from all the local DHB forums will be consolidated by the National Pharmacy Programme team, and will feed into strategic development and service structure of the next Community Pharmacist Services Agreement.

3.2 Auckland Waitemata Rural Alliance

The Auckland Waitemata Rural Alliance has been set up to provide advice and direct improvement in care and services across rural areas in Auckland DHB and Waitemata DHB. The Rural Alliance has representation from rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of 58,530 patients.

The Rural Alliance has agreed to focus on certain priority areas in their work plan to reduce a patient's need to travel by increasing access to diagnostics and interventions in the rural areas. A further focus of the Rural Alliance will be overseeing and providing direction in an advisory capacity for the review of health services on Waiheke Island.

To ensure that the Rural Alliance work plan is able to successfully achieve its goals, it is important to gather baseline information and have a clearer understanding of the current environment. To establish this baseline, a stocktake of services delivered by Auckland and Waitemata DHB Rural General Practices is currently underway. The stocktake and gap-analysis will then inform the subsequent development of the Rural Alliance Work Plan.

3.3 Green Prescription

Sport Auckland started delivering a Green Prescription Active Families Programme in October 2015 in Glenn Innes for children aged from 5 to 17. So far the Programme has focused on 5-12 year olds, with 32 enrolled children. The Programme includes 20 weeks of group physical activity sessions, nutrition education and parenting workshops for the whole family. A dedicated Teens Programme will be starting at the beginning of Term Two, working closely with Tamaki College and the Tamaki Recreation Centre. New programmes are starting in Mt Roskill in May 2016.

Sport Auckland is also utilising its own funding to pilot an Under 5s Active Families-type Programme in Glenn Innes to respond to the need for a Programme for obese children identified through the Before Schools Check. The Programme started three weeks ago and has five families enrolled so far. Sport Auckland is working with Plunket to identify families that would benefit most from physical activity and nutrition education and support. This is a fun and interactive session, initially piloted for 10 weeks with a further six months of follow up support and free activities.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

Inbetween Travel funding was devolved to DHBs to manage starting 29 February 2016. Contract variations were prepared for all Auckland providers in this respect.

The Director General's Report on HCSS is still under consideration and yet to be released. However, work continues on detailing a revised HCSS model for ADHB with an initial time bound reablement package before clients receive long term HCSS.

4.2 Aged Related Residential Care (ARRC)

The 2015/16 ARRC Agreement has a new clause that requires all facilities to use interRAI as their primary assessment tool. The table below shows performance against the MoH interRAI measure ie percentage of people in aged residential care who have a subsequent assessment completed within 230 days of their previous assessment.

	Quarter 1	Quarter 2
Auckland DHB	49%	62%

The MoH, ACC and the Health Quality and Safety Commission are working in partnership on a national Pressure Injury Prevention and Management Programme. Starting in 2016 pressure injuries will be a focus of the ARRC audit process. We expect this will see an increase in both reporting and corrective actions relating to pressure injury prevention and management. At the same time it will provide an opportunity for the DHB Quality and Monitoring Managers to support facilities to improve processes and protocols in this area of care.

5. Women, Children & Youth

5.1 Immunisation

We continue to be on track to achieving the immunisation health target, with current coverage for 8 month old infants of 95% Total (as at 8 March 2016). Efforts to increase coverage for Maori infants continue, though as previously noted, by 2 years of age 97% coverage is achieved. In addition to the systematic approach taken by general practices in which the child is enrolled, outreach services are now being engaged earlier via safety-net referrals at 10 weeks, 4 months and 6 months of age, we have a range of communications focusing on Maori whanau and we are about to establish a Maori infants case review group, a strategy which has been successful at Waitemata DHB. This group will bring together a range of health providers for a look-back case review to identify any common systems for ongoing quality improvement. This information is then brought back to the operations group to ensure best practice approaches are implemented around these learning.

5.2 Rheumatic Fever

ADHB has not yet turned the curve on Rheumatic Fever, though significant progress has been achieved in other DHBs, most notably Counties Manukau. Counties Manukau DHB's programme started before the programme in ADHB and, due to the denser clustering of cases, can be addressed more effectively simply through the primary school sore throat swabbing and management programme, supported by health promotion activity. ADHB needs to take a broader range of tactics to achieve the reduction in cases we aim to achieve. Most recently, this has seen us significantly change our contract with PHOs. Changes have resulted in exiting the Alliance arrangement at the end of its term (contract held by Alliance Health Plus on behalf of the PHOs) and entering agreements directly with each of the PHOs. The new contracts have a stronger focus on clinical leadership both for rapid response clinics and for the entire network of practices. PHOs are also tasked, through the new agreement, with engaging innovatively with the target population (Maori, Pacific and Q5). Plunket has also agreed to add RhF specific content to the B4School Check for Maori, Pacific and Q5 children with a particular focus on practical tips for warm, dry homes, the importance of getting sore throats checked and the importance of taking the full course of antibiotics as prescribed.

5.3 Annual Planning

New areas have been added to the Annual Plan including for Unintended Teenage Pregnancy and for Obesity, as required by the Ministry. In relation to obesity, there is a new health target. Activity associated with this detailed in an Audit and Finance paper. In relation to Unintended Teenage Pregnancy, we consider we are well advanced in our approaches to addressing this, though there is still work to do in the primary care space, especially regarding the provision of Long Acting Reversible contraceptives.

Overall, we have seen a decline in both terminations and in births to young women over the last ten years. Over the last decade there has been a 30% drop in terminations for women overall. The number of terminations (conducted at Epsom Day Unit) has more than halved between 2007 and 2014 (from 1247 to 522 terminations), the decline has been most marked in women under 20 years of age. This is considered due in large part to the availability of Long Acting Reversible Contraceptives, such as Jadelle sub-dermal hormonal implants, which are not reliant for effectiveness on someone remembering to take it or on using it every time (National Women's Annual Clinical Report 2014). In 2014, 39 babies were born to ADHB domiciled young women aged 12-17 years of age and 129 babies were born to young women aged 18-19 years of age. The birth rate for these women in Auckland is lower than that of Waitemata or Counties Manukau domiciled women.

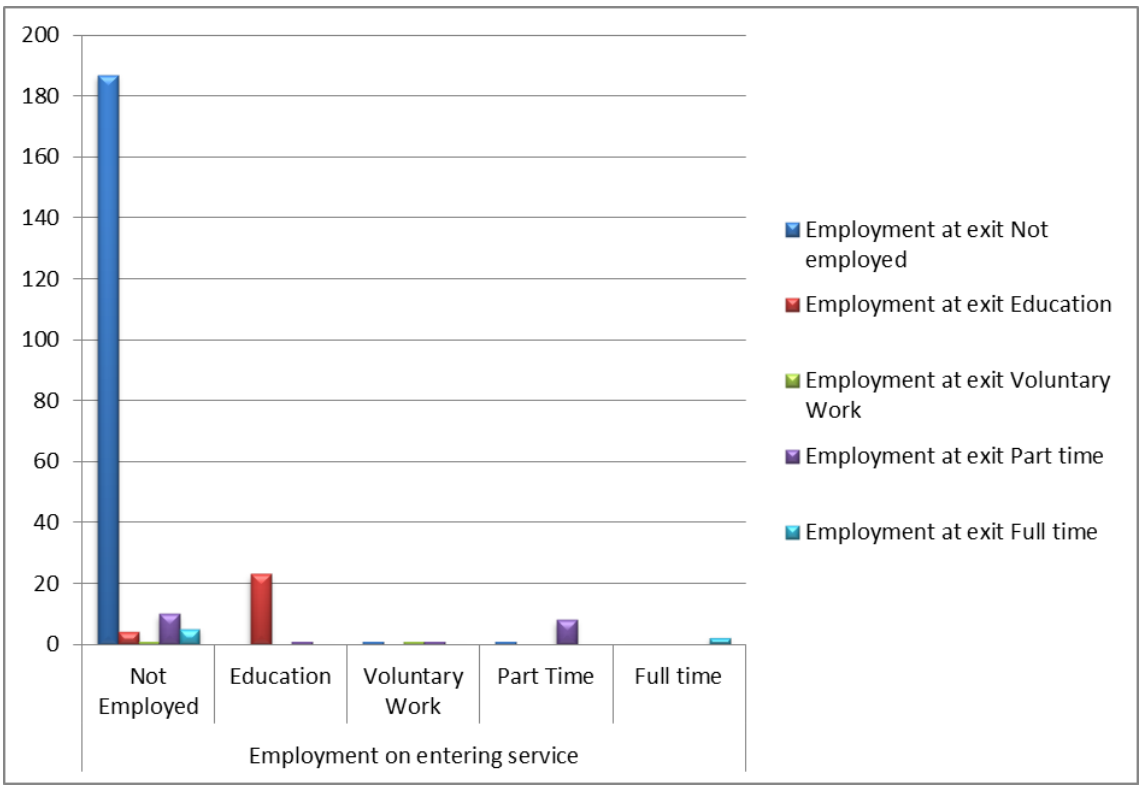
6 Mental Health and Addictions

6.1 Auckland and Waitematā DHB's Mental Health and Addictions Employment Strategy - Everyone's Business

An implementation group has been established and held its first meeting in late January 2016. A second meeting is planned for early March, too which MSD has been invited.

Table 1 shows the Auckland DHB Q1 and Q2 data for 2015/16, comparing a person's employment status when they enter service to when they exit (a total of 258 people exited during this period). The Q1 and Q2 outcomes align closely with the 2014/15 outcomes in highlighting that the majority of people enter and exit NGO services as unemployed.

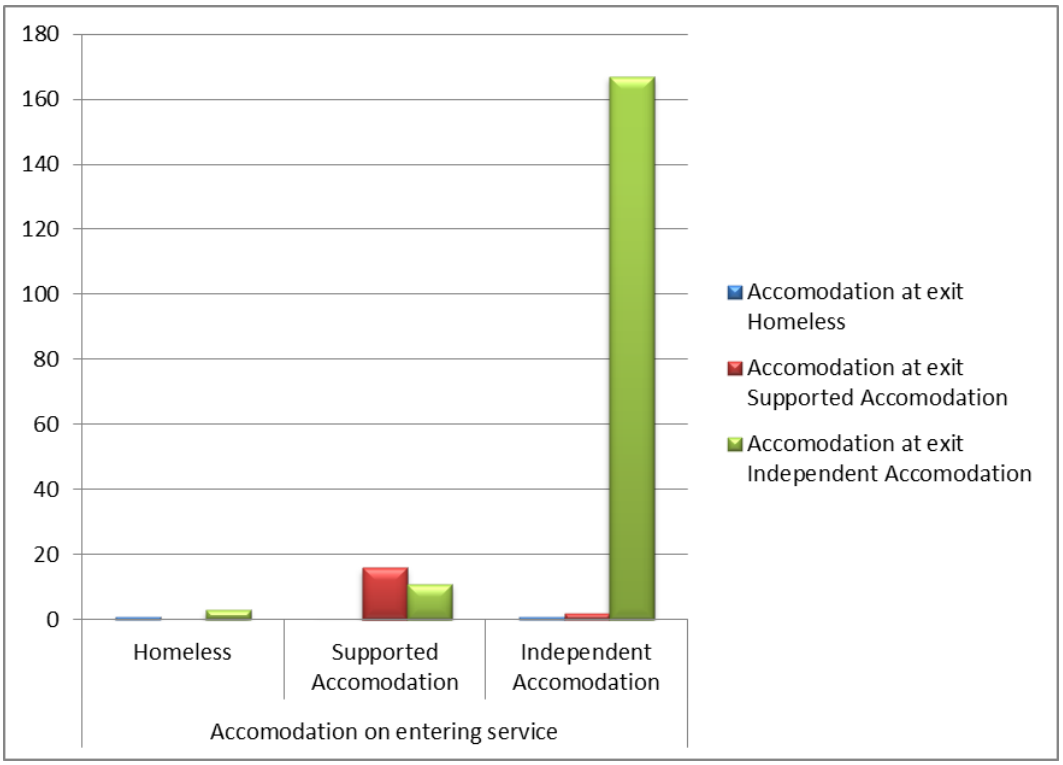
Table 1: Q2 2015/16 Employment Data for Auckland DHB (N=258)



6.2 Auckland and Waitematā DHB's Mental Health and Addictions Social Outcomes Indicators development

The social outcome indicators work undertaken by Auckland and Waitematā DHBs NGOs continues to focus on measuring changes in employment status (see Table 1), and has included housing status for 2015/16. Housing status compares a person's housing (based upon Statistics NZ definitions) status when they enter service to when they exit. The Auckland DHB Q1 and Q2 2015/16 outcomes is based upon a total of 258 people exited NGO services during this period (see Table 2).

Table 2: Q1 and Q2 2015/16 Housing Data for Auckland DHB (N=258)



6.3 Tamaki Mental Health and Wellbeing Initiative

The Tamaki Mental Health and Wellbeing initiative primary care/NGO integration pilot began in September 2015. This pilot has linked three NGOs with two GP practices and is preparing to link a third GP practice. Two further practices are currently in discussions to join the pilot.

Discussions have begun on how to bring the learnings of the pilot to the wider sector. To date the major learnings of the project have been:

1. There is no one model of NGO/GP practice integration that can be transferred to other localities or districts
2. The locality based collaborative engagement and development process utilised within the Tamaki pilot has been successful and has led to approaches by other GP practices. A critical component of this has been the involvement of GP champions whose conversations with their colleagues appears to be driving GP interest
3. The support people are wanting from NGO support workers is significantly different from what NGOs currently deliver. This learning was not anticipated and may have future workforce training implications

6.4 Substance Addiction (Compulsory Assessment and Treatment) Bill

The Ministry of Health (MoH) have requested DHBs provide a preferred model of care for alcohol and other drug (AOD) withdrawal management that will support the provision of services under the Substance Addiction (Compulsory Assessment and Treatment) Bill (SACAT Bill) to be implemented in 2016/17.

The SACAT Bill provides for the compulsory assessment and treatment of individuals who are considered to have severe substance addiction, and who do not have the capacity to participate in treatment to:

- provide for compulsory treatment of persons with severe substance dependence for the purpose of protecting them from harm and restoring their capacity to make their own decisions about their future substance use
- stabilise their health through the application of medical treatment (including supported withdrawal)
- facilitate a comprehensive assessment of their dependence
- facilitate the planning of ongoing voluntary treatment and aftercare for them
- give them an opportunity to engage in voluntary treatment.

The introduction of this legislation will have a significant impact on the AOD sector. In particular the new model of care and the need for locked treatment facilities has logistical, service design and financial implications.

The SACAT Bill provides a more effective compulsory addiction regime than the current Alcoholism and Drug Addiction Act, and is therefore likely to be used more extensively. The MoH has previously estimated that there will be set-up costs of $350,000 (excluding GST) to equip the clinical and justice sectors to undertake their statutory roles in accordance with the new regime. Ongoing operational costs are estimated to be at least $775,000 per annum (excluding GST).

To this end, the MoH have indicated the intention to devolve the funding for the five withdrawal management (social detoxification beds for methamphetamine users) beds to the Northern Region DHBs as of July 1 2016 to:

- to support existing providers social detox service provision and/or pathways
- as part of any remodelling of withdrawal management care
- to assist DHBs respond to updated compulsory addiction assessment and treatment legislation anticipated to be introduced in 2016.

These funds appear to be insufficient to establish new treatment services of this nature. The Northern Region will undertake a Service Mapping exercise to provide a regional process to determine the best use of existing resources and to highlight any gaps in service provision that will need to be addressed in order to implement the Act.

It is proposed that Waitemata DHB is the lead DHB for this process. The rationale for this is that Waitemata DHB hold the contract for Regional Community Alcohol and Drugs Services. The proposed plan is to:

- develop and design a service map of existing AOD services in the Region
- review the epidemiology to identify the estimated need
- conduct a literature review of withdrawal management models and in particular compulsory treatment internationally
- identify existing resources, service gaps and the capacity of existing services across the region to manage withdrawal both voluntary and involuntary

- support the development of the withdrawal management model of care
- estimate the funding required to support establishment of compulsory treatment
- hold a Regional forum (or series of forums) to consult and get feedback on the draft model of care
- inform the Northern Regional DHB Select Committee submission.

6.5 Funding & Development Manager – Mental Health and Addiction Services

Trish Palmer has been appointed to the role of the Funding and Development Manager, Mental Health and Addiction Services, and starts on 2 May 2016. Trish comes to the role with a wealth of experience including the last six years as the Mental Health and Addictions Funder in Northland, where she has initiated significant changes in the sector, including the introduction of Results Based Accountability in NGO contracting, and a Health Improvement Profile project in the Far North.

7. Maori Health Gain

7.1 Maori Health Providers Integrated Contract Progress Update

Implementation of the integrated contracting strategy is progressing. In 2014/15 this included conducting a systematic and quality review of the individual service lines contracted with the Maori providers. This informed the development of the integrated contract framework which has evolved from multiple contracts to one contract that aligns to Nga Painga Hauora, the Auckland and Waitemata DHB Maori health outcomes framework. Integrated contracts endeavor to take the next step towards a holistic model of care designed to measure outcomes through carefully crafted services that deliver a package of care with a clinical and a community component. We continue to work closely with the Maori providers utilizing the principles of a co-design.

Phase one completed in 2014/15 included:

- the development, sign-off and implementation of 3 year integrated contracts delivering a package of care to their community
- the development of a Maori Health Outcomes framework with Sir Mason Durie
- the development of a performance reporting management framework that includes RBA methodology, results based scorecard reporting tool, data dictionary
- establishment of a clinical advisory steering group to provide clinical support and guidance for contracted clinical services

We are currently well into phase two which includes:

- reviewing current provider health service delivery and conducting health need analyses
- establishing a change management process to implement change for service redesign and/or Deadline for sign-off
- completion of service redesign of Phase Two Cardiac Rehabilitation Model and improvement and signed off by senior management, Maori providers and process with sector services
- movement towards multi-lateral streamlined contracting with establishment of Outcomes Agreement Management Plan agreements (to be piloted with Mental Health and Health of Older People during 15/16)

The Phase Two Cardiac Rehabilitation model of care is being redesigned in response to work done by the ADHB provider arm services and northern region clinical network to improve the current model and to establish minimum guidelines for phase two cardiac rehabilitation. We are working closely with the Maori health providers and secondary services from Auckland DHB to improve quality,

safety, deliver services closer to home and improve integration of cardiac services between hospital and community.

7.2 DNA Strategy

A progress presentation on the Did Not Attend (DNA) strategy was provided to the Manawa Ora meeting in February. This summarised the evidence on drivers of DNA rates, evidence based interventions and the proposed comprehensive DNA strategic approach, which focuses on reducing inequalities for Māori and Pacific. A gap analysis is being undertaken to assess current DNA activity in Auckland DHB against this framework. This will result in a set of prioritised activities to be presented back to Manawa Ora in April 2016.

7.3 Bariatric surgery

Scoping is being finalised for the project to reduce barriers to bariatric surgery for Māori and Pacific at both Auckland and Waitemata DHB. This has highlighted several related pieces of work already underway or planned including: e-referrals; a bariatric HealthPathways proposal; patient journey mapping; and the Whānau Health Literacy and Navigator project for bariatric surgery (funded by the Ministry of Health and being undertaken at Waitemata DHB and Counties Manukau DHB). These activities have been included under the project scope. The project has identified several key areas of focus to reduce barriers including the patient selection process, the service pathway (including general practice) and written materials. Key linkages are being made between this work and DHB focus on diabetes management, adult weight management and the childhood obesity plan.

8. Asian, Migrant and Refugee Health Gain

8.1 Reducing acute flow to the Auckland City Hospital (ACH)

As previously reported, two separate pieces of work have been undertaken concurrently. The first is an analysis of:

- demographic data of people living and studying in the Auckland CBD
- stocktake of general practices (GP) in the Auckland CBD
- review of the utilisation of ED services data for domestic/long term migrants as compared to new migrants across main ethnic groups.

The second is a student survey on 'Student Awareness of Health Services and Health Information in the Auckland District'. The survey has now closed and the results of this are currently being analysed.

Current strategies to reach out to students and new migrants include podcast videos in English and Chinese (Mandarin) to be parked on the Your Local Doctor website, and promoted via a multi-platform/settings approach for example via university orientation week sessions, student health centers and hubs, ethnic media channels, Immigration NZ – NZ Now website, ethnic associations, NGO platforms, Citizen's Advice Bureau, and settlement information agencies etc.

8.2 Increasing the number of Indians who have a heart and diabetes check through targeted engagement

Health Families Waitakere, Diabetes NZ (Auckland Branch), and The Asian Network Incorporated are collaborating to develop a Strategy to engage Indian males (35-44 years) across their workplaces and communities on targeted efforts towards increasing heart and diabetes checks, and culturally appropriate healthy preventative messaging.

9 Pacific Health Gain

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

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

Two more *Incredible Yeas* parenting support programmes are being implemented in West Auckland and two are being negotiated with HVAZ churches. One *Living Without Violence* has been implemented and a review of that programme is in progress. Two other programmes are in progress.

9.2 PHAP Priority 2 –Pacific People are smoke-free

A specific plan is in place and is being implemented to assist churches not yet smoke free to achieve this status by 30 June 2016. This includes more smoke free training, the establishment of Cook Is and Tongan working groups to investigate how smokers from those communities can be better linked to quit smoke services. A Pacific specific WERO (smoke free group competition) is being designed.

9.3 Priority 3 – Pacific people are active and eat healthy

Initial meetings with people who lost weight and maintained weight loss in the three years of the Aiga Challenge (group weight loss competition) have been held. Those people have agreed to participate in a survey to identify the changes that they made in order to lose weight and the motivation to lose weight. The survey is being designed by three students undertaking their Masters in Health Science (nutrition and dietetics) degree. The students will analyse the results and prepare a report which will assist the participants of the next Aiga Challenge.

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

The *Fanau Ola* Integrated Services contract that ADHB has with AH+ PHO has been in operation for six months from July – December 2015. Within this period, two of its three providers have reached the annual target in terms of numbers of families for which this service is offered and the third provider reached 50% of its target. The top three issues that the service has identified and is responding to are breast feeding, family violence and depression. We are continuing to work with AH+ to identify the number of hours that are going into individuals and family members and outcomes that are being achieved.

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

The Pacific GM for Hospital Services reports on this priority.

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

We maintain a relationship with Ministry of Business, Innovation and Employment. MBIE is trying to do geo-spatial imaging of what the Pacific owned land asset is, to better understand what Pacific communities' collective wealth and potential collective impact might be in the future. We facilitate meetings between MBIE and Pacific church and community leaders when requested.

We have had meetings with Tamaki Regeneration Company (TRC) to explore establishing effective connections between Pacific health providers in the area and TRC. More work will be done in this area. We also wanted to know whether they have strong connections to the Pacific communities. They said that their connection to the Tongan community could be stronger so we will assist them to better engage with Tongan church and community leaders in the area.

Patient Experience Survey Net Promoter Score

Recommendation

That the Board:

1. **Approves the continuation of a Net Promotor Score based on Auckland DHB's own patient experience survey data.**
2. **Approves the creation of Net Promoter Scores using national patient experience survey data to allow comparison between Auckland and Waitemata DHBs.**

Prepared by: Michelle Webb (Committee Secretary, Auckland DHB Hospital Advisory Committee)
Endorsed by: Tony O'Connor (Director Participation and Experience) and Judith Bassett (Chair, Auckland DHB Hospital Advisory Committee)

1. Executive Summary

This was discussed by the Hospital Advisory Committee at their Open meeting held on 17 February 2016 as part of item 9.1 on the agenda (see pages 127 to 130).

The Hospital Advisory Committee (HAC) considered whether Auckland DHB should stay with a Net Promoter Score (NPS) based on the DHB's own patient experience survey data or shift to a NPS based on national patient experience survey data that will allow comparison with Waitemata DHB.

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

It suggested that both processes should be used for a period of 6 months then reviewed and reported back to the Board.

Election Services
Level 2, 198 Federal Street, Auckland
PO Box 5135, Wellesley Street
Auckland 1141
Phone: 64 9 973 5212
Email: info@electionservices.co.nz

Report to the
Auckland District Health Board
regarding the

2016 Triennial Elections

From the
Electoral Officer

17 March 2016

Table of Contents

Outline

The 2016 triennial local elections will be held on Saturday 8 October 2016. An update on preliminary matters relating to the elections is provided to the Board, including consideration of the order of candidate names to appear on the voting documents and authorization for the Chief Executive to sign the Memorandum of Understanding between the Auckland District Health Board and the Auckland Council.

Background

Local elections are required to be undertaken according to the New Zealand Public Health & Disability Act 2000, the Local Electoral Act 2001 and the Local Electoral Regulations 2001.

Certain pre-election information and tasks are outlined in this report for the Board's information and attention.

The Local Electoral Regulations 2001 provide for the Board to resolve the order of candidate names to appear on the voting documents (alphabetical, pseudo-random or random order). If no decision is made, the order of names defaults to alphabetical.

Authorisation by the Board for the Chief Executive to approve the Memorandum of Understanding between the Auckland District Health Board and the Auckland Council for the conduct of the 2016 triennial election is also sought.

Narrative

2016 Elections

An election will be required for 7 Auckland District Health Board members, elected 'at large' from the Board area which comprises the central part of the Auckland Council area.

The election will be undertaken, on behalf of the Board, by Auckland Council, the constituent territorial authority.

Following the election, the Minister of Health will appoint a further 4 members, making a total of 11 Board members.

2016 Election Timetable

With an election date of **Saturday 8 October 2016**, the following key functions and dates will apply:

Nominations open/roll opens

Friday 15 July 2016

Nominations close/roll closes (noon)

Friday 12 August 2016

Delivery of voting mailers

From Friday 16 September 2016

Close of voting

Noon Saturday 8 October 2016

Members take office

Monday 5 December 2016

A more detailed timetable is attached Appendix 1.

2016 Election Fact Sheet

A 2016 Election Fact Sheet summarising the key functions of the election (Appendix 2) is also attached.

Order of Candidate Names

Regulation 31 of the Local Electoral Regulations 2001 provides the opportunity for the Board to choose the order of candidate names appearing on the voting documents from three options – alphabetical, pseudo-random (names drawn out of a hat in random with all voting documents printed in this order) or random order (names randomly drawn by computer with each voting document different).

The Board may determine which order the names of candidates are to appear on the voting documents, but if no decision is made, the order of names defaults to alphabetical.

The Board has resolved to adopt the alphabetical order for previous triennial elections.

Auckland Council is considering this issue at their meeting on 31 March 2016 with a recommendation to adopt the alphabetical order.

Alphabetical Order

Alphabetical order is simply listing candidate surnames alphabetically and is the order traditionally used in local and Parliamentary elections.

Comments regarding alphabetical order are:

- voters are easily able to find names of candidates for whom they wish to vote. Some candidates and voters over the years have argued that alphabetical order may tend to favour candidates with names in the first part of the alphabet, but in practice this is generally not the case – most voters tend to look for name recognition, regardless of where in the alphabet the surname lies;
- the order of candidate names on the voting document matches the order listed in the candidate directory (candidate profile statements).

Pseudo-Random Order

Pseudo-random order is where candidate surnames are randomly selected and the same order is used on all voting documents for that position. The names are

randomly selected by a method such as drawing names out of a hat.

Comments regarding pseudo-random order are:

- the candidate names appear in mixed order (not alphabetical) on the voting document;
- possible voter criticism/confusion as specific candidate names are not easily found, particularly where there is a large number of candidates;
- the order of candidate names on the voting document does not match the order in the candidate directory (candidate profile statements).

Random Order

Random order is where all candidate surnames are randomly selected and are listed in a different order on every voting document. The names are randomly selected by computer so that the order is different.

Random order enables names to be listed in a completely unique order on each voting document.

Comments regarding random order are:

- the candidate names appear in mixed order (not alphabetical) on the voting document;
- possible voter criticism/confusion as specific candidate names are not easily found, particularly where there is a large number of candidates;
- the order of candidate names on the voting document does not match the order listed in the candidate directory (candidate profile statements).

There is no longer any price differential in printing costs between the three orders of candidate names.

Memorandum of Understanding

A Memorandum of Understanding for the conduct of the 2016 triennial election should again be exchanged between the Auckland District Health Board and the Auckland Council (copy attached).

The 2016 generic MOU was prepared by the SOLGM Electoral Working Party, of which the Ministry of Health has a representative.

Approval is sought from the Board for the Chief Executive to approve and sign this document on behalf of the Auckland District Health Board.

Online Voting Trials

Government has agreed to consider trialling online voting (in conjunction with postal voting) for the 2016 triennial elections.

Expressions of interest from territorial authorities were called for by Local Government New Zealand in June 2015 and 8 territorial authorities have agreed to participate. The 8 territorial authorities are Masterton District Council, Matamata-Piako District Council, Palmerston North City Council, Porirua City Council, Rotorua Lakes District Council, Selwyn District Council, Whanganui District Council and Wellington City Council.

The trial is subject to compliance with comprehensive Department of Internal Affairs requirements and to Government's final approval, expected in March/April 2016.

Recommendations

It is recommended that:

1. The Board resolves for the 2016 Auckland District Health Board triennial election, to adopt ***either:***

   (i) the alphabetical order of candidate names; ***or***

   (ii) the pseudo-random order of candidate names; ***or***

   (iii) the random order of candidate names

   as permitted under regulation 31 of the Local Electoral Regulations 2001;

2. The Board authorises the Chief Executive to approve and sign the Memorandum of Understanding on behalf of the Auckland District Health Board with the Auckland Council, for the conduct of the 2016 triennial Board election.

Author:

Dale Ofsoske
Electoral Officer // Auckland District Health Board
Election Services

APPENDIX ONE:

2016

Timetable

Triennial Election

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

SATURDAY 8 OCTOBER 2016

Wednesday 13 July 2016	Public notice of election, calling for nominations, territorial authority electoral roll open for inspection [Sec 42, 52, 53, LEA]
Friday 15 July 2016	**Nominations open / territorial authority electoral roll open for inspection** [Sec 42, LEA]
Friday 12 August 2016	**Nominations close (12 noon) / territorial authority electoral roll closes** [Sec 5, 55, LEA, Reg 21, LER]
Wednesday 17 August	Public notice of candidate names [Sec 65, LEA]
by Monday 12 September 2016	Territorial authority electoral officer certifies final electoral roll [Sec 51, LEA, Reg 23, LER]
Friday 16 September 2016	ES letter sent to unpublished roll electors
Friday 16 September - Wednesday 21 September 2016	**Delivery of voting documents** [Sec 5, LEA, Reg 51, LER]
Friday 16 September - Saturday 8 October 2016	Progressive roll scrutiny [Sec 83, LEA] Special voting period Early processing
by 12 noon, Friday 7 October 2016	Appointment of scrutineers (noon) [Sec 68, LEA]
Saturday 8 October 2016	**Election day** [Sec 10, LEA] Voting closes 12 noon - counting commences [Sec 84, LEA] Preliminary results (STV) available late Saturday [Sec 85, LEA]
after 12 noon, Saturday 8 October - Thursday 13 October 2016	Official count [Sec 84, LEA]
Saturday 15 October - Wednesday 19 October 2016	Declaration/public notice of results [Sec 86, LEA]
5 December 2016	Members come into office [Clause 14, Sch 2, NZPHDA]
Mid-December 2016	Return of election donations & expenses form [Sec 112A, LEA]

election services

// Dale Ofsoske
Electoral Officer
Auckland District Health Board
July 2015

LEA = Local Electoral Act 2001
LER = Local Electoral Regulations 2001
ES = Enrolment Services, Electoral Commission
STV = Single Transferable Voting

APPENDIX TWO:

2016

Fact Sheet

Triennial Election

GENERAL

Triennial elections for elected members of all local authorities throughout New Zealand, including district health boards, are to be conducted, by postal vote, on **Saturday 8 October 2016.**

The elections will be conducted under the provisions of the Local Electoral Act 2001, the Local Electoral Regulations 2001 and the New Zealand Public Health and Disability Act 2000.

Auckland Council is legally required to conduct the Auckland District Health Board election on its behalf.

POSITIONS

Elections for the Auckland District Health Board will be required for 7 positions, elected 'at large' from the Board area which comprises the central part of the Auckland Council area.

In addition, following the election, the Minister of Health appoints a further 4 members, making a total of 11 members per board.

NOMINATIONS

Nominations open on **Friday 15 July 2016** and will close at **noon** on **Friday 12 August 2016.**

Nomination forms will be available during this period from:

- the electoral office (Election Services, Level 2, 198 Federal Street, Auckland);
- Auckland District Health Board (Level 1, Building 37, Auckland Hospital, Park Road, Grafton [above Columbus Café]);
- by telephoning 09 973 5212 where one will be posted out;
- by accessing www.voteauckland.co.nz

To be eligible to stand for election, a candidate must be:

- enrolled as a Parliamentary elector anywhere in New Zealand; and
- a New Zealand citizen.

In addition, under the New Zealand Public Health and Disability Act 2000, as amended by the Crown Entities Act 2004, a candidate cannot be:

- a candidate for more than one district health board;
- a person who is an undischarged bankrupt;
- a person who is prohibited from being a director or promoter of, or being concerned or taking part in the management of, an incorporated or unincorporated body under the Companies Act 1993, or the Securities Act 1978, or the Securities Markets Act 1988, or the Takeovers Act 1993;
- a person who is subject to a property order under the Protection of Personal and Property Rights Act 1988;
- a person in respect of whom a personal order has been made under that Act that reflects adversely or the person's:
  - competence to manage his or her own affairs in relation to his or her property, or
  - capacity to make or communicate decisions relating to any particular aspect or aspects of his or her personal care and welfare;
- a person who has been convicted of an offence punishably by imprisonment for a term of 2 years or more, or who has been sentenced to imprisonment for any other offence, unless that person has obtained a pardon, served the sentence, or otherwise suffered the penalty imposed on the person;

- a person who has been removed as a DHB board member since the last DHB elections, under clause 9(c) or 9(e) of Schedule 3 to the NZ Public Health and Disability Act 2000;
- a person who has failed to declare a material conflict of interest before accepting nomination as candidate at the last DHB election.

Detailed candidate information booklets will be available from the electoral office (phone 09 973 5212) from May 2016.

ELECTORAL ROLL

Those eligible to vote at district health board elections are all resident electors whose names appear on the electoral roll when it closes. The preliminary electoral roll will be compiled by the Auckland Council and will be available for public inspection at all Auckland Council libraries from **Friday 15 July 2016** to Friday **12 August 2016.**

All parliamentary electors, including those on the Maori Electoral Roll, are automatically enrolled on the loca government resident electoral roll, at the address where they live. A confirmation card will be issued to all parliamentary electors in July 2016.

Any alterations to the resident roll (eg change of address details, including new postal addresses) should be made by:

- completing the appropriate form at any post shop;
- telephoning 0800 ENROLNOW (0800 367656)
- accessing the Enrolment Services, Electoral Commission website on www.elections.org.nz

ELECTORAL SYSTEM

The single transferable voting (STV) electoral system will be used for the Auckland District Health Board election. For the Auckland Council elections, the first past the post (FPP) electoral system will be used.

VOTING PERIOD

Voting documents (including the district health board election) will be sent to all eligible electors, by the Auckland Council, by post, from **Friday 16 September 2016**.

The voting period is three weeks (**Friday 16 September 2016** to **noon Saturday 8 October 2016**). Electors may post their completed voting documents back to the Auckland Council electoral officer using a pre-paid envelope sent with the voting document. A polling place for the issuing of special voting documents and for the receiving of completed voting documents will be available from the electoral office from Friday 16 September 2016 to noon, Saturday 8 October 2016.

To further assist electors, 'drop-off' vote collection points will be available at all Auckland Council libraries from 9am to noon on election day, Saturday 8 October 2016.

To be counted, all completed voting documents must be in the hands of the electoral officer or electoral official by **noon Saturday 8 October 2016.**

Preliminary results for this STV election will be known as soon as all votes have been received and counted following the close of voting. A preliminary result is expected late on **Saturday night, 8 October 2016.** Results will be accessible on Auckland District Health Board's website (www.adhb.govt.nz).

election services

For further information regarding this election, please contact the electoral office:

Auckland District Health Board

C/- Election Services, PO Box 5135, Wellesley Street, Auckland 1141

Email: info@electionservices.co.nz

Phone: 09 973 5212

Memorandum of Understanding

between the

Auckland District Health Board

and the

Auckland Council

and

Dale Ofsoske (electoral officer)

for the

2016 local government elections

MEMORANDUM OF UNDERSTANDING

Dated 2016

BETWEEN

A Auckland District Health Board (the DHB)

B Dale Ofsoske (the DHBEO)

C Auckland Council (the TA)

D Dale Ofsoske (the TAEO)

INTRODUCTORY MATTERS

1 Definitions

1.1 In this Memorandum, unless the context otherwise requires:

DHB means District Health Board and refers to the particular DHB named at the beginning of this Memorandum.

DHBEO means District Health Board Electoral Officer and refers to the particular DHBEO named at the beginning of this Memorandum.

CE ACT means the Crown Entities Act 2004.

Election means the election of seven members to the board of the DHB, to be held on 8 October 2016.

LEA means the Local Electoral Act 2001.

LER means the Local Electoral Regulations 2001.

NZPHD ACT means the New Zealand Public Health and Disability Act 2000.

Parties means the persons and entities named at the beginning of this Memorandum.

STV means the single transferable voting electoral system.

TA means Territorial Authority and refers to the particular TA named at the beginning of this Memorandum.

TAEO means Territorial Authority Electoral Officer and refers to the particular TAEO named at the beginning of this Memorandum.

2 Background

2.1 Section 29(1) of the NZPHD Act states that the board of each DHB consists of seven members elected in accordance with Schedule 2 of that Act, and up to four members appointed by the Minister of Health under section 28(1) of the CE Act.

2.2 Schedule 2 of the NZPHD Act, amongst other things, requires that:

(a) the provisions of the LEA apply, with all necessary modifications, to DHBs for the purpose of conducting elections (these provisions include to have an electoral officer in place at all times i.e. to have a DHBEO);

(b) DHB elections be held in conjunction with local government triennial general elections (with the next triennial general election to be held on 8 October 2016);

(c) every DHB election must be conducted under the STV electoral system using the New Zealand method of counting single transferable votes;

(d) the DHBEO be a person who is also the EO of any TA in whose district the DHB is wholly or partly situated; and

(e) the costs incurred by every TA in conducting a DHB election be borne and paid for by the DHB.

2.3 All DHB elections are conducted on an 'at-large' basis (i.e. all of a district's electors are able to express preferences for all candidates standing for election in that district).

3 Purpose

3.1 The purpose of this Memorandum is to:

(a) clearly identify the respective statutory responsibilities of the DHB, DHBEO, TA and TAEO in relation to the conduct of the Election, outlined in Schedules 1 to 4 to this Memorandum; and

(b) state the timing, reconciliation of, and other arrangements for the payment of costs incurred in holding the Election (see Schedule 5).

3.2 This Memorandum does not constitute or create, and shall not be deemed to constitute or create, any legally binding or enforceable obligations on the part of any Party, apart from confirming the statutory obligations that each Party has in regard to the conduct of the Election.

4 Effect of Memorandum

4.1 While this Memorandum is not intended to create legal rights, the Parties agree that they will:

(a) abide by it in accordance with its purpose, spirit and intent;

(b) take any steps reasonably necessary to give effect to it; and

(c) perform the responsibilities, and comply with the statutory obligations and requirements set out in it.

4.2 The Parties further acknowledge that the Ministry of Health, the Department of Internal Affairs and the New Zealand Society of Local Government Managers are not parties to this Memorandum.

5 Term of Memorandum

5.1 The term of this Memorandum will commence on the date it has been signed by the Parties and end on 28 February 2017.

11.1

6 Alteration of Memorandum

6.1 This Memorandum may be added to or amended only by a supplementary document signed on behalf of each of the Parties.

6.2 If any legislation or regulation which affects the conduct of the Election is to come into force after the date this Memorandum is signed, and before the Election is completed, the Parties will make such additions or amendments to this Memorandum as are necessary to reflect that legislation or regulation.

7 Mutual Co-operation

7.1 The Parties will:

(a) consult each other or any other entity whenever it may be appropriate concerning the matters covered by this Memorandum;

(b) use their respective best endeavours to ensure that their staff, and any advisers, co-operate in good faith with one another in relation to the Election, and are available at all reasonable times to consult with each other; and

(c) note that the responsibilities for undertaking the various tasks and duties associated with DHB elections under an at-large STV system can be conducted in a number of ways and that the Parties will consult with TAEOs within the DHB's district to determine the best approach to conduct the Election.

7.2 If, despite clause 7.1, any issue or dispute arises between any of the Parties concerning the matters

covered by this Memorandum, the Parties will use their best endeavours to promptly resolve the dispute in accordance with clause 13.

RESPONSIBILITIES OF PARTIES

8 Responsibilities of DHB

8.1 The DHB undertakes to perform, in relation to the Election:

(a) the responsibilities referred to in Schedule 1 to this Memorandum; and
(b) all other responsibilities that it has under the LEA, LER, NZPHD Act and any other enactment or rule of law.

9 Responsibilities of DHBEO

9.1 The DHBEO undertakes to perform, in relation to the Election:

(a) the responsibilities referred to in Schedule 2 to this Memorandum; and

(b) all other responsibilities that he or she has under the LEA, LER, NZPHD Act and any other enactment or rule of law; and

(c) all responsibilities in accordance with recognised good practice, as set out in the New Zealand Society of Local Government Managers 'Code of Good Practice for the Management of Local Authority Elections and Polls', including seeking independent assurance around electoral processes (which includes assurance around any computer software used in connection with those processes).

9.2 The DHBEO will also be required to undertake their relevant duties as the TAEO of one of the TAs wholly or partly within the DHB's boundaries.

10 Responsibilities of TA and TAEO

10.1 The TA undertakes to perform, in relation to the Election:

(a) the responsibilities referred to in Part 1 of Schedule 3 to this Memorandum; and

(b) all other responsibilities that it has under the LEA, LER, NZPHD Act and any other enactment or rule of law.

10.2 The TAEO undertakes to perform, in relation to the Election:

(a) the responsibilities referred to in Part 2 of Schedule 3 to this Memorandum; and

(b) all other responsibilities that he or she has under the LEA, LER, NZPHD Act and any other enactment or rule of law; and

(c) all responsibilities in accordance with recognised good practice, as set out in the New Zealand Society of Local Government Managers 'Code of Good Practice for the Management of Local Authority Elections and Polls', including seeking independent assurance around electoral processes (which includes assurance around any computer software used in connection with those processes).

PAYMENT OF COSTS OF ELECTION

11 Costs of Election

11.1 The costs incurred in conducting the Election are to be borne and paid for by the DHB, pursuant to clause 13 of Schedule 2 to the NZPHD Act and as set out in clauses 11.2 to 11.6 of this Memorandum.

11.1

11.2 The DHB will pay to the TA the amounts agreed to in Schedule 5 on the equivalent dates agreed to in Schedule 5, being interim payments to cover the reasonably anticipated costs of carrying out all the responsibilities of the TAEO in relation to the Election (being the responsibilities referred to in clauses 9 and 10 of this Memorandum).

11.3 Payments made pursuant to clause 11.2 are:

(a) exclusive of GST, if any, which will be accounted for separately during the cost reconciliation process outlined in clause 12 of this Memorandum; and

(b) payable only after receipt by the DHB of a tax invoice relating to the costs concerned.

11.4 All costs arising from the Election must be allocated among all the parties involved in the triennial general election using the expense allocation template which forms Attachment 1 to this Memorandum (see clause 12 below). This template provides both for direct costs to be paid by the individual Parties and for shared costs that are apportioned between the Parties.

11.5 Insurance

One of the costs that needs to be shared by all parties to the Election is for insurance cover. Insurance is required to cover any legal expenses and/or the cost of holding the Election again, arising from a breach of the provisions of the LEA. The SOLGM Electoral Working Party, in consultation with TAs, is co-ordinating an exercise to secure the necessary cover through a national collective process with significant savings in the premiums payable by individual TAs. The total premium costs will be shared across all TAs in the country based on the number of 'eligible electors' in each TA area. At a local level, these costs are then shared between the parties involved in the Election (TA, RC, DHB, LT) using the expense allocation template (Section G Miscellaneous Costs).

11.6 The DHB may seek verification of costs from the TAEO to satisfy its own internal probity requirements.

11.7 A fee is payable by the DHB direct to the DHBEO (as described in Schedule 4) in recognition of the

additional responsibilities (over and above that of the TAEO) of carrying out the DHB election.

12 Reconciliation of Costs

12.1 Once all actual costs of the Election have been determined, the TAEO will conduct a preliminary reconciliation of costs, using the expense allocation template which forms Attachment 1 to this Memorandum, and on the following basis:

(a) the TAEO will perform the preliminary reconciliation on behalf of the TA; and

(b) the TAEO will provide the preliminary reconciliation to the DHB for its consideration as soon as practicable and no later than 31 January 2017.

12.2 Following consideration of the preliminary reconciliation by the DHB, the TAEO and the DHB will reach a final reconciliation on the following basis:

(a) the TAEO and the DHB will agree to any amendments to the preliminary reconciliation, thus creating a final reconciliation no later than 10 days after the preliminary reconciliation has been provided (see 12.1.(b) above); and

(b) once the TAEO and the DHB have agreed on the final reconciliation:
(i) if the amount paid to the TA under clause 11.4 exceeds the cost which can be fairly apportioned to the DHB (as indicated in the final reconciliation), the TA will refund the difference between the two figures to the DHB; or

(ii) if the amount paid to the TA under clause 11.4 is less than the cost which can be fairly apportioned to the DHB (as indicated in the final reconciliation), the DHB will pay the difference between the two figures to the TA.

12.3 Any payment due from either the DHB or the TA to the other under clause 12.2(b) will be made as soon as practicable following the final reconciliation and no later than 28 February 2017.

12.4 Refund of Forfeited Candidate Deposits
As required by the LEA, and as provided for in Schedule 2 to this Memorandum, the DHBEO is to transfer to the DHB the deposits forfeited by those candidates who did not reach the mandated number of votes at the Election.

DISPUTE RESOLUTION AND RELATIONSHIP MANAGEMENT

13 Dispute Resolution

13.1 If any dispute arises between the Parties about interpreting or implementing this Memorandum's provisions, the Parties will first attempt to resolve the dispute in the spirit of mutual co-operation (as outlined in clause 7 of this Memorandum).

13.2 If any dispute between the Parties cannot be resolved in a mutually co-operative manner, the Parties

agree to resolve the dispute in accordance with clauses 13.3 to 13.5 as appropriate.

13.3 Negotiation:

(a) the Parties will use their best endeavours to resolve the dispute by negotiation and good faith;

(b) the Parties will attend at least one meeting to discuss and attempt to resolve the dispute as a condition precedent to taking any other steps concerning the dispute.

13.4 Mediation:

(a) if the dispute cannot be resolved by negotiation within 20 working days of the dispute arising, the Parties will refer the dispute to mediation by a mediator jointly appointed by them;

(b) if the Parties cannot agree to a mediator, the Parties will engage a mediator appointed by the chairperson of the New Zealand Chapter of Lawyers Engaged in Alternative Dispute Resolution (LEADR).

(c) any costs incurred through mediation will be apportioned between the Parties in a manner determined by the mediator.

11.1

13.5 Arbitration:

(a) if the dispute is not resolved within 15 working days of its reference to mediation under clause 13.4 then the Parties will refer the dispute to arbitration;

(b) a dispute referred to arbitration will be heard by a single arbitrator agreed on by all the Parties to the dispute or, failing agreement, to a panel of three arbitrators (the arbitration panel);

(c) where an arbitration panel is appointed to resolve the dispute:
   (i) one arbitrator will be appointed by the Chief Executive of District Health Boards New Zealand Inc (or his or her nominated representative);

   (ii) one arbitrator will be appointed by the Chief Executive of the New Zealand Society of Local Government Managers (or his or her nominated representative); and

   (iii) one arbitrator will be appointed by the President (or equivalent officer) of the New Zealand Law Society.

(d) any dispute referred to arbitration will be resolved in accordance with the rules and principles of arbitration, as established by LEADR;

(e) where an arbitration panel is appointed under this clause, a majority decision of that panel will determine the dispute and that decision will be final and binding on the Parties;

(f) any costs incurred through arbitration will be apportioned between the Parties in a manner determined by the arbitrator or arbitration panel.

14 Relationship Management

14.1 The Parties each have a vested interest in the effectiveness of this Memorandum. To facilitate this relationship, the DHB and TA have each designated a representative. The designated representatives, addresses, telephone numbers, and email addresses for correspondence between the DHB and TA are as follows:

Auckland District Health Board
Marlene Skelton, Board Secretary
Private Bag 92189,
Auckland Mail Centre,
Auckland 1142
Telephone No: (09) 630 9943 (Ext 22345)
Email address: marlenes@adhb.govt.nz

Auckland Council
Marguerite Delbet, Manager Democracy Services
Private Bag 92300,
Auckland 1142
Telephone No: (09) 890 8138
Email address: marguerite.delbet@aucklandcouncil.govt.nz

14.2 Where either of the above Parties' designated representative is no longer responsible for the management and operation of this Memorandum on behalf of that Party, that Party will notify the other Party, in writing, of the name and title of the new person responsible for the management and operation of this Memorandum and of their contact details.

SIGNED on behalf of: Auckland District Health Board by: Ailsa Claire (Chief Executive)	SIGNED by: Dale Ofsoske being the Electoral Officer for: Auckland District Health Board
SIGNED on behalf of: Auckland Council by: Phil Wilson (Governance Director)	SIGNED by: Dale Ofsoske being the Electoral Officer for: Auckland Council

11.1

10

SCHEDULE 1

Responsibilities of District Health Board

RESPONSIBILITY	RELEVANT LEGISLATION (IF ANY)
1 Appointment of DHBEO	
Appoint an electoral officer (being the TAEO of a TA wholly or partly within the DHB's boundaries).	s.12, s.14(4)&(5) LEA cl.9B, Sch.2, NZPHD Act
2 Order of candidates' names on voting documents	
Resolve whether the candidates' names are to be listed in alphabetical order of surname, pseudo-random order or random order. *Note: Regulation 31(2) of the LER permits each DHB to decide the order in which the names of candidates are arranged on voting documents. In the absence of any board resolution approving another arrangement, candidates' names must be arranged in alphabetical order of surname.*	r.31 LER
3 Costs of the Election	
Pay the costs incurred by each TA in conducting the Election in accordance with the agreed formula for apportioning these costs (see clause 11 and Schedule 5 of this Memorandum).	cl.13, Sch.2, NZPHD Act s.147 LEA
4 Provision of information to the public	
Prepare and provide to the public clear, concise and timely information about the DHB, including information about: • the objectives and functions of the DHB; • the role of the DHB board and the duties of board members; • a description of the DHB's geographical area and its relationship with other DHBs and health sector organisations; • the composition of the DHB's population; • local health issues; and • the Election (in consultation with the DHBEO, TAs and the Ministry of Health).	

5 Inquiries from the public	
Provide a readily accessible and responsive process for answering inquiries from the public and the media about the role and responsibilities of the DHB in relation to the Election, and provide information to the public about that process.	
6 Liaison with DHBEO, TAs and TAEOs	
Nominate a person to liaise with the DHBEO, TAs, TAEOs and the Ministry of Health in relation to Election matters (see clause14 of this Memorandum).	
7 Person(s) removed from DHB under NZPHD Act	
Inform the DHBEO of any person who has, since the date on which members of DHB elected at the immediately preceding election came into office, been removed as a member of the DHB for any reason specified in clause 9(c) or (e), Schedule 3 of NZPHD Act.	cl.17(1)(e), Sch.2, NZPHD Act cl.9(c) and (e), Sch.3, NZPHD Act
8 Information to Ministry of Health on candidates for election	
After the close of nominations, provide a list of candidates at the Election to the Ministry of Health to ensure that candidates are not nominated for election to more than one DHB.	cl.5, Sch.2, NZPHD Act

11.1

SCHEDULE 2

Responsibilities of District Health Board Electoral Officer[1]

RESPONSIBILITY	RELEVANT LEGISLATION (IF ANY)
1 Deputy DHBEO	
Appoint Deputy DHBEO.	s.13, s.14(4)&(5) LEA
2 Other electoral officials	
Appoint such other electoral officials as may be necessary.	s.12(2), s.14(4)&(5) LEA
3 Declarations	
Ensure the DHBEO, Deputy DHBEO and every electoral official make declarations containing information prescribed by regulations.	s.14(2) LEA; r.136 LER
4 Provision of information	
Provide each TAEO with such information as is necessary to enable that officer to undertake his or her duties in relation to the Election.	
5 Delegations	
Delegate to TAEOs or other persons any of the DHBEO's powers and duties necessary for ensuring the efficient conduct of the Election (e.g. the processing and/or counting of votes). *Note: The processing and counting of votes is the responsibility of all electoral officers in the first instance and this task needs to be formally delegated if it is not to be carried out by the DHBEO.*	s.12(2) LEA
6 Notice of Election	
(a) Give public notice of the Election no later than 15 July 2016.	s.52 LEA
(b) State in the public notice the information required in relation to nominations of candidates.	s.53 LEA
(c) Include in the public notice the logo and any other relevant	

[1] This Schedule excludes responsibilities the DHBEO undertakes when carrying out the role of TAEO.

	identification of the DHB.	
(d)	Send a copy of the public notice to each TAEO, the DHB and the Ministry of Health.	s.52(4) LEA;
7 Nominations		
(a)	Ensure every nomination paper and consent to nomination are in writing and are lodged with or given to the DHBEO no later than 12 noon on 12 August 2016.	s.55 LEA; r.25 LER
(b)	Ensure nominations meet all prescribed requirements.	s.55 LEA; r.25 LER
(c)	Ensure candidates' consents to nomination are accompanied by the required statement as to conflicts of interest.	cl.6, Sch.2, NZPHD Act
(d)	Ensure candidates are given the opportunity to provide a candidate profile statement and a photograph that complies with the LER.	s.61 LEA; r.26-29 LER
(e)	Notify all relevant candidate details to TAEOs as soon as possible after close of nominations (for inclusion in the voting documents).	
8 Rejection of nominations		
Ensure that a nomination is not accepted if:		
(a)	the candidate is not qualified to be a candidate, or has not consented to nomination, or has not certified that he or she is qualified to be a candidate, or is nominating them self as the candidate;	s.55(2)(a),(b)&(ba) LEA
(b)	the DHBEO is not satisfied that the name under which the candidate is nominated is his or her registered name or the name by which he or she is commonly known;	s.56 LEA
(c)	the persons who nominated the candidate are not qualified to do so or the nomination was not properly made;	s.55(2)(c) & (d) LEA
(d)	a deposit of $200 has not been paid to the DHBEO before 12 noon on 12 August 2016;	s.55(2)(e) LEA

(e)	the candidate is not qualified to be a parliamentary elector;	s.25(1) LEA;
		cl.4, Sch.2, NZPHD Act
		cl.6, Sch.2, NZPHD Act
		cl.17(1)(a), Sch.2, NZPHD Act;

(f)	the candidate has not given to the DHBEO the required statement as to conflicts of interest;	s.30(2)(a)-(f) CE Act cl.17(1)(e), Sch.2, NZPHD

(g) the candidate is a person described in s.30(2)(a)-(f) CE Act (but noting the exception for Members of Parliament under cl.17(3), Sch.2, NZPHD Act); (h) the candidate has, since the date on which members of boards elected at the immediately preceding election came into office, been removed as a member of a board for any reason specified in cl.9(c) or (e), Sch.3, NZPHD Act; (i) the candidate has failed to declare a material conflict of interest before accepting nomination as a candidate for the immediately preceding election; or (j) the candidate fails to declare that he or she is a New Zealand citizen. *Note: A person is not prevented from being elected as a member of a DHB simply because the person is an employee of the DHB (cl.7, Sch.2, NZPHD Act).*	Act; cl.9(c)&(e), Sch.3, NZPHD Act cl.17(1)(f), Sch.2, NZPHD Act cl.17(2), Sch.2, NZPHD Act; s.25(1) LEA
9 Candidate deposits	
Ensure that each candidate deposits the sum of $200 GST inclusive with the DHBEO by 12 noon on Friday 12 August 2016.	s.55(2)(e) LEA; r.25(3) LER
10 Withdrawal of nomination	
Allow any candidate to, before the close of nominations, withdraw his or her nomination by written notice given to the DHBEO.	s.60 LEA
11 Death or incapacity of candidate before close of nominations	
If before the close of nominations, a candidate dies or the DHBEO learns that a candidate is not qualified to be a DHB member, treat the nomination as if it had not been made.	s.60 LEA
12 Candidate profile and conflict of interest statements	
(a) Ensure that each candidate lodges the required conflict of interest statement with the DHBEO before the close of nominations at 12 noon on Friday 12 August 2016. (b) Check that candidate profile statements do not exceed 150 words (or not more than 150 words in Māori and 150 words in English) and comply with other requirements and: (i) if the profile is in Māori and English, that the two versions are substantially consistent; and	cl.6, Sch 2, NZPHD Act r.26-29 LER s.61(2) LEA

(ii) if the profile is in a language other than English or Māori, that the profile does not exceed 150 words and is accompanied by a translation into English or Māori. (c) Include a disclaimer as to the accuracy of candidate profile statements. (d) Send all finalised candidate profile statements, conflict of interest statements and photos to TAEOs and copies of these to the DHB and the Ministry of Health.	s.61(6) LEA
13 If number of candidates does not exceed vacancies, candidates to be declared elected	
If the number of candidates does not exceed the number of vacancies, declare by public notice all nominated candidates to be duly elected, as soon as practicable after the close of nominations.	s.63 LEA
14 Vacancies remaining unfilled	
If the number of candidates is less than the number of vacancies, declare the remaining vacancies as extraordinary. *Note: Any extraordinary vacancies arising are filled by Ministerial appointment, in accordance with the NZPHD Act (i.e. no by-elections are held to fill any vacancies).*	s.64 LEA; s.29(2) NZPHD Act
15 Notice of nominations and Election	
Give public notice of the day on which the Election is to be held (8 October 2016), the names of the candidates standing and other information required, as soon as practicable after the closing of nominations/ closing of the roll.	s.65 LEA; r.30 LER
16 Death etc. of candidate after close of nominations	
(a) Give public notice of the death, incapacity or invalid or cancelled nomination of a candidate that the DHBEO becomes aware of after close of nominations. (b) Take such steps as are practicable to ensure that voters do not vote for a candidate who has died, etc. (c) If, as a result of retirement etc, an election is unnecessary, give public notice declaring all remaining candidates elected.	s.71(2) LEA s.71(3) LEA s.72 LEA
17 Roll scrutiny, and processing and counting of votes	
(a) On the return of completed voting documents ensure that the	r.101-102 LER

roll scrutiny is completed, voting documents are processed and votes are counted in accordance with the LEA and LER, using the STV calculator to obtain the Election result. (b) If delegating some or all of these roles to TAEOs or other persons, ensure that on the return of completed voting documents to TAEOs, TAEOs complete roll scrutiny and either: (i) forward the DHB voting documents (or DHB portion of the voting documents) to the DHBEO for processing; or (ii) process the DHB voting documents and forward the preference data to the DHBEO in an agreed electronic format (in accordance with applicable legislation). *Note: Some or all of these duties may be delegated to TAEOs or other persons. Any such decisions require a clear network of delegations to be in place between electoral officers in the area.*	
18 Preliminary result	
Use every best endeavour to announce the preliminary result of the Election as soon as practicable after the close of voting at 12 noon on 8 October 2016, and ideally on 8 October 2016. *Note: The SOLGM Electoral Working Party recommends that progress results for STV elections be released only in the event that it has not been possible to release a preliminary result before midday on Sunday 9 October 2016.*	s.85 LEA; r.105A LER
19 Official result	
(a) Declare the official result of the Election by public notice when the scrutiny of the roll has been completed, the validity of all special votes has been determined, and all valid votes have been counted. (b) Use every best endeavour to declare the official result by 13 October 2016.	s.86 LEA; r.106 LER
20 Forfeiture or refund of deposit	
(a) Pay forfeited candidate deposits to the DHB where the total votes received by a candidate is less than one quarter of the final STV quota, as determined at the last iteration of the count. (b) Refund a candidate's deposit if (1) does not apply, if the candidate withdraws or retires, is elected without an election, dies before the close of voting, or becomes otherwise	s.59(1) LEA; r.94 LER s.59(2)(a) LEA

'incapable'. (c) Ensure that the candidate has filed a return of electoral expenses before the deposit is refunded.	s.59(2)(b) LEA; s.109 LEA
21 Death or incapacity of elected candidate after close of voting but before declaration of result	
Declare the vacancy so caused to be an extraordinary vacancy (to be treated as explained in the note to paragraph 14 above).	s.87 LEA
22 Oversee payment of costs of Election	
(a) Review the claims for the reimbursement of costs of the Election and arrange payment by the DHB to the respective TAs of the DHB's share of the costs as provided for under clause 11 of the Memorandum. (b) Review the making of payments by the DHB under cl.11 & 12 of this Memorandum, and confirm to the Ministry of Health that the payments have been made in accordance with that clause.	
23 Candidates' electoral expenses	
(a) Receive returns of candidates' electoral expenses. (b) Make returns available for public inspection for seven years and then destroy.	s.109 LEA s.110 LEA
24 All other responsibilities	
The DHBEO is responsible for all other responsibilities conferred by any enactment or rule of law, or by mutual agreement between the Parties.	
25 Electoral insurance	
Insurance to cover any legal expenses and/or the cost of holding the Election again, arising from a breach of the provisions of the LEA, has been arranged nationally, on a collective basis. All the TAs in the country have contributed to the costs of this insurance cover and, at a local level, these costs will be shared between the parties using the expense allocation template (Section G Miscellaneous Costs).	

SCHEDULE 3

Responsibilities of Territorial Authority and Territorial Authority Electoral Officer

RESPONSIBILITY	RELEVANT LEGISLATION (IF ANY)
Part 1: Responsibilities of TA	
1 Appoint TAEO	
If no existing electoral officer, appoint an electoral officer (not being its chief executive unless no other course of action is reasonably practicable in the circumstances).	s.12&14(5) LEA
Part 2: Specific responsibilities of TAEO in relation to DHBs[2]	
1 Provision of information	
Provide the DHBEO with such information as is necessary for the performance of the DHBEO's functions and duties as set out in the LEA, LER and this Memorandum.	
2 Delegations	
(a) Delegate to the DHBEO or other persons any of the TAEO's powers and duties necessary for the efficient conduct of the Election. (b) Undertake any duties delegated by the DHBEO under clause 5 of Part 2 of Schedule 2 to this Memorandum in accordance with the provisions of the LEA and LER. *Note: Decisions on such matters as how votes are processed and counted are matters for discussion between the Parties. They require a clear network of delegations to be in place between the DHBEO and TAEOs.*	s.12(2) LEA

[2] These responsibilities apply to all TAEOs in the area of a DHB including the TAEO who is also the DHBEO but for the purposes of this Schedule in the capacity of TAEO.

3 Roll of electors	
(a) Note that a person who is lawfully registered as a parliamentary elector under the Electoral Act 1993, in respect of an address that is within the area of the DHB, is qualified to be an elector of that area at an election of the DHB.	cl.3, Sched.2, NZPHD Act
(b) Indicate on the roll of electors for the district of the TA, by appropriate words, abbreviations, or marks, the names of the persons entitled to vote at the Election.	cl.11, Sched.2, NZPHD Act
(c) Compile a preliminary residential roll of electors by 15 July 2016 and a final roll of residential electors by 12 September 2016. *Note: A final roll will be required as soon as practicable after the roll closes on 12 August 2016.*	s.38, 42, 45 and 51 LEA r22 LER
4 Issue of ordinary and special voting documents	
(a) As soon as practicable after 15 September 2016 and not later than 21 September 2016, send ordinary DHB voting documents to electors together with, among other things: (i) copies of DHB candidate profile statements and photos, as provided by the DHBEO; and (ii) copies of DHB candidate conflict of interest statements, as provided by the DHBEO.	s.62 LEA; r.26-29 LER; cl.12(3), Sched.2, NZPHD Act
(b) Undertake duties relating to special voting as required by the LEA and LER including the issue of special voting documents to those DHB electors who apply for one during the period 16 September 2016 to 12 noon on Saturday 8 October 2016 (during normal business hours).	
5 Roll scrutiny, processing and counting of votes	
On the return of completed voting documents: (a) complete the roll scrutiny; and either (b) forward the DHB voting documents (or DHB portion of the voting documents) to the DHBEO for processing and counting; or (c) process and capture the DHB votes (i.e. the STV	

preferences) and forward these to the DHBEO in an electronic format (in accordance with applicable legislation). *Note: Some or all of these duties relating to DHBs may be delegated to TAEOs or other persons. Any such decisions require a clear network of delegations to be in place between electoral officers in the area.*	
6 Reconciliation of election costs	
(a) Determine the total costs incurred in running the triennial general election. (b) Undertake a preliminary reconciliation of those costs (using the expense allocation template) to determine the DHB's share of those costs. (c) Follow the procedures outlined in clause 12 of the Memorandum for reaching agreement on the final costs to be met by the DHB.	

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SCHEDULE 4

District Health Board Electoral Officer Fee

DHBEO's fee

1 The DHBEO shall be paid a fee in recognition of the additional responsibilities, over and above those of TAEO, of carrying out the DHB election as set out in clause 9 of this Memorandum. The fee is made up of two parts:

(i) a fixed component of $8,424 to be paid by 1 July 2016; and

(ii) a variable component, being $90 per 1000 (or part thereof) valid voting documents received, to be paid by 1 December 2016.

2 Payment of the DHBEO's fee will be made in accordance with the following:

(i) where the DHBEO is an employee of a TA, the DHB will pay the DHBEO's fee to the DHBEO's employer, who will in turn pay it to the DHBEO (less any taxes or other deductions); or

(ii) where the DHBEO is not an employee of a TA but is a contracted provider of election services (or an employee or representative thereof), the DHB will pay the DHBEO's fee to the contracted provider of election services.

3 Payments made pursuant to clause 1 are:

(a) exclusive of GST, if any;

(b) payable only after receipt by the DHB of a tax invoice relating to payment concerned; and

(c) in addition to any fee paid to the DHBEO for their position as a TAEO (i.e. the fee to the DHBEO is not used to subsidise any payment by the TA to the TAEO).

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SCHEDULE 5

Agreed Schedule Of Interim Payments

This agreed schedule of interim payments provides the Parties with the flexibility to determine what payments are to be made by the DHB to the TA, and when these fall due. The final date on the schedule should be on or before 28 February 2017, which is the conclusion of the reconciliation process outlined in clause 12 of this Memorandum (noting that in some cases, it will be a payment from the TA to the DHB, if the DHB's interim payments exceed its fair and reasonable share of the election costs).

The DHB may wish to use its 2013 election costs as a guide, as well as seeking an indication of any likely cost increase for 2016 from the DHBEO.

While the table below provides for two payment dates, the Parties may wish to add or subtract from this.

Schedule

Date	**Payment**	**Notes**
		Cost of 2013 ADHB election undertaken by Auckland Council was $339,669 + GST. Estimated cost for 2016 ADHB election to be undertaken by Auckland Council is $382,000+ GST.
20 September 2016	$191,000 + GST	To be invoiced by Auckland Council.
20 February 2017	To be determined	Final actual costs, determined from the expense allocation template, less the interim payment made, to be invoiced by Auckland Council.

Tāmaki Programme Update

Recommendation

That the Board:

1. **Notes the progress of the Tāmaki Mental Health and Wellbeing Initiative**
2. **Notes the related work with the Tāmaki Regeneration Company**

Prepared by: Johnny O'Connell (Programme Director - ProCare), Oliver Campbell (Project Manager – Auckland DHB), Camille Gheerbrant (Service Improvement Manager), Sue Copas (Community Participation Manager), Leigh Manson (Programme Director)

Endorsed by: Tim Wood (Deputy Director, Funding)
Andrew Old (Chief of Strategy, Participation & Improvement)

Attachments:

Strategic Alignment

Strategic Themes:	√	√	√	√	√	√	
	Community, whānau and patient centred model of care	Investment on both treatment and keeping people healthy	Service integration and/or consolidation	Intelligence and insight	Evidence informed decision making and practice	Outward focus and flexible, service orientation	Operational and financial sustainability

1. Introduction

Over the last two years, Auckland DHB has been working with ProCare and the local Tāmaki community on initiatives to improve mental health and wellbeing; a health priority that had been identified by the community. Over that time, strong relationships and community networks have been built. The programme is now in an implementation phase with the overarching goal being to improve service integration in a way that puts the person at the centre of the network of care and moves the system towards early detection and intervention.

2. Background

The Tāmaki Mental Health and Wellbeing initiative launched its first intensive co-design workshops with the Tāmaki community in November 2013. This followed concerted work by a former Auckland DHB community engagement manager who had formed a locality health partnership group to advise on health priorities for the area. This group identified mental health as the priority health issue affecting the community. Towards the end of 2013 ProCare was contracted to lead the initiative in partnership with Auckland DHB and the other members of the Auckland and Waitemata District Alliance. Over the course of 2014 extensive engagement and co-design activities were undertaken resulting in a programme of work being approved by the Alliance in April 2015. This programme comprises five work streams that seek to address the services, supports and factors that impact on people's mental health and wellbeing.

Since the initiation of this programme, the Tāmaki Regeneration Company has been reinvigorated and we are now working in active partnership with the Social and Economic Regeneration programme that sits as a key part of their work plan.

3. Current State

The programme currently consists of five projects.

Primary Support Hours

Traditionally GPs can only allocate NGO support hours when a person has been through secondary mental health services. This work-stream is developing broader access to support for people who the GP feels would benefit from assistance earlier. Taking this preventative, early intervention approach the initiative aims to integrate NGO access as a core part of Primary Care. The co-design team has defined and created a model that enables General Practice to provide early access to services that provide community support to people.

NGO Support hours began as a service in October 2015 and is successfully providing support to residents of Tāmaki through three general practices in the area. The change process has proved popular, with the mix of services and community members that we are co-producing this service with, and show's promise as a bottom up change vehicle for locality development more generally

Primary – Secondary Integration

Despite concerted individual efforts to address primary and secondary integration in Tāmaki there is a wide variance and inconsistency in the quality of the relationships at present. This work-stream aims to improve the inter-personal and technological relationships between primary and secondary clinicians. By improving the level of support that both service levels offer each other it is anticipated that more clients with moderate to severe, but stable needs, will be managed in primary care and that primary care will have more access to advice and support. These initiatives aim to set the conditions for effective stepped care and shared care.

Whole person – Whole of life support

This work-stream focuses on changing the relationship between the service user and the clinician/practice. A suite of options will be co-designed by service users and clinicians enabling whole person/whole of life information (such as relationship or financial issues) to be shared with healthcare professionals early in the relationship. Options for addressing these concerns will then be offered alongside the traditional clinical care options. Emphasis will be on creating the relational conditions for working together, in partnership, to plan care that caters to the whole person in their family, whānau and community.

Linkage Service

This work-stream connects with the Whole Person/Whole of Life initiative. The aim of the linkage service is to provide information about, and introductions to, a wide range of appropriate support for people with complex health and social issues. The look, feel and scope of the service is being co-designed and developed with the stakeholders it aims to serve. It is envisaged that service users, families, whānau and community members, along with primary and secondary care practitioners, government and community agencies will be able to contact this service for assistance to connect with appropriate support. The project is focused on providing links for both adults and youth.

Local Wellbeing

The ability to access local resources that empower people to take a lead role in cultivating and maintaining their and their families whānau's wellbeing is a real priority for the Tāmaki community. In this work-stream we will work with many stakeholders: the local community, Tāmaki Regeneration Company, Auckland Council, Ministry of Social Development and other health and social agencies to define what wellbeing is for Tāmaki. Existing provision and new developments will be coordinated into a suite of activities, events, resources and supports to enhance the communities' wellbeing. Working with the community we aim to enable and mobilise people to take a lead role in their own wellbeing.

The pace of progress in this initiative has been hampered over its course due to resourcing issues and the lack of a shared workspace. This has been addressed in recent times with new members joining the team and the securing of a dedicated programme space in Panmure. As a result the programme is growing in momentum and impact and is gaining increasing recognition for the value of what is being developed and created.

4. Success Stories

A relational support story

Danni experiences considerable social anxiety. When she visited her GP, they suggested that she might benefit from accessing primary NGO support. She was supported through a job seeking and interview process and is now in full time work.

> *"So basically she (NGO Support worker) helped me, like I was unemployed at the time and then she was helping me, I would stress out really really badly about like everything … from applying to interviewing, everything. And then in the end I was able to interview successfully and I got a job and it was like everything was kind of in a more secure place."*

A key insight from service users, which was gathered through the co-design process, was that 'concluding support' should be experienced as "a gentle and smooth" journey. We are mindful of this as we continue to develop the service. In Danni's case the decision to conclude support was mutual.

> *"So she said she would check with me a few times with a text message after we stopped meeting in person just to check in that I was okay and everything. So it basically kinda came to like a natural conclusion but occasionally, it was an occasional, 'right I'm just checking up on you to make sure that if we do need to meet again, we can meet again'"*

The working group are now prototyping a 'Go-well' pack to support people to maintain their wellbeing, through self-management and by linking them into community support networks.

Collaborative working across NGO

Three mental health NGOs are part of the working group that are prototyping the Primary NGO support service. The group is facilitated through a process of action learning, which is bringing about productive collaboration between the NGOs as well as between primary care and NGO. We have seen two examples of NGOs introducing people on to other NGOs, for cultural or workforce capability reasons. Beyond the benefits for the people using the service, collaboration is a positive

outcome in itself. Recently two NGOs have committed to co-develop and co-facilitate group peer sessions.

The value of collaboration is best summed up by the NGO representatives on the working group:

> *"The very fact we are in the same room is so valuable and creates a level of learning that's invaluable".*
>
> *"Working together is great! We are usually competing for contracts – this is so much better".*
>
> *"The underlying thing needs to be unconditional positive regard of each of the parties for one another. Working in a spirit of generosity. What currently happens all the time in the sector is we sit in our silos and throw stones at each other".*

5. Next Steps

NGO Support Hours

The NGO support hours work stream is set to evolve in two different directions:

1. By engaging with people coming from a broader range of perspectives while building on the group dynamics already in place, it will enter a phase of prototyping and action learning about what whole person care looks like. For example peer support groups and CADS have already shown interest in becoming part of this group.
2. The principles of practice will be published as a result of the action learning that has taken place so far – and is set to continue as above. Those will then be applied with a different set of general practices and NGOs in order to start the wider implementation of the new ways of working.

We are also in the process of launching two additional projects, as they were defined during the co-design workshops:

Primary and secondary integration:

We have had kick-off meetings and are in the process of engaging with the stakeholders in order to get through the inspiration phase of the design process. It aims at reinforcing the links and the relationships between primary care and secondary care clinicians by engaging key stakeholders in an action learning framework.

Social lab:

In partnership with the Tāmaki Regeneration Company we are developing a proposal to launch a social lab that would address some of the wider social issues – including but not limited to health - in the Tāmaki area. This initiative sits within the 'Local wellbeing' work stream. The proposal is to go through a round of stakeholder engagement and is planned to sit under the Social & Economic Regeneration umbrella of the Tamaki Regeneration Company (see below).

6. Tāmaki Social and Economic Regeneration Programme

The Tāmaki Regeneration Company (TRC), formerly the Tāmaki Redevelopment Company, was established in 2012 as an entity jointly owned by the Government (via Treasury) and Auckland Council.

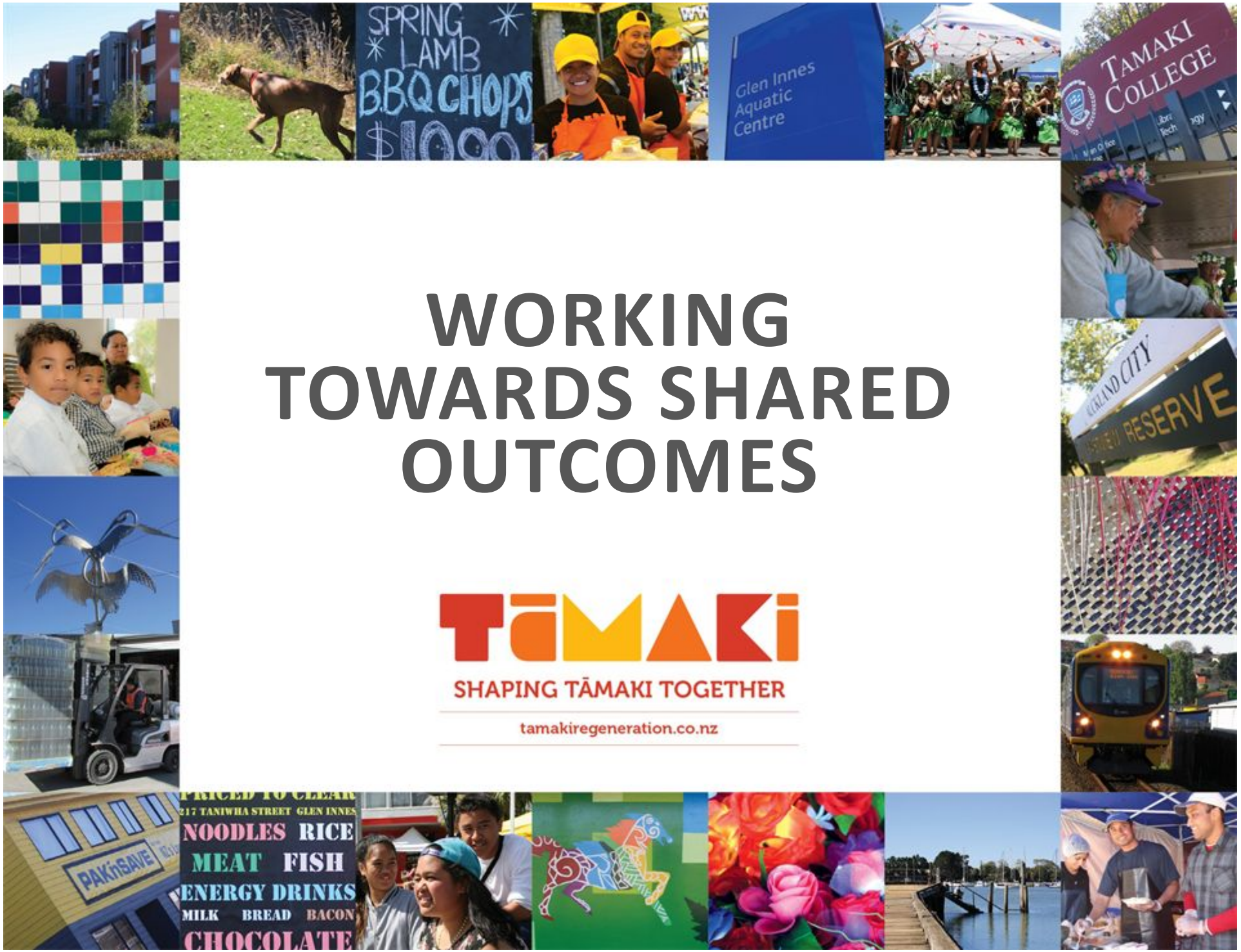
The company has two goals:

- Work collaboratively to achieve better social and economic outcomes in Tāmaki
- Build better houses and neighbourhoods

There are essentially two parts of the regeneration programme. The first is directly related to the provision of housing and involves TRC assuming ownership and management of all 2,800 Housing New Zealand houses in the suburbs of Glen Innes, Panmure and Point England from 1 April 2016 via a new entity, the Tāmaki Housing Association. There is also an ambitious building programme associated with this part of the work, with ~8,000 new dwellings planned for completion over the next few years, made possible by a $200m loan facility from Government.

The second part of the programme is the Social and Economic Regeneration Programme. Established in late 2015, this is a collective impact approach and has brought together leaders of social sector agencies aimed at regeneration not directly linked to the provision of new houses. Participants include TRC, Treasury, Auckland Council, the Ministries of Social Development and Education, Police and Auckland DHB. Key activities for this group currently include agreeing an outcomes and evaluation framework for the programme, and design and procurement of a new holistic social service to assist families needing to be rehoused as a result of the social housing changes.

It is still early days for the Social and Economic Regeneration programme, but it does afford a unique local opportunity to provide an umbrella for a range of collective impact activities such as the social lab outlined above.



WORKING TOWARDS SHARED OUTCOMES

TĀMAKI

SHAPING TĀMAKI TOGETHER

tamakiregeneration.co.nz

PURPOSE OF TODAY'S SESSION
Kaupapa O Te Ra

1. Overview of Tāmaki and the Tāmaki Regeneration Company

2. An up-date on the development of the Tāmaki Outcomes Framework

3. An up-date on the Family by Family programme

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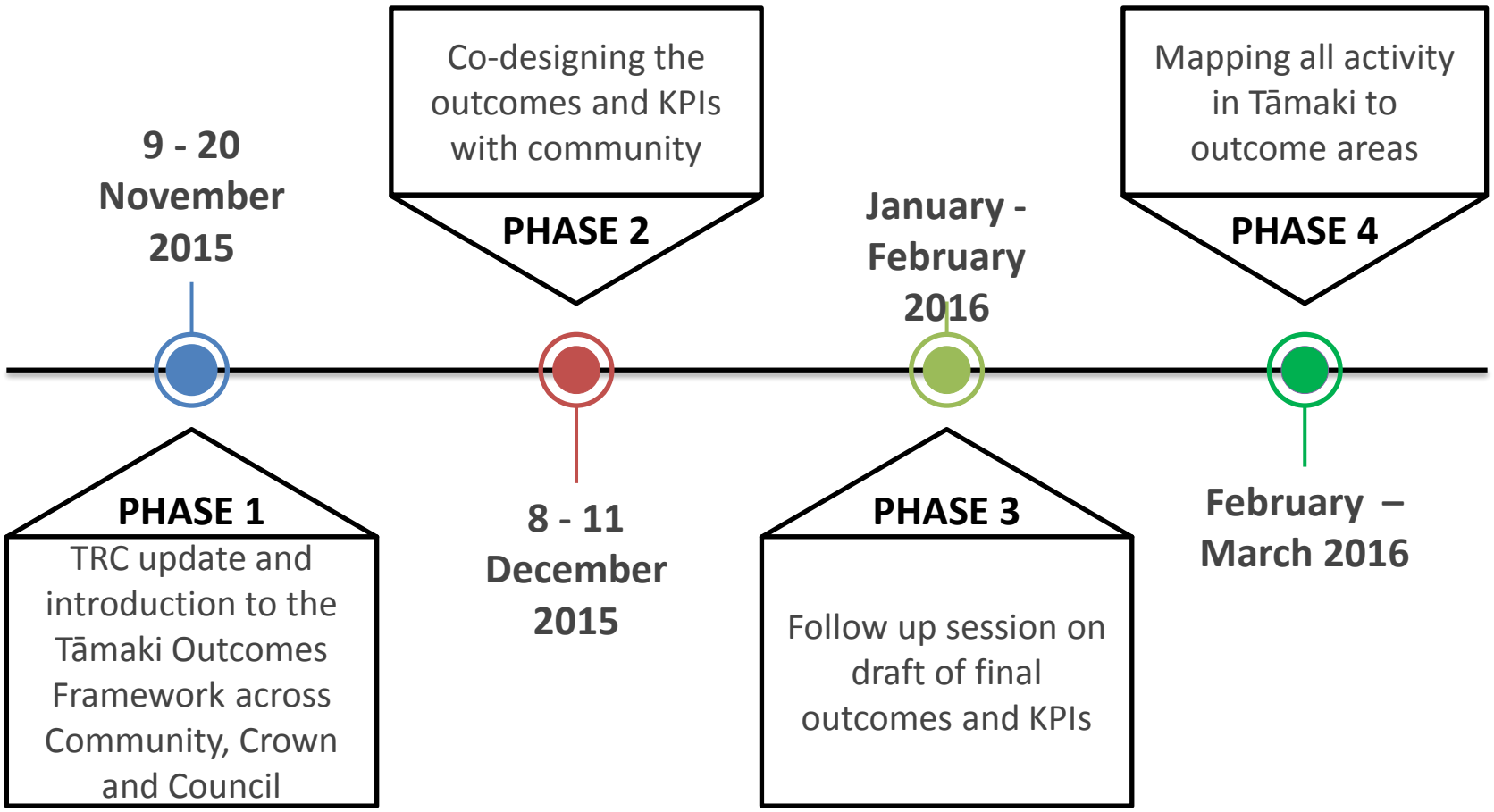
ENGAGEMENT STAGES



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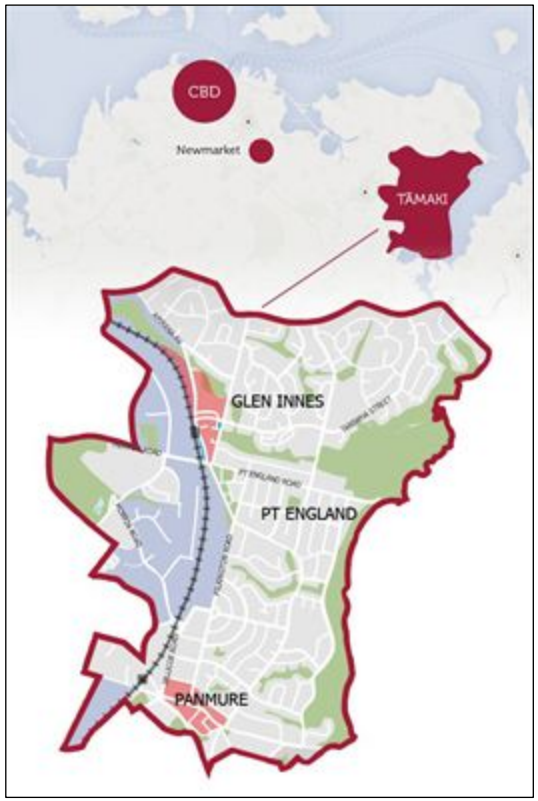
TĀMAKI

MY TAMAKI
Taku Tamaki



- Suburbs - Point England, Glen Innes and Panmure
- Primary Mana Whenua iwi - Ngāti Whātua o Ōrākei, Ngati Paoa and Ngāi Tai ki Tāmaki.
- Strong, vibrant and diverse Maori and Pasifika communities
- 12mins by train to the CBD

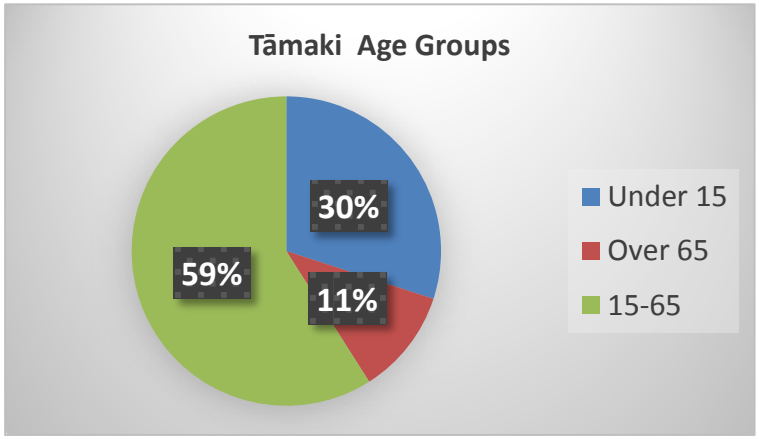
TĀMAKI TODAY

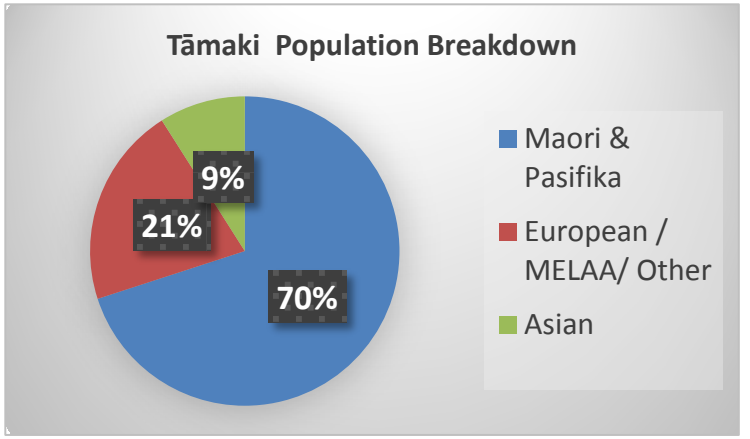
COMMUNITY DEMOGRAPHICS
Nga Whanau

- 16,000 people

- 70% Māori & Pasifika
- 21% European / MELAA / Other
- 9% Asian

- 30% of people under the age of 15 (compared to 19% in wider Auckland)
- 11% of people over the age of 65





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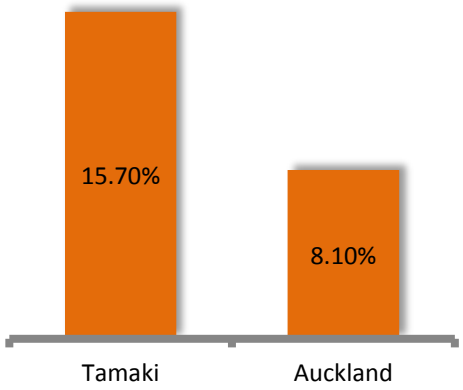
ECONOMIC SITUATION

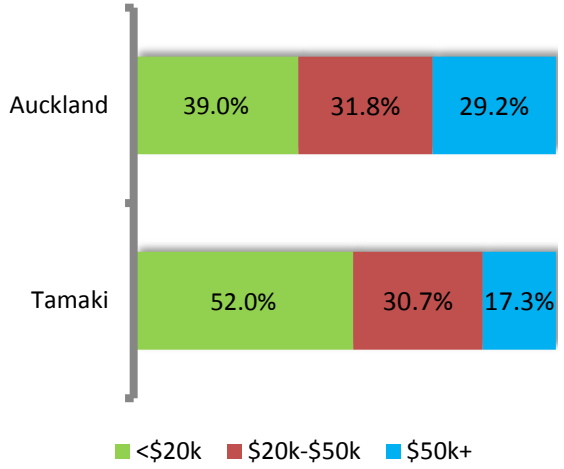
- 7,500 homes about to be built in Tāmaki, creating more than 1000 jobs
- Close proximity to hospitality (Business Hubs)
- Excellent engagement & collaboration amongst Business Associations
- World leading businesses created & operating in Tāmaki

- Approximately $74m worth of benefits into Tāmaki per annum
- 35% of Tāmaki households are estimated to be living in poverty
- Tāmaki rates at 10 on the deprivation index

Unemployment



Annual Incomes



TĀMAKI SHAPING TĀMAKI TOGETHER

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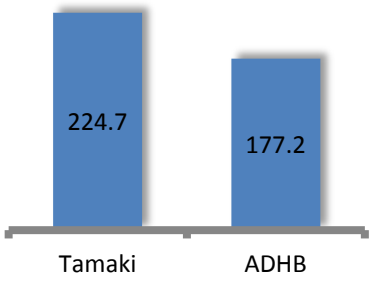
SOCIAL SITUATION

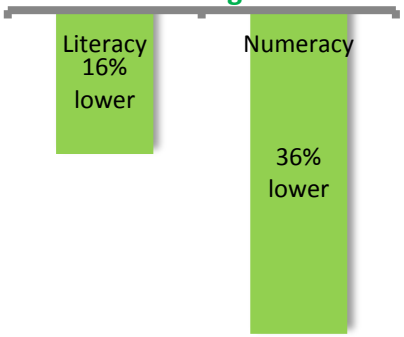
- Excellent collaboration amongst Early Childhood Education (ECE), Primary and Secondary Schools
- Strong Kohanga presence and network within the area
- World leading innovative and effective education initiatives (e.g. Manaiakalani)
- Education statistics improving

- 225 hospital admissions per 1000 population compared to average of 177 for Auckland DHB
- 31% of residents aged 15 or over smoke, compared to 16% for Auckland
- 9.8 cases of diabetes per 1000 population compared to 4.6 for Auckland DHB

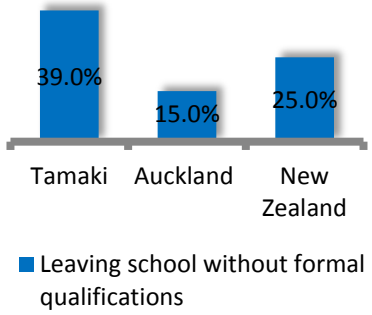
Health: Acute Admissions per 1,000 cases



Student Literacy / Numeracy vs. National Average



Academic Qualifications



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TĀMAKI REGENERATION COMPANY

The Tāmaki Regeneration Company (TRC) was established in 2012 to deliver positive outcomes through the Tāmaki Regeneration Programme

Shareholders

Auckland Council

THE TREASURY

Goals

- Work collaboratively to achieve better social and economic outcomes in Tāmaki
- Build better houses and neighbourhoods

Principles

- Tāmaki Commitment
- Economic returns focus
- Neighbourhood by neighbourhood approach
- Tāmaki community engaged
- Transfer of control to the community
- Catalysing the growth of community housing providers
- Tāmaki is an affordable place to live in Auckland
- Collective delivery
- Procurement of physical development at scale

SHAPING TĀMAKI TOGETHER

LEVERS PROVIDED ON APRIL 30 2015

- Transfer of 2800 homes from HNZC to TRC (31 March 2016)
- A $200m Loan

Mandate from shareholders to:

- Put in place an Outcomes and Evaluation Framework for Tāmaki
- Launch the Family by Family Programme
- Prepare a business case for Procurement of Scale

TRC TRANSITION PROJECT

TRANSITION PROJECTS

- Compile Business Case to build 7500 homes (in 3 phases)
- Establish a shared Outcomes & Evaluation Framework
- TRC Capability
- Start up the new Tāmaki Housing Association
- Launch the Family by Family Project

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A SHARED TĀMAKI OUTCOMES FRAMEWORK

DRAFT November 2015

CURRENT STRENGTHS & CHALLENGES AROUND SERVICE DELIVERY IN TĀMAKI

STRENGTHS

- Collaboration amongst a number of entities
- Crown agencies at the table willing to do things differently

CHALLENGES

- Multiple entities working in silo to address social need
- Landscape of service providers shows mass duplication in some areas and gaps in others
- Limited data availability and evaluation in some cases
- Funding uncertainty for some entities
- No landscape view for funders

VISION AND PURPOSE OF THE TĀMAKI OUTCOMES FRAMEWORK

Establish an Outcomes Framework for Tāmaki that ALL organisations working in Tāmaki align their activity to achieve:

i. Common agenda, KPI's & targets

ii. Provides a landscape view of who is doing what to achieve the outcomes

iii. Allows alignment of activity

iv. Allows ready access to information

v. Encourages funding certainty for entities

The Outcomes Framework has to be owned by all Community, Crown and Council entities operating in Tāmaki

WORK ON THE TĀMAKI OUTCOMES FRAMEWORK TO DATE

DRAFT November 2015

12.1

COMMON GOAL AND OUTCOME

FRAMEWORK GOAL

A tool to learn, understand and organise activities to improve outcomes for the people of Tāmaki

(academically sound and a practical operational tool, agreed by all players in Tāmaki)

OUTCOME STATEMENT

Tamaki is an awesome place to live

KEY RESULT AREAS

KEY RESULT AREAS
(A breakdown of the overarching outcome into its key components)

ECONOMIC OPPORTUNITY	HEALTH AND WELLBEING	QUALITY NEIGHBOURHOODS
Tamaki people have better independence through: • financial capability • Education, learning & skills • Housing stability **Tamaki has a thriving economy through:** • Investment • Entrepreneurship • Employment	**Tamaki people experience wellbeing and belonging through:** • Having basic needs met • Quality and accessible healthcare • Healthy lifestyles • Healthy and supportive relationships **Tamaki is a cohesive and vibrant community through:** • Inclusive activities • Shared spaces • Valuing diversity	**Houses and neighbourhoods in Tamaki are great places to live through:** • Quality housing • Housing diversity • Safe neighbourhoods • Quality open spaces • Connected streets • Access to amenities and transport • Vibrant town centres • Environmental sustainability

POPULATION INDICATORS

POPULATION INDICATORS

Key measures of change in key result areas including the adoption of a baseline and setting of targets against this (current work in progress)

ECONOMIC OPPORTUNITY

- **Financial capability**
  - increase income levels
  - increase savings levels
  - increase net-worth
  - decrease debt
  - decrease main benefit use
- **Education, learning & skills**
  - increase enrolment rates
  - increase attendance rates
  - increased achievement rates
  - increase in level 4 achievement
  - better quality achievement
- **Housing stability**
  - increased housing affordability
  - increased stability of tenure
- **Investment**
  - increase in commercial investment
- **Entrepreneurship**
  - Increased number of small businesses
- **Employment**
  - more and better jobs
  - increase in employment rates

HEALTH AND WELLBEING

- **Basic needs**
  - decrease in number of people living in poverty
  - improve child poverty index
- **Quality and accessible healthcare**
  - decrease in ASH rates
  - increased immunisation rates
  - increased primary health care enrolment rates
  - decreased avoidable mortality rates
- **Healthy lifestyles**
  - decreased obesity rates
  - decreased smoking rates
  - decreased gambling rates
  - decreased substance addiction rates
- **Healthy and supportive relationships**
  - decreased family violence
  - decreased child abuse and neglect
- **Inclusive activities**
  - increase in number of inclusive activities
- **Shared spaces**
  - increase in utilisation of shared spaces
- **Valuing diversity**
  - diversity measures

Example only

QUALITY NEIGHBOURHOODS

- **Quality housing**
  - increased number of warm, healthy, affordable homes
  - increased star rating
- **Housing diversity (tenure / typology)**
  - Greater range of housing products
- **Safe neighbourhoods**
  - Decreased crime rates
  - Increased safety perceptions
  - Increased CPTED rating
- **Quality open spaces**
  - Increased functionality of space
  - Increased accessibility
  - Increased amenity value
- **Connected streets**
  - Increased legibility of street networks
- **Access to amenities and transport**
  - Increased accessibility to public transport and facilities
- **Vibrant town centres**
  - mixed retail offerings
  - Increased street appeal
- **Environmental sustainability**
  - Increased water quality
  - Improve bio diversity
  - Increased sustainability of houses

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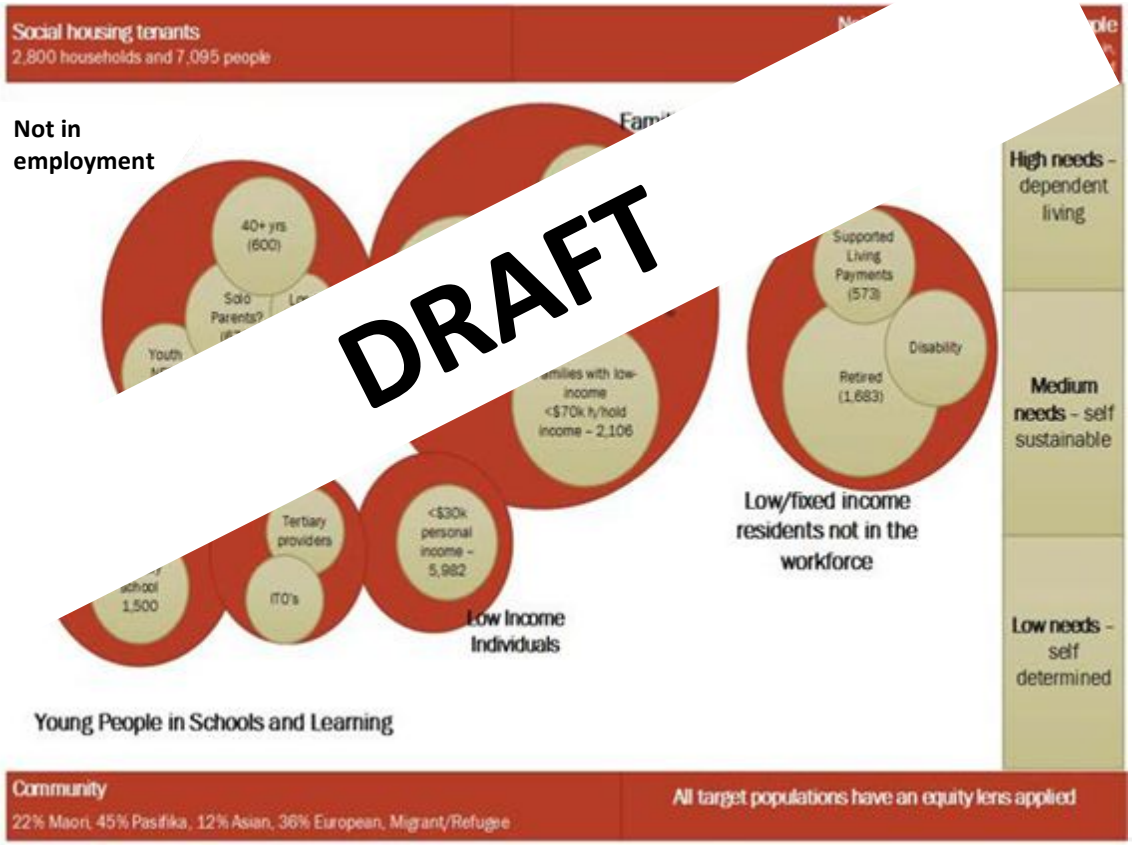
DRAFT November 2015

TARGET POPULATIONS

TARGET POPULATIONS

Population segmentation is undertaken to identify clusters of people have similar life characteristics, and are likely to respond in a similar manner to interventions and activities. Target categories are identified from this segmentation based on need; the prop[illegible]ty to change and influence over other population indicators (work in progress).



12.1

SERVICES/ACTIVITIES IN TĀMAKI

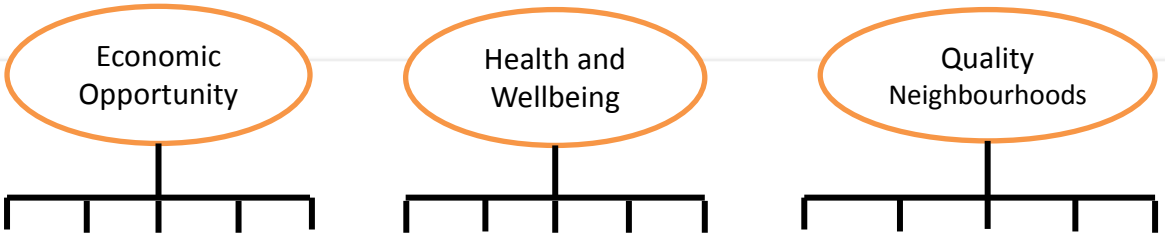
ACTIVITIES MATRIX

A matrix that maps out current services, activities and interventions in Tamaki across four levels that is in place to contribute to the achievement of the key result areas against the target population categories identified.

This is the key organising tool that provides a landscape view of services, identifying obvious gaps and overlaps (work in progress)

	ECONOMIC OPPORTUNITY	HEALTH AND WELLBEING	NEIGHBOURHOOD QUALITY
SYSTEM	XXX	XXX	XXX
TAMAKI WIDE	XXX	XXX	XXX
NEIGHBOURHOOD	XXX	XXX	XXX
FAMILY	XXX	XXX	XXX

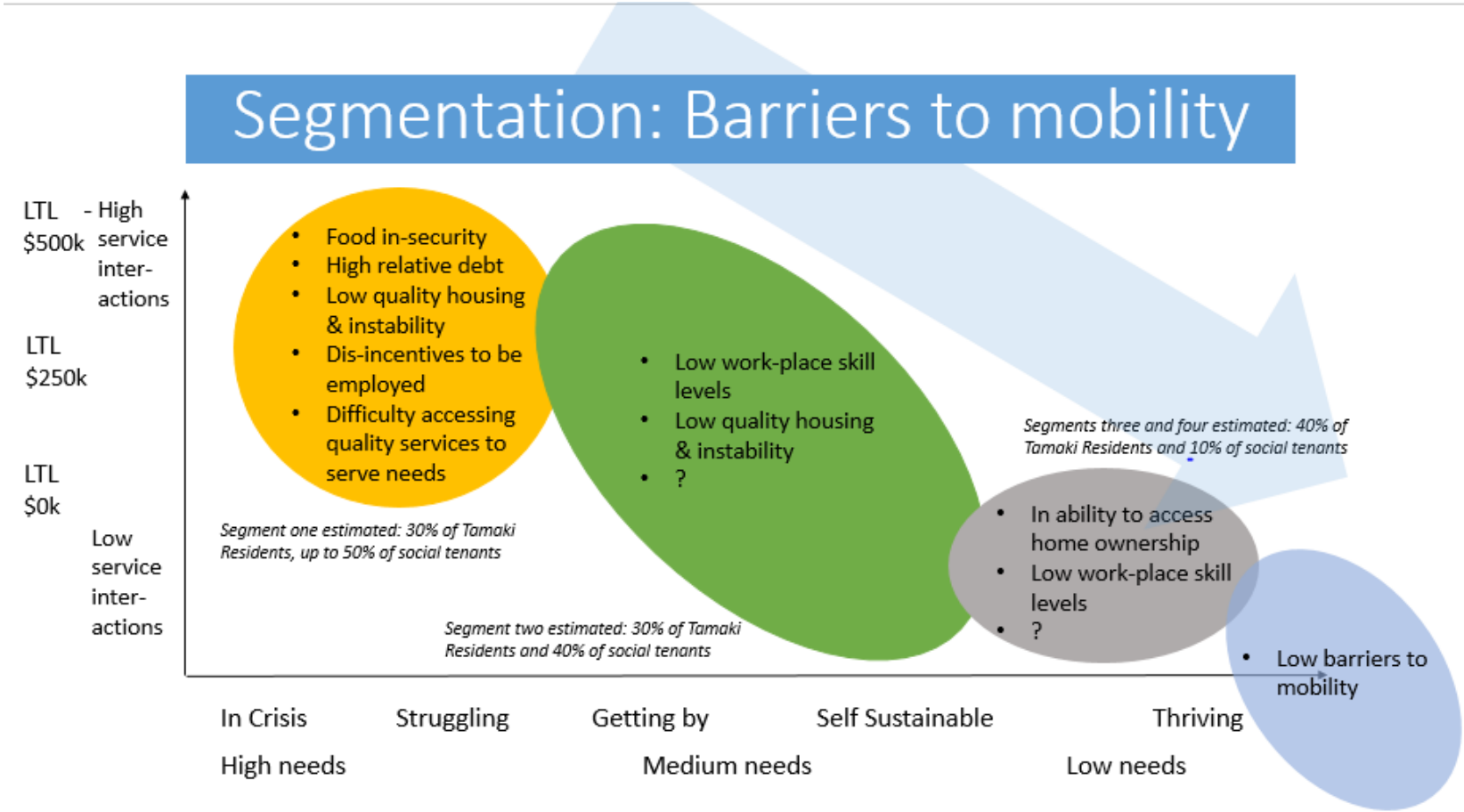
HOW DO WE WORK TOGETHER TO ACHIEVE ALIGNMENT?



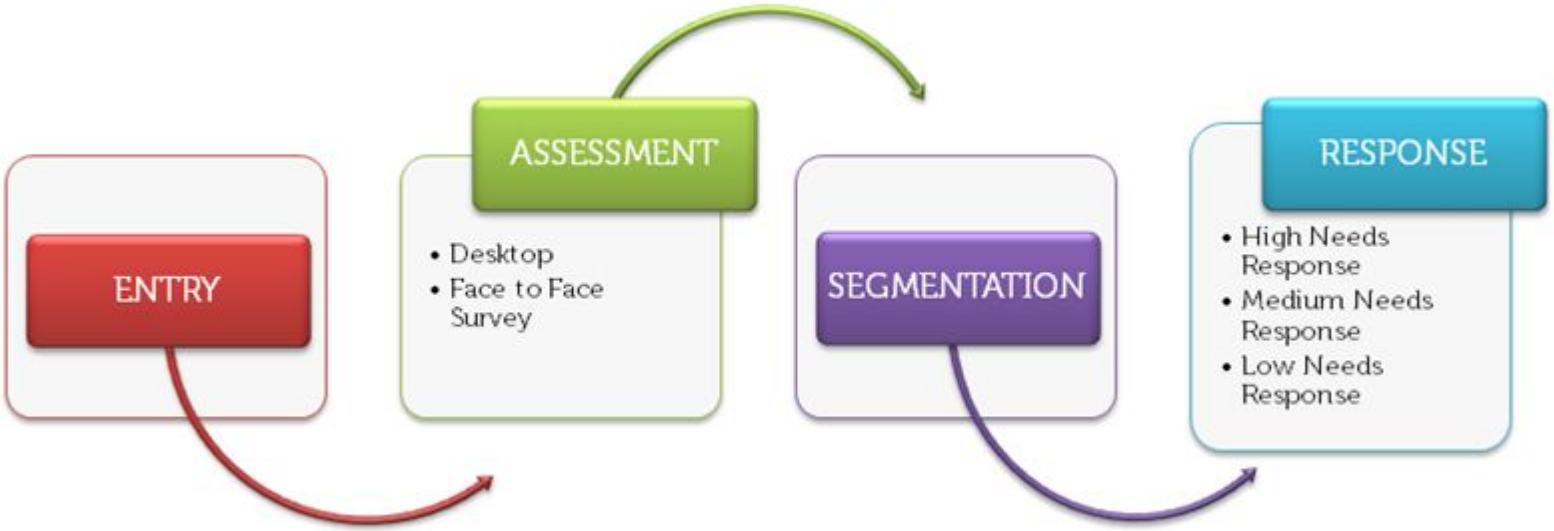
Target Segments		Stats
Not in paid Employment		
Families and their children		
Young people in schools and learning		
Low fixed income residents not in the workforce		
Low income individuals		

FAMILY BY FAMILY PROGRAMME

THEORY OF CHANGE



FAMILY BY FAMILY PROGRAMME



FAMILY BY FAMILY AND HOUSING SERVICES NEXT STEPS

NEXT STEPS

- **High needs response:** procuring a partner
- **Medium needs response:** seeking strategic partnership with existing provider
- **IT System:** procuring a partner
- **Housing Services:** seeking delivery partners